STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007135	A. BUILDING: _____ B. WING _____	R 06/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE HOME HEALTH SERVICES INC	6 MORGAN BLVD STE 101 VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments This survey was a re-visit of a state re-licensure survey conducted in conjunction with a Recertification post-condition re-visit of a home health agency.. Survey Dates: 6/3/2021 - 6/4/2021 and 6/7/2021. Facility ID: 007135	{N 000}		
{N 444}	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. This RULE is not met as evidenced by: Based on observation, record review and interview, the administrator failed to ensure the day to day operations of the home health agency. The findings include: Review of an undated agency job description, obtained 6/7/2021, titled "Job Descriptions" stated "Job Title/Position": Executive Director/Administrator ... Job Description Summary Responsible for planning,	{N 444}		

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{N 444}	Continued From page 1 coordinating, managing and directing all activities and programs of the First Choice Home Health Services Inc. Essential Job Functions/Responsibilities 1. Planning and directing operations to ensure the provision of adequate and appropriate care and services. ... Ensuring organizational compliance with legal, local, state and federal regulatory laws and regulations and accreditation standards. ... Recruiting, employing and retaining qualified personnel to maintain appropriate staffing levels. ... Ensuring program personnel have current clinical information and current practices and ensuring that a clinical manager is available during all operating hours. 8. Evaluating services and programs. 9. Ensuring personnel development including orientation, inservice education and continuing education 10. Coordinating with other program areas and management as appropriate. ... Ensuring that appropriate service policies are developed and implemented. 13. Directing personnel in performance of their duties including admission, discharge and provision of service to patients. 14. Ensures that a clinical manager is available during all operating hours. 15. Assuring appropriate personnel supervision during all operating hours. 16. Ensuring the accuracy of public information materials and activities. 17. Maintaining responsibility and availability for all day to day operations of the organization during all operating hours. 18. Appointing a similarly qualified alternate to be available at all times during operating hours in the absence of the administrator...." The administrator failed to ensure the day to day operations of the home health agency as evidenced by:	{N 444}		

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{N 444}	Continued From page 2 The administrator failed to ensure agency patients received the administrator's contact information in order to make a complaint. The administrator failed to ensure agency patients received all services ordered in the plan of care. The administrator failed to ensure patients were not filling out admission documents prior to their completion The administrator failed to ensure the comprehensive assessments were individualized and reflected the patient's current status. The administrator failed to ensure the comprehensive assessment medication reconciliation was reviewed by a registered nurse. The administrator failed to ensure the home health agency was meeting all the needs of agency patients. The administrator failed to ensure the plan of care for agency patients was followed, individualized and established by a primary care physician. The administrator failed to ensure the plan of care contained all required elements. The administrator failed to ensure all drugs, treatments, and services were only provided as ordered by a physician or other appropriate healthcare professional. The administrator failed to ensure the plan of care was revised and updated to reflect the patients current status.	{N 444}		

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{N 444}	Continued From page 3 The administrator failed to ensure the plan of care was reviewed and revised by the primary care physician every 60 days. The administrator failed to ensure the primary care physician was promptly alerted to changes in the patients condition. The administrator failed to ensure there was coordination of care amongst all agency disciplines and with outside healthcare entities who serviced agency patients. The administrator failed to ensure there was a Quality Assessment and Performance Improvement (QAPI) maintained at the home health agency. The administrator failed to ensure all home health agency staff followed standard precautions to ensure the prevention and transmission of infectious and communicable diseases. The administrator failed to ensure all home health agency skilled professionals provided services as indicated on the plan of care. The administrator failed to ensure all home health agency staff created clinical notes and/or accurate complete notes for all services provided to patients. The administrator failed to ensure all home health aide services were provided in accordance with state regulations. The administrator failed to ensure home health aides were assigned to a patient with written patient care instructions which included task	{N 444}		

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{N 444}	Continued From page 4 frequencies. The administrator failed to ensure all services provided by the home health aide were ordered by the physician, included in the plan of care, permitted to be performed under state law and consistent with the home health aides training. The administrator failed to ensure the supervising nurse ensured the home health aide followed the aide care plan. The administrator failed to ensure the governing body authorized in writing the qualified alternate administrator in the event of the administrator's absence. The administrator failed to ensure all clinical records were maintained in accordance with clinical documentation standards of practice. The administrator failed to ensure all clinical records contained all required documentation of services rendered by agency staff. The administrator failed to ensure all clinical records contained all interventions, treatments, services and response to interventions of all home health agency patients. The administrator failed to ensure all clinical records contained a discharge summary that was sent to the primary care physician. The administrator failed to ensure all clinical notes were clear, complete and appropriately authenticated. The administrator failed to ensure all clinical patient information was safeguarded against	{N 444}		

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{N 444}	Continued From page 5 unauthorized use. During an interview on 6/7/2021 at 11:58 AM, the administrator was notified of an immediate jeopardy and stated, "Oh my goodness. We are in enough trouble ... I really do think we are providing more care to the patient." The administrator indicated he understood the lack of nursing care due to missed visits and they should have put the patient on hold. The administrator was informed when a patient was accepted, it was the agency's responsibility to meet their needs and a patient should not be put on hold due to lack of staff; the agency should assist the patient to find an agency that can meet their needs. During an interview on 6/7/2021 at 4:50 PM, the administrator stated, "I believe we provide good care, regardless of your findings. I appreciate my employees." During an interview on 6/7/2021 at 5:01 PM, the administrator stated, "Let me tell you a secret, whatever you give us is probably the best-case scenario." During an interview on 6/7/2021 at 5:10 PM, the administrator stated, "We need a favorable report. Things may be black and white, but in this business is a lot of grey ... I'm not taking it personal." The administrator indicated his biggest concern was the livelihood of his staff.	{N 444}		
{N 446}	410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)	{N 446}		

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{N 446}	Continued From page 6 Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to provide infection control education to staff in 3 of 7 personnel records reviewed with direct patient care. (E, H, I) The findings include: Review of an undated agency policy, obtained 6/7/2021, titled "Infection Control Plan" stated, "... First Choice Home Health Services Inc will educate all personnel on infection control policies, procedures, and their responsibilities for implementation as contained throughout this section. ... Infection control inservices will be scheduled no less than annually ... Attendance will be mandatory and will be documented ... Records of inservice attendance will be maintained in the personnel file...." Personnel record review on 6/3/2021 for home health aide (HHA) E, date of hire 3/9/2020 and first patient contact date 3/23/2021, registered nurse (RN) H, date of hire 9/14/2020 and first patient contact date 5/5/2021, and physical therapy assistant (PTA) I, date of hire 10/1/2020 and first patient contact date 12/10/2020, failed to evidence the staff received infection control education. Review of an agency document titled "Sign-In	{N 446}		

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{N 446}	Continued From page 7 Sheet", dated 5/16/2021, indicated the inservice topics discussed included, but were not limited to, bag technique and proper handwashing. Review failed to evidence HHA E, RN H and PTA I participated in the inservice training. Review of an undated agency document titled "Inservice Sign In Sheet" failed to evidence what topic was discussed. Review failed to evidence HHA E, RN H and PTA I participated in the inservice training. During an interview on 6/4/2021 at 7:57 AM, HHA E indicated she had not participated in any inservice training at the agency. During an interview on 6/7/2021 at 4:01 PM, the administrator indicated he would look to see if there were any other inservice documents. No additional documents received.	{N 446}		
N 451	410 IAC 17-12-1(c)(8) Home health agency administration/management Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure a qualified alternate administrator was in place, as authorized in writing by the governing body, in case of the administrators absence.	N 451		

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N 451	Continued From page 8 The findings include: Review of an undated agency policy, obtained 6/7/2021, titled "Designation of Individual in Absence of Executive Director/Administrator" stated, "... In the event that the Executive Director/Administrator is absent, the Clinical Director will assume the operational duties and responsibilities at First Choice Home Health Services, Inc...." During the entrance conference on 6/3/2021 at 10:05 AM, the administrator indicated the alternate administrator was employee D and the alternate clinical manager was registered nurse B. Review of an agency document titled "Minutes of the Directors' Meeting", dated 5/9/2021 and electronically signed by the administrator, governing body member L and employee D / alternate administrator, stated, "... [registered nurse B] be appointed as Alternate Administrator as well as Alternate Director of Nursing...." Personnel record review on 6/3/2021 of employee D / alternate administrator failed to evidence an agency orientation or a signed job description. Personnel record review on 6/3/2021 of registered nurse B failed to evidence an agency orientation or a signed job description for the position of the alternate administrator or the alternate director of nursing. Review failed to evidence the governing body authorized in writing employee D since the appointment of registered nurse in the governing body minutes on 5/9/2021. During an interview on 6/4/2021 at 12:57 PM,	N 451		

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N 451	Continued From page 9 employee D indicated he was the alternate administrator and registered nurse B was the alternate clinical manager.	N 451		
{N 458}	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure personnel records included documentation of orientation to the job, receipt of job description, a copy of limited criminal history, a copy of current license and/or certification and annual performance evaluations in 7 of 8 personnel records reviewed. (A, B, C, D, E, H, I) The findings include: 1. Review of IC 16-27-2-4 Sec. 4. (a) A person who operates a home health agency under IC	{N 458}		

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{N 458}	Continued From page 10 16-27-1 or a personal services agency under IC 16-27-4 shall apply, not more than three (3) business days after the date that an employee begins to provide services in a patient's temporary or permanent residence, for a copy of the employee's limited national criminal history background check or expanded criminal history check. (Indiana State Statute; IC 16-27-2-4) 2. Review of an undated agency policy titled "Personnel Record Contents" stated, "... First Choice Home Health Services Inc will maintain accurate and complete personnel files for all staff ... and independent contractors. ... The content of the personnel files for regular full or part-time personnel will include: ... Verified professional licensure ... Orientation checklist ... Signed job description ... Criminal background check, if applicable ... Performance evaluations and competency assessment for staff patient care...." 3. Review of an agency policy, revised November 2020, titled "Orientation" stated, "... A Personnel Checklist ... will be completed for all new staff. New staff will sign and date when their orientation has been completed...." 4. Review of an undated agency policy titled "Licensure/Certification/Registration" stated, "... A current copy or other proof of licensure, certification, and/or registration will be kept in the personnel file...." 5. Review of an undated agency policy titled "Selection/Hiring of Personnel" stated, "... A criminal background check will be obtained for positions required by law, regulation, or organizational policy ... Verification of the above will be documented and maintained in the personnel record...."	{N 458}		

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{N 458}	Continued From page 11 6. Personnel record review on 6/3/2021, for administrator A, date of hire 5/7/2019, and first patient contact date 2/20/20, evidenced a document titled "State of Indiana" that had an area subtitled "License Information" which stated, "... Type: Physical Therapist [PT] ... Expiration: 06/30/2020 ...." This document evidenced the license has expired. Personnel record review failed to evidence an annual performance evaluation had been performed and a current PT [physical therapy] license. During an interview on 6/3/2021 at 4:09 PM, the administrator indicated he would have the governing body perform an annual evaluation him, but it has not happened yet. 7. Personnel record review on 6/3/2021, for alternate clinical supervisor B, date of hire 3/19/2021, and first patient contact date 4/5/2021, evidenced a document which had an area subtitled "Exp [expanded] Crim [criminal] HistoryNational Lifetime Search ..." which indicated to have no criminal history. This document stated "Order Date: 05/04/2021 ... Completion Date: 05/07/2021 ...." Review of this document failed to evidence a criminal background check was performed prior to the first patient contact date. Personnel record review failed to evidence an orientation to the job, and a signed job description. 8. Personnel record review on 6/3/2021, for clinical manager C, date of hire 10/21/2019, and first patient contact date 2/2/2021, failed to evidence a signed job description for clinical supervisor and and an annual evaluation. 9. Personnel record review on 6/3/2021, for	{N 458}		

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{N 458}	Continued From page 12 alternate administrator D, date of hire 3/1/2020, failed to evidence a signed job description, an orientation to the job, and an annual evaluation. 10. Personnel record review on 6/3/2021, for home health aide (HHA) E, date of hire 3/9/2020, failed to evidence a copy of thier current HHA certification, a national criminal background check, an orientation to the job, a signed job description and an annual evaluation. 11. Personnel record review on 6/3/2021, for registered nurse (RN) H, date of hire 9/14/2020, and first patient contact date of 5/5/2021, failed to evidence a copy of their current RN license and an orientation to the job. During an interview on 6/3/2021 at 3:01 PM, the administrator indicated that RN H told him the job description was signed, and has only been seeing one patient. The administrator indicated RN H did not have documentation of an active RN license in the personnel file, but there should be. 12. Personnel record review on 6/3/2021, for physical therapy assistant (PTA) I, date of hire 10/1/2020, and first patient contact date 12/10/2020, failed to evidence a copy of thier current PTA license, criminal background check, a signed job description, and an orientation to the job. During an interview on 6/3/2021 at 3:15 PM, the administrator indicated that PTA I should have brought the background check into the agency, along with other documents, and would need a day to find it. The administrator indicated he would always verify the contracted employees licenses, but did not know where PTA I's documentation was.	{N 458}		

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{N 458}	Continued From page 13 13. During an interview on 6/3/2021 at 3:17 PM, the administrator indicated the personnel records should be complete, with the personnel information in the personnel file.	{N 458}		
{N 460}	410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the personnel record of the supervising nurse included a national criminal history background check, annual performance evaluation and documentation of orientation to the job. (C) The findings include: Review of an undated agency policy titled	{N 460}		

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{N 460}	Continued From page 14 "Personnel Record Contents" stated, "... First Choice Home Health Services Inc will maintain accurate and complete personnel files for all staff ... and independent contractors. ... The content of the personnel files for regular full or part-time personnel will include: ... Orientation checklist ... Performance evaluations and competency assessment for staff patient care...." Personnel record review on 6/3/2021 for clinical supervisor C, date of hire 10/21/2019, and first patient contact date 2/2/2021, failed to evidence a job description for the roles as clinical manager and Registered Nurse (RN), and an annual performance evaluation. During an interview on 6/3/2021 at 4:16 PM, the administrator indicated he was working on the clinical supervisor's personnel file, because they had come in to sign the required job descriptions. The administrator indicated he did not see the signed job descriptions in the personnel file.	{N 460}		
N 462	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. This RULE is not met as evidenced by: Based on record review and interview, the agency	N 462		

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N 462	Continued From page 15	N 462		

failed to ensure employees with direct patient contact will have a physical examination completed by a physician or nurse practitioner no more than 180 days before the date the employee has direct patient contact and failed to ensure the employee's physical indicated the employee will not spread infectious or communicable diseases to patients in 4 of 8 personnel records reviewed with direct patient care. (B, E, I, J)

The findings include:

1. Review of an undated agency policy titled "Personnel Record Contents" stated, "... First Choice Home Health Services Inc will maintain accurate and complete personnel files for all staff ... and independent contractors. ... The content of the personnel files for regular full or part-time personnel will include: ... The content of a separate file, which includes health information will contain: ... TB (a contagious disease that often affects the lungs) test documentation ... Physician's statement of health...."

2. Personnel record review on 6/3/2021 for the alternate clinical supervisor B, date of hire 3/19/2021 and first patient contact date 4/5/2021, evidenced a document titled "Pre-Employment Physical Form", dated 5/27/2021, which failed to evidence the physical exam was performed within 180 days prior to the employee's first date of patient contact.

3. Personnel record review on 6/3/2021, for home health aide (HHA) E, date of hire 3/19/2020 and first patient contact date 3/23/2020, evidenced a document titled "Pre-Employment Physical Form", dated 5/27/2021, and signed by physician L. Personnel record review failed to evidence the

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N 462	Continued From page 16 physical exam was performed within 180 days prior to the employee's first patient contact. During an interview on 6/4/2021 at 7:57 AM, HHA E indicated they have not had a tele-health or in-person recently. HHA E indicated their last physical exam was performed by their primary care physician, around their date of hire. 4. Personnel record review on 6/3/2021, for Physical Therapy Assistant (PTA) I, date of hire 10/1/2020 and first patient contact date 12/10/2020, evidenced a document titled "Physical Examination Record", dated 4/11/19, which failed to evidence the employee was free of communicable and infectious disease. Personnel record review failed to evidence the physical exam was performed no more than 180 days before the employee's first date of patient contact. 5. Personnel record review on 6/3/2021 for HHA J, date of hire 3/29/2021 and first patient contact date 3/31/2021, evidenced a document titled "Pre-Employment Physical Form", dated 5/27/2021. Personnel record review failed to evidence the physical exam was performed within 180 days prior to the employee's first date of patient contact. 6. During an interview on 6/4/2021 at 5:00 PM, the administrator indicated physician L, a member of the governing body, conducted physical exams for employees for 2 days at the agency and via tele-health.	N 462		
N 464	410 IAC 17-12-1(i) Home health agency administration/management	N 464		

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N 464	Continued From page 17 Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact;	N 464		

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N 464	Continued From page 18 unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to follow the agency policy and a nationally accepted tuberculosis (TB) screening protocol, to ensure employees with direct patient contact were evaluated for tuberculosis prior to first patient contact or within the past 12 months in 4 of 8 personnel records reviewed with direct patient contact. (B, C, E, I) The findings include: 1. Review of an undated agency policy titled "Personnel Record Contents" stated, "... First Choice Home Health Services Inc will maintain accurate and complete personnel files for all staff ... and independent contractors. ... The content of the personnel files for regular full or part-time personnel will include: ... The content of a separate file, which includes health information will contain: ... TB [tuberculosis; a contagious disease that often affects the lungs] test documentation...." 2. Review of an undated agency policy titled "Tuberculosis Exposure Control Plan" stated, "... All personnel will be tested for TB according to the risk assessment identification for which personnel have potential exposure to TB and in	N 464		

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N 464	Continued From page 19 accordance with federal, state, and/or local regulations. ... Where required by state and/or local regulations, a two (2) step TST [tuberculin skin test] will be given to all personnel upon hire, if no TST has been performed within 12 months of hire date, and thereafter, according to risk assessment. ... In addition to the TB screening test, all patient care personnel will be given an individual TB risk assessment to establish a baseline...." 3. Personnel record review on 6/3/2021, for the alternate clinical supervisor B, date of hire 3/19/2021 and first patient contact date 4/5/2021, failed to evidence the employee was screened for tuberculosis since October 2019. During an interview on 6/3/2021 at 12:30 PM, the alternate clinical supervisor indicated they had a one step TB test, but thier former employer would not provide the results. The alternate clinical supervisor further indicated they did not have a two step TB test, which would be a nationally accepted form of screening protocol. 4. Personnel record review on 6/3/2021 for clinical supervisor C, date of hire 10/21/2019, and first patient contact date 2/2/2021, failed to evidence the employee was evaluated for tuberculosis. 5. Personnel record review on 6/3/2021 for home health aide (HHA) E, date of hire 3/19/2020 and first patient contact date 3/23/2020, failed to evidence the employee was evaluated for tuberculosis. 6. Personnel record review on 6/3/2021 for Physical Therapy Assistant (PTA) I, date of hire 10/1/2020 and first patient contact date	N 464		

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N 464	Continued From page 20 12/10/2020, failed to evidence the employee was evaluated for tuberculosis since 4/9/2019. 7. During an interview on 6/3/2021 at 3:04 PM, the administrator was queried where the policy explained a nationally accepted TB screening protocol was adopted to comply with the waiver. The administrator stated, "We added something about the waiver but no, it doesnt say what we're going to do for screening."	N 464		
{N 466}	410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the health information for personnel was maintained in separate medical files for 6 of 8 employee files reviewed. (B, D, E, H, I, J) 1. Review of an agency policy titled "Personnel Record Contents" stated, "... First Choice Home Health Services Inc will maintain accurate and complete personnel files for all staff ... and independent contractors. ... All health related information on personnel will be kept in a separate file to maintain confidentiality...."	{N 466}		

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{N 466}	Continued From page 21 2. On 6/3/2021 at 3:00 PM, a binder titled "Employee Medical Records" was received, which contained physical exams, TB (tuberculosis) skin tests and/or screenings, and drug screen results. The employee's medical documents were maintained together and not separated to ensure personal health information remained confidential. 3. Record review of the Employee Medical Records binder on 6/3/2021, for alternate clinical supervisor B, date of hire 3/19/2021, evidenced documentation of a TB skin test, a pre-employment physical exam, and a list of prescribed medications. Review failed to evidence the employee's personal health information was maintained separately to ensure confidentiality. 4. Record review of the Employee Medical Records binder on 6/3/2021, for alternate administrator D, date of hire 3/1/2020, evidenced documentation of a TB skin test and a pre-employment physical exam. Review failed to evidence the employee's personal health information was maintained separately to ensure confidentiality. 5. Record review of the Employee Medical Records binder on 6/3/2021, for home health aide (HHA) E, date of hire 3/9/2020, evidenced documentation of a pre-employment physical exam. Review failed to evidence the employee's personal health information was maintained separately to ensure confidentiality.	{N 466}		

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{N 466}	Continued From page 22 During an interview on 6/4/2021, at 7:57 AM, HHA E indicated they have not had a tele-health or in-person recently. HHA E indicated their last physical exam was performed by their primary care physician, around their date of hire. 6. Record review of the Employee Medical Records binder on 6/3/2021, for registered nurse (RN) H, date of hire 9/14/2020, evidenced documentation of a pre-employment physical exam. Review failed to evidence the employee's personal health information was maintained separately to ensure confidentiality. 7. Record review of the Employee Medical Records binder on 6/3/2021, for physical therapy assistant (PTA) I, date of hire 10/1/2020, evidenced documentation of a TB skin test. Review failed to evidence the employee's personal health information was maintained separately to ensure confidentiality. 8. Record review of the Employee Medical Records binder on 6/3/2021, for HHA J, date of hire 3/19/2021, evidenced documentation of a TB skin test, a pre-employment physical exam, and results from a drug sceen. Review failed to evidence the employee's personal health information was maintained separately to ensure confidentiality. 9. During an interview on 6/3/2021, at 3:10 PM, the alternate clinical manager indicated someone told her it was acceptable to put employee's personal health information together, but could not remember who.	{N 466}		

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{N 470}	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. This RULE is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections in 2 of 2 home visits. (#1, #2) The findings include: 1. Review of an undated agency policy, obtained 6/7/2021, titled "Hand Hygiene" stated, "... Hand decontamination with an alcohol-based hand rub ... Apply alcohol-based hand rub product to palm of one (1) hand and rub hands together, covering all surfaces of hands and fingers (including under nails) until hands are dry. ... Hand decontamination using an alcohol-based hand rub should be performed: ... After contact with a patient's intact skin (when taking a pulse, blood pressure, or lifting a patient) ... After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, if hands are not visibly contaminated ... When moving from a contaminated body site to a clean body site during patient care ... After removing gloves ...." 2. During an observation of care at the home of patient #1, start of care 3/11/2021, on 6/4/2021 at 7:40 AM, the patient was observed lying on her left side in bed and home health aide (HHA) E	{N 470}		

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{N 470}	Continued From page 24 was observed washing the patient's right buttock with a washcloth. An open area was observed on the right buttock with a red wound base the size of a dime, and an open area was observed on the back of the upper right thigh with a red wound base and the size of a nickel. The HHA was observed washing over the open areas while washing the patient's right buttock. The HHA placed the washcloth in the wash basin, and the HHA was observed to roll the patient to her back. The HHA was observed to retrieve the washcloth from the wash basin and wash the patient's perineal (small area on the body from the anus to the vaginal opening for a female) area. The HHA was not observed to have changed the water in the wash basin and not observed to have used a different wash cloth after washing the patient's buttocks and open areas before washing the patient's perineal area. During an interview on 6/4/2021 at 4:23 PM, the administrator indicated the home health aide should not use the same washcloth after washing the patient's buttocks before washing the patient's perineal area. 3. On 6/4/2021 at 12:33 PM, the physical therapist/administrator was observed providing care to patient #2. At 1:12 PM, the physical therapy session with the patient was completed. The administrator/physical therapist and HHA (home health aide) D, began to transfer the patient from the wheelchair to the bed. HHA D was observed not wearing gloves during patient contact. At 1:14 PM, HHA D indicated they do not like to wear gloves, but knows where the patient has been, and had only been caring for patient #2. HHA D also indicated they wash their hands	{N 470}		

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{N 470}	Continued From page 25 constantly. At 1:18 PM, HHA D turned the patient to their side, and a small amount of bowl movement was observed. HHA D donned a pair of gloves, pulled the soiled brief from underneath the patient's bottom, and then rolled the soiled brief into a plastic waste bag. HHA D removed her gloves and rolled them into a plastic waste bag with the soiled brief. At 1:25 PM, HHA D donned new gloves, wiped patients buttocks with baby wipes, rubbed baby oil on the patients legs, and pushed a clean brief underneath the patient halfway. At 1:34 PM, the patient was turned on their right side, the remaining portion of the clean brief was pulled through and the aide secured the sides of the brief. HHA D removed gloves and washed hands in kitchen sink, which was the only time HHA D demonstrated hand hygiene. Observation during the home visit failed to evidence HHA D used proper universal precautions during patient contact and diaper change. HHA D failed to sanitize hands prior to donning new gloves and after removing soiled gloves. HHA D failed to practice universal precautions by failing to wear gloves during patient contact and prior to opening the patients brief. During an interview on 6/4/2021 at 4:16 PM, the administrator indicated it was agency policy to wear gloves during patient contact, while performing patient care, after a patient was incontinent, and during perineal care.	{N 470}		
{N 472}	410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance	{N 472}		

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{N 472}	Continued From page 26 improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to analyze quality indicators and other aspects of performance that enable the agency to assess processes of care, agency services and operations. The findings include: Review of an undated agency policy titled "Organizational Planning" stated, "... The leaders plan and monitor the organization's care and services to be consistent with its mission and patient needs. The planning process includes: ... The data needed to measure the performance of the processes and outcomes of care and services ... Results of organization performance improvement activities...." Request was made to the administrator to review the quality assurance and performance improvement (QAPI) program on 6/7/2021 at 11:14 AM. Review of the agency's QAPI program failed to evidence adverse patient events in the improvement plan. Review evidenced an agency document titled "2021 Infection Control Report" which was undated, and stated "2nd Quarter ... Total	{N 472}		

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{N 472}	Continued From page 27 Patients This Quarter 16 ..." This document had a column titled, "Infection----Patients" which stated " ... 5. Reparatory [sic] ... 6.3% ... 7. Wound ... 13% ...." Review evidenced 6.3% of patients had respiratory infections and 13% of patients had wounds. Review failed to evidence the agency analyzed quality indicators and other aspects of performance that enabled the agency to assess processes of care. During an interview on 6/7/2021 at 11:14 AM, the alternate clinical supervisor indicated the agency's performance improvement projects were timeliness of documentation and a more thorough drug screening of employees process during orientation. During an interview on 6/7/2021 at 11:36 AM, the administrator indicated some examples of adverse events included wounds, infections, falls, hospitalizations, and complaints. The administrator stated "Yes, we would look at those" when queried if the examples given would be a concern for the patients.	{N 472}		
{N 478}	410 IAC 17-12-2(d) Q A and performance improvement Rule 12 Sec. 2(d) If personnel under contracts are used by the home health agency, there shall be a written contract between those personnel and the home health agency that specifies the following: (1) That patients are accepted for care only by the primary home health agency. (2) The services to be furnished. (3) The necessity to conform to all applicable home health agency policies including personnel qualifications.	{N 478}		

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FIRST CHOICE HOME HEALTH SERVICES INC	6 MORGAN BLVD STE 101 VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 478}	Continued From page 28 (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency. (6) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation. (7) The procedures for payment for services furnished under the contract. This RULE is not met as evidenced by: Based on record review, the home health agency failed to ensure their contract with an outside entity contained all needed elements, in 1 of 2 contracts. The findings include: An undated agency policy, retrieved 3/23/2021, titled "Written Agreements For Contracted Services" Policy No. [number] 4.020.1 stated "Purpose To specify the contents of a written agreement by defining the nature and scope of services provided by clinicians and others not directly employed by the organization. Policy ... When the organization provides care and services through another source, the patients are entitled to the same level of performance from that source as from the organization itself. These contracted services will be defined by a written agreement before individuals from that source will be permitted to provide services on behalf of the organization. Procedure 1. The written agreement between the organization and the contract service/individual will define the nature and scope of services. ... 2. The organization shall ensure that all services furnished under	{N 478}		

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{N 478}	Continued From page 29	{N 478}		

arrangement provided by other entities or individuals meet the requirements of the Medicare Conditions of Participation and accreditation standards. ... 3. There written agreement will address: A. The type of services to be provided B. The role, if any, of the organization and the contracted individual in the following: 1. The patient admission process 2. The patient assessment process, including who is responsible for initial and ongoing assessments 3. Who is responsible for developing, reviewing and revising the plan of care 4. The scheduling of visits, shifts or hours 5. Discharge planning C. What documentation the organization requires, and the required time frame for completing and submitting the documentation to the organization. D. Qualification, including appropriate current licensure, of the personnel organization providing services E. The responsibility of the contracted individual or organization to adhere, as appropriate, to applicable policies and personnel qualifications including criminal background checks, Medicare Conditions of Participation and Joint Commission Accreditation Standards when providing care F. The procedure for determining charges and reimbursement G. The responsibility of the contracted care provider to maintain patient confidentiality H. The term of the agreement, and the conditions for renewal or termination ... 6. As part of the organization's annual evaluation process the Executive Director/Administrator, with the assistance of other organization personnel, will monitor, evaluate, and audit the contracted services to ensure that they are being provided according to the contract, Joint Commission standards, and Medicare Condition of Participation. 7. If during the annual evaluation it is found that the contractor does not meet expectations the organization will meet with the

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{N 478}	Continued From page 30	{N 478}		

contractor and consider the following improvement efforts. A. Increase monitoring efforts B. Provide training to the contractor C. Renegotiate the terms of the contract D. Apply defined penalties E. Terminate contract...."

Review of an agency contract titled "Written Agreements for Home Health Services" dated 5/5/2021, and signed only by OTR (occupational therapist registered) K. This document indicated the "Organization" as First Choice Home Health Services" and the "contractor" as OTR K. This document had an area subtitled "5. Planning and Delivery of Services" which stated, "The Contractor will provide those patient care services, and will perform those other activities, described in detail on Attachment B ..." Another area subtitled "16. Complete Agreement" stated "This written Agreement (with its attachments) reflects the complete agreement between the parties. Any previous written, verbal , or implied contractual relationship between the parties is hereby rescinded. No verbal undertakings or representations not set forth herein will be binding on either party. No agent, employee, or representative of either party has authority subsequently to modify the terms of this Agreement, except in a writing signed by the party to be charged ...." Included with this Written Agreement was a document titled, "Attachment A" which stated, "... 6. All individuals performing services to Organization patients under this Agreement will maintain a State licensure or registration as a _____...." Another document included in this Written Agreement was titled "Attachment B" which stated "Services Provided By Contractor: ... Discipline -Specific Job Description.... "

Review of the written agreement failed to

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{N 478}	Continued From page 31 evidence what services were to be provided by OTR K. Review failed to evidence "Attachment A" was filled out completely to include witness signatures or which license/registration contracted employees should obtain. Review failed to evidence "Attachment B" was completed to include services and activities to be performed by OTR K. During an interview on 6/3/2021 at 4:00 PM, the administrator indicated the written agreement did not specify the services provided by OTR K. When queried if the written agreement had been completely filled out, the administrator stated, "We tried."	{N 478}		
N 484	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure coordination of care amongst all agency staff who provided care to patients in 1 of 3 active clinical records reviewed. (#1) The findings include: 1. Review of an undated agency policy, obtained 6/7/2021, titled "Care Coordination" stated, "...	N 484		

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N 484	Continued From page 32 Written evidence of care coordination will be recorded during the case conference and repeated in skilled nursing visit reports in the patient's clinical records ... Care coordination will include, but not be limited to: A. Clearly outlining each clinician's responsibilities to avoid duplication of services B. Developing complementary actions and goals ... Timely documentation of coordination of care activities ... Integration of services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines ... Organization personnel will communicate changes in a timely manner via telephone, one-to-one meetings, case conferences and home visits. Documentation of all communications will be included in the clinical record on a communication note, case conference summary, or clinical note. Documentation will include: the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication. 8. Written evidence of care coordination may be found in the plan of care, case conference summary forms, or clinical notes in the patient's clinical record. 9. The transmission of patient care information will be timely, accurate, and standardized, whenever possible...." 2. Clinical record review for patient #1, start of care 3/11/2021, certification period 5/10/2021 - 7/8/2021, evidenced an agency document titled "Physician Order", dated 4/13/2021 and electronically signed by the alternate clinical manager. This document indicated the patient was to receive physical therapy services 1 time per week for range of motion, bed mobility and	N 484		

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N 484	Continued From page 33 transfer training. Review of the agency's electronic health record evidenced documents titled "Physical Therapy Progress Visit", dated 5/13/2021 and 5/20/21, which stated, "In Progress". Review evidenced an agency document titled "Oasis D1-Recertification", dated and signed by registered nurse C on 5/5/2021. This document indicated 0 therapy visits were needed and failed to evidence frequency and duration of physical therapy services. The document failed to evidence care coordination was completed with the physical therapist. Review failed to evidence care coordination between the case manager and the physical therapist. During an interview on 6/3/2021 at 10:50 AM, the administrator indicated the patient received physical therapy services 1 time per week. The administrator indicated he was the physical therapist conducting the visits and indicated the patient's physical therapy goals were to sit and working with her in her power wheelchair. The administrator indicated the patient has received physical therapy services weekly since the physician's order was obtained on 4/13/2021. During an interview on 6/4/2021 at 11:35 AM, the clinical manager indicated she was unaware the patient was receiving physical therapy services.	N 484		
{N 486}	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall	{N 486}		

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{N 486}	Continued From page 34 coordinate its services with other health or social service providers serving the patient. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure coordination of care amongst outside healthcare entities that provided services to their agency patients in 2 of 2 active clinical records reviewed that received services from outside healthcare entities. (#2 #3) The findings include: 1. Review of an undated agency policy, obtained 6/7/2021, titled "Coordination Of Services With Other Providers" stated, "... The Case manager will be responsible for coordinating services provided to the patient by the organization, including services provided directly and through contract. The Case Manager will act as liaison with other organizations or individuals also providing care to the patient to ensure effective coordination of related services. Procedure 1. Other providers and all referral to other service providers will be documented in the clinical record. 2. The other service provider will be responsible to contact the physician ... for orders for its evaluation and treatment. 3. The Case Manager or Clinical Supervisor will be responsible for the coordination between service providers, which will include, but not be limited to: A. Organization personnel's understanding of each organization's/individual's responsibility in providing care. B. Initiation of communication with other organizations/individuals when there are significant changes in the patient's care, treatment, or services. C. Lack of duplication or conflict of services provided by various organizations or individuals. If anyone is aware of duplication or conflict, attempts to correct the	{N 486}		

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{N 486}	Continued From page 35 situation are necessary. D. Sharing relevant information to facilitate coordination and continuity of care and to avoid duplication of services ... Ongoing communication regarding specific patients will be the responsibility of the Case Manger or the appropriate clinician. 6. Ongoing communication regarding issues and concerns with the organizations or individuals providing care will be the responsibility of First Choice Home Health Services Inc's management." 2. Clinical record review on 6/6/2021 for patient #3, start of care 5/16/2021, evidenced an agency document titled "OASIS D1 - Start of Care", electronically signed and dated 5/16/2021 by the alternate clinical manager and identified by the alternate clinical manager as the initial comprehensive assessment. The comprehensive assessment indicated the patient had a surgical wound to the second toe on the right foot and was covered by a non-removable dressing. Review failed to evidence care coordination regarding wound care with another agency. During an interview on 6/7/2021 at 1:33 PM, the alternate clinical manager indicated the patient lived in assisted living facility E and the wound to the second toe on the right foot was cared for by a nurse at assisted living facility E. The alternate clinical manager indicated she spoke with the nurse at assisted living facility E once before the nurse went to see the patient and there had not been any communication since then. The alternate clinical manager indicated there was no documentation of care coordination but stated, "It's in my head."	{N 486}		

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{N 486}	Continued From page 36 5. Clinical record review on 6/7/2021 for patient #2, start of care 3/11/2021, primary diagnosis of a pressure ulcer stage 2 (a sore which wears below the surface of the skin, usually caused by pressure near bony prominences), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/10/2021 - 7/8/2021, which was electronically signed by physician F on 6/4/2021. An area subtitled "21. Orders for Discipline and Treatments (Specific Amount/Frequency/Duration)" stated " ... HHA [home health aide] provides all ADL [activities of daily living] care during the day, and family checks on [him/her] in the evening ...." Review evidenced an agency document titled "Physical Therapy Evaluation" dated 5/14/2021, and electronically signed by the administrator. This document had an area subtitled "Social Supports / Safety Hazards" which stated, "Patient lives: ... Alone ... Assistance is Available: ... Has assistance from aides between 2 agencies [for] 12-16 hours per day including weekends ...." Review of the patients clinical record failed to evidence care coordination with another agency who provided home health aide care to the agency patient. During an interview on 6/4/2021 at 12:48 PM, patient #2 indicated a HHA from agency G comes in the evening after HHA D is gone. During an interview on 6/7/2021 at 1:03 PM, the administrator indicated care coordination would be documented in the clinical record and would not be documented anywhere else.	{N 486}		

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N 494	Continued From page 37	N 494		
N 494	410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to obtain the patient's or legal representative's signature confirming that a copy of the notice of rights and responsibilities was received in 1 of 3 active clinical records reviewed. (#1) The findings include: Review of an undated agency policy, obtained 6/7/2021, titled "Rights/Responsibilities" stated, "... The patient or legal representative will be requested to sign the Patient Rights and Responsibilities form. The original form will be kept in the patient's clinical record. A copy will be maintained by the patient. The patient's refusal to sign will be documented in the clinical record, including the reason for refusal...." Clinical record review on 6/3/2021 and 6/7/2021 for patient #1, start of care 3/11/2021, evidenced	N 494		

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N 494	Continued From page 38 an undated agency document titled "Patient Rights and Responsibilities". This form failed to evidence the patient or the patient's legal representative signed a copy of the notice of rights and responsibilities. During an interview on 6/4/2021 at 10:51 AM, the administrator indicated the patient's admission consents were not in the chart to include the signed patient rights and responsibilities form. During an interview on 6/4/2021 at 10:51 AM, the alternate clinical manager indicated the agency has had difficulty getting the signed consents to transfer from the clinician's phone once the patient or legal representative signed them into the electronic clinical record.	N 494		
{N 520}	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. This RULE is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the patient needs were met in 1 of 1 clinical record reviewed of a bedbound patient with multiple sclerosis and wounds. This citation had the potential to affect all patients in the home health agency. The findings include: 1. Review of an undated agency policy, obtained 6/7/2021, titled "Care Planning Process" stated, "	{N 520}		

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{N 520}	Continued From page 39 ... To provide clinical direction to clinicians providing direct patient care. ... Based on the assessment and conclusions, the plan of care will include, but not be limited to: ... Patient specific interventions and education ... All patient care orders from all physicians involved in the plan of care including verbal orders ... Specific services and treatments to be provided ... Actions to be taken to meet the patient goals ... The care planning decisions will be reflected in the specific services that will be provided and the associated actions planned and implemented to meet individualized patient problems and goals ... The plan of care will be based upon the physician's ... orders and will encompass the equipment, supplies and services required to meet the patient's needs ... The plan of care will be revised as frequently as deemed necessary by the clinician, based on the ongoing assessments of the patient ... Clinicians will inform the patient's physician of any changes that suggest a need to alter the plan of care ...." 2. Review of an undated agency policy, obtained 6/7/2021, titled "Physician Participation In Plan Of Care" stated "... A physician will direct the care of every home health patient admitted for service. The attending physician will certify that medical, skilled, rehabilitation, and social services provided by the organization are medically necessary and meets the requirements to be covered by Medicare. ... The care will be provided in compliance with his/her therapeutic and diagnostic orders and accepted standards and practice. ... Physician ... orders will be individualized, based on patient's needs, and include: ... Treatments and/or procedures needed, including type, frequency, duration, and goals ... Orders will be reviewed and revised by the patient's physician (or other authorized	{N 520}		

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{N 520}	Continued From page 40 licensed independent practitioner) based on: A. Changes in the care or service being provided ... E. Changes in diagnoses or treatment, including procedures, medications and equipment ... 12. If a patient is under the care of more than one (1) physician, the nurse will be responsible to the first referring physician. All other physicians should be made aware of the services being provided to the patient. The referring physician will be informed of the involvement of other medical clinicians...." 3. Review of an undated agency policy, obtained 6/7/2021, titled "Initial And Comprehensive Assessment" stated "... The comprehensive assessment shall reflect and determine: ... Plan of care, including type of services, frequency, and duration ... The ability of the organization to adequately meet the patient's medical, nursing, rehabilitation, social services, and discharge needs ... Information gathered during the initial and comprehensive assessments will be used by the physician in developing and authorizing the plan of care ...." 4. Review of an undated agency policy, obtained 6/7/2021, titled "Ongoing Assessments" stated, " ... Based on the findings of the reassessment, additional orders will be generated and forwarded to the physician (or other authorized licensed independent practitioner) for signature(s) ...." 5. Review of an undated agency policy, obtained 6/7/2021, titled "Uniform Quality of Care" stated, " ... All patients ... have the right to receive the same quality of care and to have access to the home health resources they need to meet their health care needs ... The organization will maintain a clinical record review process to ensure that the organization's policies and	{N 520}		

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{N 520}	Continued From page 41 procedures are followed by all clinical personnel ...." 6. Clinical record review on 6/3/2021 and again on 6/7/2021 for patient #1, start of care 3/11/2021 with diagnoses, including but not limited to, Stage II pressure ulcer of right buttock and multiple sclerosis (a disease of the brain and spinal cord causing permanent damage or deterioration of the nerves), evidenced an agency document titled "OASIS D1 - Start of Care". The administrator identified the document to be the initial comprehensive assessment completed by the administrator, physical therapist, on 3/11/2021. The initial comprehensive assessment evidenced the patient was assessed to have 1 Stage II pressure ulcer to the right buttock measuring 0.5 centimeters (cm) in length, 0.5 cm in width and 0.1 cm in depth with a pink wound base. Review indicated the wound treatment for the wound was cleanse the wound with mild soap and water and apply moisture barrier liberally. The initial comprehensive assessment indicated the patient lived with a caregiver who was not willing to provide wound care, and the document stated, " ... Caregiver is not comfortable looking at patients [sic] naked body ...." The initial comprehensive assessment evidenced the patient was assessed to be incontinent of bowel and bladder (loss of voluntary control of urine and bowel movements) and patient wore adult briefs. Review evidenced the patient was dependent for toileting and rolling left and right while lying on her back. The document stated, " ... Limited by mobility limitations ... May lead to other skin issues or pressure sores due to immobility ...." The initial comprehensive assessment evidenced the patient was to receive skilled nursing services 1 time a week for 9 weeks and home health aide services 1 time a week for 1 week and then 3	{N 520}		

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	007135	A. BUILDING: _____ B. WING _____	R 06/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE HOME HEALTH SERVICES INC	6 MORGAN BLVD STE 101 VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 520}	Continued From page 42 times a week for 8 weeks through Medicare. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 3/11/2021 - 5/9/2021 and identified by the administrator as the Medicare plan of care, evidenced to be signed by physician A on 4/27/2021. The plan of care indicated the patient was to receive home health aide services 4-5 hours a visit, 1-2 visits a day, 5-7 days a week for personal care/hygiene and ADL (activities of daily living) assistance. The plan of care stated, " ... Patient will be free from complications of immobility, as evidenced by intact skin ...." The plan of care failed to evidence the patient's wound and wound care treatment as indicated in the initial comprehensive assessment. The plan of care failed to evidence the patient would receive skilled nursing services as indicated in the initial comprehensive assessment. Review failed to evidence any additional plan of care for the certification period of 3/11/2021-5/9/2021 reviewed by the physician. Review of agency documents titled "Wound Note Worksheet", electronically signed by the clinical manager, evidenced on 3/17/2021 the patient had 1 pressure ulcer to the right buttock measuring 1.0 cm in length, 1.0 cm in width and 0.1 cm in depth with a pink wound base and normal surrounding tissue. Review evidenced the skilled nurse provided wound treatment which was cleansing the wound with mild soap and water and apply moisture barrier cream. Review failed to evidence the wound was assessed after 3/17/2020 until document dated 4/12/2021 which evidenced the patient had 3 wounds: 1 pressure ulcer to the right buttock measuring 1.5 centimeters (cm) in length, 1.5 cm in width and 0.1 cm in depth with a pink wound base and	{N 520}		

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{N 520}	Continued From page 43 reddened surrounding tissue; 1 pressure ulcer on the left ischial tuberosity (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis) was assessed to be 1.5 cm in length, 1.5 cm in width and 0.1 cm in depth with a pink wound base and normal surrounding tissue; and 1 pressure ulcer on the right ischial tuberosity was assessed to be 1.5 cm in length, 1.5 cm in width and 0.1 cm in depth with a pink wound base and normal surrounding tissue. Review indicated the skilled nurse provided wound treatment for all 3 wounds which was to cleanse the wounds with mild soap and water and apply moisture barrier cream. Review failed to evidence a physician order for skilled nursing services to include providing wound care. Documents dated 4/21/2021 and 4/29/2021 evidenced the patient had 3 wounds: 1 pressure ulcer to the right buttock measuring 1.5 centimeters (cm) in length, 1.5 cm in width and 0.1 cm in depth with a pink wound base and reddened surrounding tissue; 1 pressure ulcer on the left ischial tuberosity (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis) was assessed to be 1.5 cm in length, 1.5 cm in width and 0.1 cm in depth with a pink wound base and normal surrounding tissue; and 2 pressure ulcer on the right ischial tuberosity was assessed to be 1.5 cm in length, 1.5 cm in width and 0.1 cm in depth with a pink wound base and normal surrounding tissue. Review indicated the skilled nurse provided wound treatment for all 3 wounds which was to cleanse the wounds with mild soap and water and apply moisture barrier cream. Review of agency documents titled "Skilled Nursing Visit Note", electronically signed by the clinical manager, evidenced the nurse on 4/12/2021 contacted the physician regarding the 2 additional wounds to the right ischial tuberosity	{N 520}		

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{N 520}	Continued From page 44 and left ischial tuberosity and no new orders were obtained. Review failed to evidence which physician was contacted. Review evidenced the skilled nurse completed a head-to-toe physical assessment and cleansed the wounds and applied a moisture barrier cream to pressure ulcers to the right buttock, right ischial tuberosity and left ischial tuberosity. Documents dated 4/21/2021, 4/29/2021 and 5/5/2021, indicated the skilled nurse completed a head-to-toe physical assessment and cleansed the wounds and applied moisture barrier to pressure ulcers to the right buttock, right ischial tuberosity and left ischial tuberosity. Review failed to evidence any orders for wound care treatment and attempts by the nurse to notify the physician regarding the status of the wounds and to obtain a new treatment order since 4/12/2021. Review of an agency document titled "OASIS D-1 Recertification" the administrator identified the document to be the comprehensive assessment evidenced to be electronically signed by the clinical manager and dated 5/5/2021. Review evidenced the patient was assessed to have 3 stage II pressure ulcers. The wound identified on the right buttock was assessed to be 1.5 cm in length, 1.5 cm in width and 0.1 cm in depth with a pink wound base and reddened surrounding tissue. The wound identified on the left ischial tuberosity was assessed to be 1.5 cm in length, 1.5 cm in width and 0.1 cm in depth with a pink wound base and normal surrounding tissue. The wound on the right ischial tuberosity was assessed to be 1.5 cm in length, 1.5 cm in width and 0.1 cm in depth with a pink wound base and normal surrounding tissue. Review indicated the wound treatment for all 3 wounds was to cleanse the wounds with mild soap and water and apply moisture barrier to the entire buttocks. Review	{N 520}		

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{N 520}	Continued From page 45 evidenced the caregiver was not willing to perform wound care and stated, " ... PCG [patient caregiver] is patient's brother and he is not comfortable with caring for patient's naked body ...." Review evidenced the patient was assessed to be incontinent of bowel and bladder (loss of voluntary control of urine and bowel movements) and patient wore adult briefs. Review evidenced the skilled nurse assessed the patient as dependent for toileting and requiring maximum assistance for rolling left and right while lying on her back. The document stated, " ... Patient has limited mobility and relies on others for all care ... How might the patient's limitations affect their safety and/or progress? May impede the healing ...." Review failed to evidence the wounds were measured and assessed for wound appearance after 5/5/2021. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 5/10/2021 - 7/8/2021, electronically signed by the clinical manager on 5/5/2021, was identified by the administrator as the Medicare plan of care. The plan of care failed to evidence it was reviewed by the physician. The plan of care indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks and home health aide services 3 times a week for 8 weeks then 2 times a week for 1 week. The plan of care evidenced the skilled nurse interventions included, but were not limited to, establishing measures on how to prevent skin breakdown from prolonged immobility such as keeping skin clean, dry and moisturized as necessary, to reposition patient every 2 hours as needed and to instruct on and perform wound care to buttocks every visit. The plan of care stated, " ... Cleanse wounds with mild soap and water. Apply moisture barrier ointment generously	{N 520}		

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{N 520}	Continued From page 46 with each incontinent care. Caregiver to perform wound care in absence of nurse ...." The plan of care failed to evidence the number of wounds and the exact locations of the wounds. The plan of care failed to be individualized to the patient's needs in regards to the caregiver was not willing to provide wound care. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 5/10/2021 - 7/8/2021 was identified by the administrator as the Medicaid plan of care and to be used simultaneously with the Medicare plan of care. The plan of care failed to evidence it was reviewed by the physician. The plan of care indicated the patient was to receive home health aide services 4-5 hours a visit, 1-2 visits a day, 5-7 days a week. The plan of care evidenced the home health aide was to assist the patient with personal care/hygiene and ADL assistance. The plan of care evidenced the patient's goals were to be free of complications of immobility as evidenced by intact skin. Review of an agency document titled "Skilled Nursing Visit Note", electronically signed by the clinical manager and dated 5/10/2021, stated, " ... There are 2 wounds noted to bil [bilateral] ischial tuberosities and 1 buttocks wound. Skin care performed by SN [skilled nurse] at this visit ...." Review failed to evidence the skilled nurse assessed the wounds to include size and wound appearance and failed to evidence communication with the physician. Review failed to evidence any skilled nurse visit after 5/10/2021 as directed in the plan of care. Review of agency documents titled "Home Health Aide Visit", dated 5/10/2021, 5/11/2021, 5/12/2021, 5/13/2021, 5/14/2021, 5/16/2021,	{N 520}		

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{N 520}	Continued From page 47 5/17/2021, 5/18/2021, 5/20/2021, 5/21/2021, 5/22/2021, 5/23/2021, 5/24/2021, 5/25/2021, 5/27/2021, 5/28/2021, 5/29/2021, 5/30/2021, 5/31/2021, 6/1/2021, 6/2/2021 and 6/3/2021 and electronically signed by home health aide (HHA) E and dated 5/19/2021 and signed by HHA G, were identified by the administrator as the Medicaid home health aide visits. Review indicated home health aide services were provided for 8 hours in 1 visit daily except for on 5/17/2021 which home health aide services were provided for 6 hours in 1 visit. Review failed to evidence home health aide services were provided as directed in the plan of care. Review of agency documents dated 5/10/2021, 5/12/2021, 5/14/2021, 5/17/2021, 5/21/2021, 5/24/2021, 5/28/2021 and 5/31/2021 and electronically signed by HHA E and dated 5/19/2021 and electronically signed by HHA G, were identified by the administrator as the Medicare home health aide visits. Review indicated home health aide services were provided for a 1 hour visit from 5:00 PM to 6:00 PM. 7. During an observation of care at the patient's home on 6/4/2021 at 7:30 AM, the patient was observed to be lying on her right side in bed and the brief was observed to be saturated and contain a brown substance when the home health aide removed the patient's brief. An open area was observed on the left buttock with a red wound base the size of a quarter and a scabbed area half the length of a pen was observed under the open area. An open area was observed on the right buttock with a red wound base the size of a dime. At 7:40 AM, the home health aide rolled the patient to the left side and an open area was observed on the back of the upper left thigh with a red wound base and the size of a nickel.	{N 520}		

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{N 520}	Continued From page 48 An open area was observed on the back of the upper right thigh with a red wound base and the size of a nickel. The patient was observed to require maximum assistance from the home health aide to roll from her back to both her left and right side. At 7:46 AM, the home health aide was observed to apply an ointment to the patient's buttocks which the home health aide indicated was Vaseline (a skin protectant). 8. During an interview on 6/4/2021 at 7:50 AM, the patient indicated no one changed her adult brief or provided incontinent care after the home health aide left in the afternoon until the morning when the home health aide arrived. The patient indicated one home health aide provided one visit during the morning and afternoon, and no separate visits were provided. The patient indicated she was unable to turn self in bed. The patient stated, "It would be nice to have someone change me again," when queried if she needed assistance in the evenings. The patient indicated her caregiver did not provide incontinent care when the home health aide was not present. The patient indicated there was no other caregiver to provide personal care in the absence of the home health aide. 9. During an interview on 6/4/2021 at 7:57 AM, home health aide E indicated the patient did not receive multiple visits per day due to not having enough staff. The home health aide indicated she was unsure which days were the Medicare visits and she completed the home health aide visit notes that were scheduled in the electronic health record. The home health aide confirmed no one else lived at the patient's home other than the patient and the caregiver. 10. During an interview on 6/4/2021 at 8:05 AM,	{N 520}		

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{N 520}	Continued From page 49 the patient's caregiver indicated he is the patient's only caregiver. When queried if he provides incontinent care when the aide is not present, the caregiver stated, "I won't. I can't do that. I'm her brother." The caregiver indicated only one home health aide visit is provided each day and indicated any additional visits the patient could receive would be helpful. 11. During an interview on 6/4/2021 at 11:03 AM, the clinical manager indicated the patient was admitted to the home care agency with no wounds and the date of onset for the wounds to the right buttock, left ischial tuberosity and right ischial tuberosity was 4/12/2021. The clinical manager indicated the patient was bedbound, cannot turn herself in bed and cannot perform incontinence care. The clinical manager indicated the patient's needs were not being fully met and the patient needed multiple home health aide visits each day to include a visit in the evening. At 1:24 PM, the clinical manager indicated she has tried other treatments for the patient's wounds but tried the change in wound treatments without contacting the physician and obtaining wound care orders because she "tried it for a day and it didn't work." The clinical manager indicated she tried a Mepilex dressing (a type of wound treatment using a foam absorbent dressing) and another foam dressing on the wounds, both of which did not work. The clinical manager indicated physician B came to the patient's home and was aware of the wounds on 4/12/2021. When queried what were the wound care orders from physician B, the clinical manager indicated physician B instructed her to keep the patient clean and dry. The clinical manager indicated the barrier cream has helped the most which was why barrier cream was the wound treatment the nurse used but there was not a wound care order	{N 520}		

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{N 520}	Continued From page 50 obtained from a physician. When queried when the clinical manager last spoke to the physician regarding the wounds, the clinical manager indicated she has not communicated with physician B since 4/12/2021 at the time of the onset of the wounds. The clinical manager indicated she was waiting for physician B to make another home visit but he has not come yet. The clinical manager indicated physician B was not the physician responsible for the plan of care which was physician A. The clinical manager indicated she has not spoken to physician A about the patient's wounds. 12. During an interview on 6/4/2021 at 10:29 AM, the administrator indicated the agency had not provided any skilled nurse visit after 5/10/2021 because the clinical manager had surgery and was off work. The administrator indicated the clinical manager was the skilled nurse for the patient, and the agency should have put the patient's skilled nursing services on hold while the clinical manager was sick. When queried if the patient had skilled nursing needs during the time the clinical manager was off work, the administrator indicated the patient did have skilled nursing needs which the agency was not meeting. At 11:15 AM, the administrator indicated they have discussed the patient's need for more hours and split home health aide shifts. The administrator indicated another home health aide was hired but she was having family issues and they are still working on it. At 3:45 PM, the administrator indicated staff did not want to provide "in and out" visits and indicated the home health aides did not want to leave and then return to the patient's home which makes staffing difficult. The administrator indicated the agency wanted to stagger the patient's home health aide hours but could not staff it. At 4:06 PM, the	{N 520}		

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{N 520}	Continued From page 51	{N 520}		

administrator stated, "All [patient] is asking us to do is just take care of her so doesn't go back to the nursing home. Without staggered shifts, I see wounds getting worse."

13. During an interview on 6/4/2021 at 10:29 AM, the alternate clinical manager indicated she was unaware the clinical manager was providing skilled nurse visits to the patient and thought the clinical manager was doing supervisory visits only which was the reason she did not schedule a replacement nurse to conduct the patient's skilled nurse visits while the clinical manager was off work. At 11:29 AM, the alternate clinical manager indicated she spoke to the patient's caregiver because the agency was concerned about the patient getting wounds. The alternate clinical manager indicated the agency offered the patient 10 hours a day of home health aide services in one visit, but the caregiver refused because he did not want someone in his house all day.

14. During an interview on 6/4/2021 at 11:33 AM, the clinical manager indicated the caregiver was agreeable to splitting the home health aide shifts throughout the day but only did not want one home health aide all day for 10 hours. The clinical manager indicated she informed the administrator of the patient caregiver's request for splitting the home health aide shifts.

15. During an interview on 6/4/2021 at 11:33 AM, the administrator indicated there were no other attempts made by the agency to meet the patient's needs. The administrator indicated the physician responsible for the plan of care was not aware of the patient's unmet needs.

16. During an interview on 6/9/2021 at 10:18 AM in response to a call placed to the office of

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{N 520}	Continued From page 52 physician A on 6/7/2021, the medical assistant for physician A indicated there was no order or communication regarding wounds and no coordination with physician B. The medical assistant for physician A indicated the only signed order since 3/11/2021 was the plan of care for certification period 3/11/2021-5/9/2021 signed by the physician on 4/27/2021.	{N 520}		
{N 522}	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the patients received the services as directed in the plan of care and the plan of care was individualized in 3 of 3 active clinical records reviewed. (#1, #2, #3) The findings include: 1. Review of an undated agency policy, obtained 6/7/2021, titled "Care Planning Process" stated, " ... Purpose To provide clinical direction to clinicians providing direct patient care. ... Based on the assessment and conclusions, the plan of care will include, but not be limited to: ... Patient specific interventions and education ... All patient care orders from all physicians involved in the plan of care including verbal orders ... Specific services and treatments to be provided ... Actions to be taken to meet the patient goals ... The care planning decisions will be reflected in	{N 522}		

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{N 522}	Continued From page 53 the specific services that will be provided and the associated actions planned and implemented to meet individualized patient problems and goals ... The plan of care will be based upon the physician's ... orders and will encompass the equipment, supplies and services required to meet the patient's needs ... The plan of care will be revised as frequently as deemed necessary by the clinician, based on the ongoing assessments of the patient ... Clinicians will inform the patient's physician of any changes that suggest a need to alter the plan of care ...." 2. Clinical record review on 6/3/2021 and again on 6/7/2021 for patient #1, start of care 3/11/2021 with diagnoses, including but not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the right buttock and multiple sclerosis (a disease of the brain and spinal cord causing permanent damage or deterioration of the nerves), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/10/2021 - 7/8/2021. The document evidenced to be electronically signed by the clinical manager and dated 5/5/2021 and was identified by the administrator as the Medicare plan of care. The plan of care indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks and home health aide services 3 times a week for 8 weeks then 2 times a week for 1 week. The plan of care evidenced the skilled nurse interventions included, but were not limited to, establishing measures on how to prevent skin breakdown from prolonged immobility such as keeping skin clean, dry and moisturized as necessary, to reposition patient every 2 hours as	{N 522}		

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{N 522}	Continued From page 54 needed and to instruct on and perform wound care to buttocks every visit. The plan of care stated, " ... Cleanse wounds with mild soap and water. Apply moisture barrier ointment generously with each incontinent care ... Monitor disease processes, instruct medications and assess efficacy...." Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 5/10/2021 - 7/8/2021 was identified by the administrator as the Medicaid plan of care and to be used simultaneously with the Medicare plan of care. The plan of care indicated the patient was to receive home health aide services 4-5 hours a visit, 1-2 visits a day, 5-7 days a week to assist the patient with personal care/hygiene and ADL assistance. Review failed to evidence any skilled nurse visit after 5/10/2021 as directed in the plan of care. During an interview on 6/4/2021 at 10:29 AM, the administrator indicated the agency had not provided any skilled nurse visit after 5/10/2021 because the clinical manager had surgery and was off work. The administrator indicated the clinical manager was the skilled nurse for the patient, and the agency should have put the patient's skilled nursing services on hold while the clinical manager was sick. During an interview on 6/4/2021 at 10:29 AM, the alternate clinical manager indicated she was unaware the clinical manager was providing skilled nurse visits to the patient and thought the clinical manager was doing supervisory visits only which was the reason the a replacement nurse was not scheduled to conduct the patient's skilled nurse visits while the clinical manager was off	{N 522}		

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{N 522}	Continued From page 55 work. Review of agency documents titled "Home Health Aide Visit", dated 5/10/2021, 5/11/2021, 5/12/2021, 5/13/2021, 5/14/2021, 5/16/2021, 5/17/2021, 5/18/2021, 5/20/2021, 5/21/2021, 5/22/2021, 5/23/2021, 5/24/2021, 5/25/2021, 5/27/2021, 5/28/2021, 5/29/2021, 5/30/2021, 5/31/2021, 6/1/2021, 6/2/2021 and 6/3/2021 and electronically signed by home health aide (HHA) E and dated 5/19/2021 and signed by HHA G, were identified by the administrator as the Medicaid home health aide visits. Review indicated home health aide services were provided for 8 hours in 1 visit daily except for on 5/17/2021 which home health aide services were evidenced to have been provided for 6 hours in 1 visit. Review failed to evidence home health aide services were provided 4-5 hours a day as directed in the Medicaid plan of care. Review of agency documents dated 5/10/2021, 5/12/2021, 5/14/2021, 5/17/2021, 5/21/2021, 5/24/2021, 5/28/2021 and 5/31/2021 and electronically signed by HHA E and dated 5/19/2021 and electronically signed by HHA G, were identified by the administrator as the Medicare home health aide visits. Review failed to evidence home health aide services were provided 3 times a week as directed in the Medicare plan of care during the week of 5/23/2021. During an interview on 6/4/2021 at 7:57 AM, home health aide E indicated the patient did not receive multiple visits per day due to not having enough staff. The home health aide indicated she was unsure which days were the Medicare visits and she completed the home health aide visit notes that were scheduled in the electronic health record.	{N 522}		

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{N 522}	Continued From page 56 During an interview on 6/4/2021 at 10:36 AM, the administrator indicated the patient's caregiver signed the note but there was no documentation of care provided by the home health aide. At 3:45 PM, the administrator indicated staff did not want to provide "in and out" visits and indicated the home health aides did not want to leave and then return to the patient's home which makes staffing difficult. The administrator indicated the agency wanted to stagger the patient's home health aide hours but could not staff it. 3. Clinical record review on 6/6/2021 for patient #3, start of care 5/16/2021 and a primary diagnosis of Alzheimer's Disease (a gradually progressive brain disorder which causes problems with memory, thinking and behavior), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/16/2021 - 7/14/2021. This document evidenced to be dated 5/16/2021 and electronically signed by the alternate clinical manager and signed and dated 6/4/2021 by the physician. The plan of care indicated the patient was to receive home health aide services 7-8 hours a visit, 1 visit a day, 5-7 days a week. Review of agency documents titled "Home Health Aide Visit", electronically signed by HHA M, indicated home health aide services were provided for 11 hours on 5/29/2021 and 5/30/2021. Review failed to evidence home health aide services were provided 7-8 hours a day as directed in the plan of care. Review of untitled agency documents the alternate clinical manager identified as employee time sheets indicated home health aide M provided home health aide services for 3 hours on 5/16/2021, 11 hours on 5/23/2021 and 4 hours	{N 522}		

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{N 522}	Continued From page 57 on 5/25/2021 and 5/27/2021. Review failed to evidence home health aide services were provided for 7-8 hours per day as directed in the plan of care. Review indicated on 5/18/2021 and 5/20/2021 home health aide N provided home health aide services from 9:00 AM to 12:00 PM and home health aide M provided home health aide services from 1:30 PM to 5:00 PM. Review failed to evidence home health aide services were provided in 1 visit per day as directed in the plan of care. During an interview on 6/7/2021 at 1:42 PM, the alternate clinical manager indicated the home health aide services were not provided as directed in the plan of care. The alternate clinical manager indicated the days the multiple shifts were provided and the days the home heath aide provided services for 11 hours was to make-up for the days the home health aide could not work 7-8 hours. 4. Clinical record review on 6/7/2021 for patient #2, start of care 3/11/2021, primary diagnosis of a pressure ulcer stage 2 (a sore which wears below the surface of the skin, usually caused by pressure near bony prominences), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/10/2021 - 7/8/2021, which was electronically signed by physician F, on 6/4/2021. This document had an area subtitled "Safety Measures" which stated "24 hr. [hour] supervision ..." Another area subtitled "21. Orders for Discipline and Treatments (Specific Amount/Frequency/Duration)" that stated " ...PT [physical therapy] 2v/wk x's [two visits per week, for] 9 weeks and 1-2/visits per week PRN [as needed] for soiled dressings as needed ...." Review failed to evidence the patient received	{N 522}		

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{N 522}	Continued From page 58 24-hour supervision. Review evidenced PT visits were made on 5/14/2021, 5/20/2021, and 6/4/2021. Review failed to evidence PT was provided twice a week, as ordered on the plan of care. During an interview on 6/7/2021 at 12:40 PM, the administrator acknowledged information for services provided by agency G was not mentioned on the plan of care. The administrator indicated agency G provides HHA care in the evenings, however, the patient does not receive 24-hour supervision. During an interview on 6/7/2021 at 12:44 PM, the administrator indicated the reason for inaccurate PT visit frequencies was due to a weakness in their process, that was learning to navigate the electronic health records efficiently.	{N 522}		
{N 524}	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements.	{N 524}		

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{N 524}	Continued From page 59 (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. This RULE is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the plan of care was individualized and included all required information for treatment of the patient in 3 of 4 clinical records reviewed. (#1, #3, #4) The findings include: 1. Review of an undated agency policy, obtained 6/7/2021, titled "Care Planning Process" stated, "... A written individualized plan of care will be initiated within five (5) days of start of care and updated at least every 60 days, or as patient's condition warrants ... Individualized Plan of Care: The patient-specific clinical plan of care includes all pertinent diagnoses, mental status, types of services/equipment, frequency of visits, goals and interventions appropriate to each discipline, prognosis, rehabilitation potential, functional limitations, precautions, activities, nutritional requirements, food/drug allergies, medications, treatments, safety measures, instructions, discharge plan. ... At the time of the initial assessment, the clinician, along with the physician and other involved disciplines, will develop the patient plan of care based upon the patient's identified needs and will review it with the patient and family/caregiver. 2. All clinicians	{N 524}		

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{N 524}	Continued From page 60 will consider the conclusions of initial and ongoing assessments in their care planning process, including, but not limited to: A. Individualized patient needs and resultant problems related to care, functional status, and family/caregiver support systems ... Pain and symptom management, as appropriate ... Patient and caregiver education and training that the organization will provide specific to the patient's care needs. 3. Based on the assessment and conclusions, the plan of care will include, but not be limited to: A. Patient specific interventions and education ... Identified patient problems and needs, including functional limitations, activities permitted, nutritional requirements D. Reasonable, measurable, and individualized goals and outcomes identified by the organization and the patient anticipated to occur as a result of implementing and coordinating the plan of care ... All medications M. Safety measures to protect against injury ... The care planning decisions will be reflected in the specific services that will be provided and the associated actions planned and implemented to meet individualized patient problems and goals...." 2. Clinical record review on 6/3/2021 and again on 6/7/2021 for patient #1, start of care 3/11/2021 with diagnoses, including but not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the right buttock and multiple sclerosis (a disease of the brain and spinal cord causing permanent damage or deterioration of the nerves), evidenced an agency document titled "OASIS D-1 Recertification". The administrator identified the document to be the comprehensive assessment, which was	{N 524}		

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{N 524}	Continued From page 61 evidenced to be electronically signed by the clinical manager and dated 5/5/2021. Review evidenced the patient was assessed to have 3 stage II pressure ulcers; 1 on the right buttock, 1 on the left ischial tuberosity (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis) and 1 on the right ischial tuberosity. Review indicated the wound treatment for all 3 wounds was to cleanse the wounds with mild soap and water and apply moisture barrier to the entire buttocks. Review evidenced the caregiver was not willing to perform wound care and stated, " ... PCG [patient caregiver] is patient's brother and he is not comfortable with caring for patient's naked body ...." Review evidenced the patient was assessed to be incontinent of bowel and bladder (loss of voluntary control of urine and bowel movements) and patient wore adult briefs. Review evidenced the skilled nurse assessed the patient as dependent for toileting and requiring maximum assistance for rolling left and right while lying on her back. The document stated, " ... Patient has limited mobility and relies on others for all care ... How might the patient's limitations affect their safety and/or progress? May impede the healing ...." Review of an agency document titled "Physician Order", dated 4/13/2021 and electronically signed by the alternate clinical manager, indicated the patient was to receive physical therapy services 1 time per week for range of motion, bed mobility and transfer training. Review of the agency's electronic health record evidenced documents titled "Physical Therapy Progress Visit", dated 5/13/2021 and 5/20/21, which stated, "In Progress".	{N 524}		

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{N 524}	Continued From page 62 During an interview on 6/4/2021 at 10:50 AM, the administrator indicated the patient received physical therapy services 1 time per week. The administrator indicated he was the physical therapist conducting the visits and indicated the patient's physical therapy goals were to sit and working with her in her power wheelchair. The administrator indicated the patient has received physical therapy services weekly since the physician's order was obtained on 4/13/2021. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 5/10/2021 - 7/8/2021, electronically signed by the clinical manager on 5/5/2021, was identified by the administrator as the Medicare plan of care. The plan of care indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks and home health aide services 3 times a week for 8 weeks then 2 times a week for 1 week. The plan of care failed to evidence the number of wounds and the exact locations of the wounds. The plan of care stated, " ... Caregiver to perform wound care in absence of nurse ...." The plan of care failed to be individualized to the patient's needs in regards to the caregiver was not willing to provide wound care as indicated in the comprehensive assessment. Review failed to evidence the plan of care included frequency of visits, interventions and goals related to the physical therapy services provided. Review failed to evidence the plan of care included Nystatin (a medication used to treat fungal infections) cream in the patient's medication and failed to evidence the home health aide interventions included applying medication. Review of an agency document titled "Home Health Certification and Plan of Care" for	{N 524}		

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{N 524}	Continued From page 63 certification period 5/10/2021 - 7/8/2021 was identified by the administrator as the Medicaid plan of care and to be used simultaneously with the Medicare plan of care. The plan of care indicated the patient was to receive home health aide services 4-5 hours a visit, 1-2 visits a day, 5-7 days a week. The plan of care evidenced parameters to notify the physician if the patient's fasting and random blood sugar levels were less than 70 or greater than 400. Review failed to evidence the plan of care included Nystatin cream in the patient's medication and failed to evidence the home health aide interventions included applying medication. During an interview on 6/4/2021 at 10:50 AM, the administrator indicated the plan of care did not include interventions and goals for the physical therapy services and stated, "We missed that on the plan of care." The administrator indicated the plan of care should include the frequency ordered for the physical therapy services. During an interview on 6/4/2021 at 11:04 AM, the clinical manager indicated the plan of care should include each wound location. The clinical manager indicated the patient was not a diabetic (a person with a chronic disorder which affects how the body turns food into energy affecting the blood sugar levels) and the plan of care should not include fasting and random blood sugar parameters. During an observation of care on 6/4/2021 at 7:30 AM at the patient's home, a sign was observed hanging in the patient's bedroom that stated, "Aides [sic] List for [patient] ... Nystatin cream under both breasts and between legs." A tube labeled "Nystatin" was observed in the patient's bedroom.	{N 524}		

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{N 524}	Continued From page 64 During an interview on 6/4/2021 at 7:46 AM, home health aide E indicated she has applied Nystatin cream under the patient's breasts when they were red. The home health aide stated, "It goes away in just a couple of hours after putting that on." During an interview on 6/4/2021 at 4:23 PM, the administrator indicated the Nystatin cream should be included on the plan of care. 3. Clinical record review on 6/6/2021 for patient #3, start of care 5/16/2021 and a primary diagnosis of Alzheimer's Disease (a gradually progressive brain disorder which causes problems with memory, thinking and behavior), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/16/2021 - 7/14/2021. This document evidenced to be dated 5/16/2021 and electronically signed by the alternate clinical manager and signed and dated 6/4/2021 by the physician. The plan of care indicated the patient was to receive home health aide services 7-8 hours a visit, 1 visit a day, 5-7 days a week but failed to evidence interventions and care the home health aide was to provide. This document indicated the patient was homebound due to the patient had dementia and poor safety awareness and was unable to safely ambulate, and the plan of care failed to evidence patient-specific goals. The plan of care evidenced parameters to notify the physician if the patient's fasting and random blood sugar levels were less than 70 or greater than 400. This document stated, "... Weight [less than] or [greater than] lbs [pounds] Notify MD [medical doctor] ..." The patient's list of medication included, but was not limited to, Venelex (a medication used to promote wound	{N 524}		

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{N 524}	Continued From page 65 healing). The plan of care indicated the patient was to receive Venelex twice a day to the wound to the second toe on the right foot. The plan of care failed to evidence who was to provide wound care. During an interview on 6/7/2021 at 1:27 PM, the alternate clinical manager indicated the patient was not diabetic and the blood sugar parameters should have been removed from the plan of care. The alternate clinical manager indicated the patient was not being weighed so the parameter related to the weight should have been erased. The alternate clinical manager indicated there should be patient-specific goals on the plan of care. The alternate clinical manager indicated the plan of care did not include home health aide interventions but that it should include the home health aide should monitor safety, provide personal care and assist with ADL (activities of daily living). Review of an agency document evidenced an agency document titled "OASIS D1 - Start of Care", dated 5/16/2021 and electronically signed by the alternate clinical manager and identified by the alternate clinical manager as the initial comprehensive assessment. The comprehensive assessment indicated the patient had a surgical wound to the second toe on the right foot and was covered by a non-removable dressing. During an interview on 6/7/2021 at 1:33 PM when queried why Venelex was not applied per the plan of care at the initial comprehensive assessment, the alternate clinical manager indicated the plan of care was incorrect. The alternate clinical manager indicated Venelex was to be applied to both of the patient's legs and not to the wound. Review failed to evidence the plan of care	{N 524}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 524}	Continued From page 66 included the patient-specific treatment of Venelex to be applied to the patient's legs. 4. Clinical record review on 6/6/2021 for patient #4, start of care 5/17/2021 and a primary diagnosis of malignant neoplasm of bilateral breasts (cancerous tumor to both breasts), evidenced an agency document titled "OASIS D1-Start of Care", electronically signed by the alternate clinical manager and dated 5/17/2021 and identified to be the initial comprehensive assessment. This document indicated the patient had a surgical wound to the right breast and a surgical wound to the left breast, each with a surgical drain and 3 stitches. This document indicated the skilled nurse cleansed the wounds with alcohol, covered with a bio patch (a foam patch with topical antiseptic used to prevent infection) and applied a tegaderm dressing (a transparent film wound dressing). This document indicated the patient would receive skilled nursing services 1 time per week for 9 weeks. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 5/17/2021 - 7/15/2021, failed to evidence the services and frequency of those services the patient was to receive. This document failed to evidence the surgical wound care orders for the left and right breasts. This document failed to evidence patient-specific goals related to the patient's surgical wounds. During an interview on 6/7/2021 at 12:08 PM, the alternate administrator indicated the plan of care did not include the orders for skilled nursing services which was for a skilled nurse 1 time a week for the certification period. The alternate administrator indicated the plan of care did not include the wound care orders which was to	{N 524}		

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{N 524}	Continued From page 67 monitor the surgical drains to each breast for infections and output and replace the dressing if dislodged. 5. During an interview on 6/7/2021 at 12:38 PM, the alternate clinical manager indicated the plan of care should be individualized and complete with services to be provided, frequency of services, medical equipment, medication and goals. 6. Clinical Record review on 6/7/2021, for patient #2, start of care 3/11/2021, evidenced two agency documents titled "Home Health Certification and Plan of Care", for certification period 5/10/2021 - 7/8/2021. These documents were identified by the administrator as one plan of care for the Medicare-covered services and one plan of care for the Medicaid-covered services. The administrator indicated the Medicare plan of care was identified with the medical record number beginning with "MR" and the Medicaid plan of care was identified with the medical record number beginning with "HHA". The Medicare plan of care was electronically signed by physician F on 6/4/2021. This document had an area subtitled "18. Functional Limitations" which stated " ... 2 ... Bowel/Bladder (incontinence) [inability of the body to control the evacuation functions of urination and/or defecation] ... 9 ... Legally Blind ... " which had check marks to indicate they applied to the patient. An area subtitled "21. Orders for Discipline and Treatments (Specific Amount/Frequency/Duration)" stated " ... HHA [home health aide] provides all ADL [activities of daily living] care during the day, and family checks on [him/her] in the evening ... PT 2v/wk x's [two visits per week, for] 9 weeks and 1-2/visits per week PRN for soiled dressings as needed ... HHA 7- 8h/v- 5 - 7v/wk x's [7 to 8 hour	{N 524}		

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{N 524}	Continued From page 68 visits, 5 to 7 days a week, for] 9 weeks Funded by Medicaid ... HHA PRN Visits for care up to 2h/wk [2 hours per week] ... HHA 2/wk x's [twice per week for] 9 weeks Medicare funded ...." Review failed to evidence DME [durable medical equipment] and supplies related to incontinence care listed on the plan of care. Review failed to evidence orders for when and by whom the PureWick system should have been applied and removed, and the supplies associated listed on the plan of care. Review failed to evidence a care plan for HHA services associated with the Medicare record review. Review failed to evidence medications listed on the Medicaid care plan. Record review of an agency document titled "Home Health Certification and Plan of Care" for certification period 5/10/2021 - 7/8/2021, which was electronically signed by the alternate clinical supervisor on 5/7/2021. This document evidenced a medical record starting with "HHA" and had an area subtitled "21. Orders for Discipline and Treatments (Specific Amount/Frequency/Duration)" stated " ... HHA provides all ADL care during the day, and family checks on [him/her] in the evening ... HHA 7-8h/v- 5 - 7v/wk x's [7 to 8 hour visits, 5 to 7 days a week, for] 9 weeks Funded by Medicaid ... HHA PRN Visits for care up to 3h/wk [3 hours per week] ...." Review failed to evidence a list of current medications. Review failed to evidence treatment orders for SN [skilled nurse], PT, and wound care. Observation of a home visit on 6/4/2021 at 12:33 PM, with the physical therapist [administrator], evidenced HHA D was present from the home	{N 524}		

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{N 524}	Continued From page 69 health agency and was providing the patient services. HHA D reported she worked with the patient during the day, then another HHA from agency G comes a few hours in the evening. The administrator and HHA D transferred patient #2 into a motorized wheelchair, which was controlled and driven by the patient. At 12:55 PM, the administrator and HHA D guided the patient through the doorway and down the ramp outside. The administrator and patient #2 practiced driving around the parking lot until 1:12 PM. The administrator and HHA D then transferred the patient back into the bed. HHA D changed the patient's soiled brief, placed on a clean brief and chux [absorbent under pad] underneath the patient. Review failed to evidence incontinence supplies such as briefs and under pads [chux] listed on the plan of care. Review failed to evidence contact information and services provided by Agency G listed on the plan of care. Review of agency documents titled "Skilled Nursing Visit Note" evidenced the patient received a skilled nurse [SN] visit on the following dates: 5/13/2021, 5/21/2021, 5/28/2021, and 6/4/2021. Review failed to evidence orders for SN frequencies and treatments listed on the plan of care. Review of an agency document titled "Skilled Nursing Visit Note" dated 6/4/2021, and was electronically signed by the alternate clinical supervisor on 6/4/2021. This document had an area subtitled "Narrative and Teaching" which stated "...Explained to patient that wound is healed up and [he/she] is seeking an MD [doctor of medicine] breast leakage ... Changed dressing to left breast, dry dressing so that [his/her] shirt does not stick to [his/her] breast. Cleansed areola with wound wash to remove crusty [sic] that had	{N 524}		

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{N 524}	Continued From page 70 developed. Patted dry and clean dry dressing applied and secured with tape ...." Review failed to evidence the plan of care contained orders for dressing changes to the left breast. Review evidenced an agency document titled "Oasis D1-Start of Care" dated and signed by employee A (physical therapist) on 3/11/2021. This Oasis Start of Care had an area subtitled, "Genitourinary [pertaining to elimination and genitals]" which stated "Patient will benefit from PureWick Urine collection system and will become part of the patient's supply list ...." Review failed to evidence PureWick system and supplies added to the plan of care. During an interview on 6/7/2021, at 12:37 PM, the administrator indicated diapers and chux were not added to the plan of care. During an interview on 6/7/2021, at 12:39 PM, the alternate clinical supervisor indicated patient #2 is not legally blind. Record review failed to evidence the plan of care was individualized to reflect accurate functional limitations. During an interview on 6/7/2021, at 12:40 PM, the administrator acknowledged information for services provided by agency G was not mentioned on the plan of care. The administrator indicated agency G provides HHA care in the evenings. During an interview on 6/7/2021, at 12:43 PM, the administrator indicated the plan of care will be updated to include orders for the PureWick system. During an interview on 6/7/2021, at 1:11 PM, the alternate clinical supervisor indicated order for	{N 524}		

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{N 524}	Continued From page 71 dressing changes should be on the plan of care. They did not think it was necessary since the breast was only leaking.	{N 524}		
N 526	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) The total medical plan of care shall be reviewed by the attending physician, dentist, chiropractor, optometrist or podiatrist, and home health agency personnel as often as the severity of the patient's condition requires, but at least once every two (2) months. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the individualized plan of care was reviewed by the physician responsible for the plan of care no less frequently than once every 60 days in 1 of 2 patients who received skilled nursing services. (#2) The findings include: The undated agency policy, titled "60-Day Summary Report" stated "Purpose To define the process for completion of a 60-day summary of patient care to assist the organization to assure communication with all physicians involved in the plan of care. Policy ... The summary will be forwarded to all physicians involved in the patient's care. Procedure 1. Upon determination that a patient requires ongoing care and will be recertified for an additional episode of care, the patient's Case Manager may complete a 60-day summary. ... 2. A copy of the 60-day summary report will be retained in the clinical record."	N 526		

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N 526	Continued From page 72 The undated agency policy, titled "Care Planning Process" stated, "... All clinicians, including the physician, involved in the patient's care, either directly or indirectly, will contribute to the plan of care ... The clinicians will be responsible to revise the plan of care or update the plan of care at least every 60 days...." Clinical record review on 6/7/2021 for patient #2, start of care 3/11/2021, primary diagnosis of a pressure ulcer stage 2 (a sore which wears below the surface of the skin, usually caused by pressure near bony prominences), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 3/11/2021 - 5/9/2021, which was electronically signed by physician F, on 3/27/2021. Record review on 6/7/2021, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/10/2021 - 7/8/2021, which was electronically signed by physician F, on 6/4/2021. Review failed to evidence the plan of care was reviewed by the physician at least every 60 days.	N 526		
N 527	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.	N 527		

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N 527	Continued From page 73 This RULE is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the physician was promptly notified in changes in the patient's condition which suggest the plan of care may need to be updated in 2 of 2 active clinical records reviewed receiving skilled nursing services. (#1, #2) The findings include: 1. The undated agency policy, obtained on 6/7/2021, titled "Monitoring Patient's Response/Reporting To Physician" stated, "... Clinicians will monitor, document, and report the patient's response to care and treatment provided on each home visit. Progress toward goals will be measured at regular intervals. Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient. Procedure 1. During each home visit, the clinician will monitor the patient's response to care against the established goals, including, but not limited to: A. Care interventions and treatments ... All conferences or attempts to communicate with the physician will be documented in the clinical record. A. Documentation of physician notification will include: 1. Date and time contacted 2. Patient name 3. Name of physician notified or his/her representative 4. Reason for notification 5. Physician's response 6. Action taken or orders obtained 7. Professional's signature and titled B. Documentation of attempted physician notification will include: 1. Date and time 2. Patient name 3. Name of physician attempting to notify 4. Reason for notification 5. Name of person taking message...." 2. The undated agency policy, obtained	N 527		

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N 527	Continued From page 74 6/7/2021, titled "Physician Responsibility In Managing Home Health Patients" stated, "... Physician Rights The physician has a right to: ... Be provided with timely information regarding his/her patient. Notification and contact will occur with, but will not be limited to, the following: 1. Changes in the patient's condition...." 3. Clinical record review on 6/3/2021 and again on 6/7/2021 for patient #1, start of care 3/11/2021 with diagnoses, including but not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the right buttock and multiple sclerosis (a disease of the brain and spinal cord causing permanent damage or deterioration of the nerves), evidenced an agency document titled "OASIS D1 - Start of Care". The administrator identified the document to be the initial comprehensive assessment completed by the administrator, physical therapist, on 3/11/2021. The initial comprehensive assessment evidenced the patient was assessed to have 1 Stage II pressure ulcer to the right buttock and the wound treatment for the wound was cleanse the wound with mild soap and water and apply moisture barrier liberally. The initial comprehensive assessment evidenced the patient was to receive skilled nursing services 1 time a week for 9 weeks Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 3/11/2021 - 5/9/2021 and identified by the administrator as the Medicare plan of care, evidenced to be signed by physician A on 4/27/2021. The plan of care failed to evidence the patient's wound and wound care	N 527		

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N 527	Continued From page 75 treatment as indicated in the initial comprehensive assessment. The plan of care failed to evidence the patient was to receive skilled nursing services as indicated in the initial comprehensive assessment. Review failed to evidence any additional plan of care for the certification period of 3/11/2021-5/9/2021 reviewed by the physician. Review of agency documents titled "Wound Note Worksheet", electronically signed by the clinical manager, evidenced on 3/17/2021 the patient had 1 pressure ulcer to the right buttock and evidenced the skilled nurse provided wound treatment which was cleansing the wound with mild soap and water and apply moisture barrier cream. Review failed to evidence the wound was assessed after 3/17/2020 until document dated 4/12/2021 which evidenced the patient had 3 wounds: 1 pressure ulcer to the right buttock, 1 pressure ulcer on the left ischial tuberosity (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis) and 1 pressure ulcer on the right ischial tuberosity. Review indicated the skilled nurse provided wound treatment for all 3 wounds which was to cleanse the wounds with mild soap and water and apply moisture barrier cream. Documents dated 4/21/2021 and 4/29/2021 evidenced the skilled nurse provided wound treatment for all 3 wounds which was to cleanse the wounds with mild soap and water and apply moisture barrier cream. Review failed to evidence the physician was notified of the new wound to the left ischial tuberosity and the new wound to the right ischial tuberosity and the need for skilled nursing services for wound care. Review of agency documents titled "Skilled Nursing Visit Note", electronically signed by the	N 527		

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N 527	Continued From page 76 clinical manager, evidenced the nurse on 4/12/2021 contacted the physician regarding the 2 additional wounds to the right ischial tuberosity and left ischial tuberosity and no new orders were obtained. Review failed to evidence which physician was contacted. Review evidenced the skilled nurse completed a head-to-toe physical assessment and cleansed the wounds and applied a moisture barrier cream to pressure ulcers to the right buttock, right ischial tuberosity and left ischial tuberosity. Documents dated 4/21/2021, 4/29/2021 and 5/5/2021, indicated the skilled nurse completed a head-to-toe physical assessment and cleansed the wounds and applied moisture barrier to pressure ulcers to the right buttock, right ischial tuberosity and left ischial tuberosity. Review failed to evidenced the physician responsible for the plan of care (physician A) was notified of the wounds. During an observation of care at the patient's home on 6/4/2021 at 7:30 AM, the patient was observed to be lying on her right side in bed. An open area was observed on the left buttock with a red wound base the size of a quarter and a scabbed area half the length of a pen was observed under the open area. An open area was observed on the right buttock with a red wound base the size of a dime. At 7:40 AM, the home health aide rolled the patient to the left side and an open area was observed on the back of the upper left thigh with a red wound base and the size of a nickel. An open area was observed on the back of the upper right thigh with a red wound base and the size of a nickel. During an interview on 6/4/2021 at 1:24 PM, the clinical manager indicated she has tried other treatments for the patient's wounds but tried the change in wound treatments without contacting	N 527		

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N 527	Continued From page 77 the physician and obtaining wound care orders because she "tried it for a day and it didn't work." The clinical manager indicated she tried a Mepilex dressing (a type of wound treatment using a foam absorbent dressing) and another foam dressing on the wounds, both of which did not work. The clinical manager indicated physician B came to the patient's home and was aware of the wounds on 4/12/2021. When queried what were the wound care orders from physician B, the clinical manager indicated physician B instructed her to keep the patient clean and dry. The clinical manager indicated the barrier cream has helped the most which was why barrier cream was the wound treatment the nurse used but there was not a wound care order obtained from a physician. When queried when the clinical manager last spoke to the physician regarding the wounds, the clinical manager indicated she has not communicated with physician B since 4/12/2021. The clinical manager indicated she was waiting for physician B to make another home visit but he has not come yet. The clinical manager indicated physician B was not the physician responsible for the plan of care which was physician A. The clinical manager indicated she has not spoken to physician A about the patient's wounds. Review failed to evidence physician A or physician B were communicated with regarding the additional wounds on the back of the patient's left upper thigh and the back of the patient's right upper thigh. During an interview on 6/9/2021 at 10:18 AM in response to a call placed to the office of physician A on 6/7/2021, the medical assistant for physician A indicated there was no order or communication regarding wounds and no coordination with	N 527		

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N 527	Continued From page 78	N 527		

physician B. The medical assistant for physician A indicated the only signed order since 3/11/2021 was the plan of care for certification period 3/11/2021-5/9/2021 signed by the physician on 4/27/2021.

4. Clinical record review on 6/7/2021 for patient #2, start of care 3/11/2021, primary diagnosis of a pressure ulcer stage 2 (a sore which wears below the surface of the skin, usually caused by pressure near boney prominences), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/10/2021 - 7/8/2021, which was electronically signed by physician F, on 6/4/2021. This document had an area subtitled "21. Orders for Discipline and Treatments (Specific Amount/Frequency/Duration)" stated " ...Family member to do dressing when PT [physical therapy] is not there ... Therapist will continue wound debridement and intervention with sharps including scalpel scissors and tweezers in a sterile environment as well as optimal wound medication and dressing to promote healing ... Wound care orders: cleanse wound with wound cleanser / NS [normal saline] pat dry, apply santyl [topical medication used to remove necrotic tissue from wounds] as needed and cover with a clean dry dressing daily and PRN [as needed] for soilage ...."

Review of an agency document titled "Skilled Nursing Visit Note" dated 6/4/2021, electronically signed by the alternate clinical supervisor and dated 6/4/2021. This document had an area subtitled "Narrative and Teaching" which stated "...Explained to patient that wound is healed up and [he/she] is seeking an MD [doctor of medicine][sic] breast leakage ... Changed dressing to left breast, dry dressing so that

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FIRST CHOICE HOME HEALTH SERVICES INC	6 MORGAN BLVD STE 101 VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 527	Continued From page 79 [his/her] shirt does not stick to [his/her] breast. Cleansed areola with wound wash to remove crusty that had developed. Patted dry and clean dry dressing applied and secured with tape ...." Review failed to evidence physician F was notified of dressing changes to the left breast. Review failed to evidence physician F was notified of the stage 2 wound on the right buttocks had been healed. During an interview on 6/7/2021 at 12:52 PM, the alternate clinical supervisor indicated the patient's wound to the right buttocks had healed. The alternate clinical supervisor indicated physician F was notified when they called the physician's office. Documentation of care coordination with physician F was not received prior to exit. During an interview on 6/7/2021 at 1:11 PM, the alternate clinical supervisor indicated physician F was aware the patient's breast was leaking. They did not think it was necessary for dressing orders since the breast was only leaking. Documentation of care coordination with physician F was not received prior to exit.	N 527		
{N 533}	410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. (b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information.	{N 533}		

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{N 533}	Continued From page 80 (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan. This REQUIREMENT is not met as evidenced by: Based on record review, the home health agency failed to ensure an aide care plan was developed by the skilled nurse in 1 of 3 active clinical records reviewed. (#2) The findings include: Review of an undated agency policy, obtained on 6/7/2021, titled "Home Health Aide Plan Of Care" stated, "... Each patient receiving home health aide services will have an individualized plan developed and utilized to direct care performed by the assigned aide ... The patient's Case Manager or other appropriate skilled professional ... upon initialization of aide services, will develop the written home health aide plan of care, consistent with the comprehensive plan of care and physician orders. 2. The home health aide plan of care will be individualized to the specific patient and will include at least: ... Frequency of visits ... Specific procedure(s) to be performed, including amount, frequency, and duration...." Clinical Record review on 6/7/2021, for patient #2,	{N 533}		

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{N 533}	Continued From page 81 start of care 3/11/2021, evidenced two agency documents titled "Home Health Certification and Plan of Care", for certification period 5/10/2021 - 7/8/2021. These documents were identified by the administrator as one plan of care for the Medicare-covered services and one plan of care for the Medicaid-covered services. The administrator indicated the Medicare plan of care was identified with the medical record number beginning with "MR" and the Medicaid plan of care was identified with the medical record number beginning with "HHA". The plan of care that had a medical record starting with "MR" and was electronically signed by physician F on 6/4/2021. This document had an area subtitled "10. Medications" which indicated the patient was prescribed Baclofen, Ocrevus and Ibuprofen. An area subtitled "21. Orders for Discipline and Treatments (Specific Amount/Frequency/Duration) stated " ... HHA [home health aide] provides all ADL [activities of daily living] care during the day, and family checks on [him/her] in the evening ... HHA 7-8h/v- 5 - 7v/wk x's [7 to 8 hour visits, 5 to 7 days a week, for] 9 weeks Funded by Medicaid ... HHA PRN Visits for care up to 2h/wk [2 hours per week] ... HHA 2/wk x's [twice per week for] 9 weeks Medicare funded ...." Review failed to evidence a home health aide care plan associated with the plan of care beginning with "MR".	{N 533}		
N 540	410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:	N 540		

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N 540	Continued From page 82 (A) Make the initial evaluation visit. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the comprehensive assessment was completed to reflect the patient's current health status in 3 of 3 active clinical records reviewed. (#1, #2, #3) The findings include: 1. Review of an undated agency policy, obtained 6/7/2021, titled "Initial And Comprehensive Assessment" stated, "... The assessment will be patient-specific and comprehensive to include the patient's need for home health care, rehabilitative care, social services, and discharge planning ... The comprehensive assessment for each patient must be completed in its entirety by the same clinician ... During the initial and comprehensive patient assessments, all baseline data to be used in measuring the patient's progress toward goals and other relevant information will be documented in the patient's clinical record, including at least the following information, if applicable: ... A physical assessment, including blood pressure, temperature, pulse, respirations, skin, pain status, approximate height/weight, nutritional status, and other relevant data related to pertinent physical findings ... The patient's and family's educational needs, abilities, motivation, and readiness to learn...." 2. Clinical record review on 6/3/2021 and again on 6/7/2021 for patient #1, start of care 3/11/2021 and diagnoses, including but not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed	N 540		

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N 540	Continued From page 83	N 540		

between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the right buttock and multiple sclerosis (a disease of the brain and spinal cord causing permanent damage or deterioration of the nerves), evidenced an agency document titled "Oasis D1-Recertification". This document was dated 5/5/2021 and electronically signed by the clinical manager and identified by the alternate clinical manager as the comprehensive assessment. The comprehensive assessment failed to be complete, and failed to evidence the gyneco-urinary (reproductive and urinary system) assessment and nutritional risk assessment. This document failed to evidence the follow-up performance was completed. This document indicated personal goals were discussed but failed to evidence with whom the goals were discussed. This document indicated 0 therapy visits were needed and failed to evidence frequency and duration of physical therapy services.

Review of an agency document titled "Physician Order", dated 4/13/2021 and electronically signed by the alternate clinical manager, indicated the patient was to receive physical therapy services 1 time per week for range of motion, bed mobility and transfer training.

Review of the agency's electronic health record evidenced documents titled "Physical Therapy Progress Visit", dated 5/13/2021 and 5/20/21, which stated, "In Progress".

During an interview on 6/4/2021 at 10:50 AM, the administrator indicated the patient received physical therapy services 1 time per week. The administrator indicated he was the physical

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N 540	Continued From page 84 therapist conducting the visits and indicated the patient's physical therapy goals were to sit and working with her in her power wheelchair. The administrator indicated the patient has received physical therapy services weekly since the physician's order was obtained on 4/13/2021. During an interview on 6/4/2021 at 11:35 AM, the clinical manager indicated she completed the OASIS form at time of the comprehensive assessment, but then the office was supposed to review it and some things must have been missed. The clinical manager indicated she was unaware the patient was receiving physical therapy services. 3. Clinical record review for patient #3, start of care 5/16/2021 and a primary diagnosis of Alzheimer's Disease (a gradually progressive brain disorder which causes problems with memory, thinking and behavior), evidenced an agency document titled "Oasis D1-Start of Care". This document was dated 5/16/2021 and electronically signed by the alternate clinical manager and identified as the initial comprehensive assessment. The comprehensive assessment failed to be complete and failed to evidence the eyes were assessed. Review failed to evidence the patient/primary caregiver was provided education and failed to evidence a patient summary. Review failed to evidence the patient's strengths and limitations were completed. During an interview on 6/7/2021 at 1:33 PM, the alternate clinical manager indicated the comprehensive assessment should have been complete. 4. Clinical record review on 6/7/2021 for patient #2, start of care 3/11/2021, certification period	N 540		

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N 540	Continued From page 85 3/11/2021 - 5/9/2021, evidenced an agency document titled "Oasis D1-Start of Care" dated and signed by the administrator (physical therapist) on 3/11/2021. This document failed to be complete. This document failed to evidence the patient's home safety assessment, professional services provided, discharge plans, and rehabilitation potential. An area subtitled, "Pain" stated "Patient has no pain ..." Under numeric pain assessment, this document stated "Onset ... Chronic ... present level (0-10) ... 3 ... Worst pain gets (0-10) ... 8 ...." This section failed include what relieved patient's pain and if breakthrough pain medication was needed. This comprehensive assessment failed to be complete, accurate and include the patient's full assessment of their health, physical, and psychosocial needs. During an interview on 6/7/2021 at 1:33PM, the administrator indicated pain should be a complete comprehensive assessment because it was the 5th vital sign.	N 540		
{N 541}	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. This RULE is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure all medications currently used by the patient were reviewed by a registered nurse in order to identify any potential adverse effects and	{N 541}		

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{N 541}	Continued From page 86 drug reactions in 3 of 3 clinical records reviewed receiving skilled nursing services. (#1, #2, #4) The findings include: 1. Review of an undated agency policy, obtained 6/7/2021, titled "Initial And Comprehensive Assessment" stated, "... Prior to completion of a comprehensive assessment by a therapist, a registered nurse or qualified clinician must conduct a Drug Regimen Review...." 2. Review of an undated agency policy, obtained 6/7/2021, titled "Medication Profile" stated, "... Patients receiving medications will have a current, accurate medication profile in the clinical record ... Procedure ... The admitting nurse will initiate a medication profile to document the current medication regimen, including name, dose, strength, route, frequency, date and time of administration and a diagnosis, condition, or indication for use for each medication ordered. A. In rehabilitation therapy-only cases, the patient's therapist must submit a list of patient medications to a registered nurse for review ... During subsequent home visits, the medication profile will be used as a care planning and teaching guide to ensure that the patient and family/caregiver, as well as other clinicians, understand the medication regiment. This includes, but will not be limited to: ... Using the medication profile to teach the purpose of medication, dosages, routes, administration times, side effects, and contraindications C. Using the medication profile as a communication tool for other clinicians involved in care...." 3. During an observation of care on 6/4/2021 at 7:30 AM, at the home of patient #1, start of care 3/11/2021, a sign was observed hanging in the	{N 541}		

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{N 541}	Continued From page 87	{N 541}		

patient's bedroom that stated, "Aides List for [patient] ... Nystatin [a medication used to treat fungal infections] cream under both breasts and between legs." A tube labeled "Nystatin" was observed in the patient's bedroom.

During an interview on 6/4/2021 at 7:46 AM, home health aide E indicated she has applied Nystatin cream under the patient's breasts when they were red. The home health aide stated, "It goes away in just a couple of hours after putting that on."

Clinical record review for patient #1 on 6/3/2021 evidenced an agency document titled "Home Health Certification and Plan of Care", for certification period 5/10/2021 - 7/8/2021, which failed to evidence Nystatin cream included in the patient's medication.

Review of an agency document titled "Patient Medication Profile", for episode period 5/10/2021 - 7/8/2021, failed to evidence Nystatin cream was included and reviewed for potential adverse effects and drug reactions. This document failed to evidence a name and signature of the clinician who reviewed the medication. Review failed to evidence the medication was reviewed by a registered nurse.

During an interview on 6/4/2021 at 4:23 PM, the administrator indicated the Nystatin cream should be included on the plan of care and medication profile. The administrator indicated if the medication was not entered on the medication profile, the medication was not reviewed for potential adverse effects and drug reactions.

4. Clinical record review on 6/6/2021 for patient #4, start of care 5/17/2021, evidenced an agency

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{N 541}	Continued From page 88 document titled "Home Health Certification and Plan of Care" for certification period 5/17/2021 - 7/15/2021. The patient's medication failed to evidence Ibuprofen (a medication to treat pain and inflammation). Review of an agency document titled "Patient Medication Profile" for episode period 5/16/2021 - 7/14/2021 failed to evidence the patient's medication included Ibuprofen. This document failed to evidence a name and signature of the clinician who reviewed the medication. Review failed to evidence the medication was reviewed by a registered nurse. Review of an agency document titled "OASIS D1-Start of Care", electronically signed by the alternate clinical manager and dated 5/17/2021, indicated the patient's pain was rated 7 on a scale from 0-10. During an interview on 6/7/2021 at 12:11 PM when queried what the intervention was for the patient's pain during the initial comprehensive assessment identified on 5/17/2021, the alternate administrator indicated she administered 400 milligrams of Ibuprofen to the patient. The clinical manager indicated Ibuprofen was not included on the medication profile and was not reviewed for potential adverse side effects and drug reactions. 5. During an interview at the entrance conference on 6/3/2021 at 10:05 AM, the administrator indicated a registered nurse is to review the medication for potential side effects and drug reactions upon admission and every 60 days with the comprehensive assessment. The administrator indicated the medication then is entered into the electronic clinical record on to the medication profile where the registered nurse can	{N 541}		

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{N 541}	Continued From page 89 then run a drug review. 6. Clinical record review for patient #2, start of care 03/11/2020, evidenced an unsigned, agency document titled "Patient Medication Profile" which indicated a medication start date of 03/09/2021. This document indicated the patient was prescribed Baclofen, Ocrevus and Ibuprofen. This document also indicated the patient was prescribed Santyl, a topical cream, which was discontinued on 4/28/2021. Review failed to evidence the patient medication profile was signed to ensure a registered nurse reviewed the patient's medications.	{N 541}		
{N 544}	410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the skilled nurse prepared clinical notes in 1 of 3 clinical records reviewed receiving skilled nursing services. (#4) The findings include: Review of an undated agency policy, obtained 6/7/2021, titled "Entries Into The Clinical Record" stated "... Home health personnel providing direct patient care and supervisory functions have authority to make entries into the clinical record. Documentation in the clinical record will be timely, detailed, accurate, and reflect the care or	{N 544}		

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{N 544}	Continued From page 90 services provided ... The clinical note will include: A. Care that was provided B. Treatment and/or invasive procedures performed C. Patient response to treatment and/or procedures D. The date the service was provided (month, day, year) E. Signature of clinician and his/her credentials...." Clinical record review on 6/6/2021 for patient #4, start of care 5/17/2021, evidenced an agency document titled "Skilled Nursing Evaluation", electronically signed by the alternate clinical manager and dated 5/19/2021. This document indicated the patient's vital signs but failed to evidence any additional assessment. The document evidenced to be incomplete and the patient's mental status, pain, nutritional status, cardio/pulmonary status, gastrointestinal status, genitourinary status and integumentary status was blank. During an interview on 6/7/2021 at 12:17 PM, the alternate clinical manager indicated she provided skilled nursing care to the patient on 5/19/2021 but she had difficulty with the electronic health record application on her phone and the documentation was not uploaded into the electronic health record.	{N 544}		
{N 546}	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs,	{N 546}		

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{N 546}	Continued From page 91 participate in inservice programs, and supervise and teach other nursing personnel. This RULE is not met as evidenced by: Based on observation, record review, the home health agency failed to ensure all physicians ordering care for the agency patient were communicated and approved by the primary care physician in 1 of 1 clinical records with more than one physician. (#1) The findings include: Review of an undated agency policy, obtained on 6/7/2021, titled "Physician Participation In Plan Of Care" stated, "... Orders will be reviewed and revised by the patient's physician (or other authorized licensed independent practitioner) based on: A. Changes in the care or service being provided ... Changes in diagnoses or treatment, including procedures, medications and equipment ... If a patient is under the care of more than one (1) physician, the nurse will be responsible to the first referring physician. All other physicians should be made aware of the services being provided to the patient. The referring physician will be informed of the involvement of other medial clinicians...." Clinical record review on 6/3/2021 and again on 6/7/2021 for patient #1, start of care 3/11/2021 with diagnoses, including but not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the right buttock and multiple sclerosis (a disease of the brain and spinal cord causing permanent damage or	{N 546}		

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{N 546}	Continued From page 92 deterioration of the nerves), evidenced an agency document titled "OASIS D1 - Start of Care". The administrator identified the document to be the initial comprehensive assessment completed by the administrator, physical therapist, on 3/11/2021. This document indicated the patient's primary physician was physician A and failed to evidence the involvement of any other physician. The initial comprehensive assessment evidenced the patient was assessed to have 1 Stage II pressure ulcer to the right buttock and the wound treatment for the wound was cleanse the wound with mild soap and water and apply moisture barrier liberally. The initial comprehensive assessment evidenced the patient was to receive skilled nursing services 1 time a week for 9 weeks Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 3/11/2021 - 5/9/2021 and identified by the administrator as the Medicare plan of care, evidenced to be signed by physician A on 4/27/2021. The plan of care failed to evidence the patient's wound and wound care treatment as indicated in the initial comprehensive assessment. The plan of care failed to evidence the patient was to receive skilled nursing services as indicated in the initial comprehensive assessment. There was no evidence on the plan of care or in the clinical record the authorization or acknowledgement of acceptance of any other physician orders. Review failed to evidence the plan of care was reviewed by physician B. Review of agency documents titled "Skilled Nursing Visit Note", electronically signed by the clinical manager, evidenced the nurse on 4/12/2021 contacted the physician regarding the	{N 546}		

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{N 546}	Continued From page 93 2 additional wounds to the right ischial tuberosity and left ischial tuberosity and no new orders were obtained. Review failed to evidence which physician was contacted. Review evidenced the skilled nurse cleansed the wounds and applied a moisture barrier cream to pressure ulcers to the right buttock, right ischial tuberosity and left ischial tuberosity. Documents dated 4/21/2021, 4/29/2021 and 5/5/2021, indicated the skilled nurse completed a head-to-toe physical assessment and cleansed the wounds and applied moisture barrier to pressure ulcers to the right buttock, right ischial tuberosity and left ischial tuberosity. Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/10/2021 - 7/8/2021. The document evidenced to be electronically signed by the clinical manager on 5/5/2021 and was identified by the administrator as the Medicare plan of care. The plan of care indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks and evidenced the skilled nurse interventions included, but were not limited to, establishing measures on how to prevent skin breakdown from prolonged immobility such as keeping skin clean, dry and moisturized as necessary, to reposition patient every 2 hours as needed and to instruct on and perform wound care to buttocks every visit. The plan of care stated, " ... Cleanse wounds with mild soap and water. Apply moisture barrier ointment generously with each incontinent care ... Monitor disease processes, instruct medications and assess efficacy...." Review failed to indicate it was reviewed by physician A and physician B. During an observation of care at the patient's home on 6/4/2021 at 7:30 AM, the patient was	{N 546}		

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{N 546}	Continued From page 94 observed to be lying on her right side in bed. An open area was observed on the left buttock with a red wound base the size of a quarter and a scabbed area half the length of a pen was observed under the open area. An open area was observed on the right buttock with a red wound base the size of a dime. At 7:40 AM, the home health aide rolled the patient to the left side and an open area was observed on the back of the upper left thigh with a red wound base and the size of a nickel. An open area was observed on the back of the upper right thigh with a red wound base and the size of a nickel. During an interview on 6/4/2021 at 1:24 PM, the clinical manager indicated she has tried other treatments for the patient's wounds but tried the change in wound treatments without contacting the physician and obtaining wound care orders because she "tried it for a day and it didn't work." The clinical manager indicated she tried a Mepilex dressing (a type of wound treatment using a foam absorbent dressing) and another foam dressing on the wounds, both of which did not work. The clinical manager indicated physician B came to the patient's home and was aware of the wounds on 4/12/2021. When queried what were the wound care orders from physician B, the clinical manager indicated physician B instructed her to keep the patient clean and dry. The clinical manager indicated the barrier cream has helped the most which was why barrier cream was the wound treatment the nurse used but there was not a wound care order obtained from a physician. When queried when the clinical manager last spoke to the physician regarding the wounds, the clinical manager indicated she has not communicated with physician B since 4/12/2021. The clinical manager indicated she was waiting for physician	{N 546}		

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{N 546}	Continued From page 95 B to make another home visit but he has not come yet. The clinical manager indicated physician B was not the physician responsible for the plan of care which was physician A. The clinical manager indicated she has not spoken to physician A about the patient's wounds. Review failed to evidence physician A or physician B were communicated with regarding the additional wounds on the back of the patient's left upper thigh and the back of the patient's right upper thigh. During an interview on 6/9/2021 at 10:18 AM in response to a call placed to the office of physician A on 6/7/2021, the medical assistant for physician A indicated there was no order or communication regarding wounds and no coordination with physician B. The medical assistant for physician A indicated the only signed order since 3/11/2021 was the plan of care for certification period 3/11/2021-5/9/2021 signed by the physician on 4/27/2021.	{N 546}		
{N 547}	410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). This RULE is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure all treatments provided by staff were ordered by a physician in 2 of 2 clinical records	{N 547}		

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{N 547}	Continued From page 96 reviewed with wounds. (#1, #4) The findings include: 1. Review of an agency job description for Registered Nurse, obtained 6/7/2021, stated, "... Essential Job Functions/Responsibilities ... Initiates appropriate preventive and rehabilitative nursing procedures. Administers medications and treatments as prescribed by the physician..." 2. Review of an undated agency policy, obtained 6/7/2021, titled "Home Health Aide Plan Of Care" stated, "... Each patient receiving home health aide services will have an individualized plan developed and utilized to direct care performed by the assigned aide ... The home health aide plan of care will be individualized to the specific patient and will include at least: A. Type of services/procedures to be provided, such as hands on personal care, the performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medication ordinarily self-administered...." 3. Clinical record review on 6/3/2021 and again on 6/7/2021 for patient #1, start of care 3/11/2021 with diagnoses, including but not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the right buttock and multiple sclerosis (a disease of the brain and spinal cord causing permanent damage or deterioration of the nerves), evidenced an agency document titled "OASIS D1 - Start of Care". The administrator identified the document to be the initial comprehensive assessment completed by	{N 547}		

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{N 547}	Continued From page 97 the administrator, physical therapist, on 3/11/2021. The initial comprehensive assessment evidenced the patient was assessed to have 1 Stage II pressure ulcer to the right buttock and the wound treatment for the wound was cleanse the wound with mild soap and water and apply moisture barrier liberally. The initial comprehensive assessment evidenced the patient was to receive skilled nursing services 1 time a week for 9 weeks Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 3/11/2021 - 5/9/2021 and identified by the administrator as the Medicare plan of care, evidenced to be signed by physician A on 4/27/2021. The plan of care failed to evidence the patient's wound and wound care treatment as indicated in the initial comprehensive assessment. The plan of care failed to evidence the patient was to receive skilled nursing services as indicated in the initial comprehensive assessment. Review failed to evidence any additional plan of care for the certification period of 3/11/2021-5/9/2021 reviewed by the physician. Review of agency documents titled "Wound Note Worksheet", electronically signed by the clinical manager, evidenced on 3/17/2021 the patient had 1 pressure ulcer to the right buttock and evidenced the skilled nurse provided wound treatment which was cleansing the wound with mild soap and water and apply moisture barrier cream. Review failed to evidence the wound was assessed after 3/17/2020 until document dated 4/12/2021 which evidenced the patient had 3 wounds: 1 pressure ulcer to the right buttock, 1 pressure ulcer on the left ischial tuberosity (the area of the skin on the lower buttock region that	{N 547}		

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{N 547}	Continued From page 98	{N 547}		

covers the rounded bone of the pelvis) and 1 pressure ulcer on the right ischial tuberosity. Review indicated the skilled nurse provided wound treatment for all 3 wounds which was to cleanse the wounds with mild soap and water and apply moisture barrier cream. Documents dated 4/21/2021 and 4/29/2021 evidenced the skilled nurse provided wound treatment for all 3 wounds which was to cleanse the wounds with mild soap and water and apply moisture barrier cream. Review failed to evidence a physician order for skilled nursing services to include providing wound care.

Review of agency documents titled "Skilled Nursing Visit Note", electronically signed by the clinical manager, evidenced the nurse on 4/12/2021 contacted the physician regarding the 2 additional wounds to the right ischial tuberosity and left ischial tuberosity and no new orders were obtained. Review failed to evidence which physician was contacted. Review evidenced the skilled nurse completed a head-to-toe physical assessment and cleansed the wounds and applied a moisture barrier cream to pressure ulcers to the right buttock, right ischial tuberosity and left ischial tuberosity. Documents dated 4/21/2021, 4/29/2021 and 5/5/2021, indicated the skilled nurse completed a head-to-toe physical assessment and cleansed the wounds and applied moisture barrier to pressure ulcers to the right buttock, right ischial tuberosity and left ischial tuberosity. Review failed to evidence a physician order for skilled nursing services to include conducting an assessment and providing wound care.

Review of an agency document titled "OASIS D-1 Recertification" the administrator identified the document to be the comprehensive assessment

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{N 547}	Continued From page 99 evidenced to be electronically signed by the clinical manager and dated 5/5/2021. Review evidenced the patient was assessed to have 3 stage II pressure ulcers; 1 to the right buttock, 1 to the left ischial tuberosity and 1 to the right ischial tuberosity. Review indicated the wound treatment for all 3 wounds was to cleanse the wounds with mild soap and water and apply moisture barrier to the entire buttocks. Review evidenced two agency documents titled "Home Health Certification and Plan of Care", for certification period 5/10/2021 - 7/8/2021. Neither documents were evidenced to be reviewed by the physician. These documents were identified by the administrator as one plan of care for the Medicare-covered services and one plan of care for the Medicaid-covered services. The administrator indicated the Medicare plan of care was identified with the medical record number beginning with "MR" and the Medicaid plan of care was identified with the medical record number beginning with "HHA [home health aide]". The Medicare plan of care indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks and home health aide services 3 times a week for 8 weeks then 2 times a week for 1 week. The plan of care evidenced the skilled nurse interventions included, but were not limited to, to instruct on and perform wound care to buttocks every visit. The plan of care stated, " ... Cleanse wounds with mild soap and water. Apply moisture barrier ointment generously with each incontinent care...." The Medicaid plan of care indicated the home health aide was to provide a 4-5 hour visit for 1-2 visits a day for 5-7 days a week. Both plans of care plans failed to evidence Nystatin [a medication used to treat fungal infections] was included in the patient's current medication and failed to evidence Nystatin was to	{N 547}		

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{N 547}	Continued From page 100 be applied under the patient's breasts. Review failed to evidence a physician's order for the application of Nystatin cream. Review failed to evidence an order from the physician for the treatment of the wounds. During an observation of care at the patient's home on 6/4/2021 at 7:30 AM, a sign was observed hanging in the patient's bedroom that stated, "Aides [sic] List for [patient] ... Nystatin cream under both breasts and between legs." A tube labeled "Nystatin" was observed in the patient's bedroom. During an interview on 6/4/2021 at 7:46 AM, home health aide E indicated she has applied Nystatin cream under the patient's breasts when they are red. The home health aide stated, "It goes away in just a couple of hours after putting that on." During an interview on 6/4/2021 at 4:23 PM, the administrator indicated there was not a physician order for Nystatin cream. During an interview on 6/4/2021 at 1:24 PM, the clinical manager indicated she has tried other treatments for the patient's wounds but tried the change in wound treatments without contacting the physician and obtaining wound care orders because she "tried it for a day and it didn't work." The clinical manager indicated she tried a Mepilex dressing (a type of wound treatment using a foam absorbent dressing) and another foam dressing on the wounds, both of which did not work. The clinical manager indicated physician B came to the patient's home and was aware of the wounds on 4/12/2021. When queried what were the wound care orders from physician B, the clinical manager indicated	{N 547}		

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{N 547}	Continued From page 101 physician B instructed her to keep the patient clean and dry. The clinical manager indicated the barrier cream has helped the most which was why barrier cream was the wound treatment the nurse used but there was not a wound care order obtained from a physician. The clinical manager indicated physician B was not the physician responsible for the plan of care which was physician A. The clinical manager indicated she has not spoken to physician A about the patient's wounds. Review failed to evidence a physician order for the Mepilex and foam dressing the nurse indicated she applied to the patient's wounds. 4. Clinical record review on 6/6/2021 for patient #4, start of care 5/17/2021 and a primary diagnosis of malignant neoplasm of bilateral breasts (cancerous tumor to both breasts), evidenced an agency document titled "OASIS D1-Start of Care", electronically signed by the alternate clinical manager and dated 5/17/2021 and identified to be the initial comprehensive assessment. This document indicated the patient had a surgical wound to the right breast and a surgical wound to the left breast, each with a surgical drain and 3 stitches. This document indicated the skilled nurse cleansed the wounds with alcohol, covered with a bio patch (a foam patch with topical antiseptic used to prevent infection) and applied a tegaderm dressing (a transparent film dressing). This document indicated the patient would receive skilled nursing services 1 time per week for 9 weeks. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 5/17/2021 - 7/15/2021, failed to evidence the verbal order for start of care was	{N 547}		

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{N 547}	Continued From page 102 received by the physician. The plan of care failed to evidence the skilled nursing services and frequency of those services the patient was to receive. This document failed to evidence the surgical wound care orders for the left and right breasts. Review failed to evidence any orders from or communication with the physician. During an interview on 6/7/2021 at 12:05 PM, the alternate administrator indicated a specific admission order was not written since the agency received an order from the physician. When the admission order was requested, the alternate clinical manger indicated the order was not in the clinical record and stated, "I don't know where it is." The alternate administrator indicated the plan of care did not include the wound care orders which was to monitor the surgical drains to each breast for infections and output and replace the dressing if dislodged. The alternate administrator indicated the plan of care did not include orders for the skilled nursing services and frequency.	{N 547}		
N 566	410 IAC 17-14-1(c)(5) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (5) prepare clinical notes; This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the physical therapist prepared clinical notes in 2 of 3 clinical records reviewed receiving physical therapy services. (#1, #2) The findings include: 1. Review of an undated agency policy, obtained	N 566		

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N 566	Continued From page 103 6/7/2021, titled "Entries Into The Clinical Record" stated "... Home health personnel providing direct patient care and supervisory functions have authority to make entries into the clinical record. Documentation in the clinical record will be timely, detailed, accurate, and reflect the care or services provided ... The clinical note will include: A. Care that was provided B. Treatment and/or invasive procedures performed C. Patient response to treatment and/or procedures D. The date the service was provided (month, day, year) E. Signature of clinician and his/her credentials...." 2. Clinical record review on 6/3/2021 and again on 6/7/2021 for patient #1, start of care 3/11/2021 with diagnoses, including but not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of right buttock and multiple sclerosis (a disease of the brain and spinal cord causing permanent damage or deterioration of the nerves), evidenced an agency document titled "Physician Order", dated 4/13/2021 and electronically signed by the alternate clinical manager. This document indicated the patient was to receive physical therapy services 1 time per week for range of motion, bed mobility and transfer training. Review of the agency's electronic health record evidenced documents titled "Physical Therapy Progress Visit", dated 5/13/2021 and 5/20/21, which stated, "In Progress". During an interview on 6/4/2021 at 10:50 AM, the administrator indicated the patient received physical therapy services 1 time per week. The	N 566		

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N 566	Continued From page 104 administrator indicated he was the physical therapist conducting the visits and indicated the patient's physical therapy goals were to sit and working with her in her power wheelchair. The administrator indicated the patient has received physical therapy services weekly since the physician's order was obtained on 4/13/2021. The administrator indicated the physical therapy visit notes for 5/13/2021 and 5/20/2021 were not yet completed. 4. Clinical record review on 6/7/2021 for patient #2, start of care 3/11/2021, primary diagnosis of a pressure ulcer stage 2 (a sore which wears below the surface of the skin, usually caused by pressure near bony prominences), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/10/2021 - 7/8/2021, which was electronically signed by physician F on 6/4/2021. This document failed to evidence skilled nurse (SN) frequencies and orders for skilled tasks listed on the plan of care. Record review on 6/7/2021, evidenced an agency document titled "Oasis D1-Start of Care" dated and signed by the administrator (physical therapist) on 3/11/2021. This document failed to be complete. This document failed to evidence the patient's home safety assessment, professional services provided, discharge plans, and rehabilitation potential. An area subtitled "Pain" stated "Patient has no pain ..." Under numeric pain assessment, this document stated "Onset ... Chronic ... present level (0-10) ... 3 ... Worst pain gets (0-10) ... 8 ...." This section failed to include what relieved patient's pain and if breakthrough pain medication was needed. This	N 566		

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N 566	Continued From page 105 comprehensive assessment failed to be complete, accurate and included the patient's full assessment of their health, physical, and psychosocial needs. Record review evidenced agency documents titled Physical Therapy Progress Visit" dated and signed by the administrator (physical therapist) on 5/20/2021 and 6/4/2021. The physical therapy progress documents failed to be completed to include pain assessments, exercises/activities, and plans/goals. Review of agency documents titled, "Home Health Aide Visit" for the Medicare record starting with "MR" which were electronically signed by HHA D, failed to evidence any tasks were completed for the following dates: 5/13/2021, 5/18/2021, 5/20/2021, and 5/25/2021. Review of agency documents titled, "Home Health Aide Visit" for the Medicaid record starting with "HHA", which were electronically signed by HHA D, failed to evidence any of the assigned tasks were completed for the following dates: 5/11/2021, 5/13/2021, and 5/23/2021. During an interview on 6/7/2021 at 1:03 PM, when queried if the administrator can report what the patient did by reviewing the physical therapy progress visit note, he replied, "No." The administrator indicated there was so much to do on the notes. During an interview on 6/7/2021 at 1:10 PM, the alternate clinical supervisor stated "No good reason" when queried why HHA visit notes were blank. During an interview on 6/7/2021 at 1:33PM, the	N 566		

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N 566	Continued From page 106 administrator indicated pain should be a complete assessment and was usually done at the start of the visit, because pain was the 5th vital sign.	N 566		
N 604	410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure all home health aides reported changes in the patient's condition for 1 of 2 home visits conducted. (#2) The findings include: Clinical Record review on 6/7/2021, for patient #2, start of care 3/11/2021, evidenced two agency documents titled "Home Health Certification and Plan of Care", for certification period 5/10/2021 - 7/8/2021. These documents were identified by the administrator as one plan of care for the Medicare-covered services and one plan of care for the Medicaid-covered services. The administrator indicated the Medicare plan of care was identified with the medical record number beginning with "MR" and the Medicaid plan of care was identified with the medical record number beginning with "HHA". The plan of care that had a medical record starting with "MR" and was electronically signed by physician F on 6/4/2021. This document had an area subtitled "10. Medications" which indicated the patient was prescribed Baclofen, Ocrevus and Ibuprofen. An area subtitled "21. Orders for Discipline and	N 604		

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N 604	Continued From page 107 Treatments (Specific Amount/Frequency/Duration) stated " ... HHA [home health aide] provides all ADL [activities of daily living] care during the day, and family checks on [him/her] in the evening ... HHA 7-8h/v- 5 - 7v/wk x's [7 to 8 hour visits, 5 to 7 days a week, for] 9 weeks Funded by Medicaid ... HHA PRN Visits for care up to 2h/wk [2 hours per week] ... HHA 2/wk x's [twice per week for] 9 weeks Medicare funded ...." Review failed to evidence a home health aide care plan associated with the "MR" . The Medicaid plan of care failed to indicate it was reviewed by the physician. An area subtitled "21. Orders for Discipline and Treatments (Specific Amount/Frequency/Duration) stated " ... HHA provides all ADL care during the day, and family checks on [him/her] in the evening ... HHA 7-8h/v- 5 - 7v/wk x's 9 weeks Funded by Medicaid ... HHA PRN Visits for care up to 3h/wk [3 hours per week] ...." This document failed to evidence the patient had medications ordered/prescribed. Review of an agency document titled, "Home Health Aide Care Plan" which was electronically signed by the alternate clinical supervisor on 5/10/2021 for the clinical record starting with "HHA". This document had a list of tasks to be performed by the HHA, for the patient, and stated "Medication Reminder ... Daily ...." During an interview on 6/4/2021, at 12:33 PM, HHA D queried what to do about a new medication prescribed by physician F. HHA D indicated they do not understand why a beta blocker (medication used to manage abnormal heart rhythms) would be prescribed right before physician F retired. Review failed to evidence	N 604		

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N 604	Continued From page 108 HHA D informed the alternate clinical supervisor about a new medication. During an interview on 6/4/2021, at 1:36 PM, HHA D indicated she is afraid to give the patient a new medication because it might make the patient lethargic. HHA D indicated they had not picked up the new medication from the pharmacy yet, but would call the alternate clinical supervisor when she did. HHA D indicated it was odd that physician F resigned and then put the patient on a beta blocker, because the patient has been in the same condition for a long time. During an interview on 6/7/2021, at 4:27 PM, the administrator stated, "We are essentially family" for some patients. The administrator indicated it is not agency policy for a HHA to give medications. The administrator indicated it is not on the care plan for HHA D to pick up medications for the patient.	N 604		
{N 606}	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. This RULE is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the supervising nurse ensured the home health aide was following the aide care plan in 3 of 3 clinical record reviewed with home health aide services. (#1, #2, #3)	{N 606}		

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{N 606}	Continued From page 109 The findings include: 1. Review of an agency policy revised November 2020, titled "Home Health Aide Supervisory Visits" stated, "... The registered nurse and/or appropriate skilled professional will be responsible for: A. supervision of all services provided for in the plan of care ... Supervisory visits and overall supervision will be documented in the clinical record. A. Supervisory visits will be documented on a supervisory visit form. Each supervisory visit shall contain documentation to ensure that the aide is furnishing care in a safe and effective manner, including, but not limited to, the following elements: 1. Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or another appropriate skilled professional...." 2. During an observation of care on 6/4/2021 at 7:30 AM, at the home of patient #1, start of care 3/11/2021, a sign was observed hanging in the patient's bedroom that stated, "Aides List for [patient] ... Nystatin [a medication used to treat fungal infections] cream under both breasts and between legs." A tube labeled "Nystatin" was observed in the patient's bedroom. At 7:46 AM, home health aide E was observed applying an ointment from a jar labeled "Vaseline" to the patient's buttocks. During an interview on 6/4/2021 at 7:46 AM, home health aide E indicated she has applied Nystatin cream under the patient's breasts when they are red. The home health aide stated, "It goes away in just a couple of hours after putting that on." Clinical record review for patient #1 on 6/3/2021	{N 606}		

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{N 606}	Continued From page 110 evidenced two agency documents titled "Home Health Aide Care Plan", electronically signed by the clinical manager and dated 5/10/2021. These documents were identified by the administrator as one care plan for the Medicare home health aide visits and one care plan for the Medicaid home health aide visits. The Medicare home health aide care plan indicated the home health aide was to provide 3 visits a week for 8 weeks. The Medicaid home health aide care plan indicated the home health aide was to provide a visit for 7-10 hours a day, 7 days a week. Both home health aide care plans failed to evidence the home health aide was assigned to apply Nystatin cream under the patient's breasts and failed to evidence the home health aide was assigned to apply Vaseline to the patient's buttocks. The Medicare home health aide care plan indicated the home health aide was to turn and reposition the patient, provide perineal care (the cleaning of the private areas) and provide nail care/cut nails at every visit. The Medicaid home health aide care plan indicated the home health aide was to bathe the patient 3 times a week, shampoo the patient's hair and shave the patient weekly, provide incontinent (loss of control of the bowel and/or bladder) care 2-3 times daily, perineal care 2-3 times daily and provide skin care/check for pressure areas daily. Review of agency documents titled "Home Health Aide Visit" and identified by the administrator as the Medicare home health aide visit notes failed to evidence home health aide E turned and repositioned the patient and provided perineal care and nail care on 5/10/2021, 5/12/2021, 5/14/2021, 5/17/2021, 5/19/2021 and 5/21/2021 as directed in the Medicare home health aide care plan. Review failed to evidence home health aide E provided perineal care and nail care on 5/24/2021, 5/28/2021 and 5/31/2021 as directed	{N 606}		

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{N 606}	Continued From page 111 in the Medicare home health aide care plan. Review of agency documents titled "Home Health Aide Visit" and identified by the administrator as the Medicaid home health aide visit notes indicated the home health aide bathed and shaved the patient and shampooed the patient's hair 6 times during the weeks of 5/10/2021 and 5/16/2021 and failed to provide services as directed in the Medicaid home health aide care plan. The visit notes failed to evidence home health aide E provided perineal care and incontinence care on 5/10/2021 and failed to evidence home health aide E provided skin care/check for pressure areas on 5/31/2021 as directed in the Medicaid home health aide care plan. Review of an agency document titled "CHHA [certified home health aide] Supervisory Visit", electronically signed by the alternate clinical manager and dated 5/28/2021, failed to evidence the supervising nurse ensured the home health aide was following the home health aide care plan for completion of tasks assigned to the home health aide. During an interview on 6/4/2021 at 10:46 AM when queried why the home health aide did not provide care as directed in the home health aide care plan, the administrator stated, "You are exposing some things we have to fix." At 4:23 PM, the administer indicated the home health aide care plan should include any creams the home health was to apply to the patient. The administer indicated the home health could not assess the need for anti-fungal cream and could not apply medication to the patient. During an interview on 6/4/2021 at 10:49 AM, the	{N 606}		

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{N 606}	Continued From page 112 alternate clinical manager indicated if the home health aide was not following the care plan, the home health aide should be directed to provide the care assigned on the home health aide care plan or the care plan should be updated to meet the patient's needs. When queried how the agency ensured the home health aide was following the care plan, the alternate clinical manger indicated not all of the home health aide visit notes had been reviewed. 3. Clinical record on 6/6/2021 for patient #3, start of care 5/16/2021, evidenced an agency document titled "Home Health Aide Care Plan", electronically signed by the alternate clinical manager and dated 5/16/2021. This document indicated the home health aide was to provide services for 5-7 hours per visit, 1 visit per day, 5-7 days a week. This document indicated the home health aide was directed to shower, shampoo, shave the patient 3 times a week and provide nail care 2 times a week. Review of agency documents titled "Home Health Aide Visit", electronically signed by HHA M on 5/16/2021, 5/18/2021, 5/20/2021, 5/21/2021, 5/25/2021, 5/27/2021, 5/28/2021, 5/29/2021, 5/30/2021, 6/1/2021, 6/3/2021 and 6/4/2021 and electronically signed by HHA N on 5/17/201, 5/19/2021, 5/24/2021, 5/26/2021, 5/31/2021 and 6/2/2021 indicated the home health aide showered, shampooed and shaved the patient and provided nail care 6 times during the weeks of 5/16/2021, 5/23/2021 and 5/30/2021. Review failed evidence the home health aide provided services as directed in the home health aide care plan. Review of an agency document titled "CHHA [certified home health aide] Supervisory Visit",	{N 606}		

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{N 606}	Continued From page 113 electronically signed by the alternate clinical manager and dated 6/1/2021, failed to evidence the supervising nurse ensured the home health aide was following the home health aide care plan for completion of tasks assigned to the home health aide. During an interview on 6/4/2021 at 10:37 AM, the administrator indicated the agency was to review the home health aide notes weekly for completion. During an interview on 6/7/2021 at 1:43 PM, the alternate clinical manager indicated she had not reviewed the home health aide notes yet and indicated the home health aides should be educated on the frequency of tasks directed on the home health aide care plan. 4. Clinical Record review on 6/7/2021, for patient #2, start of care 3/11/2021, evidenced two agency documents titled "Home Health Certification and Plan of Care", for certification period 5/10/2021 - 7/8/2021. These documents were identified by the administrator as one plan of care for the Medicare-covered services and one plan of care for the Medicaid-covered services. The administrator indicated the Medicare plan of care was identified with the medical record number beginning with "MR" and the Medicaid plan of care was identified with the medical record number beginning with "HHA". The plan of care that had a medical record starting with "MR" and was electronically signed by physician F on 6/4/2021. This document had an area subtitled "10. Medications" which indicated the patient was prescribed Baclofen, Ocrevus and Ibuprofen. An area subtitled "21. Orders for Discipline and Treatments (Specific Amount/Frequency/Duration) stated " ... HHA	{N 606}		

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{N 606}	Continued From page 114 [home health aide] provides all ADL [activities of daily living] care during the day, and family checks on [him/her] in the evening ... HHA 7-8h/v- 5 - 7v/wk x's [7 to 8 hour visits, 5 to 7 days a week, for] 9 weeks Funded by Medicaid ... HHA PRN Visits for care up to 2h/wk [2 hours per week] ... HHA 2/wk x's [twice per week for] 9 weeks Medicare funded ...." Review failed to evidence a home health aide care plan associated with the plan of care beginning with "MR". Review of agency documents titled, "Home Health Aide Visit" for the Medicare record starting with "MR" which were electronically signed by HHA D, failed to evidence any tasks were completed for the following dates: 5/13/2021, 5/18/2021, 5/20/2021, and 5/25/2021. Review failed to evidence the home health aide performed tasks as ordered on the HHA care plan. Review failed to evidence supervisory visits were performed to ensure the aide was furnishing care appropriately. The Medicaid plan of care failed to indicate it was reviewed by the physician. An area subtitled "21. Orders for Discipline and Treatments (Specific Amount/Frequency/Duration) stated " ... HHA [home health aide] provides all ADL [activities of daily living] care during the day, and family checks on [him/her] in the evening ... HHA 7-8h/v- 5 - 7v/wk x's [7 to 8 hour visits, 5 to 7 days a week, for] 9 weeks Funded by Medicaid ... HHA PRN Visits for care up to 3h/wk [3 hours per week] ...." Review of an agency document titled, "Home Health Aide Care Plan" which was electronically	{N 606}		

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{N 606}	Continued From page 115 signed by the alternate clinical supervisor on 5/10/2021, for the clinical record starting with "HHA". This document had a list of tasks to be performed by the HHA, for the patient, including but not limited to, Oral care, skin care/ check pressure areas, assist with feeding, and medication reminders. Review of an agency documents titled, "Home Health Aide Visit" for the Medicaid record starting with "HHA", which were electronically signed by HHA D, failed to evidence any of the assigned tasks were completed for the following dates: 5/11/2021, 5/13/2021, and 5/23/2021. Review failed to evidence the HHA performed tasks as ordered on the care plan. Review of an agency document titled , "CHHA Supervisory Visit" which was electronically signed by the alternate clinical supervisor on 5/21/2021. This document stated "Name of Staff Being Supervised: [HHA D] ... Nurse Supervisor doing Supervisory Visit: [alternate clinical supervisor] ...." This document indicated all the HHA performed all personal care and ADL care to satisfactory, and patient/family is satisfied with care. Review failed to evidence the supervising nurse ensured the care plan was being followed. Review of an agency document titled , "CHHA Supervisory Visit" which was electronically signed by the alternate clinical supervisor on 6/4/2021. This document stated "Name of Staff Being Supervised: [HHA M] ... Nurse Supervisor doing Supervisory Visit: [alternate clinical supervisor] ...." This document indicated all the HHA performed, all personal care and ADL [activities of daily living] care to satisfactory, and patient/family was satisfied with care. Review failed to evidence	{N 606}		

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{N 606}	Continued From page 116 the supervising nurse ensured the care plan was being followed. Review failed to evidence HHA M provided care to patient #2. Clinical record review failed to evidence a supervisory visit completed for HHA D. During an interview on 6/4/2021 at 1:36 PM, HHA D indicated she was afraid to give the patient a new medication because it might make the patient lethargic. HHA D indicated they had not picked up the new medication from the pharmacy yet, but would call the alternate clinical supervisor when she did. During an interview on 6/7/2021 at 1:10 PM, the alternate clinical supervisor stated "No good reason" when queried why HHA visit notes were blank. During an interview on 6/7/2021 at 2:27 PM, the administrator stated, "We are essentially family" for some patients. The administrator indicated it was not agency policy for a HHA to give medications. The administrator indicated it was not on the care plan for HHA D to pick up medications for the patient.	{N 606}		
{N 608}	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed	{N 608}		

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{N 608}	Continued From page 117 to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the discharge summary was completed and sent to the primary care physician in 1 of 1 closed clinical records reviewed. (#4) The findings include: Review of an undated agency policy, obtained 6/7/2021, titled "Discharge Summary" stated, "... Each patient discharged from a service and from the organization will have a written discharge summary filed in the clinical record. Procedure 1. Each clinician who provides care will complete a discharge summary at the time his/her discipline is discharged, which may include, as appropriate: A. The date of discharge, including the date the physician and the patient were informed of discharge B. The reason for discharge C. The reason for discharge, including, as applicable, the name of the organization to which the patient is being transferred D. The status of problems identified at admission and during the provision of care E. The progress towards goals/desired outcomes F. Medical status at discharge, including continuing symptom management needs G. The overall status of the patient H. A summary of care or services provided 2. The discharge summary and other relevant clinical record documents will be completed and	{N 608}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE HOME HEALTH SERVICES INC	6 MORGAN BLVD STE 101 VALPARAISO, IN 46383

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{N 608}	Continued From page 118 submitted within 72 hours of discharge from service...." Clinical record review on 6/6/2021 for patient #4, start of care 5/17/2021, evidenced an agency document titled "Communication Note", electronically signed by the alternate clinical manager and dated 5/25/2021. This document indicated the patient was no longer in need of services and the physician discharged the patient. Review of an agency document titled "Discharge Summary", electronically signed by the alternate clinical manager and dated 5/25/2021, failed to be complete to include the date of discharge, last visit date, disciplines involved and discharge instructions. Review failed to evidence the discharge summary had been sent to the physician. During an interview on 6/7/2021 at 12:32 PM, the alternate clinical manager indicated she had problems with the application on her phone for the electronic health record when queried why the discharge summary was incomplete. The alternate clinical manager indicated the discharge summary was faxed from the electronic health record but there was no fax confirmation. The alternate clinical manager indicated the agency needed a better fax tracking system. During an interview on 6/7/2021 at 12:39 PM, the administrator indicated the electronic health record could print the fax confirmation. No additional documentation received.	{N 608}		
{N 610}	410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible,	{N 610}		

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{N 610}	Continued From page 119 clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure all clinical records were clear, legible and appropriately authenticated in 4 of 4 clinical records reviewed. (#1, #2, #3, #4) The findings include: 1. Review of an undated agency policy, obtained on 6/7/2021, titled "Entries Into The Clinical Record" stated, "... A clinical record will be initiated and maintained for each patient receiving care or services, according to organization policies found in this manual, and will include at a minimum: ... The clinical note will include: ... The date the service was provided (month, day, year) E. Signature of clinician and his/her credentials...." 2. Clinical record review on 6/3/2021 and again on 6/7/2021 for patient #1, start of care 3/11/2021, evidenced an agency document titled "Oasis D1-Recertification", dated and signed by registered nurse C on 5/5/2021. The recertification document failed to evidence the gyneco-urinary (reproductive and urinary systems) assessment and nutritional risk assessment. This document failed to evidence the follow-up performance was completed. This document indicated personal goals were discussed but failed to evidence with whom the goals were discussed. This document indicated 0 therapy visits were needed and failed to evidence	{N 610}		

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{N 610}	Continued From page 120 frequency and duration of physical therapy services. This document failed to be complete and accurate. Review of the agency's electronic health record evidenced documents titled "Physical Therapy Progress Visit", dated 5/13/2021 and 5/20/21, which stated, "In Progress". During an interview on 6/4/2021 at 10:50 AM, the administrator indicated the patient received physical therapy services 1 time per week and indicated he was the physical therapist conducting the visits. The administrator indicated the physical therapy visit notes for 5/13/2021 and 5/20/2021 were not yet completed. During an interview on 6/4/2021 at 11:35 AM, the clinical manager indicated she completed the OASIS form at time of the assessment, but then the office was supposed to review it and some things must have been missed. The clinical manager indicated she was unaware the patient was receiving physical therapy services. Review evidenced an agency document titled "Home Health Certification and Plan of Care", for certification period 5/10/2021 - 7/8/2021. This documents was identified by the administrator as the plan of care for the Medicaid-covered services and identified with the medical record number beginning with "HHA" (home health aide). The plan of care failed to evidence the clinician's name, signature and date for whom completed the plan of care. During an interview on 6/4/2021 at 10:40 AM, the administrator indicated the Medicaid plan of care is for billing purposes only and is not sent to the physician. The administrator indicated the plan of	{N 610}		

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{N 610}	Continued From page 121 care should have been signed and dated by the clinician. During an interview on 6/4/2021 at 11:35 AM, the clinical manager indicated she completed the plan of care. 3. Clinical record on 6/6/2021 for patient #3, start of care 5/16/2021, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/16/2021 - 7/14/2021, electronically signed by the alternate clinical manager and dated 5/16/2021. This document indicated the patient was to receive home health aide services 7-8 hours per visit, 1 visit per day, 5-7 days a week. Review evidenced agency documents titled "Home Health Aide Visit" electronically signed by HHA N and dated 5/17/2021, 5/19/2021, 5/24/2021, 5/26/2021, 5/31/2021 and 6/2/2021 indicated the home health aide provided home health aide services from 12:00 AM to 12:00 AM. The documents electronically signed by HHA M and dated 5/18/2021 and 5/20/2021 indicated the HHA provided home health aide services from 1:30 AM to 5:00 PM. The documents electronically signed by HHA M dated 5/25/2021, 5/27/2021, 6/1/2021 and 6/3/2021 indicated the HHA provided home health aide services from 1:00 AM to 5:00 PM. During an interview on 6/7/2021 at 1:42 PM, the alternate clinical manager indicated the times on the home health aide visit notes were not correct. Review of an agency document titled "Patient Medication Profile" for episode period 5/16/2021 - 7/14/2021 failed to evidence the name and signature of the clinician who completed the	{N 610}		

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{N 610}	Continued From page 122	{N 610}		

document and failed to evidence the date the form was completed.

Review an agency document titled "Oasis D1-Start of Care", dated 5/16/2021 and electronically signed by the alternate clinical manager, was identified by the alternate clinical manager as the initial comprehensive assessment. This document failed to be complete. The document failed to evidence the eyes were assessed. Review failed to evidence the patient/primary caregiver was provided education and failed to evidence a patient summary. Review failed to evidence the patient's strengths and limitations were completed.

During an interview on 6/7/2021 at 1:33 PM, the alternate clinical manager indicated the comprehensive assessment should have been complete.

4. Clinical record review on 6/6/2021 for patient #4, start of care 5/17/2021, evidenced an agency document titled "Communication Note", electronically signed by the alternate clinical manager and dated 5/25/2021. This document indicated the patient was no longer in need of services and the physician discharged the patient.

Review of an agency document titled "Discharge Summary", electronically signed by the alternate clinical manager and dated 5/25/2021, failed to be complete to include the date of discharge, last visit date, disciplines involved and discharge instructions.

During an interview on 6/7/2021 at 12:32 PM, the alternate clinical manager indicated she had problems with the application on her phone for the electronic health record when queried why the

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{N 610}	Continued From page 123 discharge summary was incomplete. Review of an agency document titled "Patient Medication Profile" for episode period 5/16/2021 - 7/14/2021 failed to evidence the name and signature of the clinician who completed the document and failed to evidence the date the form was completed. During an interview on 6/7/2021 at 12:15 PM, the alternate clinical manager indicated she did not see a signature on the medication profile. Clinical record review on 6/6/2021 for patient #4, start of care 5/17/2021, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/17/2021 - 7/15/2021. This document failed to evidence the clinician's name and signature for whom completed the plan of care. Review of an agency document titled "Skilled Nursing Evaluation", electronically signed by the alternate clinical manager and dated 5/19/2021, indicated the patient's vital signs but failed to evidence any additional assessment. The document evidenced to be incomplete and the patient's mental status, pain, nutritional status, cardio/pulmonary status, gastrointestinal status, genitourinary status and integumentary status was not assessed. During an interview on 6/7/2021 at 12:17 PM, the alternate clinical manager indicated she provided skilled nursing care to the patient on 5/19/2021 but she had difficulty with the electronic health record application on her phone and the documentation was not uploaded into the electronic health record.	{N 610}		

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{N 610}	Continued From page 124 Review evidenced an agency document titled "Oasis D1-Discharge From Agency". This document was dated and signed by the alternate clinical manager on 5/25/2021 and identified by the alternate clinical manager as the discharge comprehensive assessment. This document indicated the patient had a bilateral (to each side) mastectomy (the surgical removal of the breast) and had pain daily but not constantly. The document failed to evidence the location, duration and description of the pain. The document failed to evidence pain relieving measures. This document indicated the patient did not have wounds but the document stated, "... Patient has bilateral drains that have 3 stiches [sic] each. Covered with a tegaderm [a transparent film wound dressing]and a bio patch [a foam patch with topical antiseptic used to prevent infection]. Dressing changed using sterile technique. Cleansed with acholol [sic] and covered with bio patch and secured with tegaderm. Drains were removed by MD [medical doctor] ion [sic] last visit and wounds are healed ...." The document failed to be complete with the patient's weight. During an interview on 6/7/2021 at 12:18 PM, the alternate clinical manager indicated she completed the discharge assessment and did not assess the previous surgical wounds to each breast because there was a bandaid over each area. The alternate administrator indicated the surgical drains had been removed and the wounds were healed. The alternate administrator indicated she did not provide wound care as indicated by the discharge assessment, but rather the wound care description was pulled over from the admission document. The alternate clinical manager indicated the OASIS document should have been complete and accurate.	{N 610}		

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{N 610}	Continued From page 125 5. Clinical record review on 6/7/2021 for patient #2, start of care 3/11/2021, primary diagnosis of a pressure ulcer stage 2 (a sore which wears below the surface of the skin, usually caused by pressure near bony prominences), evidenced an agency document titled "Oasis D1-Start of Care" dated and signed by the administrator (physical therapist) on 3/11/2021. This document failed to be completed. This document failed to evidence the patient's home safety assessment, professional services provided, discharge plans, and rehabilitation potential. An area subtitled "Pain" stated "Patient has no pain ..." Under numeric pain assessment, this document stated "Onset ... Chronic ... present level (0-10) ... 3 ... Worst pain gets (0-10) ... 8 ...." This section failed to include what relieved patient's pain and if breakthrough pain medication was needed. This comprehensive assessment failed to be complete, accurate and include the patient's full assessment of their health, physical, and psychosocial needs. Record review evidenced agency documents titled Physical Therapy Progress Visit" dated and signed by the administrator (physical therapist) on 5/20/2021 and 6/4/2021. The physical therapy progress documents failed to be completed to include pain assessments, exercises/activities, and plans/goals. Review of agency documents titled, "Home Health Aide Visit" for the Medicare record starting with "MR" which were electronically signed by home health aide D, failed to evidence any tasks were completed for the following dates: 5/13/2021, 5/18/2021, 5/20/2021, and 5/25/2021. Review of agency documents titled, "Home Health Aide Visit" for the Medicaid record starting	{N 610}		

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{N 610}	Continued From page 126 with "HHA", which were electronically signed by home health aide D, failed to evidence any of the assigned tasks were completed for the following dates: 5/11/2021, 5/13/2021, and 5/23/2021. During an interview on 6/7/2021 at 1:03 PM, when queried if the administrator can report what the patient did by reviewing the physical therapy progress visit note, he replied, "No." The administrator indicated there was so much to do on the notes. During an interview on 6/7/2021 at 1:10 PM, the alternate clinical supervisor stated "No good reason" when queried why HHA visit notes were blank. During an interview on 6/7/2021 at 1:33PM the administrator indicated pain should be a complete assessment and was usually done at the start of the visit because pain was the 5th vital sign.	{N 610}		
{N 614}	410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service.	{N 614}		

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{N 614}	Continued From page 127 This RULE is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure all clinical records and patient information was safeguarded from unauthorized use. The findings include: The undated agency policy, retrieved on 3/23/21, titled "Confidentiality Of Informant" Policy No. [number] 1-015.1 stated "Purpose To ensure the patient's right to privacy is protected by following the policies and procedures regarding confidentiality and use and disclosure of protected health information (PHI), as necessary. Policy First Choice Home Health Services Inc and its personnel will maintain as confidential all patient-protected health information. Protected health information will be used and disclosed in accordance with the organization's policies and procedures. ... Procedure 1. During the orientation process, this Confidentiality Policy will be reviewed by organization personnel ... 11. The organization respects the safety and security of patients and their property ...13. The following patient information will be secured after business hours: A. Clinical records B. Field clinical records C. Patient intake...." The undated agency policy, retrieved on 3/23/21, titled "Privacy Of PHI [protected health information]" Policy No. [number] 1-024.1 stated "Purpose To establish a procedure to prevent, detect, contain and correct privacy violations involving protected health information. Policy The organization will identify risks and safeguard protected health information against loss,	{N 614}		

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{N 614}	Continued From page 128 destruction, tampering, or unauthorized use. Procedure ... 3. First Choice Home Health Services Inc will train all employees and volunteers on the privacy policies and procedures as necessary and appropriate for them to carry out their functions. ... 5. First Choice Home Health Services Inc will implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with HIPAA security standards...." During an observation of a home visit on 6/4/2021 at 12:55 PM, in the home of patient #2, a blue folder was evidenced near the television, which contained a document of the patients personal health information. These documents included, but were not limited to, the emergency preparedness plan and admission consent. Upon review of the blue folder, a document was evidenced containing the personal health information for patient #1. This document was titled, "Individualized Emergency Plan" which had personal health information including, but not limited to, the patient's name, date of birth, phone number, diagnoses, and emergency contact information. The home health agency failed to ensure the personal information of patient #1 was safeguarded against unauthorized use. During an interview on 6/4/2021 at 7:04 AM, patient #1 indicated the administrator delivered the agency folder the previous night at 10:30 PM. The patient indicated the agency had not provided the visit schedule before last night. During an interview on 6/4/2021 at 4:07 PM, the administrator indicated he was unsure how patient #1's personal health information ended up in the home of patient #2. The administrator stated they made the blue folders and were	{N 614}		

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{N 614}	Continued From page 129 brought to the patients' homes "about 2 weeks ago". The administrator was informed that patient #1 had already indicated he brought the folder to their home the day prior. The administrator stated "You are good" and indicated it was an error on his part.	{N 614}		
{N9999}	Final Observations Review of Indiana Code 16-27-2.5 stated in "... Sec. 1. (a) After giving a job applicant written notice of the home health agency's drug testing policy, a home health agency shall require a job applicant who is seeking employment with the home health agency for a position that will have direct contact with a patient to be tested for the illegal use of a controlled substance. ... (c) If a job applicant is hired by the home health agency before the job applicant's results of the drug test are received, the hired individual may not have any contact with patients until the home health agency obtains results of the drug test that indicate that the individual tested negative on the drug test. If the drug test results indicate that the individual tested positive on the drug test, the home health agency shall discharge or discipline the individual. If the home health agency disciplines the individual, the individual may have no direct contact with a patient for at least six (6) months. Section 2.(a) A home health agency must: (1) have a written drug testing policy that is distributed to all employees; and (2) require each employee to acknowledge receipt of the policy. (b) A home health agency shall randomly test: (1) at least fifty percent (50 %) of the home health agency's employees who: (A) have direct contact with patients; and (B) are not licensed by a board or commission under IC 25; at least annually; or (2) when the home health agency has reasonable	{N9999}		

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{N9999}	Continued From page 130	{N9999}		

suspicion that an employee is engaged in the illegal use of a controlled substance...."

Based on record review and interview, the agency failed to ensure employees tested negative on the drug test before having direct contact with patients in 2 of 2 personnel records reviewed of unlicensed staff with direct patient contact. (E, J)

The findings include:

1. Review of an undated agency policy titled "Controlled Substance Testing Policy" stated, "... Upon completion of all other aspects of the hiring process, if a decision to hire a Covered Applicant is made, the Covered Applicant will be offered employment conditioned upon taking and passing a Test for Controlled Substances. ... The test results will be placed in the confidential portion of the individual's personnel file...."

2. Personnel record review on 6/3/2021 for home health aide (HHA) E, date of hire 3/9/2020, and first patient contact date 3/23/2020, failed to evidence the HHA tested negative for controlled substances prior to patient contact.

3. Personnel record review on 6/3/2021 for HHA J, date of hire 3/29/2020 and first patient contact date 3/31/2021, failed to evidence the HHA tested negative for controlled substances prior to patient contact.

During an interview on 6/3/2021 at 12:57 p.m., the alternate clinical supervisor indicated the drug screen was performed for HHA J, but did not document.

4. During an interview on 6/3/2021 at 4:43 PM, the alternate clinical supervisor indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007135	A. BUILDING: _____ B. WING _____	R 06/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE HOME HEALTH SERVICES INC	6 MORGAN BLVD STE 101 VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N9999}	Continued From page 131 employee drug screens are completed at the agency during orientation. The alternate clinical supervisor indicated they perform the drug screens, document the results on the employee's drug screen consent form, which was then stored in the log.	{N9999}		