STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K164	A. BUILDING _____ B. WING _____	C 11/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE TREE HOME HEALTH CARE SERVICES, LLC	5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS	G 000		

This was a federal recertification and state re-licensure survey, and an investigation of two (2) complaints.
This was a fully extended survey.

IN00307091 - Substantiated with findings
IN00341250 - Substantiated with findings

The survey began on March 11, 13, and 16. The survey was interrupted due to COVID-19 and suspension of survey activity per CMS. The survey resumed on October 27, 28, 29, 30, November 2, 5, 9, 10, 12, 16, 17, 18, 20 of the year 2020.

Facility number: 014207
Provider number: 15K164

Current census: 23

Record review with home visits: 3
Record review without home visits: 7
Total records reviewed: 10

Apple tree Home Health Care Services, LLC is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning November 20, 2020 to November 20, 2022 for being found out of compliance with the Conditions of Participation 42 CFR 484.50 Patient Rights, 484.55 Comprehensive Assessment of Patients, 484.60 Care planning, coordination, quality of care, 484.65 Quality assessment and performance improvement, 484.70 Infection Prevention and Control, 484.105 Organization and Administration of Services, and 484.110 Clinical Records.

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

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G 000	Continued From page 1 These deficiencies reflects State Findings cited in accordance with 410 IAC 17. Refer to the State Form for additional State Findings.	G 000		
G 374	Quality Review Completed 01/04/2020 Area 1 Accuracy of encoded OASIS data CFR(s): 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. This STANDARD is not met as evidenced by: Based on record review and interview, the registered nurse (RN) failed to ensure outcome and assessment information set (OASIS) questions were answered accurately for 2 of 5 active records reviewed (#2, 3). Findings include: 1. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 8/27/20-10/25/20 which indicated a diagnosis of anoxic brain injury and orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 3 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), meal preparation, set up assist, bathing, dressing, and light housekeeping.	G 374		

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G 374	Continued From page 2	G 374		

During a home visit on 10/29/20 at 11:00 AM, the spouse of patient #2 indicated they lived together in the apartment, that he required 24 hour care due to his brain injury.

A start of care comprehensive assessment was completed on 8/27/20 by the director of nursing indicated on question M1100 that the "patient lives with other person(s) in the home," with "09" marked which indicated "occasional," when "06" should have been marked to indicate "around the clock." Question M2001 indicated "No issues found during the review," but should have been marked as "Issues found during review."

On 11/20/20 all medications from the agency plan of care were checked on Drugs.com for interactions. The interactions showed major interactions with atorvastatin and ranolazine as well as multiple moderate interactions. The Drugs.com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit."

2. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated the patient had a diagnosis of lupus (causes pain, stiffness, and swelling of muscles, tendons and joints), the medications, but not limited to, tramadol and "toujeo [injectable medication used for diabetes] 300/10 units daily subcutaneous."

A recertification comprehensive assessment was completed on 9/15/20 answered question M1242 about the patients pain interfering with activity or movement which was marked "patient has no

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G 374	Continued From page 3 pain, but the patient takes tramadol pain medication twice daily and a diagnosis that typically has pain. "M2030 about the patient's ability to prepare and take all prescribed injectable medication as "N/A-No injectable medications prescribed." 3. During an interview on 10/26/20 at 1:35 PM, the alternate administrator stated the director of nursing was responsible for reviewing the records for accuracy and she also reviewed them.	G 374		
G 406	Patient rights CFR(s): 484.50 Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. This CONDITION is not met as evidenced by: Based on observation, record review, and interview the agency failed to ensure the patients were provided privacy practice notices, patient rights information, information regarding a confidential clinical record, correct contact information for the state and funded programs required, access to auxiliary aides, discharge notice, and adequate discharge notice. These practices impacted all patients. The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients rights were protected as required by the Condition of Participation 484.50 Patient Rights. Findings include:	G 406		

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G 406	Continued From page 4	G 406		

The agency failed to ensure an Outcome and assessment information set (OASIS) privacy notice was given to all patients who received an OASIS assessment (See Tag G 416).

The agency failed to ensure a written copy of the patent's rights and responsibilities were given to the patient/caregiver and maintained in the home folder, to be reviewed periodically with the patient/caregiver by agency staff (See Tag G 422).

The agency failed to ensure all patients were notified of their right to a confidential clinical record and failed to ensure that every patient had a confidential clinical record maintained (See Tag G 438).

The agency failed to ensure all patients were advised orally and in writing of the charges for home care service before care is initiated (See Tag G440).

The agency failed to ensure their policy correlated with regulatory requirements for discharge notice, and failed to ensure patients received a 15 day notice of discharge (See Tag G442).

The agency failed to advise that patients of the correct hours of operation for the Indiana Department of Health (See Tag G444).

The agency failed to provide the names, addresses, and telephone numbers of the following federally-funded and state-funded entities that serve the patients' area of residence, to include the following: Agency on Aging, Center for Independent Living, Protection and Advocacy Agency, Aging and Disability Resource Center,

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G 406	Continued From page 5 and the Quality Improvement Organization (See Tag G446). The agency failed to ensure patients were informed of access to auxiliary aids and language services, and how to access them (See Tag G450). The agency failed to ensure all complaints with resolutions were documented (See Tag G484).	G 406		
G 416	OASIS privacy notice CFR(s): 484.50(a)(1)(iii) (iii) An OASIS privacy notice to all patients for whom the OASIS data is collected. This ELEMENT is not met as evidenced by: Based on observation, and record review, and interview the agency failed to ensure an Outcome and assessment information set (OASIS) privacy notice was given to all patients who received an OASIS assessment for 3 of 3 home visit observations (#1, 2, 3). Findings include: 1. An undated agency policy titled "Home Care Bill of Rights," Policy #C-380 stated "... SPECIAL INSTRUCTIONS... Clients/families will be informed of their right to privacy and confidentiality related to personal health care information data collection and transmission (OASIS) ...." 2. A blank admission packet was reviewed on 10/26/20 at 2:40 PM, and failed to evidence an OASIS privacy practice notice. 3. A home visit observation was conducted with	G 416		

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G 416	Continued From page 6 employee H, home health aide (HHA), on 10/29/20 at 8:00 AM, with patient #1 (start of care 7/11/17). During the visit, the patient's home folder was viewed and failed to evidence an OASIS privacy practice notice. 4. A home visit observation was conducted with employee OO, HHA, on 10/29/20 at 11:00 AM, with patient #2 (start of care 8/27/20). During the visit, the patient's home folder was viewed and failed to evidence an OASIS privacy practice notice. 5. A home visit observation was conducted with employee C, director of nursing (DON), on 10/29/20 at 12:40 PM, with patient #3 (start of care 5/14/20). During the visit, the patient's home folder was viewed and failed to evidence an OASIS privacy practice notice. 6. During an interview on 11/5/20 at 3:00 PM, the administrator stated the patients should receive an OASIS privacy notice.	G 416		
G 422	Written notice within 4 business days CFR(s): 484.50(a)(4) Provide written notice of the patient's rights and responsibilities under this rule and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section to a patient-selected representative within 4 business days of the initial evaluation visit. This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure a written copy of the patent's rights and responsibilities were given to the patient/caregiver and maintained in the home folder, to be reviewed	G 422		

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G 422	Continued From page 7	G 422		

periodically with the patient/caregiver by agency staff, for 2 of 3 home visit observations (#2, 3).

Findings include:

1. An undated agency policy titled "Home Care Bill of Rights," Policy #C-380 stated "Policy: Clients and their representatives will be informed of their rights as a consumer of home care services prior to the start of care ... Special Instructions: 1. A designated registered nurse/therapist shall provide the client with a written notice of the home care bill of rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated...."

2. A blank admission packet was reviewed on 10/26/20 at 2:40 PM, and failed to evidence patient right and responsibility information.

3. A home visit observation was conducted with employee OO, HHA, on 10/29/20 at 11:00 AM, with patient 1 (start of care 8/27/20). During the visit, the patient's home folder was viewed and failed to evidence any patient right and responsibility information.

4. A home visit observation was conducted with employee C, director of nursing (DON), on 10/29/20 at 12:40 PM, with patient 1 (start of care 5/14/20). During the visit, the patient's home folder was viewed and failed to evidence any patient right and responsibility information.

5. During an interview on 11/5/2020 at 3:00 PM, the administrator stated it is the responsibility of the director of nursing to ensure the patients receive a copy of the patient rights and

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G 422	Continued From page 8 responsibilities.	G 422		
G 438	Have a confidential clinical record CFR(s): 484.50(c)(6) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure all patients were notified of their right to a confidential clinical record and failed to ensure that every patient had a confidential clinical record maintained for 19 of 19 partial or full missing records (#4, 5, 20, 21, 22, 23, 24, 25, 26, 28, 31, 32, 34, 35, 36, 37, 39, 40, and 41). Findings include: 1. An undated agency policy titled "Home Care Bill of Rights," Policy #C-380 stated "POLICY: ...The agency will provide verbal notice of the client's rights and responsibilities ... SPECIAL INSTRUCTIONS... A designated registered nurse/therapist shall provide the client with a written notice of the home care bill of rights in advance of furnishing care to the client or during the initial evaluation visit before treatments is initiated ... Clients/families will be informed of their right to privacy and confidentiality related to personal health care information data collection and transmission (OASIS) ...." An undated agency policy titled "Clinical records/medical record retention," Policy #C-870 stated "POLICY: ...A clinical record will be maintained for very client receiving home health	G 438		

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services. All client information shall be regarded as confidential and available only to authorized users ...."

2. A required state form was completed by the alternate administrator which indicated the unduplicated census for the last 12 months was 23 (16 home health aide only, 3 personal service only, and 4 skilled patients).

3. During the entrance conference on 10/26/20 at 1:05 PM, the alternate administrator was given a list of items to submit. The list included (but not limited to), active patient census list, and a list of all discharged patients since the last survey (12/20/17).

4. The agency active census list revealed the active patients were #1, 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 27.

5. The agency discharge list revealed the discharged patients were # 8, 9, 13, 14, 15, 16, 17, 29, 30, 33, and 38.

6. Review of the previous survey roster revealed patient # 20, which was not listed on either patient lists provided.

7. Review of billing documents from June 2018 to October 2020, revealed billing to Medicaid for patients # 22, 23, 24, 25, 26, 39.

8. A document provided by previous employee R, contained a list of patients the agency serviced from billing and scheduling documentation (but not limited to) patients # 21, 23, and 25 (not on either list from the agency).

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G 438	Continued From page 10	G 438		

9. An email that was sent by person D to the administrator and employee EE on 11/24/18 at 7:59 PM, was reviewed and contained a quality review document titled "285/certification review Q.A [quality assurance] chart," that listed patients # 31, 32, 34, 35, 36, 37, 40, and 41 (none were listed on the agency's census/discharge lists), had a spot for "Y" for yes and "N" for no and stated "auditor signature: [employee EE] each certification period needs audited. Each item missing needs corrected and a note made on how corrected."

10. During record review of the clinical record for patient #4 on 10/30/20 indicated a start of care date of 4/22/20. The last page of the orders section of the hard chart revealed a plan of care with a start of care date of 8/24/18 with a certification period of 2/16/20-4/14/20. The record failed to evidence any other documents in the chart for that timeframe.

The alternate administrator was questioned on the whereabouts of the older record on 10/30/20 at 1:20 PM. The alternate administrator indicated the record was not in the office. Requested she contact the administrator to see if he knew the whereabouts of the record. Six minutes later she stated the administrator was looking for it. No record prior to the current start of care was ever submitted for review.

11. During record review of the clinical record for patient #5 on 10/30/20 it indicated a start of care date of 9/20/17 with a plan of care dated 9/4/20-11/2/20. The client profile in the electronic medical record stated the start of care date was 9/20/17. The "financial responsibility and assignment of benefits,"consent in the hard chart

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of the medical record was dated and signed by the patient on 6/17/18. The "home health beneficiary notice," was signed and dated by the patient on 6/17/18. The "client rights and responsibilities," was dated and signed by the patient on 2/18/18. The "revised admission and discharge policy," was dated and signed by the patient on 6/17/18. The "consent for the use and disclosure of protected health information, was dated and signed by the patient on 6/17/18. The record failed to evidence any documents in the record from 9/20/17 to 2/18/18.

The alternate administrator was questioned regarding the missing documentation on 10/30/20 at 2:00 PM. She stated when the previous administrator left there had been documents which were shredded, and indicated when the office was moved from Fort Wayne to Indianapolis some were found but there were gaps in services.

12. An interview was completed on 11/2/20 at 11:17 AM and 11/10/20 at 8:35 AM with patient #21. The patient stated they were a patient with the agency from approximately March 2019-August 2019 and received HHA and SN services. An email was received on 11/20/20 which contained admission, discharge, plan of care, and assignment sheet documents for patient #21 while under the care of Apple tree. The documents were Apple tree documents which failed to be evidenced at the agency while on survey.

13. During an interview on 10/26/20 at 2:18 PM, the alternate administrator was asked if all records were present in the office. She indicated the majority of records were in the office and the

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administrator had a storage in Fort Wayne, but he could bring them to the office if they were needed.

During an interview on 11/5/20 at 9:19 AM, the administrator was asked if all agency records were in the office, he stated "yes." He was then asked if there was a storage facility in Fort Wayne (per the alternate administrator). He stated the storage facility was his garage. He was asked if there were currently any records there which he stated, "not that I know of." The administrator was then given the names of patients #20, 21, 22, 23, 24, 25, 26, 28, 31, 32, 34, 35, 36, 37, 39, 40, and 41 and asked if any of those patients were or had ever been patients of the agency. He stated none had ever been patients. When questioned why the names of the patients were found on documents retained from previous employees, previous surveys, or billing the administrator stated patient #20 was "never a client because that was my auntie." The clinical record was shown to him from the Indiana Department of Health database from the last survey as a part of the chosen sample of patients reviewed. After more questioning of specific patients he indicated that patient #21 was a family member of a board member and had been a previous patient, but indicated he did not know where the records were. Then changed his answer by stating there could be records in his garage. When asked how confident he was that their were records in the garage he stated "I am very confident that there could be" due to boxes in the garage from when he moved. When asked how secure, protected and confidential the records would be from family, visitors, or damage he indicated they would be very secure and protected.

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G 438	Continued From page 13 410 IAC 17-12-3 (2) (B)	G 438		
G 440	Payment from federally funded programs CFR(s): 484.50(c)(7)(i, ii, iii, iv) Be advised, orally and in writing, of- (i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (ii) The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (iii) The charges the individual may have to pay before care is initiated; and (iv) Any changes in the information provided in accordance with paragraph (c)(7) of this section when they occur. The HHA must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f). This ELEMENT is not met as evidenced by: Based on observation and record review, the agency failed to ensure all patients were advised orally and in writing of the charges for home care service before care is initiated for 7 of 8 full records reviewed, in a total sample of 10 (#1, 3, 4, 5, 8, 9, 29). Findings include: 1. An undated agency policy titled "Client admission process," Policy # C-140 stated "...SPECIAL INSTRUCTIONS: ... 1. g The client has then financial ability to fund the home care services provided. if no other funding source is	G 440		

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available. ... 10. The admission professional will: ...g. Advise the client/caregiver/representative of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client/caregiver financial liability, and other methods of payment. h. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any possible financial obligations related to the care ...."

2. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a document titled "Financial responsibility and assignment of benefits for insurance and private pay clients," dated and signed by the patient and the director of nursing on 6/13/18. The document stated "...Please check the following services and enter rates as they apply ...." then space on the form to check which services the patient was going to get and space to write in the cost for the service after. The document had marked that the patient was going to receive skilled nursing and home health aide services, but failed to evidence charges/fees for services.

During a home visit observation completed on 10/29/20 at 8:00 AM, this document failed to be evidenced in the patient's home folder in the group home.

3. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a document titled "Apple tree home health care charges," which stated "...Apple tree Home Hewalth [sic] care supplies benefit coverage will begin on 5/14/20

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G 440	Continued From page 15	G 440		

...." The document was signed on the bottom by the director of nursing only.

4. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a document titled "Apple tree home health care charges," which stated "...Apple tree Home Hewalth [sic] care supplies benefit coverage will begin on 4/24/20 ...." The document failed to evidence a signature from patient/caregiver or agency staff.

5. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a document titled "Financial responsibility and assignment of benefits for insurance and private pay clients," dated and signed by the patient on 6/17/18. The document stated "...Please check the following services and enter rates as they apply ...." then space on the form to check which services the patient was going to get and space to write in the cost for the service after, which was blank and "NA[not applicable]" written over some of the words on the document.

6. The clinical record of patient #8 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a document titled "Financial responsibility and assignment of benefits for insurance and private pay clients," that failed to be signed by the patient/family or agency staff. The document stated "...Please check the following services and enter rates as they apply ...." an "x" was marked beside home health aide with a rate of $18.88 per hour.

7. The clinical record of patient #9 was reviewed on 11/2/20 and indicated a start of care date of

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G 440	Continued From page 16 9/20/17. The record contained a document titled "Financial responsibility and assignment of benefits for insurance and private pay clients," that was completely blank with the exception of "NA" written in the middle of the document, it also failed to be signed by the patient/family or agency staff. 8. The clinical record of patient #29 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record failed to evidence any consents for treatment including any for charges for services.	G 440		
G 442	Written notice for non-covered care CFR(s): 484.50(c)(8) Receive proper written notice, in advance of a specific service being furnished, if the HHA believes that the service may be non-covered care; or in advance of the HHA reducing or terminating on-going care. The HHA must also comply with the requirements of 42 CFR 405.1200 through 405.1204. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure their policy correlated with regulatory requirements for discharge notice and failed to ensure patients received a 15 day notice of discharge for 3 of 3 discharged records reviewed, in a total sample of 10 (# 8, 9, 29). Findings include: 1. A blank admission packet was reviewed on 10/26/20 at 2:40 PM. An agency policy revised on 12/1/19, titled "Transfer and discharge policy, stated "...If any of the above or other circumstances arise that give cause for	G 442		

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transfer/discharge, I understand that the agency will keep me and or my caregiver involved in the process and I will be provided with proper notice as soon as applicable, being at least (10) calendar days before the services are stopped .... Apple tree will continue, in good faith, to attempt to provide services during the (10) day period ...."

2. The agency discharge list revealed the discharged patients were # 8, 9, 13, 14, 15, 16, 17, 29, 30, 33, and 38, but failed to evidence the dates of discharge.

3. The entire clinical record provided by the agency for patient #8 was reviewed on 11/2/20 which indicated a start of care date of 7/18/19, and unknown discharge date. The record failed to evidence anything regarding discharge (order, comprehensive assessment, notice to patient/caregiver).

4. The clinical record of patient #9 was reviewed on 11/2/20. The record contained several start of care and discharge dates combined into one record. The record failed to evidence any discharge notice was given during any period. The periods extended from 8/11/17 to 12/6/19. The findings are as follows:

An agency safety evaluation was completed on 8/11/17 with referral sheet that stated the start of care was completed on 8/11/17. A discharge outcome and assessment information set (OASIS) was completed on 10/11/17 with an order for the discharge to be completed "per client & caregiver request." A discharge summary was completed by employee U on 10/11/17.

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G 442	Continued From page 18 Admission consents and plan of care was completed with a start of care date of 3/21/18. An order was written on 9/29/19 to discharge the patient. A discharge OASIS assessment was completed on 12/6/19. 5. The clinical record of patient #29 was reviewed on 11/2/20, which indicated a start of care date of 7/18/19, and unknown discharge date. The record failed to evidence anything regarding discharge (order, comprehensive assessment, notice to patient/caregiver). 6. During an interview on 10/26/20 at 1:35 PM, the alternate administrator was asked how many days notice of discharge patients receive. She stated "At least 10." During an interview on 10/30/20 at 9:15 AM, the alternate administrator submitted the list of discharged patients. No discharge dates were listed. When queried about this, she stated she didn't know when all the patients were discharged, but would try to find out. No further information was submitted for review.	G 442		
G 444	State toll free HH telephone hotline CFR(s): 484.50(c)(9) Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local HHAs. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to advise that patients of the correct hours of operation for the Indiana Department of Health. This impacted all patients.	G 444		

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G 444	Continued From page 19 Findings include: A blank admission packet was reviewed on 10/26/20 at 2:40 PM. An agency document from the admission packet that was to be signed on start of care by an agency registered nurse (RN) and the patient or authorized representative stated "...Home health agency Hotline: 1-800-227-6334 24 hours day, 7 days a week...." The hours of operation failed to be accurately represented for the Indiana Department of Health (8:15 AM-4:45 PM). During an interview on 10/26/20 at 2:40 PM, the alternate administrator stated she was not aware that the hours of operation were incorrect and she would get it updated.	G 444		
G 446	IAC 410 17-12-13(b)(2)(c) Contact info Federal/State-funded entities CFR(s): 484.50(c)(10)(i,ii,iii,iv,v) Be advised of the names, addresses, and telephone numbers of the following Federally-funded and state-funded entities that serve the area where the patient resides: (i) Agency on Aging (ii) Center for Independent Living (iii) Protection and Advocacy Agency, (iv) Aging and Disability Resource Center; and (v) Quality Improvement Organization. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to provide the names, addresses, and telephone numbers of the following federally-funded and state-funded entities that serve the patients' area of residence, to include	G 446		

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the following: Agency on Aging, Center for Independent Living, Protection and Advocacy Agency, Aging and Disability Resource Center, and the Quality Improvement Organization. This practice affected all patients.

Findings include:

Review of the completed geographic form (by the alternate administrator), indicated the agency provided services to patients in the following counties in Indiana: Allen, Madison, Hamilton, Hancock, Marion, Hendricks, and Johnson.

A blank admission packet was reviewed on 10/26/20 at 2:40 PM. Review of the agency's admission folder, contained a list of emergency phone numbers (no addresses) for Allen county fire department, police departments, and hospitals. Community resource numbers listed were the Indiana Home and Aging for northeast Indiana, the Indiana Department of Health, Allen County Adult Protective Services, and Indiana Department of Child Services. The list failed to evidence the phone numbers or addresses for the Center for Independent Living, Aging and Disability Resource Center, and the Quality Improvement Organization as well as addresses for the Agency on Aging or Protection and Advocacy Agency.

During an interview on 10/26/20 at 3:52 PM, the alternate administrator was asked if there was one admission packet or more than one for the areas they serve. She indicated there was an Indianapolis (where the agency is now located) and a Fort Wayne admit packet (where the patients are located). She stated the only difference with the 2 folders was a list of local

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G 446	Continued From page 21 pantries and emergency numbers that are different and everything else was the same. During that time, she was notified of the missing entities contact information.	G 446		
G 450	Access to auxiliary aids and language service CFR(s): 484.50(c)(12) Be informed of the right to access auxiliary aids and language services as described in paragraph (f) of this section, and how to access these services. This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure patients were informed of access to auxiliary aids and language services, and how to access them. This practice impacted all patients. Findings include: A blank admission packet was reviewed on 10/26/20 at 2:40 PM. The admission packet failed to evidence information for patients regarding access to auxiliary aids and language services. Home visit observations were completed on 10/29/20 at 8:00 AM with patient #1 and employee H, on 10/29/20 at 11:00 AM with patient #2 and employee OO, and on 10/29/20 at 12:40 PM with patient #3 and employee C. During the home visit observations, the patient's home folders were viewed and they failed to evidence information regarding access to auxiliary aids and language services. During an interview on 11/5/20 at 3:34 PM, the alternate administrator stated information	G 450		

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G 450	Continued From page 22 regarding auxiliary aides was added to the admission paperwork and would be made available to the patient within 24 hours of admission at no cost to the patient.	G 450		
G 484	Document complaint and resolution CFR(s): 484.50(e)(1)(ii) (ii) Document both the existence of the complaint and the resolution of the complaint; and This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure all complaints with resolutions were documented. This practice had the potential to affect all patients. Findings include: An undated agency policy titled "Client/family complaint/grievance policy," Policy # C-381 stated "...SPECIAL INSTRUCTIONS: ...Client complaints will be documented on a client complaint form and filed with the complaint log in an administrative file ...." Review of the agency complaint log on 3/12/20 at 10:32 AM, revealed a complaint regarding patient #30 dated 2/24/20, and signed by the alternate administrator on 2/25/20. At that time the alternate administrator was asked if it was entire complaint log. She indicated that was the log of complaints since she started in December of 2019, then added the administrator and herself did not know where the previous log was as it had disappeared with management changes. Review of the agency complaint log on 10/27/20 at 10:40 AM, revealed an empty complaint log. At 11:00 AM when queried where the previously	G 484		

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G 484	Continued From page 23 viewed complaint was, the alternate administrator indicated "we did log it, I have to find it" and that since the agency moved she could not find it. At that time she was notified of the concern that all complaints, grievances from patients, families and staff must be logged and investigated thoroughly. She acknowledged receipt of the information by stating "ok." Prior to exit she indicated she found it on her laptop. During an interview on 11/5/20 at 3:00 PM, the administrator was asked if he had ever received or investigated any complaints, he stated "No, never have." Then indicated that was incorrect that he had received a call one time from the father of patient #30. The alternate administrator stated that was the complaint that she made a copy of in March. The administrator stated he was responsible for complaints. During an interview on 11/9/20 at 4:56 PM, previous employee R stated when they were employed with the agency, there was a complaint log with several complaints logged in it.	G 484		
G 510	IAC 410 17-12-3(c)(2) Comprehensive Assessment of Patients CFR(s): 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment.	G 510		

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This CONDITION is not met as evidenced by:
Based on observation, record review, and interview, the registered nurse (RN) failed to ensure all components were present on the comprehensive assessment.

The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR 484.55 Comprehensive Assessment of Patients.

Findings include:

The RN failed to ensure the comprehensive assessment reflected the patient's current health psychosocial, functional, and cognitive status (See Tag G 528).

The RN failed to ensure the comprehensive assessment contained the patient's goals, and care preferences, as well as information to demonstrate progress toward achievement of goals identified by the patient and measurable outcomes identified by the agency (See Tag G 530).

The RN failed to ensure the comprehensive assessment contained information regarding the patient's medical, nursing, rehabilitative, social, and discharge planning needs (See Tag G 534).

The RN failed to ensure the comprehensive assessment contained information regarding the patient's primary caregiver, or lack of one, and their willingness and ability to provide care, availability, and schedule (See Tag G 538).

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G 510	Continued From page 25 The RN failed to update the comprehensive assessment with updated and revised information (See Tag G 544). The RN failed to ensure the recertification comprehensive assessment was completed the last 5 days of the 60 period (See Tag G 546).	G 510		
G 528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the registered nurse (RN) failed to ensure the comprehensive assessment reflected the patient's current health psychosocial, functional, and cognitive status for 8 of 8 complete records reviewed, in a sample of 10 total (1, 2, 3, 4, 5, 8, 9, 29). Findings include: 1. An undated agency policy titled "Comprehensive client assessment," Policy# C-145 stated "POLICY: The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the client's return home ... The assessment identifies facilitating factors and possible barriers to client reaching his or her goals including presenting problems ... PURPOSE: To determine the appropriate care, treatment, and services to meet the client initial needs and his/her changing needs. To collect data about the client's health history, physical, functional and psychosocial and cognitive status and their needs as appropriate to the home care setting. ... To identify clients medical, nursing,	G 528		

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rehabilitative, social and discharge planning needs ... SPECIAL INSTRUCTIONS ... The comprehensive assessment must accurately reflect the client's status, and must include at a minimum, the following information: The client's current health status ... assess the functional status ...."

2. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 10/23/20-12/21/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 12 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), around the clock supervision, meal preparation, set up assist, bathing, dressing, and light housekeeping. Furthermore, it indicated diagnoses of benign prostatic hyperplasia with lower urinary tract symptoms, hyperlipidemia, and type 2 diabetes, and a functional limitation of paralysis (failed to evidence to what area). The summary indicated the patient had a previous traumatic brain injury, headaches, left sided weakness, and short-term memory loss. Additionally there were medications, but not limited to, calcium with vitamin D (supplement), divalproex (commonly used for seizures or mental illness disorders), docusate (for constipation), fluticasone nasal spray (used for allergies), levothyroxine (used for thyroid dysfunction), loratadine (used for allergies), quetiapine (used for mental illness, typically bipolar and schizophrenia), sertraline (used for depression), and acetaminophen, naproxen, and ibuprofen (all pain medications). Lastly, it

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identified goals as "client will verbalize understanding of proper use of pain medication by the end of the care period. Neuro [neurological] status will be within normal limits and free from S&S [signs and symptoms] of complications or further deterioration. The client will be free from falls during the care period. The client will be free from injury during care period."

During a home visit completed on 10/29/20 at 8:00 AM, patient #1 was observed having left side paralysis of upper and lower extremities, patient lived in a group home with staff there and available, and the use of a toilet riser when using the bathroom.

An agency aide care plan dated 10/23/20 stated "encourage to wear oxygen."
A recertification comprehensive assessment was completed on 10/22/20 by the director of nursing. The assessment stated, "Client has history of traumatic brain injury and gets occasional headaches." The assessment also failed to evidence any vital signs or a weight, but stated in the cardiac section "SN to perform weekly weights," stated the patient had a "medical power of attorney" (but failed to identify the person for coordination purposes), failed to identify a pain level on a 0-10 scale (left blank) but stated "Client has history of traumatic brain injury and gets occasional headaches," failed to evidence lung sounds, stated the patient was a non-insulin dependent diabetic, and stated "client does not have current orders for glucose checks. Writer reached out to [person B] today for orders regarding checks and frequency" (this was also written verbatim on the last recertification dated 8/20/20 and no orders were ever obtained), stated last bowel movement was "6/23/20" (4

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months prior, and same date was listed on previous recertification), and an incomplete section regarding the care and/or teaching needed from the home health agency (SN or HHA and for what), and detailed no lung sounds or information about oxygen use.

3. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 8/27/20-10/25/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 3 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), meal preparation, set up assist, bathing, dressing, and light housekeeping.

The consent form on admission, dated 8/27/20 indicated "the anticipated apple tree home health care services and frequency to be provided," was skilled nursing 1 hour weekly, home health aide 2 hours a day, and waiver 3 times a week.

A office visit encounter from the patient's physician dated 8/14/20 indicated the patient had diagnoses of COPD (chronic obstructive pulmonary disease), hypertension, history of hypercholesterolemia, history of myocardial infarction, history of right hand fracture, gouty arthritis, arthritis, and compression fractures.

During an interview on 10/29/20 at 10:45 AM, the spouse of patient #2 stated the patient had a pacemaker/defibrillator placed in 2009.

A recertification comprehensive assessment was

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completed on 10/25/20 by the director of nursing. The assessment stated, "conclusions" were "skilled intervention needed," but failed to evidence what was needed for the patient also "community resource info needed to manage care," was marked "yes" but failed to evidence what was needed. It failed to evidence the patient's pacemaker/defibrillator, stated the patient had no teeth, but then failed to complete a nutritional assessment (to determine if the patient was a high nutritional risk) and failed to identify a diet order (left blank), and indicated the "SN to assess client filling medication box to determine if client is preparing correctly," but stated the patient had "anoxic brain damage."

4. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated the medication, but not limited to, "toujeo [injectable medication used for diabetes] 300/10 units daily subcutaneous," a diet order of "regular diabetic diet," diagnoses of lupus, type II diabetes, hypertension, orders for a registered nurse every other week for med set up, assessment, and aide and skilled nurse supervision as well as HHA 3 hours, 5 days per week for personal care, range of motion, ambulation, meal prep.

An office note dated 5/12/20 from the patient's physician indicated the patient had diagnoses, but not limited to, iron deficiency anemia, gastric bypass status for obesity, and osteopenia.

A recertification comprehensive assessment was completed on 9/15/20 by the director of nursing. The assessment indicated the nutritional risk as a

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"0" but the patient eats alone most of the time (she lives by herself and would give her 5 points), and takes 3 or more prescribed or over the counter medications daily which would give her an additional 5 points), thus the nutritional assessment was incorrect. Furthermore, the patient has diabetes, and had a gastric bypass surgery, all which would affect nutritional status. The assessment also failed to have vital signs taken, respiratory stated "WNL(within normal limits," but failed to have lung sounds despite documenting shortness of breath "when walking 20 feet or climbing stairs," stated endocrine system is "WNL" but was a diabetic managed with diet, but listed diet as "regular" (incorrect due to injectable diabetic medications taken daily per the plan of care)and was able to use glucometer. There was no blood sugar ranges documented from the last week or other time period, failed to determine if the patient was able to prep and administer the injectable diabetic medication and failed to take a random or fasting blood sugar during the recertification assessment. The cardiovascular and urinary systems were documented as ""WNL" but no assessment findings the presence of urine characteristics, frequency, urgency, heart sounds, edema, chest pain (just as an example of items that could be assessed). The nutrition system was marked as "WNL" but the patient has a history of bariatric surgery (listed on start of care assessment), assessed nutritional risk as a "0" but the patient eats alone most of the time (she lives by herself and would give her 5 points), and takes 3 or more prescribed or over the counter medications daily which would give her an additional 5 points), thus the nutritional assessment was incorrect. It states the patient was on a regular diet, but in another section stated diabetes was managed

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with diet (diabetic patients have to eat a balanced and modified diet). The psychosocial and client strengths were left blank (not assessed).

5. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated SN orders once per month for aide supervisory visits and head to toe assessment, and HHA orders for 9 hours per day, 5 days per week to assist with ADL's, IADL's and "monitoring disease process."

A comprehensive recertification assessment was documented on 10/22/20 by the director of nursing (DON). The assessment failed to evidence any vital signs were taken, no weight, listed only one diagnosis of "spastic quadriplegic cerebral palsy," Under the mouth section states the pt has dysphasia, but under nutrition it is not listed as an area of concern. The document contained no assessment of lung sounds, only stated "WNL," in the cardiac section there was an intervention listed for "SN to instruct on daily/weekly weights and recordings," but failed to evidence if it was to be done weekly or daily, where it was documented, who completed it, and if they were to be reported to the physician. It stated the patient had nausea/vomiting, and last bowel movement was "8/20/20" (2 months prior to assessment). It indicated the presence of a peg tube with an adequate diet of "pediasure 1/0 every 4-5 hours." The assessment failed to evidence the size, type, or when the peg tube was last changed, who changed it, or when it was due to be changed, flush orders, water bolus, ability to take in food/fluids by mouth even with peg tube. The assessment failed to evidence the patient

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was a high-risk nutritional risk (see family interview), stated in the diet recommendations that the patient was on a "regular" diet, and failed to evidence any information about the patient's scoliosis, or other diagnoses per the physician.

During an interview on 11/2/20 at 12:53 PM, the mother of patient #4 stated the patient currently stayed with grandmother and came to her house every other weekend, that the patient can has a gastrostomy tube (G-tube), but can have small things by mouth such as capri sun or small snacks and the aide assists the patient when taking things in orally. After a conversation with the mother, a call was placed to the grandmother at 1:03 PM. She indicated the patient had a g-tube which all medications and feeding go through and that the patient's grandfather managed it during the day due to being off work and aides were not helping with that. Stated the G-tube had to be in place to get the patient's weight up to 70 lbs. The patient required a surgery for Scoliosis (curvature of the spine), but the physicians would not do the surgery until the patient's weight had reached and maintained at 70 pounds.

A physician's "final report," from the hospital dated 6/21/20 indicated the patient had been hospitalized for malnutrition and failure to thrive. The patient was discharged with a new pump for the feeding that stated "Pediasure 1.0 420 ml via pump over 1 hour 4 times per day," the patient required AFO's (ankle foot orthosis) to be taken to an outpatient vendor to be readjusted. Additionally, it stated the patient had "No free water needs but may flush meds [medications] with free water. [patient] may eat pureed foods and honey thick liquids by mouth." Lastly, the

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physician had diagnoses listed as "schizencephaly [a developmental birth defect affecting the brain which causes delays in speech, language, seizures, and problems with brain/spinal cord] hydrocephalus, scoliosis, failure to thrive, tetraplegic cerebral palsy, constipation, GER [gastroesophageal reflux] with vomiting."

6. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated HHA orders for 2 hours per day, 4 days per week for personal care, meal preparation, light housekeeping, and weight log at each visit.

A physician office note dated 9/12/17 stated the patient had a past medical history of, but not limited to, arteriovenous malformation of the stomach, bursitis of the left shoulder, coronary artery disease, COPD with asthma, deafness, vitamin D deficiency, hypertension, hyperlipidemia, microcytic anemia, morbid obesity, and unstable angina.

The comprehensive recertification assessment dated 9/3/20 failed to reflect the patient's current health psychosocial, functional, status as there was not a full and complete assessment, or documentation regarding need for medication set up.

7. The clinical record of patient #8 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 which indicated orders for HHA 2 hours per day during the certification period for personal care, check pressure areas, and light housekeeping. The

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recertification comprehensive assessment dated 11/13/19, completed by employee G, failed to evidence the patient's assessment of lungs, heart tones, edema, nutritional risk, hospitalization risk, risk for skin breakdown, psychosocial, and functional status.

8. The clinical record of patient #9 was reviewed on 11/2/20 and indicated a start of care date of 11/14/19 and a discharge date of 12/6/19. The record contained a plan of care for the certification period of 11/14/19-1/12/20 which indicated orders for HHA 12 hours per day for the certification period for personal care, meal preparations, and light housekeeping.

The comprehensive start of care assessment dated 11/14/19 failed to reflect the patient's current health psychosocial, functional, and cognitive status, as it only revealed the outcome and assessment information set (OASIS) questions.

9. The clinical record of patient #29 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 which indicated orders for HHA 2 hours per day during the certification period for personal care, DME of a left leg brace and medications, but not limited to, docusate (for constipation), polyethylene glycol (for constipation), simvastatin (for high cholesterol), levothyroxine (for thyroid dysfunction), diazepam (for seizures of anxiety), and terrazzo (for insomnia or mental illnesses). The recertification comprehensive assessment dated 11/13/19, completed by employee G, failed to evidence the patient's assessment of lungs, heart tones, bowel

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G 528	Continued From page 35 sounds, edema, nutritional risk, hospitalization risk, risk for skin breakdown, psychosocial, fall risk, diagnoses for the above medications, rationale for leg brace, and functional status. 10. During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked if the patient's comprehensive assessment should contain the current health, psychosocial, functional, and cognitive status, she stated "yes."	G 528		
G 530	IAC 410 17-14-1(a)(1)(b) Strengths, goals, and care preferences CFR(s): 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; This ELEMENT is not met as evidenced by: Based on record review and interview, the registered nurse (RN), failed to ensure the comprehensive assessment contained the patient's goals, and care preferences, as well as information to demonstrate progress toward achievement of goals identified by the patient and measurable outcomes identified by the agency for 8 of 8 complete record reviews, in a total sample of 10 (1, 2, 3, 4, 5, 8, 9, 29). Findings include: 1. An undated agency policy titled "Comprehensive client assessment," Policy# C-145 stated " ... PURPOSE: To determine the appropriate care, treatment, and services to meet	G 530		

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the client initial needs and his/her changing needs. To collect data about the client's health history, physical, functional and psychosocial and cognitive status and their needs as appropriate to the home care setting. ... To identify clients medical, nursing, rehabilitative, social and discharge planning needs ... SPECIAL INSTRUCTIONS ... The comprehensive assessment must accurately reflect the client's status, and must include at a minimum, the following information: ... The client's goals, and care preferences ...."

2. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 10/23/20-12/21/20 which indicated a primary diagnosis of Benign prostatic hyperplasia with lower urinary tract symptoms and orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 12 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), around the clock supervision, meal preparation, set up; assist, bathing, dressing, and light housekeeping.

The recertification comprehensive assessment dated on 10/22/20 failed to evidence the patient's goals, and care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.

3. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for

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the certification period of 10/26/20-12/24/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 3 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), meal preparation, set up assist, bathing, dressing, and light housekeeping.

A recertification comprehensive assessment was completed on 10/25/20 failed to evidence the patient's goals, and care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.

4. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated orders for a registered nurse every other week for med set up, assessment, and aide and skilled nurse supervision as well as HHA 3 hours, 5 days per week for personal care, range of motion, ambulation, meal prep.

A recertification comprehensive assessment was completed on 9/15/20 by the director of nursing failed to evidence the patient's strengths, goals, and care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.

5. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which

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indicated SN orders once per month for aide supervisory visits and head to toe assessment, and HHA orders for 9 hours per day, 5 days per week to assist with ADL's, IADL's and "monitoring disease process."

A comprehensive recertification assessment was documented on 10/22/20 by the director of nursing (DON) failed to evidence the patient's goals, and care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.

6. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated HHA orders for 2 hours per day, 4 days per week for personal care, meal preparation, light housekeeping, and weight log at each visit.

The comprehensive recertification assessment dated 9/3/20 failed to evidence the patient's goals, and care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.

7. The clinical record of patient #8 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 that indicated orders for HHA, 2 hours per day during the certification period for personal care, check pressure areas, and light housekeeping.

The recertification comprehensive assessment dated 11/13/19, failed to evidence the patient's

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strengths, goals, and care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.

8. The clinical record of patient #9 was reviewed on 11/2/20 and indicated a start of care date of 11/14/19 and a discharge date of 12/6/19. The record contained a plan of care for the certification period of 11/14/19-1/12/20 which indicated orders for HHA 12 hours per day for the certification period for personal care, meal preparations, and light housekeeping.

The comprehensive start of care assessment dated 11/14/19 failed evidence the patient's strengths, goals, and care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.

9. The clinical record of patient #29 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 which indicated orders for HHA 2 hours per day during the certification period for personal care.

The recertification comprehensive assessment dated 11/13/19, completed by employee G, failed to evidence the patient's strengths, goals, and care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.

10. During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked if the patient's

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G 530	Continued From page 40 strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA should be present on the comprehensive assessment, she stated "yes."	G 530		
G 534	Patient's needs CFR(s): 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; This ELEMENT is not met as evidenced by: Based on record review and interview, the registered nurse (RN) failed to ensure the comprehensive assessment contained information regarding the patient's medical, nursing, rehabilitative, social, and discharge planning needs for 8 of 8 complete record reviews, in a total sample of 10 (#1, 2, 3, 4, 5, 8, 9, 29). Findings include: 1. An undated agency policy titled "Comprehensive client assessment," Policy# C-145 stated "... PURPOSE: To determine the appropriate care, treatment, and services to meet the client initial needs and his/her changing needs. To collect data about the client's health history, physical, functional and psychosocial and cognitive status and their needs as appropriate to the home care setting. ... To identify clients medical, nursing, rehabilitative, social and discharge planning needs ...." 2. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of	G 534		

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7/11/17. The record contained a plan of care for the certification period of 10/23/20-12/21/20 which indicated a primary diagnosis of Benign prostatic hyperplasia with lower urinary tract symptoms and orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 12 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), around the clock supervision, meal preparation, set up; assist, bathing, dressing, and light housekeeping.

The comprehensive assessment dated on 10/22/20 failed to evidence information regarding the patient's medical, nursing, rehabilitative, social, and discharge planning needs.

3. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 10/26/20-12/24/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 3 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), meal preparation, set up assist, bathing, dressing, and light housekeeping.

A recertification comprehensive assessment was completed on 10/25/20 failed to evidence information regarding the patient's medical, nursing, rehabilitative, social, and discharge planning needs.

4. The clinical record of patient #3 was reviewed

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on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated orders for a registered nurse every other week for med set up, assessment, and aide and skilled nurse supervision as well as HHA 3 hours, 5 days per week for personal care, range of motion, ambulation, meal prep.

A recertification comprehensive assessment was completed on 9/15/20 failed to evidence information regarding the patient's medical, nursing, rehabilitative, social, and discharge planning needs.

5. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated SN orders once per month for aide supervisory visits and head to toe assessment, and HHA orders for 9 hours per day, 5 days per week to assist with ADL's, IADL's and "monitoring disease process."

A comprehensive recertification assessment was documented on 10/22/20 failed to evidence information regarding the patient's medical, nursing, rehabilitative, social, and discharge planning needs.

6. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated HHA orders for 2 hours per day, 4 days per week for personal care, meal preparation, light housekeeping, and weight log at each visit.

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The comprehensive recertification assessment dated 9/3/20 failed to evidence information regarding the patient's medical, nursing, rehabilitative, social, and discharge planning needs.

7. The clinical record of patient #8 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 that indicated orders for HHA, 2 hours per day during the certification period for personal care, check pressure areas, and light housekeeping.

The recertification comprehensive assessment dated 11/13/19, failed to evidence information regarding the patient's medical, nursing, rehabilitative, social, and discharge planning needs.

8. The clinical record of patient #9 was reviewed on 11/2/20 and indicated a start of care date of 11/14/19 and a discharge date of 12/6/19. The record contained a plan of care for the certification period of 11/14/19-1/12/20 which indicated orders for HHA 12 hours per day for the certification period for personal care, meal preparations, and light housekeeping.

The comprehensive start of care assessment dated 11/14/19 failed to evidence information regarding the patient's medical, nursing, rehabilitative, social, and discharge planning needs.

9. The clinical record of patient #29 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of

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G 534	Continued From page 44 11/16/19-1/14/20 which indicated orders for HHA 2 hours per day during the certification period for personal care. The recertification comprehensive assessment dated 11/13/19, completed by employee G, failed to evidence information regarding the patient's medical, nursing, rehabilitative, social, and discharge planning needs. 10. During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked if the comprehensive assessment should contain the patient's medical, nursing, rehabilitative, social, and discharge planning needs, she stated "yes."	G 534		
G 536	IAC 410 17-14-1(a)(1)(b) A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is not met as evidenced by: Based on record review and interview, the registered nurse (RN) failed to ensure the comprehensive assessment contained a complete review of medications, drug interactions were identified, and medication lists were accurately maintained for 8 of 8 complete records reviewed, in a sample of 10 total (1, 2, 3, 4, 5, 8, 9, 29). Findings include:	G 536		

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1. An undated agency policy titled "Comprehensive client assessment," Policy# C-145 stated " ... SPECIAL INSTRUCTIONS ... f. A review of all medications the client is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy ...."

An undated agency policy titled "medication profile," Policy# C-700 stated " ... complete a medication profile ... PURPOSE: ... To provide documentation of the comprehensive assessment of all medications the client is currently taking and identify discrepancies ... SPECIAL INSTRUCTIONS: ...the admission professional shall check all medications a client may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated mediation. The clinician shall promptly report any identified problems to the physician ...."

2. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 10/23/20-12/21/20 which indicated medications, but not limited to, acetaminophen, nasal saline, clobetasol, derma smooth, guaifenesin, hydrocortisone cream, ibuprofen, milk of magnesia, naproxen (listed twice), nystatin, phenergan, triple antibiotic ointment, urea topical cream, vitamin A&D cream, and aspirin. The plan of care and medication list failed to evidence indications for the use of as needed (PRN) medications, where topical agents were to be applied, and failed to evidence a thorough medication review which identified

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major medication interactions and duplicate therapies.

On 11/20/20 all medications from the agency plan of care were checked on Drugs.com for interactions. The interactions showed major interactions with ibuprofen and aspirin as well as multiple moderate interactions. The Drugs.com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit."

3. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 8/27/20-10/25/20 which indicated medications, but not limited to, atorvastatin, bacitracin, and ranolazine. The plan of care and medication list failed to evidence indications for the use of PRN medications, where topical agents were to be applied, and failed to evidence a thorough medication review which identified major medication interactions.

An undated agency document titled "drug-drug interactions," stated "No interactions found during this screening."

On 11/20/20 all medications from the agency plan of care were checked on Drugs.com for interactions. The interactions showed major interactions with atorvastatin and ranolazine as well as multiple moderate interactions. The Drugs.com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit."

4. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of

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5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated orders for a registered nurse every other week for med set up, assessment, and aide and skilled nurse supervision as well as HHA 3 hours, 5 days per week for personal care, range of motion, ambulation, meal prep. The plan of care and medication list failed to evidence a thorough medication review which identified moderate medication interactions.

On 11/20/20 all medications from the agency plan of care were checked on Drugs.com for interactions. The interactions showed major interactions with tramadol with mirtazapine, cyclobenzaprine with tramadol, ondansetron with tramadol, hydroxychloroquine with tramadol, buspirone with tramadol, buspirone with mirtazapine, tramadol with lyrica, calcium with vitamin D3, hydroxychloroquine with mirtazapine, buspirone with savella, buspirone with cyclobenzaprine, hydroxychloroquine with ondansetron, ondansetron with mirtazapine, buspirone with ondansetron, ondansetron with milnacipran, cyclobenzaprine with milnacipran, cyclobenzaprine with mirtazapine, tramadol with milnacipran, and mirtazapine with milnacipran as well as multiple moderate interactions. The Drugs.com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit."

5. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated SN orders once per month for aide supervisory visits and head to toe assessment, and HHA orders for 9 hours per day, 5 days per

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week to assist with ADL's, IADL's and "monitoring disease process." The plan of care and medication list failed to evidence indications for the use of as needed PRN tylenol, where topical agents were to be applied, and failed to evidence a thorough medication review which identified moderate medication interactions.

On 11/20/20 all medications from the agency plan of care were checked on Drugs.com for interactions. The interactions showed moderate interactions with diazepam with baclofen, triamcinolone with senna, ondansetron with senna, triamcinolone with lactulose, ondansetron with lactulose, senna with lactulose, diazepam with esomeprazole, triamcinolone with miralax, ondansetron with miralax, senna with miralax, and lactulose with miralax. The Drugs.com moderate interaction definition stated "Moderately clinically significant. Usually avoid combinations; use it only under special circumstances."

6. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated HHA orders for 2 hours per day, 4 days per week for personal care, meal preparation, light housekeeping, and weight log at each visit. The plan of care and medication list failed to evidence a thorough medication review which identified moderate medication interactions.

On 11/20/20 all medications from the agency plan of care were checked on Drugs.com for interactions. The interactions showed major interactions with potassium with lisinopril, potassium with cyclobenzaprine, and albuterol with carvedilol. The Drugs.com Major interaction

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definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit."

7. The clinical record of patient #8 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 that indicated medication orders, but not limited to, lidocaine ointment and salonpas pain patch.

The recertification comprehensive assessment dated 11/13/19, where topical agents (lidocaine and salonpas) were to be applied, and failed to evidence a thorough medication review which identified moderate medication interactions.

On 11/20/20 all medications from the agency plan of care were checked on Drugs.com for interactions. The interactions showed moderate interactions with divalproex with topiramate, venlafaxine with lacosamide, venlafaxine with topiramate, venlafaxine with divalproex, vitamin D2 with magnesium chloride, baclofen with topiramate, baclofen with venlafaxine, lorazepam with divalproex, lorazepam with venlafaxine, and lorazepam with baclofen. The Drugs.com moderate interaction definition stated "Moderately clinically significant. Usually avoid combinations; use it only under special circumstances."

8. The clinical record of patient #9 was reviewed on 11/2/20 and indicated a start of care date of 11/14/19 and a discharge date of 12/6/19. The record contained a plan of care for the certification period of 11/14/19-1/12/2 indicated medication orders for clorazepate, centrum, and colace.

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The agency medication list dated 11/14/19 which indicated the following medication: clorazepate, centrum, colace, losartan, cymbalta, adderal, multivitamin, omeprazole.

On 11/20/20 all medications from the agency medication list were checked on Drugs.com for interactions. The interactions showed major interactions adderal with cymbalta. The Drugs.com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit."

9. The clinical record of patient #29 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 which indicated medication orders, but not limited to, bacitracin ointment, diazepam "at bedtime or PRN."

The recertification comprehensive assessment dated 11/13/19, completed by employee G, failed to evidence an indication for the use diazepam with clear directions of either PRN or at bedtime (not both, or a separate order for each), where topical agents were to be applied, and failed to evidence a thorough medication review which identified moderate medication interactions.

On 11/20/20 all medications from the agency plan of care were checked on Drugs.com for interactions. The interactions showed major interactions with diazepam with olanzapine, terrazzo with fluvoxamine, robitussin with terrazzo, robitussin with fluvoxamine, and diazepam with fluvoxamine. The Drugs.com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the

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G 536	Continued From page 51 interaction outweighs the benefit." 10. During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked if the comprehensive assessment should contain the review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy, she stated "yes."	G 536		
G 538	IAC 410 17-14-1(a)(1)(b) Primary caregiver(s), if any CFR(s): 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the registered nurse (RN) failed to ensure the comprehensive assessment contained information regarding the patient's primary caregiver, or lack of one, and their willingness and ability to provide care, availability, and schedule for 8 of 8 complete record reviews, in a total sample of 10 (#1, 2, 3, 4, 5, 8, 9, 29). Findings include: 1. An undated agency policy titled "Comprehensive client assessment," Policy# C-145 stated " ... The assessment identifies facilitating factors and possible barriers to client reaching his or her goals including presenting	G 538		

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problems ... PURPOSE: To determine the appropriate care, treatment, and services to meet the client initial needs and his/her changing needs. ... SPECIAL INSTRUCTIONS ... The primary caregiver (s), if any, willingness and ability to provide care, and their availability and schedules ...."

2. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 10/23/20-12/21/20 which indicated a primary diagnosis of Benign prostatic hyperplasia with lower urinary tract symptoms and orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 12 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), around the clock supervision, meal preparation, set up; assist, bathing, dressing, and light housekeeping.

During a home visit completed on 10/29/20 at 8:00 AM, the patient was observed living in an group home and a staff person from the group home was present in the home.

The comprehensive assessment dated on 10/22/20 failed to evidence information regarding the patient's primary caregiver, group home information, their willingness and ability to provide care, availability and schedules.

3. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 10/26/20-12/24/20

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which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 3 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), meal preparation, set up assist, bathing, dressing, and light housekeeping.

During a home visit completed on 10/29/20 at 11:00 AM, the patient was observed living in an apartment with the spouse.

A recertification comprehensive assessment was completed on 10/25/20 failed to evidence information regarding the patient's primary caregiver, their willingness and ability to provide care, availability and schedules.

4. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated orders for a registered nurse every other week for med set up, assessment, and aide and skilled nurse supervision as well as HHA 3 hours, 5 days per week for personal care, range of motion, ambulation, meal prep.

A start of care comprehensive assessment was completed on 5/14/20 in one area of the assessment stated the patient did not have a primary caregiver, and then later in the assessment identified the son and niece as primary caregivers, but failed to identify their willingness and ability to provide care, availability and schedules.

5. The clinical record of patient #4 was reviewed

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on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated SN orders once per month for aide supervisory visits and head to toe assessment, and HHA orders for 9 hours per day, 5 days per week to assist with ADL's, IADL's and "monitoring disease process."

A comprehensive recertification assessment was documented on 10/22/20 failed to evidence information regarding the patient's primary caregiver, their willingness and ability to provide care, availability and schedules.

6. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated HHA orders for 2 hours per day, 4 days per week for personal care, meal preparation, light housekeeping, and weight log at each visit.

The comprehensive recertification assessment dated 9/3/20 failed to evidence information regarding the patient's primary caregiver, their willingness and ability to provide care, availability and schedules.

7. The clinical record of patient #8 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 that indicated orders for HHA, 2 hours per day during the certification period for personal care, check pressure areas, and light housekeeping.

The recertification comprehensive assessment dated 11/13/19, failed to evidence information

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regarding the patient's primary caregiver, their willingness and ability to provide care, availability and schedules.

8. The clinical record of patient #9 was reviewed on 11/2/20 and indicated a start of care date of 11/14/19 and a discharge date of 12/6/19. The record contained a plan of care for the certification period of 11/14/19-1/12/20 which indicated orders for HHA 12 hours per day for the certification period for personal care, meal preparations, and light housekeeping.

The comprehensive start of care assessment dated 11/14/19 failed to evidence information regarding the patient's primary caregiver, their willingness and ability to provide care, availability and schedules.

9. The clinical record of patient #29 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 which indicated orders for HHA 2 hours per day during the certification period for personal care.

The recertification comprehensive assessment dated 11/13/19, completed by employee G, failed to evidence information regarding the patient's primary caregiver, their willingness and ability to provide care, availability and schedules.

10. During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked if the comprehensive assessment should contain information about the patient's primary caregiver(s), if any, and other available supports, including their: willingness and ability to provide

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G 538	Continued From page 56 care, and availability and schedules, she stated "yes."	G 538		
G 540	The patient's representative (if any); CFR(s): 484.55(c)(7) The patient's representative (if any); This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the registered nurse (RN) failed to ensure the comprehensive assessment reflected the patient's representative for 3 of 3 records reviewed with needed representatives (#1, 4, 9), in a total sample of 10. Findings include: 1. An undated agency policy titled "Comprehensive client assessment," Policy# C-145 stated " ... The assessment identifies facilitating factors and possible barriers to client reaching his or her goals including presenting problems ... PURPOSE: To determine the appropriate care, treatment, and services to meet the client initial needs and his/her changing needs. ... SPECIAL INSTRUCTIONS ... The client's representative, if any ...." 2. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 10/23/20-12/21/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 12 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), around the clock supervision, meal	G 540		

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preparation, set up; assist, bathing, dressing, and light housekeeping.

During a home visit completed on 10/29/20 at 8:00 AM, the patient was observed living in an group home and a staff person from the group home was present in the home.

A recertification comprehensive assessment was completed on 10/22/20 by the director of nursing failed to evidence who the patient's representative was.

An undated document from the medical record titled "kardex," stated "Guardian [person H]."

3. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated SN orders once per month for aide supervisory visits and head to toe assessment, and HHA orders for 9 hours per day, 5 days per week to assist with ADL's, IADL's and "monitoring disease process."

During an interview on 11/2/20 at 1:03 PM, the grandmother of the patient stated the patient was staying at her house currently, but did go to the patient's mother and father's houses.

A comprehensive recertification assessment was documented on 10/22/20 by the director of nursing (DON) failed to evidence who the patient's representative was, who had custody of patient.

4. The clinical record of patient #9 was reviewed on 11/2/20 and indicated a start of care date of

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G 540	Continued From page 58 11/14/19 and a discharge date of 12/6/19. The record contained a plan of care for the certification period of 11/14/19-1/12/20 which indicated orders for HHA 12 hours per day for the certification period for personal care, meal preparations, and light housekeeping. The comprehensive start of care assessment dated 11/14/19 failed to evidence who the patient's representative was. During an interview on 10/28/20 at 9:22 AM, person D indicated they were patient #9's guardian. 5. During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked if the comprehensive assessment should contain information about the patient's representative, she stated "yes."	G 540		
G 544	Update of the comprehensive assessment CFR(s): 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- This STANDARD is not met as evidenced by: Based on record review, the registered nurse (RN) failed to update the comprehensive assessment with updated and revised information for 2 of 5 active records reviewed (#1, 4), in a sample of 10.	G 544		

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Findings include:

1. An undated agency policy titled "Comprehensive client assessment," Policy# C-145 stated "POLICY: The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the client's return home ... The assessment identifies facilitating factors and possible barriers to client reaching his or her goals including presenting problems ... PURPOSE: To determine the appropriate care, treatment, and services to meet the client initial needs and his/her changing needs. To collect data about the client's health history, physical, functional and psychosocial and cognitive status and their needs as appropriate to the home care setting. ... To identify clients medical, nursing, rehabilitative, social and discharge planning needs ... SPECIAL INSTRUCTIONS ... The comprehensive assessment must accurately reflect the client's status ...Reassessments are conducted based on client needs, physician orders ... and for any changes in the plan of care will be sent to the physician.

An undated agency policy titled "Client reassessment/update of Comprehensive assessment," Policy# C-155 stated "POLICY: The comprehensive assessment will be updated and revised as often as the client's condition warrants due to major decline or improvement in health status. ... Reassessments must be done at least: ...within last five (5) days of the episode ... within 48 hours of client return home from the hospital ... within 48 hours of discharge or transfer ...."

2. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for

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the certification period of 8/24/20-10/22/20 and 10/23/20-12/21/20 both which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 12 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), around the clock supervision, meal preparation, set up, assist, bathing, dressing, and light housekeeping.

A recertification comprehensive assessment was completed on 8/20/20 and 10/22/20 by the director of nursing. The assessments mirrored each other and failed to be updated as evidenced by: it failed to evidence a weight, but stated in the cardiac section "SN to perform weekly weights," stated the patient had a "medical power of attorney" (but failed to identify the person for coordination purposes), failed to identify a pain level on a 0-10 scale (left blank) but stated "Client has history of traumatic brain injury and gets occasional headaches," stated the patient was a non insulin dependant diabetic, and stated "client does not have current orders for glucose checks. Writer reached out to [person B] today for orders regarding checks and frequency," stated last bowel movement was "6/23/20" (4 months prior), and an incomplete section regarding the care and/or teaching needed from the home health agency (SN or HHA and for what).

3. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated SN orders once per month for aide supervisory visits and head to toe assessment,

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G 544	Continued From page 61 and HHA orders for 9 hours per day, 5 days per week to assist with ADL's, IADL's and "monitoring disease process." The registered nurse failed to update the comprehensive assessment as evidenced by: A comprehensive recertification assessment was documented on 10/22/20 by the director of nursing (DON), stated the patient's last bowel movement was "8/20/20" (2 months prior to assessment). IAC 410 17-14-1(a)(1)(b)	G 544		
G 546	Last 5 days of every 60 days unless: CFR(s): 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. This ELEMENT is not met as evidenced by: Based on record review and interview, the registered nurse (RN) failed to ensure the recertification comprehensive assessment was completed the last 5 days of the 60 day period for 2 of 5 active record reviews, in a total sample of 10 (#3, 4). Findings include: 1. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. A home health certification period was 5/21/20-7/19/20 (but should have been	G 546		

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5/14/20-7/12/20). A recertification was due between 7/8/20-7-/12/20. The recertification comprehensive assessment was completed by the agency director of nursing (DON) on 7/15/20 (late).

A home health certification period was 7/20/20-9/17/20 (but should have been 7/13/20-9/10/20). A recertification was due between 9/6/20-9/10/20. On 10/28/20 at 7:30 AM, the electronic medical record was viewed and no recertification comprehensive assessment was completed between these dates, but a regular nurse visit was documented from the DON on 9/8/20 and 9/15/20.

A home health certification period was 9/18/20-11/16/20 (but should have been 9/11/20-11/9/20).

During an interview on 10/30/20 at 11:23 AM, the alternate administrator was queried about the missing recertification comprehensive assessment in September. She indicated she would look into it. She called the software company and asked when the visit was created and completed. The electronic record company stated the visit was completed by the alternate administrator on 9/15/20 (which she stated she does when a visit is due) and then completed by the director of nursing on 10/30/20.

2. The clinical record of patient #4 was reviewed on 10/30/20. The "client profile" indicated a start of care date of 4/22/20.

All plans of care dated 6/25/20-current stated the start of care date was 4/22/20.

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G 546	Continued From page 63 An agency document titled "Comprehensive adult nursing assessment," M0030 Start of care date of 4/24/20, and signed/dated by employee G on 4/24/20. The first home health certification period was 4/24/20-6/23/20 (which was accurate). A subsequent home health certification period was dated 6/25/20-8/23/20 (but should have been 6/24/20-8/22/20). A subsequent home health certification period was dated 8/24/20-10/22/20 (but should have been 8/23/20-10/21/20). A subsequent home health certification period was dated 10/23/20-12/21/20 (but should have been 10/22/20-12/20/20). A recertification was due between 10/17/20-10/21/20. The director of nursing completed the recertification comprehensive assessment on 10/22/20 (late).	G 546		
G 570	IAC 410 17-14-1(a)(1)(b) Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the	G 570		

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comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice.
This CONDITION is not met as evidenced by:
Based on observation, record review, and interview the agency failed to ensure an accurate and complete plan of care was completed, coordination of care was completed, and that patients were provided with required documents.

The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.60 Care planning, coordination, quality of care.

Findings include:

The agency failed to ensure the plan of care contained all pertinent diagnoses, allergies, measurable goals and outcomes established by the agency and patient, frequency and duration of visits, the patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient and caregiver education to facilitate timely discharge, patient specific interventions and education, advance directive information (See Tag G 574).

The agency failed to ensure care was not provided absent of a physician's order for the start of care (See Tag G 580).

The registered nurse failed to ensure physician

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G 570	Continued From page 65 verbal orders indicated who the order was received from, and orders were signed in an appropriate amount of time (See Tag G 584). The director of nursing failed to ensure the physician was notified of changes (See Tag G 590). The agency failed to ensure coordination of care was completed with the group homes where the patients resided(See Tag G 608). The agency failed to ensure the patient/family received a copy of the visit schedule for home health staff (See Tag G 614). The agency failed to ensure the patient/family received a written copy of the plan of care in order to have knowledge of any treatments to be administered, including teaching or medication set up (See Tag G 618). The agency failed to ensure the name and contact information of the director of nursing was given to the patients in writing (See Tag G 622).	G 570		
G 574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis;	G 574		

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G 574	Continued From page 66 (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure the plan of care contained all pertinent diagnoses, allergies, measurable goals and outcomes established by the agency and patient, frequency and duration of visits, the patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient and caregiver education to facilitate timely discharge, patient specific interventions and education, advance directive information for 8 of 8 complete record reviews in a total sample of 10 records (#1, 2, 3, 4, 5, 8, 9, 29). Findings include: 1. An undated agency policy titled "Plan of Care," Policy #C-580 stated "...A plan of care shall be completed in full to include: all pertinent	G 574		

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diagnosis(es) ... type, frequency, and durations ... medications, treatments ... medical supplies and equipment required ...."

2. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 10/23/20-12/21/20 which indicated diagnoses of benign prostatic hyperplasia with lower urinary tract symptoms, hyperlipidemia, and type 2 diabetes, and a functional limitation of paralysis (failed to evidence to what area). The summary indicated the patient had a previous traumatic brain injury, headaches, left sided weakness, and short term memory loss. Additionally there were medications, but not limited to, calcium with vitamin D (supplement), divalproex (commonly used for seizures or mental illness disorders), docusate (for constipation), fluticasone nasal spray (used for allergies), levothyroxine (used for thyroid dysfunction), loratadine (used for allergies), quetiapine (used for mental illness, typically bipolar and schizophrenia), sertraline (used for depression), and acetaminophen, naproxen, and ibuprofen (all pain medications). Lastly, it identified goals as "client will verbalize understanding of proper use of pain medication by the end of the care period. Neuro [neurological] status will be within normal limits and free from S&S [signs and symptoms] of complications or further deterioration. The client will be free from falls during the care period. The client will be free from injury during care period."

During a home visit completed on 10/29/20 at 8:00 AM, patient #1 was observed having left side paralysis of upper and lower extremities, patient lived in a group home with staff there and

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available, and the use of a toilet riser when using the bathroom.

A recertification comprehensive assessment was completed on 10/22/20 by the director of nursing. The assessment stated "Client has history of traumatic brain injury and gets occasional headaches."

Patient #1's plan of care failed to evidence diagnoses, but not limited to, traumatic brain injury, headaches, left sided hemiplegia (paralysis), short term memory loss, pain (or disorder that causes pain), seizures and/or mental illness (whichever divalproex was being used for), allergies, hypothyroidism (thyroid dysfunction), and depression. The plan of care also failed to evidence if the patient had any food or drug allergies, any goals and interventions related to all the medications and diagnoses above, patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient and caregiver education to facilitate timely discharge, patient specific interventions and education, durable medical equipment (DME) of a toilet riser, advance directive information, and information regarding the group home living and guardian with contact information.

3. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 8/27/20-10/25/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 3 hours per day for 7 days a week for personal activities of daily living

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(ADL), instrumental activities of daily living (IADL), meal preparation, set up assist, bathing, dressing, and light housekeeping.

The consent form on admission, dated 8/27/20 indicated "the anticipated apple tree home health care services and frequency to be provided," was skilled nursing 1 hour weekly, home health aide 2 hours a day, and waiver 3 times a week.

A office visit encounter from the patient's physician dated 8/14/20 indicated the patient had diagnoses of COPD (chronic obstructive pulmonary disease), hypertension, history of hypercholesterolemia, history of myocardial infarction, history of right hand fracture, gouty arthritis, arthritis, and compression fractures.

A recertification comprehensive assessment was completed on 10/25/20 by the director of nursing stated the assessment "conclusions" were "skilled intervention needed," but failed to evidence what was needed for the patient.

Patient #2's plan of care failed to evidence diagnoses, but not limited to, COPD, hypertension (high blood pressure), history of hypercholesterolemia (high cholesterol), history of myocardial infarction (heart attack), history of right hand fracture, gouty arthritis, arthritis, and compression fractures. The plan of care also failed to evidence a diet order, waiver discipline, frequency and duration with tasks to be completed, any measurable and interventions related to all the diagnoses above, patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient and caregiver education to facilitate timely discharge, patient specific

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interventions and education, and advance directive information.

4. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated the medication, but not limited to, "toujeo [injectable medication used for diabetes]300/10 units daily subcutaneous " diagnoses of lupus, type II diabetes, hypertension, and orders for a registered nurse every other week for med set up, assessment, and aide and skilled nurse supervision as well as HHA 3 hours, 5 days per week for personal care, range of motion, ambulation, meal prep.

An office note dated 5/12/20 from the patient's physician indicated the patient had diagnoses, but not limited to, iron deficiency anemia, gastric bypass status for obesity, and osteopenia.

A recertification comprehensive assessment was completed on 9/15/20 by assessed the nutritional risk as a "0" but the patient eats alone most of the time (she lives by herself and would give her 5 points), and takes 3 or more prescribed or over the counter medications daily which would give her an additional 5 points), thus the nutritional assessment was incorrect. Furthermore, the patient has diabetes, and had a gastric bypass surgery, all which would affect nutritional status.

Patient #3's plan of care failed to evidence diagnoses, but not limited to, iron deficiency anemia, gastric bypass status for obesity, and osteopenia. The plan of care also failed to evidence a diet order which matched the assessment, waiver discipline, frequency and

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duration with tasks to be completed, any measurable goals and interventions related to all the diagnoses above, patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient education to facilitate timely discharge, patient specific interventions and education, and advance directive information.

5. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated SN orders once per month for aide supervisory visits and head to toe assessment, and HHA orders for 9 hours per day, 5 days per week to assist with ADL's, IADL's and "monitoring disease process."

A comprehensive recertification assessment was documented on 10/22/20 by the director of nursing (DON). The assessment stated the pt has dysphasia, order for "SN to instruct on daily/weekly weights and recordings," the patient had nausea/vomiting, the presence of a peg tube.

During an interview on 11/2/20 at 12:53 PM, the mother of patient #4 stated the patient currently stayed with grandmother and came to her house every other weekend, that the patient can has a gastrostomy tube (G-tube), but can have small things by mouth such as capri sun or small snacks and the aide assists the patient when taking things in orally. After a conversation with the mother, a call was placed to the grandmother at 1:03 PM. She indicated the patient had a g-tube which al meds and feeding go through and that the patient's grandfather managed it during the day due to being off work and aides were not

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helping with that. Stated the G-tube had to be in place to get the patient's weight up to 70 lbs. The patient required a surgery for Scoliosis (curvature of the spine), but the physicians would not do the surgery until the patient's weight had reached and maintained at 70 pounds.

A physician's "final report," from the hospital dated 6/21/20 indicated the patient had been hospitalized for malnutrition and failure to thrive. The patient was discharged with a new pump for the feeding that stated "Pediasure 1.0 420 ml via pump over 1 hour 4 times per day,"the patient required AFO's to be taken to an outpatient vendor to be readjusted. Additionally, it stated the patient had "No free water needs but may flush meds with free water. [patient] may eat pureed foods and honey thick liquids by mouth." Lastly, the physician had diagnoses listed as "schizencephaly, hydrocephalus, scoliosis, failure to thrive, tetraplegic cerebral palsy, constipation, GER [gastroesophageal reflux] with vomiting."

Patient #4's plan of care (and all care plans since hospitalization in June 2020) failed to evidence diagnoses, but not limited to, schizencephaly, hydrocephalus, scoliosis, failure to thrive, tetraplegic cerebral palsy, constipation, and GER. The plan of care also failed to evidence a pureed diet with thickened liquid order, orders for feeding (whether bolus or continuous), water/flush orders for G-tubes, the DME of a carseat, AFO's, type of pump and specific supplies for g-tube feedings, safety measures of aspiration precautions (due to dysphasia), daily weight orders or vital sign parameters to notify the physician, any measurable goals and interventions related to all the diagnoses above, patient's risk for emergency room visits and hospitalization with interventions

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to address the underlying risk factors, patient education to facilitate timely discharge, patient specific interventions and education, and advance directive information.

6. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated HHA orders for 2 hours per day, 4 days per week for personal care, meal preparation, light housekeeping, and weight log at each visit, that the patient had "COPD [chronic obstructive pulmonary disease] with oxygen use at 2L[liters]," and goals stated "client will verbalize understanding of proper use pain medication by the end of the care period. Neuro status will be free of S&S [signs and symptoms] of complications or further deterioration client will be free from falls during the care period. Client will remain safe in home while home health aide is present."

A physician office note dated 9/12/17 stated the patient had a past medical history of, but not limited to, arteriovenous malformation of the stomach, bursitis of the left shoulder, coronary artery disease, COPD with asthma, deafness, vitamin D deficiency, hypertension, hyperlipidemia, microcytic anemia, morbid obesity, and unstable angina.

Patient #5's plan of care failed to evidence diagnoses of arteriovenous malformation of the stomach, bursitis of the left shoulder, coronary artery disease, COPD with asthma, deafness, vitamin D deficiency, hypertension, hyperlipidemia, microcytic anemia, morbid obesity, unstable angina, daily weight parameters

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to notify the physician, any measurable goals and interventions related to all the diagnoses above, patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient education to facilitate timely discharge, patient specific interventions and education, and advance directive information.

7. The clinical record of patient #8 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 which indicated medication orders, but not limited to, acetaminophen, salonpas (both for pain), but failed to evidence any interventions or goals to assist with mitigation of pain, patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient education to facilitate timely discharge, patient specific interventions and education, and advance directive information.

8. The clinical record of patient #9 was reviewed on 11/2/20 and indicated a start of care date of 11/14/19 and a discharge date of 12/6/19. The record contained a plan of care for the certification period of 11/14/19-1/12/20 which indicated medication orders for clorazepate, centrum and colace.

The agency medication list dated 11/14/19 which indicated the following medication: clorazepate, centrum, colace, losartan, cymbalta, adderal, multivitamin, omeprazole.

Patient #9's plan of care failed to evidence diagnoses all medications, any measurable goals and interventions related to all medications,

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G 574	Continued From page 75 patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient education to facilitate timely discharge, patient specific interventions and education, and advance directive information. 9. The clinical record of patient #29 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 which failed to evidence the patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient education to facilitate timely discharge, patient specific interventions and education, and advance directive information. An agency document titled "Items required for completion of plan of care," contained empty/incomplete boxes for choices for "Homebound status ... DME ...Safety measures ... diet ... functional limitations ... activities permitted ... mental status ... prognosis ... required for physician orders ...goals ... rehabilitation potential ... disaster codes ...." and was signed and dated by the person listed in the record as "caregiver taking lead responsibility for patient" on 11/25/19. IAC 410 17-13-1(a)(1)(C) IAC 410 17-13-1(a)(1)(D)(ii) IAC 410 17-13-1(a)(1)(D)(iii) IAC 410 17-13-1(a)(1)(D)(viii) IAC 410 17-13-1(a)(1)(D)(ix) IAC 410 17-13-1(a)(1)(D)(xiii)	G 574		
G 580	Only as ordered by a physician	G 580		

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G 580	Continued From page 76 CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician. This ELEMENT is not met as evidenced by: Based on record review the agency failed to ensure care was not provided absent of a physician's order for the start of care for 1 of 5 active records (#3), in a total sample of 10. Findings include: The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 7/20/20-9/17/20. A faxed order was sent to the agency on 5/7/20 that stated "admit & treat to home care medication management." On the order signature line it stated "person I/person J," but was not signed by the physician. The record failed to evidence a physician's order prior to being seen by the agency.	G 580		
G 584	IAC 410 17-13-1(a) Verbal orders CFR(s): 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in	G 584		

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accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician in accordance with applicable state laws and regulations, as well as the HHA's internal policies.
This ELEMENT is not met as evidenced by:
Based on record review and interview, the registered nurse failed to ensure physician verbal orders indicated who the order was received from, and orders were signed in an appropriate amount of time for 5 of 5 active records reviewed, in a sample of 10 (# 1, 2, 3, 4, 5).

Findings include:

1. An undated agency policy titled "Physician orders," Policy #C-635 stated "...SPECIAL INSTRUCTIONS: ...shall write the order as given and then read the order back to the physician verifying that the person receiving the order heard it correctly ... verbal orders are accepted by authorized, licensed agency personnel in accordance with applicable law...."

2. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 10/23/20-12/21/20.

An agency physician order dated 10/26/20 by the director of nursing stated "Verbal order obtained from [person B] for HHA [home health aide] services. 16 hours a day and medication set up once a week to continue." There was a box that stated "Order read back and verified." The order failed to evidence if the order was obtained by the physician or from a nurse at the physician's office.

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During an interview on 10/30/20 at 1:00 PM, the alternate administrator was queried about the verbal order. The alternate administrator looked at order and indicated the order was incorrect, that the director of nursing must have wrote the order wrong because the patient could not have more than 12 hours and stated "I will have to call her." Later, at 1:30 PM, a text message was shown from the director of nursing to the alternate administrator that the order was incorrect and should have read 12 hours, not 16. The alternate administrator was notified of the concern, that if read back and verified (like documented) the order should have been correct.

3. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 8/27/20-12/24/20.

An agency physician order dated 8/28/20 by the director of nursing stated "verbal order contained for patient to have SN [skilled nurse] weekly medication set up and HHA services 3 hours a day 7 days a week." The order failed to evidence if the order was obtained by the physician or from a nurse at the physician's office.

4. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20.

An agency physician order dated 9/17/20 by the director of nursing stated "Received VO [verbal order] for home care services to continue through the next certification period. HHA 2 hrs [hours] a day 5 days a week for grooming, bathing, light

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G 584	Continued From page 79 housekeeping." The order indicated at the top of the document that it was faxed to the physician on 10/29/20 at 1:13 PM and re-faxed back to the agency signed by the physician on 11/5/20 at 11:58 AM. The order failed to indicate who the order was obtained from or if it was read back and verified. 5. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20. An agency physician order dated and signed by the director of nursing on 8/20/20 stated "senna 176 mg/5 ml daily by mouth (PO)." The order failed to identify it was a verbal order, or where the order was received from. During an interview on 11/2/20 at 1:03 PM, the grandmother of patient #4 indicated the patient had a g-tube which all meds and feeding went through. 6. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20. An agency physician order dated and signed 9/8/20 by the director of nursing which stated "Verbal order for SN medication set up weekly and HHA 2 hours a day 4 days a week." The order failed to identify it was a verbal order, or where the order was received from.	G 584		
G 588	IAC 410 17-14-1 (a)(F) Reviewed, revised by physician every 60 days	G 588		

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G 588	Continued From page 80 CFR(s): 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. This ELEMENT is not met as evidenced by: Based on record review the agency failed to ensure the plan of care was reviewed and revised to ensure accurate information was recorded for 1 of 5 active records (#1), in a total sample of 10. Findings include: The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated diagnoses of benign prostatic hyperplasia with lower urinary tract symptoms, hyperlipidemia, and type 2 diabetes. Additionally the plan of care stated "[patient] has not had any injuries or hospital visits during this cert [certification] period...." A recertification comprehensive assessment was completed on 8/20/20 by the director of nursing. A physician's order dated 8/10/20 indicated the home health aide notified the nurse that the patient was not feeling well and the RN instructed the aide to send the patient to the emergency department. The patient did have a visit to the emergency department that day for vomiting and constipation with a new order for promethazine (medication to treat nausea and vomiting). The plan of care failed to be updated to show that the patient had a visit to the hospital during the	G 588		

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G 588	Continued From page 81 previous 60 day period. Additionally, the plans of care dated 8/24/20-10/22/20 and 10/23/20-12/21/20 were identical and failed to evidence updates with any differences in goals, teaching, or care that the patient required.	G 588		
G 590	IAC 410 17-13-1(a)(2) Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This ELEMENT is not met as evidenced by: Based on observation and record review the director of nursing failed to ensure the physician was notified of changes in condition for 1 of 1 skilled nurse visits observed (#3). Findings include: The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated orders for a registered nurse every other week for med set up, assessment, and aide and skilled nurse supervision as well as HHA 3 hours, 5 days per week for personal care, range of motion, ambulation, meal prep. A home visit observation was completed on 10/29/20 at 12:40 PM with patient #3 and employee C. Employee C took the temperature	G 590		

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G 590	Continued From page 82 of patient # 3 and it revealed low grade temperature of 99.7. Furthermore, the patient complained about "feeling shaky" on the inside, having pain in the back and chest, and feeling an "electric" feeling in her head. Employee C failed to document the visit (at all) and the symptoms the patient was having, and failed to notify the physician.	G 590		
G 608	IAC 410 17-13-1(a)(2) Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure coordination of care was completed with the group homes where the patients resided for 1 of 1 active patients who lived in a group home (#1), in a total sample of 10. Findings include: The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 10/23/20-12/21/20 which indicated home health aide (HHA) orders 12 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), around the clock supervision, meal preparation, bathing, dressing, and light housekeeping.	G 608		

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G 608	Continued From page 83 During a home visit completed on 10/29/20 at 8:00 AM, the patient was observed living in an group home and a staff person from the group home was present in the home, but the agency staff failed to communicate with group home staff during the visit. The comprehensive assessment dated on 10/22/20 failed to evidence information regarding the patient living in a group home. The record failed to evidence documentation of coordination of care with the group home staff.	G 608		
G 614	Visit schedule CFR(s): 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the patient/family received a copy of the visit schedule for home health staff for 3 of 3 home visit observations (#1, 2, 3). Findings include: The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 8/24/20-10/22/20. During a home visit observation on 10/29/20 at 8:00 AM, the home folder for patient #1 was viewed and the last visit schedule observed was from April 2020. The folder failed to have an up to date visit calendar from the current certification period.	G 614		

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G 614	Continued From page 84 The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 8/27/20-10/25/20. During a home visit observation on 10/29/20 at 11:00 AM, the home folder for patient #2 was viewed and failed to evidence a visit schedule of home health staff. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 7/20/20-9/17/20. During a home visit observation on 10/29/20 at 12:40 AM, the home folder for patient #3 was viewed and failed to evidence a visit schedule of home health staff. During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked if patients received a schedule of visits, she stated "I'm not sure."	G 614		
G 618	Treatments and therapy services CFR(s): 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the patient/family received a written copy of the plan of care in order to have knowledge of any treatments to be administered (including teaching, or medication set up) for 3 of 3 home visit observations completed (#1, 2, 3). Findings include:	G 618		

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G 618	Continued From page 85 The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 10/23/20-12/21/20. During a home visit observation on 10/29/20 at 8:00 AM, the home folder for patient #1 was viewed and it failed to evidence a plan of care from the current certification period. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 8/27/20-10/25/20. During a home visit observation on 10/29/20 at 11:00 AM, the home folder for patient #2 was viewed and it failed to evidence a plan of care from the current certification period. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 7/20/20-9/17/20. During a home visit observation on 10/29/20 at 12:40 AM, the home folder for patient #3 was viewed and it failed to evidence a plan of care from the current certification period. During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked if patients received a copy of their plan of care, she stated "yes, not all have been mailed out."	G 618		
G 622	Name/contact information of clinical manager CFR(s): 484.60(e)(5) Name and contact information of the HHA clinical manager. This ELEMENT is not met as evidenced by:	G 622		

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G 622	Continued From page 86 Based on record review and interview the agency failed to ensure the name and contact information of the director of nursing was given to the patients in writing for 3 of 3 home visit observations completed (#1, 2, 3). Findings include: 1. A home visit observation was conducted with employee H, home health aide (HHA), on 10/29/20 at 8:00 AM, with patient #1 (start of care 7/11/17). The home folder was viewed and failed to identify the name and contact information of the director of nursing. 2. A home visit observation was conducted with employee OO, HHA, on 10/29/20 at 11:00 AM, with patient #2 (start of care 8/27/20). The home folder was viewed and failed to identify the name and contact information of the director of nursing. 3. A home visit observation was conducted with employee C, director of nursing (DON), on 10/29/20 at 12:40 PM, with patient #3 (start of care 5/14/20). The home folder was viewed and failed to identify the name and contact information of the director of nursing. 4. During an interview on 10/29/20 at 12:50 PM, the director of nursing stated she gave her name and contact information verbally to patients at home visits.	G 622		
G 640	Quality assessment/performance improvement CFR(s): 484.65 Condition of participation: Quality assessment and performance improvement (QAPI).	G 640		

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The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS.
This CONDITION is not met as evidenced by:
Based on observation, record review and interview, the agency failed to develop, implement, evaluate, and maintain an effective, ongoing, agency wide, data-driven quality assurance performance improvement program (QAPI), failed to indicate the frequency and method in which quality indicators were to be measured, analyzed, and tracked, failed to show measurable improvement for the quality indicators to improve health, safety, and quality of care, failed to ensure the frequency and detail of the data collection was approved by the governing body, and failed to implement performance improvement projects all with an emphasis on infection control due to the public health emergency related to COVID-19. These practices had the potential to affect all patients.

The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.65 Quality assessment and performance improvement.

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Findings include:

An undated agency policy titled "Quality Assessment and Performance Improvement (QAPI)," Policy #B-260 stated "Policy: Agency will develop, implement, evaluate, and maintain an effective, ongoing agency wide, data driven QAPI program. ... SPECIAL INSTRUCTIONS: The agency's governing body must ensure that the program reflects the complexity of its organization and services ... SCOPE OF PROGRAM: The program will be capable of showing measurable improvement in indicators that will improve health outcomes, client safety, and quality for care. The agency will identify, measure, analyze, and track quality indicators that include client adverse events, and other relevant data to assess processes of care, services, and operations. The frequency and detail of the data collection must be approved by the governing body ...STANDARD PROGRAM ACTIVITIES: The agency's performance improvement activities will focus on high risk, high volume, or problem prone areas that are specific to this agency ... Adverse events will be tracked and analyzed for cause and document the implementation of prevention actions ... PERFORMANCE IMPROVEMENT PROJECTS: Beginning July 13, 2018, agencies must conduct performance improvement projects ...."

The entire QAPI binder was reviewed on 10/27/20 at 11:05 AM. The binder evidenced an unsigned and undated "QAPI summary report, ten documents titled "service/care documentation review" (5 dated 12/4/18 for patients #10, 14, 15, 16, and 17 and 5 dated 1/28/19 for patients #1, 5, 11, 13, 30). The document asked a series of 10

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yes/no questions as followed: "Do the day services are provided match the assigned days? [sic] If no, what days are missing? Does services provided match the client assignment sheet? If assigned task not completed, is there documentation why (refused, ect?) Is there any task completed that is not on the assignment sheet? If yes, what service was provided but not assignment? Is the weekly documentation form legible? Is there any indications that the documentation sheet was a copy of a previous assignment sheet? (form has marks, signatures, initials same as previous sheets) IS staff time, signature and client/family signature present? Is there any documentation needed to clarify care provided? (example, PRN [as needed] care, client refused bath but would allow face to be washed, client had bath prior to visit)" The documents failed to evidence which quality indicators were being monitored (none related to COVID-19), any measurable improvement.

During an interview on 10/26/20 at 1:35 PM, the alternate administrator was asked who was responsible for the oversight of the QAPI program and she indicated herself and the director of nursing was. She was also asked if the agency had an infection control program and she stated, "we have a policy, yes," and the director of nursing was responsible for the oversight of the infection control program.

During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked if she was involved with the QAPI program. She stated "I don't believe so, I don't know what that is."

During an interview on 10/30/20 at 3:30 PM, the alternate administrator stated the QAPI binder

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"probably don't have all that they are supposed to."

During an interview on 10/30/20 at 5:25 PM, the administrator stated the director of nursing was responsible for the QAPI program, and no QAPI data had been approved by the governing body for 3 months.

During an interview on 11/5/20 at 10:28 AM the alternate administrator stated that previous employee D typed up the last QAPI report after previous employee E, and herself submitted chart audits they had completed for human resources. She also indicated the administrator completed a QAPI meeting sometime after March 2020, but "I wasn't able to be there." When queried if she knew where that report was, she stated "He might not have made one."

During an interview on 11/5/20 at 3:00 PM, the administrator was asked when the last QAPI meeting was, he indicated he thought it was completed in late April 2020. He also indicated they did not have a committee it was "myself, [employee EE], and the clinical supervisor], and there were no QAPI minutes. When asked if the agency had an infection control program he stated "I don't have a program." When queried what the agency did to screen and prevent COVID-19, the administrator indicated each staff should ask that patient about COVID symptoms before having hands on contact. Furthermore, he stated patient and staff temperatures should be taken and should be documented in the patient's home, and the director of nursing should make rounds to the patient's home to pick them up. Lastly he stated "to my knowledge these procedures aren't being done as they should be."

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G 640	Continued From page 91 Home visit observations were completed on 10/29/20 at 8:00 AM with patient #1 and employee H, on 10/29/20 at 11:00 AM with patient #2 and employee OO. During the home visit observations, the patient's home folders were viewed and they failed to evidence temperature logs from patients and staff, aides failed to ask the patients about COVID 19 symptoms or take the patient's temperature. During a home visit observation on 10/29/20 at 12:40 PM with patient #3 and employee C the patient's home folder was viewed and they failed to evidence temperature logs from patients and staff. Employee C failed to ask the patient about COVID-19 symptoms. Employee C took the temperature of patient # 3 and it revealed low grade temperature of 99.7. Furthermore, the patient complained about "feeling shaky" on the inside, having pain in the back and chest, and feeling an "electric" feeling in her head. Employee C failed to document the visit and the symptoms the patient was having, or notify the physician of the symptoms.	G 640		
G 680	IAC 410 17-12-2(a) Infection prevention and control CFR(s): 484.70 Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, record review, and	G 680		

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G 680	Continued From page 92 interview, the agency failed to ensure all staff followed infection control policies, standard precautions, and that an effective infection control program was created and utilized. These practices affected all patients. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.70 Infection Prevention and Control. Findings include: The agency failed to ensure all staff followed standard precautions and infection control policies (See Tag G 682) The agency failed ensure an agency-wide infection control program was maintained for the surveillance, identification, prevention, control, and investigation of patient and staff infections with the addition of data regarding the public health emergency related to COVID-19 (See Tag G 684).	G 680		
G 682	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure all staff followed standard precautions and infection control policies for 3 of 3 home visits observed (# 1, 2, 3).	G 682		

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G 682	Continued From page 93	G 682		

Findings include:

1. An undated agency policy titled "Handwashing/Hand Hygiene," Policy # D-330 stated "...PURPOSE: To improve hand hygiene practices of agency staff and reduce transmission of pathogenic microorganisms to clients and personnel in the home care setting. ...HAND HYGIENE TECHNIQUE: ... When washing hands with soap and water. wet hands first with water, apply an amount of product recommended by manufacturer to hands and rub hands together vigorously for at least 20 seconds, covering all surfaces of hand and fingers ...."

2. A home visit observation was completed on 10/29/20 at 8:00 AM with patient #1 (start of care 7/11/17) and employee H, (home health aide) who provided personal care. During the visit, employee H completed handwashing seven (7) times. For 7 out of 7 handwashes, employee H washed hands between 10-15 seconds each time at least in part under running water. Employee H failed to wash hands for the appropriate amount of time per CDC requirements and agency policy of 20 seconds, and failed to ensure the hand scrub was not completed under running water.

3. A home visit observation was completed on 10/29/20 at 11:00 AM with patient #2 (start of care 8/27/20) and employee OO, (home health aide) who provided personal care. During the visit employee OO completed handwashing 3 times. The first hand washing was not observed, prior to care initiation. After supplies were obtained, and patient was in shower, employee OO completed a 7 second hand wash while wearing gloves. After employee OO dressed patient #2 (after shower),

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G 682	Continued From page 94 gloves were removed, and 15 second hand wash was completed. Then employee OO trimmed patient's beard, hair and mustache. Lastly, gloves were removed, and new gloves donned (without providing hand hygiene). Employee H failed to wash hands for the appropriate amount of time per CDC requirements and agency policy of 20 seconds, failed to remove gloves prior to hands being washed, and failed to complete hand hygiene prior to donning new gloves. 4. A home visit observation was completed on 10/29/20 at 12:40 PM with patient #3 (start of care 5/14/20) and employee C, (director of nursing) who provided a nurses assessment. Prior to care hands were washed for 27 seconds, then gloves were donned. The patient's temperature was taken and thermometer placed back into nursing bag (without being cleaned). Employee C then took the patient's oxygen saturation and pulse via the pulse oximeter, wiped it off with an alcohol pad and placed it back in the nursing bag. The patient's blood pressure was taken, then the cuff was wiped with an alcohol pad and placed back in bag. Nursing assessment was then completed, gloves removed, and a 22 second handwash was completed. Employee C failed to remove gloves, and complete hand hygiene prior to re-entering the clean bag (to put each alcohol equipment inside), thus contaminating nursing bag. 5. During an interview on 10/30/20 at 3:53 PM, the alternate administrator stated staff should wash their hands for 20 seconds.	G 682		
G 684	IAC 410 17-12-1(m) Infection control	G 684		

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G 684	Continued From page 95 CFR(s): 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the agency failed ensure an agency-wide infection control program was maintained for the surveillance, identification, prevention, control, and investigation of patient and staff infections with the addition of data regarding the public health emergency related to COVID-19. These practices had the potential to affect all patients. Findings include: An undated agency policy titled "Infection control surveillance," Policy B-402 stated "POLICY: Apple Tree Home Health Care Services, LLC will establish a continuous data monitoring and collecting system to detect infections or identify changes in infection trends ...." An undated agency policy titled "Infection	G 684		

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Prevention/Control," Policy #B-403 stated "Apple tree home health services, LLC will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC) ...."

An article published by the CDC on 11/4/2020 titled "Interim infection prevention and control recommendations for healthcare personnel during he coronavirus disease 2019 (COVID-19) Pandemic," stated "...Although screening for symptoms will not identify asymptomatic or pre-symptomatic individuals with SARS-CoV-2 infection, symptom screening remains an important strategy to identify those who could have COVID-19 so appropriate precautions can be implemented ...."

The entire infection control binder was reviewed on 10/27/20 at 11:05 AM. The binder evidenced infection control policies B-401, B-402, B-403, B-406, and a blank "infection control report." Additionally, there was 2 "infection prevention screening," tools one for the alternate administrator dated 4/28/20 and one for employee PP dated 4/27/20. These screenings asked 5 questions regarding flu like symptoms, fever, and travel and a documented temperature document.

During an interview on 10/27/20 at 11:22 AM, the alternate administrator indicated they had not had anyone with "any infections that required to be logged."

During an interview on 10/26/20 at 1:35 PM, the alternate administrator was asked if the agency had an infection control program and she stated, "we have a policy, yes," and the director of

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G 684	Continued From page 97	G 684		

nursing was responsible for the oversight of the infection control program.

During an interview on 11/5/20 at 3:00 PM, the administrator was asked if the agency had an infection control program he stated "I don't have a program." When queried what the agency did to screen and prevent COVID-19, the administrator indicated each staff should ask that patient about COVID symptoms before having hands on contact. Furthermore, he stated patient and staff temperatures should be taken and should be documented in the patient's home, and the director of nursing should make rounds to the patient's home to pick them up. Lastly he stated "to my knowledge these procedures aren't being done as they should be."

Home visit observations were completed on 10/29/20 at 8:00 AM with patient #1 and employee H, on 10/29/20 at 11:00 AM with patient #2 and employee OO. During the home visit observations, the patient's home folders were viewed and they failed to evidence temperature logs from patients and staff, aides failed to ask the patients about COVID 19 symptoms or take the patient's temperature.

During a home visit observation on 10/29/20 at 12:40 PM with patient #3 and employee C the patient's home folder was viewed and they failed to evidence temperature logs from patients and staff. Employee C failed to ask the patient about COVID-19 symptoms. Employee C took the temperature of patient # 3 and it revealed low grade temperature of 99.7. Furthermore, the patient complained about "feeling shaky" on the inside, having pain in the back and chest, and feeling an "electric" feeling in her head.

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G 684	Continued From page 98 Employee C failed to document the visit and the symptoms the patient was having, or notify the physician of the symptoms.	G 684		
G 706	Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; This ELEMENT is not met as evidenced by: Based on record review, the skilled nurse (SN) failed to complete a thorough and complete assessment of the patient during subsequent nursing visits for 2 of 4 patients with skilled nursing (#3, 5), in a sample of 10. Findings include: 1. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated orders for a registered nurse every other week for med set up, assessment, and aide and skilled nurse supervision as well as HHA 3 hours, 5 days per week for personal care, range of motion, ambulation, meal prep. Skilled nursing visits were completed for the certification period by the director of nursing from 9/22/20-10/20/20. All the visits were marked as the cardiovascular system was "WNL (within normal limits)," failed to provide heart sound characteristics, presence of edema, the date of the last bowel movement was 9/8/20 on every visit documented. 2. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of	G 706		

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G 706	Continued From page 99 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated orders for skilled nursing (SN) once per week for medication set up and assessment as well as HHA 2 hours per day, 4 days per week for personal care, meal preparation, light housekeeping, and weight log at each visit. Skilled nurse visits were completed by the director of nursing on 9/10/20-10/22/20. All the visits were marked as the cardiovascular system was "WNL (within normal limits)," the morning (AM) blood sugar reading was 150 every visit, the date of the last bowel movement was 9/8/20 on every visit documented.	G 706		
G 710	IAC 410 17-12-2(g) Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician as indicated in the plan of care; This ELEMENT is not met as evidenced by: Based on record review the skilled nurse (SN) failed to follow the written plan of care for 4 of 4 active records reviewed with skilled nursing services, in a total of 10 records reviewed (#1, 2, 3, 5). Findings include: 1. An undated agency policy titled "Clinical documentation," Policy# C-680 stated "Policy: Agency will document each direct contact with the client ... PURPOSE: To ensure that there is an accurate record of the services provided ...." 2. The clinical record of patient #1 was reviewed	G 710		

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G 710	Continued From page 100	G 710		

on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides. The summary of the plan of care stated "SN to instruct client to take pain medication before pain becomes severe to achieve better pain control. SN to assess skin for breakdown every visit. SN to perform weekly weights. SN to performs a neurological assessment each visit. SN to instruct client to use prescribed assistive device when ambulating...."

The skilled nurse failed to follow the plan of care orders as evidenced by: All SN visits (which were all completed by the director of nursing) between 9/8/20-10/27/20 all failed to evidence a weight was obtained, teaching regarding pain medication, or instructing on assistive devices was completed during the visit.

3. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 8/27/20-10/25/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 3 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), meal preparation, set up assist, bathing, dressing, and light housekeeping.

All electronic medical record document copies were requested on 10/30/20 at 11:39 AM.

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The alternate administrator was asked on 10/30/20 after receiving copies at 1:09 PM of the clinical record if the copies received for patient #2 was everything from "8/27/20 to current" and she indicated it was.

The record failed to evidence any skilled nurse visits had been completed/documented, except for the start of care (8/27/20) and recertification (10/25/20) thus the SN frequency was not met.

4. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated orders for a registered nurse every other week for med set up, assessment, and aide and skilled nurse supervision as well as HHA 3 hours, 5 days per week for personal care, range of motion, ambulation, meal prep.

All nursing visits completed for the certification period to date (9/22/20-10/20/20), failed to evidence completion of med box set up, or if the patient was compliant with taking the medications.

5. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated orders for skilled nursing (SN) once per week for medication set up and assessment as well as HHA 2 hours per day, 4 days per week for personal care, meal preparation, light housekeeping, and weight log at each visit.

Skilled nurse visits were completed by the director of nursing on 9/10/20-10/22/20. All the

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G 710	Continued From page 102 visits documented, and interventions completed were "diabetic monitoring care check bs [blood sugar] daily ... diet teaching reg [regular]." The SN failed to evidence completion of med box set up, or if the patient was compliant with taking the medications.	G 710		
G 798	IAC 410 17-14-1(a)(1)(H) Home health aide assignments and duties CFR(s): 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). This STANDARD is not met as evidenced by: Based on record review and interview, the registered nurse (RN) failed to assign home health aides to specific patients and failed to ensure the aide care plan contained patient specific/individualized directions for the home health aide (HHA) to follow that was created by an RN for 5 of 5 active records reviewed with home health aide services (#1, 2, 3, 4, 5), in a sample of 10 records. Findings include: 1. An undated agency policy titled "clinical manager," Policy#B-105 stated ""POLICY ... This position provides clinical oversight over all client care services and staff ... SPECIAL	G 798		

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INSTRUCTIONS:...4. The oversight provided by the clinical manager(s) [director of nursing] includes a. making client and personnel assignments ...."

An undated agency policy titled "Home health aide care plan," Policy# C-751 stated " ...A complete and appropriate care plan ... shall be developed by a registered nurse ... All home health aide staff will follow the identified plan. ... The home health aide shall be assigned to a particular client by a registered nurse ...."

2. During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked who made the personnel assignments, she stated "[employee B] does that."

During an interview on 11/2/20 at 12:39 PM, employee E (licensed practical nurse) stated during her time of employment, employee B (as well as herself) made personnel assignments.

During an interview on 10/30/20 at 3:05 PM, the alternate administrator indicated she made the staff and patient schedules.

3. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 10/23/20-12/21/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 12 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), around the clock supervision, meal preparation, set up assist, bathing, dressing, and

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light housekeeping.

An Agency document titled "HHA Care Plan" dated 10/23/20 and signed by the director of nursing (DON) evidenced fall precautions, standard precautions/Infection Control, and oxygen (O2) precautions as tasks for the HHA to complete, but failed to evidence what skills or equipment were needed for those precautions.

4. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 8/27/20-10/25/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 3 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), meal preparation, set up assist, bathing, dressing, and light housekeeping.

An Agency document titled "HHA Care Plan" dated 10/26/20 and signed by the director of nursing (DON) evidenced fall precautions, standard precautions/Infection Control, safety in ADLs as tasks for the HHA to complete, but failed to evidence what skills or equipment were needed for those precautions.

An agency personal service care plan dated 9/23/20 at 10:45 AM, assigned by the alternate administrator (a home health aide) evidenced fall precautions, standard precautions/Infection Control, safety in ADLs as tasks for the HHA to complete, but failed to evidence what skills or equipment were needed for those precautions. Additionally, the alternate administrator assigned

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the personal service assistants to complete "shower, hair care/comb hair, oral care, skin care, assist with transfer, range of motion, assist with ambulation, light housekeeping," to be completed "every visit."

5. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated HHA orders for 3 hours, 5 days per week for personal care, range of motion, ambulation, meal prep.

An Agency document titled "HHA Care Plan" dated 9/18/20 and signed by the director of nursing (DON) evidenced fall precautions, seizure precautions, standard precautions/Infection Control, safety in ADLs, and proper position during meals as tasks for the HHA to complete, but failed to evidence what skills or equipment were needed for those precautions.

6. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated HHA orders for 9 hours per day, 5 days per week.

An Agency document titled "HHA Care Plan" dated 8/24/20 and signed by the director of nursing (DON) evidenced fall precautions, standard precautions/Infection Control, and safety in ADLs as tasks for the HHA to complete, but failed to evidence what skills or equipment were needed for those precautions.

7. The clinical record of patient #5 was reviewed

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G 798	Continued From page 106 on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated HHA orders for 2 hours per day, 4 days per week for personal care, meal preparation, light housekeeping, and weight log at each visit. An Agency document titled "HHA Care Plan" dated 9/6/20 and signed by the director of nursing (DON) evidenced fall precautions, standard precautions/Infection Control, oxygen precautions, and safety in ADLs as tasks for the HHA to complete, but failed to evidence what skills or equipment were needed for those precautions.	G 798		
G 800	IAC 410 17-14-1(m) Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is not met as evidenced by: Based on record review and interview, the home health aide failed to follow the plan of care for 8 of 8 complete clinical records reviewed, in a total sample of 10 records (#1, 2, 3, 4, 5, 8, 9, 29). Findings include: 1. An undated agency policy titled "Home health aide care plan," Policy# C-751 stated " ...A complete and appropriate care plan ... shall be developed by a registered nurse ... All home	G 800		

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health aide staff will follow the identified plan. ... The home health aide shall be assigned to a particular client by a registered nurse ...."

2. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 12 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), around the clock supervision, meal preparation, set up assist, bathing, dressing, and light housekeeping. The patient's calendar was viewed in the electronic record, but visit documentation was not viewed. Based on the list of hours, the HHA failed to follow the ordered frequency as evidenced by:

On 8/29/20, 10/4/20, and 10/14/20, no visits were made to the patient.

On 9/12/20, 9/13/20, 9/20/20, and 9/26/20, two hour visits were completed each day.

On 9/4/20, 9/5/20 and 10/2/20, and 10/12/20, four hour visits were completed each day.

On 8/28/20, 9/6/20, 9/9/20, 9/10/20, 9/11/20, 9/14/20-9/18/20, 9/21/20, and 9/22/20, five hour visits were completed each day.

On 8/30/20, a six hour visit was completed.

On 8/24/20-8/27/20, 9/1/20, 9/2/20, 9/3/20, 9/7/20, 9/8/20, and 9/28/20, seven hour visits

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were completed each day.

On 9/19/20, 9/27/20, 9/29/20, 10/3/20, 10/6/20, 10/11/20, 10/16/20-10/18/20, eight hour shifts were completed each day.

On 9/23/20, a ten hour shift was completed.

On 9/25/20 and 10/1/20, eleven hour shifts were completed each day.

During an interview on 10/30/20 at 11:39 AM, the alternate administrator was asked for copies patient #1 record which included all the HHA notes from 8/24/20-10/22/20. The alternate administrator indicated the HHA had all her visits "saved" not "completed" and when the documentation was viewed, it was not able to be visualized. She indicated she would contact her to have her complete them so they could be printed. No documentation was ever submitted.

3. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 8/27/20-10/25/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 3 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), meal preparation, set up assist, bathing, dressing, and light housekeeping.

All electronic medical record document copies were requested on 10//30/20 at 11:39 AM.

The alternate administrator was asked on

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10/30/20 after receiving copies at 1:09 PM of the clinical record if the copies received for patient #2 was everything from "8/27/20 to current" and she indicated it was.

The record failed to evidence any home health aide visits had been completed/documented, thus the HHA frequency was not met.

4. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of 5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated HHA orders for 3 hours, 5 days per week for personal care, range of motion, ambulation, meal prep. The HHA failed to follow the ordered frequency as evidenced by:

The record evidenced every day fro 9/18/20 to 10/20/20, one to five visits per day ranging from 1-4 hours each being completed daily. Total hours per day ranged from 1 hour to 13 hours.

5. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated HHA orders for 9 hours per day, 5 days per week. The HHA failed to follow the ordered frequency the entire certification period as evidenced by:

On 9/12/20-9/13/20, 9/15/20-9/23/20, 9/26/20-9/27/20, 10/1/20-10/7/20, 10/9/20-10/11/20, 10/17/20 and 10/18/20, no visits were made to the patient.

On 9/14/20, 9/24/20, 9/25/20, 9/28/20, 9/30/20, 10/8/20, 10/12/20-10/16/20, 10/19/20-10/20/20, a

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five hour shift was completed each day.

On 9/29/20 and 10/16/20, a 4 hour shift was completed each day.

On 10/21/20 a 5.5 hour shift was completed, and on 10/22/20 a 3.5 hour shift was completed.

6. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated HHA orders for 2 hours per day, 4 days per week for personal care, meal preparation, light housekeeping, and weight log at each visit.

On 9/13/20-9/19/20, no visits were documented.

On visits documented from 9/27/20-10/17/20, the HHA documented tasks completed, visits were signed, but they failed to evidence how many hours/what times the visit was conducted which failed to verify if the HHA met the ordered frequency.

Every visit logged this certification period, failed to evidence a weight logged on the documentation.

7. The clinical record of patient #8 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 that indicated orders for HHA 2 hours per day during the certification period for personal care, check pressure areas, and light housekeeping.

On 11/17/19, 11/22/19, 11/24/19, 12/1/19, 12/7/19, 12/8/19, 12/14/19, 12/15/19 only a 1 hour shift was completed (not 2 hours per order).

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G 800	Continued From page 111 On 12/21/19, 1/6/20, and 1/14/20 no visit was completed. 8. The clinical record of patient #9 was reviewed on 11/2/20 and indicated a start of care date of 11/14/19 and a discharge date of 12/6/19. The record contained a plan of care for the certification period of 11/14/19-1/12/20 which indicated orders for HHA 12 hours per day for the certification period for personal care, meal preparations, and light housekeeping. The record failed to evidence any home health aide visits had been completed/documented, thus the HHA frequency was not met. 9. The clinical record of patient #29 was reviewed on 11/2/20 and indicated a start of care date of 7/18/19. The record contained a plan of care for the certification period of 11/16/19-1/14/20 which indicated orders for HHA 2 hours per day during the certification period for personal care. On 11/16/19-12/15/19, 12/21/19-12/22/19, 12/28/19-12/29/19, 1/4/20-1/6/20, 1/11/20-1/14/20, no visits were completed/documented. 10. During an interview on 10/29/20 at 12:50 PM, the director of nursing indicated staff should follow the plan of care and HHA should follow the aide care plan.	G 800		
G 804	Aides are members of interdisciplinary team CFR(s): 484.80(g)(4) Home health aides must be members of the	G 804		

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G 804	Continued From page 112 interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures. This ELEMENT is not met as evidenced by: Based on record review and interview, the home health aides (HHA) failed have knowledge that all changes in patient's condition must be reported to a registered nurse for 2 of 2 interviewed HHA's (employees H and OO). Findings include: An undated agency policy titled "Position: Home Health Aide," Policy# C-140 stated " ...Reports any observed or reported changes in the client's condition and /or needs to the registered nurse...." During an interview on 10/29/20 at 8:00 AM, employee H was asked if they had a concern about a patient's condition, who they would report it to. She stated "[employee B] if it was after hours, would call the on call number. During an interview on 10/29/20 at 11:00 AM, employee OO was asked if they had a concern about a patient's condition, who they would report it to. She stated "[employee B] or [employee C]"	G 804		
G 940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing	G 940		

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optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished.
This CONDITION is not met as evidenced by:
Based on observation, record review, and interview, the agency failed to ensure staff knew who the administrator and alternate administrator were for 1 of 2 home health aide's (HHA) interviewed during home visits (employee H), the the governing body, administrator, and director of nursing fulfilled all responsible duties. These practices impacted all patients.

The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure the provision of quality of care in a safe environment for the Condition of Participation 42 CFR 484.105 Organization and Administration of Services.

In regards to G 940, findings include:

During an interview on 10/29/20 at 8:00 AM, employee H was asked who the agency's administrator was. She stated "[employee B]." She then was asked who the alternate administrator was. She stated "[person H], I think" (There was no employee by that name on the employee roster).

IAC 410 17-12-1(a)(2)

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Findings include:

The governing body minutes failed to evidence information regarding policy review updates, and approvals, fiscal operation approvals, budget approvals, operational plans and approvals, and quality assessment performance improvement (QAPI) approvals (See Tag G 942).

The administrator failed to be responsible for the day to day functions of the agency (See Tag G 948).

The administrator failed to ensure that the director of nursing was available during all operating hours (see Tag G 950).

The agency failed to ensure the alternate administrator was authorized in writing by the governing body (See Tag G 954).

The administrator failed to be available during all operating hours (See Tag G 956).

The director of nursing (DON) failed to make all personnel and patient assignments (See Tag G 960).

The director of nursing (DON) failed to coordinate patient care (See Tag G 962).

The director of nursing (DON) failed to make all personnel and patient assignments (See Tag G 964).

The director of nursing (DON) failed to ensure plans of care were developed, implemented, and updated per the individualization of the patient (See Tag G 968).

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G 942	Governing body CFR(s): 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. This STANDARD is not met as evidenced by: Based on record review and interview, the governing body minutes failed to evidence information regarding policy review updates, and approvals, fiscal operation approvals, budget approvals, operational plans and approvals, and quality assessment performance improvement (QAPI) approvals. Findings include: An undated agency policy titled "Governing body," Policy B-100 stated "...SPECIAL INSTRUCTIONS: The duties and responsibilities of the governing body shall include ... 4. provide direction and leadership and be directly involved in the agency's quality assessment and performance improvement program(QAPI). 5. Adopt and periodically review and approve the administrative and personnel policies, client care policies and procedures, bylaws as required by state licensure regulations, the annual operating budget, and capital expenditure plan ...." The survey was conducted by the Indiana Department of Health onsite in the office (located in Indianapolis) on 10/27/20, 10/28/20, 10/30/20, and 11/5/20. Home visits were conducted all day	G 942		

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in Fort Wayne on 10/29/20. No members of the Governing body showed presence in the survey until 11/5/20 (when the administrator was present).

During the entrance conference on 10/26/20 a copy of the governing body members was requested. At 1:18 PM, a copy of the board members was received with the names of the board members as: Employee's A, EE, U, AA, Person D, and patient#5. At 1:44 PM, another list of board members was submitted by the alternate administrator with the names of the board as: Employee S, EE, AA, Person D, and patient #5.

Review of the agency governing body minutes was completed on 10/30/20 at 3:10 PM, which were requested since inception of the company. The meeting dates from 2018 to current were as followed:

The governing body meeting minutes for 4/26/18 failed to have any information regarding policies, budgets, operational plans, QAPI, or PIPS.

The governing body meeting minutes for 8/2/18 stated "[person F] changed and modified some of the Apple Tree Home health policies] but failed to have any information regarding budgets, operational plans, QAPI, or PIPS.

The governing body meeting minutes for 10/10/18 failed to have any information regarding policies, budgets, operational plans, QAPI, or PIPS.

The governing body meeting minutes for 11/14/18 stated "QA [quality assurance] report: HHAs [home health aides] not calling in when they cannot make it ... Miscellaneous: Need to have

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end of the year meeting and report on (QA. HR [human resources], financials ...." The meeting failed to have any information regarding policies, budgets, operational plans, QAPI, or PIPS.

The governing body meeting minutes for 12/12/18 was blank under the categories: old business, new business, PSA (personal service agency) application, HR report, QA report, supervisor report, financials and failed to have any information regarding policies, budgets, operational plans, QAPI, or PIPS.

A singular document titled "Apple Tree Home Heath Care Services, LLC BUDGET 2019 & 2020 Board approval date 1/8/2019," with the signatures of employee A and EE. The document failed to evidence a full governing body meeting was held and it failed to contain any specifics about the agencies budget and failed to be signed by all the members of the governing body.

The governing body meeting minutes for 2/19/19 stated "[patient 2] is waiting to get serviced" and failed to have any information regarding policies, budgets, operational plans, QAPI, or PIPS.

The governing body meeting minutes for 5/21/19 stated "Vote [employee A] as the new administrator," but failed to have any information regarding policies, budgets, operational plans, QAPI, or PIPS.

The governing body meeting minutes for 8/12/19 stated "New business: prepare a new budget for approval" but failed to have any information regarding policies, budgets, operational plans, QAPI, or PIPS.

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APPLE TREE HOME HEALTH CARE SERVICES, LLC	5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220

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G 942	Continued From page 118 The governing body meeting minutes for 11/5/19 (last documented meeting) was blank under the categories: approval of budget, new hires, home health services application, VA[veteran affairs] services application, new clients, administrator's report, and failed to have any information regarding policies, budgets, operational plans, QAPI, PIPS, or the appointment of the alternate administrator (employee B) whose date of hire was listed as 12/10/19 on the employee list. A copy of the agency's bylaws was requested and received on 11/5/20 at 3:35 PM. The bylaws failed to be dated as adopted or last reviewed by the governing body. During an interview on 10/26/20 at 1:35 PM, the alternate administrator stated the governing body met one time per year. During an interview on 10/30/20 at 3:30 PM, the alternate administrator stated the governing body binder "probably don't have all that they are supposed to." During an interview on 11/5/20 at 3:00 PM, the administrator was asked if the governing body reviewed and approved updates to policies, bylaws, budgets, QAPI and PIPS, and how often it was completed, to which he stated "Yes, not sure when last approval was off hand." (No further information was ever submitted regarding that information). Lastly, the administrator was asked if the board approved the new site location. He stated "Yes, I have to get documentation from [employee EE]." IAC 410 17-12-1(b)	G 942		

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G 948	Continued From page 119	G 948		
G 948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is not met as evidenced by: Based on record review and interview, the administrator failed to be responsible for the day to day functions of the agency. Findings include: An undated agency policy titled "Governing body," Policy B-100 stated "...SPECIAL INSTRUCTIONS: The duties and responsibilities of the governing body shall include 1. Appoint a qualified administrator. Delegate to that individual the authority and responsibility for the operations of the agency to include provision of home care services in accordance with state and federal regulation, accreditation standards, and agency mission. 2. The administrator or a pre-designated person is available during all operating hours. The backup person assumes the administrator's responsibilities and obligations when acting in that role. This position must be approved by the governing body. Available means physically present in the office or able to be contacted by telephone or other electronic means...." The survey was conducted by the Indiana Department of Health onsite in the office (located in Indianapolis) on 10/27/20, 10/28/20, 10/30/20, and 11/5/20. Home visits were conducted all day in Fort Wayne on 10/29/20. The administrator showed presence in the survey only on 11/5/20. The alternate administrator provided copies, answered interview questions, obtained access to	G 948		

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G 948	Continued From page 120	G 948		

the electronic medical record system for the surveyor, made calls to families and patients to set up home visits and was the active face of the agency in the office.

A call was placed to the administrator on 10/30/20 at 2:51 PM, there was no answer and a voicemail was left.

An interview was conducted with the alternate administrator on 10/30/20 at 3:05 PM. She was asked who was in charge of the day to day functions of the agency. She stated "me." When asked what her day to day functions looked like she indicated she did everything from scheduling, to making sure aides were doing what they were supposed to be doing, chart audits, helped the director of nursing with quality assurance duties, made sure orders were faxed out, answered all incoming calls, returned calls, took patient calls especially scheduling, if patient care issues arose she made sure the director of nursing knew about it, hired all staff except nurses which went through the director of nursing, completed audits with personnel files, handled complaints and consulted with the director of nursing if the complaint was clinical, worked with the director of nursing to approve referrals/admission, but stated she did nothing with governing body or the budget and stated "I am an office manager with an alternate administrator title." She indicated she reported to the administrator and he was in the office about once per week when the office initially moved to Indianapolis, but not as often now and she had not seen in him a couple weeks. Furthermore, she indicated she was available 24 hours a day/7 days per week, only worked at the agency with no other job and worked at the agency (in the office) every day,

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G 948	Continued From page 121	G 948		

even sometimes on the weekends. When queried on the role of the administrator she stated "he is the administrator by title." He has called a patient's family to get me a visit when they refused, he handled some concerns with aides in the field, he oversees payroll and billing, and dealt with the budget.

An interview was conducted when a returned call was finally received by the administrator on 10/30/20 at 5:25 PM. He was asked who was in charge of the day to day functions of the agency? He stated "Me and [employee B] is." He was asked what his day to day functions look like as the administrator. He indicated he was always on-call for phone calls from the alternate administrator (employee B), sometimes he had to run out for supplies, or anything (employee B) "calls me about to take care of on this end." He was asked how often he came to the office. He indicated that he went to the office a minimum of once per week. When queried if he had a full-time job elsewhere he stated "Yes ma'am." Lastly, when asked what his availability was, he indicated he was salary not hourly so that gave him flexibility and stated "we are currently looking to readjust the administrative staff, and removing myself." At that time, he was notified that there were several concerns noted with the agency and that they were all reviewed with the alternate administrator.

During an interview on 11/5/20 at 3:00 PM, the administrator indicated he lived in Fort Wayne and the office was in Indianapolis. When queried on reasoning for moving office to Indianapolis when all patients were currently in Fort Wayne, he indicated it was the intention for the agency to be in Indianapolis from the start, and since

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G 948	Continued From page 122 employee B was hired he wanted to move the office to Indianapolis since "she lives down here." He was asked if he knew the patient's plan of care documents had the street address of the Indianapolis office, but the city and state was Fort Wayne, Indiana. He stated "no I didn't know that." The alternate administrator then indicated it hasn't been updated in the electronic medical record as it is pre-populated. Lastly, he was asked if he was aware the purpose of an alternate administrator should only be to to act in the capacity of the administrator only when the administrator is unavailable due to acute illness or vacation. He stated "OK, I am aware of it now," then indicated he would be submitting the alternate administrator's name to the board to take over as the administrator. IAC 410 17-12-1(b)(3) IAC 410 17-12-1(c)(1)	G 948		
G 950	Ensure clinical manager is available CFR(s): 484.105(b)(1)(iii) (iii) Ensure that a clinical manager as described in paragraph (c) of this section is available during all operating hours; This ELEMENT is not met as evidenced by: Based on record review and interview, the administrator failed to ensure that the director of nursing was available during all operating hours. Findings include: An undated agency policy titled "Governing body," Policy B-100 stated "...SPECIAL INSTRUCTIONS: The duties and responsibilities of the governing body shall include ...3. Approves the clinical manager who will provide oversight of	G 950		

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G 950	Continued From page 123	G 950		

all patient care services and personnel...."

The agency phone number was called on 10/26/20 at 10:10 AM, and employee B answered. Employee B reported the agency moved to 5257 N Tacoma Ave, Indianapolis, about a month ago, there was no longer an office in Fort Wayne, there's only a "virtual site" for staff to drop off paperwork, and there's a nurse available 24 hours per day.

During an interview on 10/29/20 at 10:45 AM, the family of patient #2 stated they were unaware that a nurse was available for needs after office hours.

During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked if there was any days/times that she was not available to fulfill her role as director of nursing. She indicated right now Monday and Friday she was in school for clinical's from 8:00 AM- 5:00 PM. When asked who would be able to respond in the even that a clinical need came up during that time. She stated there would be "no one to respond," that she possibly would be able to step away to make a phone call but if someone needed a nursing visit she would not be able to be there. She reported the alternate administrator is on call most of the time after hours. She stated she used to take the on call phone but since the office moved to Indianapolis she had no longer been on call. If a clinical need came up, employee B would call her, she would determine if it was emergent or if it could wait until the next day.

The agency phone number was called on 10/29/2020 7:41 PM. The call went straight to voicemail, and indicated to call 911 if emergency, otherwise call would be returned by the end of the

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G 950	Continued From page 124 day. Left voicemail which indicated a call back from a nurse was requested, with a phone number for the agency to call back. No name or patient name was left. Employee B (alternate administrator) returned a call on 10/30/2020 at 8:11 AM. She indicated there was a voicemail left about needing to speak with a nurse, apologized for the delay, and stated they had trouble with the phones. She asked if everything was okay, if the call was about a particular patient, and if needed to speak with a nurse. She was instructed the need was the previous night and that a nurse call was no longer needed. During an interview on 10/30/20 at 9:00 AM, the alternate administrator stated there was issues with the phone lines and the phones were not rolled over to the cell phone so the voicemail was not obtained until the morning from the night before. She stated it had happened a couple times, but she had been in contact with the company. During an interview on 10/30/20 at 3:05 PM, the alternate administrator stated she was unaware that the director of nursing was not available on Monday and Fridays for patient needs.	G 950		
G 954	IAC 410 17-12-1(d) Ensures qualified pre-designated person CFR(s): 484.105(b)(2) When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same	G 954		

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G 954	Continued From page 125	G 954		

responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section.
This ELEMENT is not met as evidenced by:
Based on record review and interview, the agency failed to ensure the alternate administrator was authorized in writing by the governing body.

Findings include:

An undated agency policy titled "Governing body," Policy B-100 stated "...SPECIAL INSTRUCTIONS: The duties and responsibilities of the governing body shall include 1. Appoint a qualified administrator. Delegate to that individual the authority and responsibility for the operations of the agency to include provision of home care services in accordance with state and federal regulation, accreditation standards, and agency mission. 2. The administrator or a pre-designated person is available during all operating hours. The backup person assumes the administrator's responsibilities and obligations when acting in that role. This position must be approved by the governing body. Available means physically present in the office or able to be contacted by telephone or other electronic means...."

Review of the agency governing body minutes was completed on 10/30/20 at 3:10 PM. The governing body meeting minutes for 4/26/18, 8/2/18, 10/10/18, 11/14/18, 12/12/18, 2/19/19, 5/21/19, 8/12/19, and 11/5/19 failed to evidence the appointment of employee B as the alternate administrator.

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G 954	Continued From page 126 During an interview on 10/26/20 at 1:35 PM, the alternate administrator stated the administrator appointed her to the position. IAC 410 17-12-1(d)(8)	G 954		
G 956	Available during all operating hours CFR(s): 484.105(b)(3) The administrator or a pre-designated person is available during all operating hours. This ELEMENT is not met as evidenced by: Based on record review and interview, the administrator failed to be available during all operating hours. Findings include: An undated agency policy titled "Governing body," Policy B-100 stated "...SPECIAL INSTRUCTIONS: The duties and responsibilities of the governing body shall include 1. Appoint a qualified administrator. Delegate to that individual the authority and responsibility for the operations of the agency to include provision of home care services in accordance with state and federal regulation, accreditation standards, and agency mission. 2. The administrator or a pre-designated person is available during all operating hours. The backup person assumes the administrator's responsibilities and obligations when acting in that role. This position must be approved by the governing body. Available means physically present in the office or able to be contacted by telephone or other electronic means...." The survey was conducted by the Indiana Department of Health onsite in the office (located	G 956		

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G 956	Continued From page 127	G 956		

in Indianapolis) on 10/27/20, 10/28/20, 10/30/20, and 11/5/20. Home visits were conducted all day in Fort Wayne on 10/29/20. The administrator showed presence in the survey only on 11/5/20. The alternate administrator provided copies, answered interview questions, obtained access to the electronic medical record system for the surveyor, made calls to families and patients to set up home visits and was the active face of the agency in the office.

A call was placed to the administrator on 10/30/20 at 2:51 PM, there was no answer and a voicemail was left.

An interview was conducted with the alternate administrator on 10/30/20 at 3:05 PM. She was asked who was in charge of the day to day functions of the agency. She stated "me." When asked what her day to day functions looked like she indicated she did everything from scheduling, to making sure aides were doing what they were supposed to be doing, chart audits, helped the director of nursing with quality assurance duties, made sure orders were faxed out, answered all incoming calls, returned calls, took patient calls especially scheduling, if patient care issues arose she made sure the director of nursing knew about it, hired all staff except nurses which went through the director of nursing, completed audits with personnel files, handled complaints and consulted with the director of nursing if the complaint was clinical, worked with the director of nursing to approve referrals/admission, but stated she did nothing with governing body or the budget and stated "I am an office manager with an alternate administrator title." She indicated she reported to the administrator and he was in the office about once per week when the office

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G 956	Continued From page 128	G 956		

initially moved to Indianapolis, but not as often now and she had not seen in him a couple weeks. Furthermore, she indicated she was available 24 hours a day/7 days per week, only worked at the agency with no other job and worked at the agency (in the office) every day, even sometimes on the weekends. When queried on the role of the administrator she stated "he is the administrator by title." He has called a patient's family to get me a visit when they refused, he handled some concerns with aides in the field, he oversees payroll and billing, and dealt with the budget.

An interview was conducted when a returned call was finally received by the administrator on 10/30/20 at 5:25 PM. He was asked who was in charge of the day to day functions of the agency? He stated "Me and [employee B] is." He was asked what his day to day functions look like as the administrator. He indicated he was always on-call for phone calls from the alternate administrator (employee B), sometimes he had to run out for supplies, or anything (employee B) "calls me about to take care of on this end." He was asked how often he came to the office. He indicated that he went to the office a minimum of once per week. When queried if he had a full-time job elsewhere he stated "Yes ma'am." Lastly, when asked what his availability was, he indicated he was salary not hourly so that gave him flexibility and stated "we are currently looking to readjust the administrative staff, and removing myself." At that time, he was notified that there were several concerns noted with the agency and that they were all reviewed with the alternate administrator.

During an interview on 11/5/20 at 3:00 PM, the

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G 956	Continued From page 129 administrator indicated he lived in Fort Wayne and the office was in Indianapolis. When queried on reasoning for moving office to Indianapolis when all patients were currently in Fort Wayne, he indicated it was the intention for the agency to be in Indianapolis from the start, and since employee B was hired he wanted to move the office to Indianapolis since "she lives down here." He was asked if he knew the patient's plan of care documents had the street address of the Indianapolis office, but the city and state was Fort Wayne, Indiana. He stated "no I didn't know that." The alternate administrator then indicated it hasn't been updated in the electronic medical record as it is pre-populated. Lastly, he was asked if he was aware the purpose of an alternate administrator should only be to to act in the capacity of the administrator only when the administrator is unavailable due to acute illness or vacation. He stated "OK, I am aware of it now," then indicated he would be submitting the alternate administrator's name to the board to take over as the administrator.	G 956		
G 960	Make patient and personnel assignments, CFR(s): 484.105(c)(1) Making patient and personnel assignments, This ELEMENT is not met as evidenced by: Based on record review and interview, the director of nursing (DON) failed to make all personnel and patient assignments. Findings include: An undated agency policy titled "clinical manager," Policy#B-105 stated ""POLICY ... This position provides clinical oversight over all client care services and staff ... SPECIAL	G 960		

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G 960	Continued From page 130 INSTRUCTIONS:...4. The oversight provided by the clinical manager(s) [director of nursing] includes a. making client and personnel assignments ...." During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked who made the personnel assignments, she stated "[employee B] does that." During an interview on 11/2/20 at 12:39 PM, employee E (licensed practical nurse) stated during her time of employment, employee B (as well as herself) made personnel assignments. During an interview on 10/30/20 at 3:05 PM, the alternate administrator indicated she made the staff and patient schedules.	G 960		
G 964	IAC 410 17-14-1(a)(1)(k) Coordinate referrals; CFR(s): 484.105(c)(3) Coordinating referrals, This ELEMENT is not met as evidenced by: Based on record review and interview, the director of nursing (DON) failed to coordinate agency referrals. Findings include: An undated agency policy titled "clinical manager," Policy#B-105 stated "POLICY ... This position provides clinical oversight over all client care services and staff ... SPECIAL INSTRUCTIONS:...4. The oversight provided by the clinical manager(s) [director of nursing] includes ... c. coordinating referrals...."	G 964		

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G 964	Continued From page 131 During an interview on 10/29/20 at 12:50 PM, the director of nursing was asked once a referral was received, who approved it. She stated "[employee B]."	G 964		
G 968	Assure implementation of plan of care CFR(s): 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. This ELEMENT is not met as evidenced by: Citation Text for Tag 0968, Regulation D101 Stout, Amber Based on record review and interview, the director of nursing (DON) failed to ensure plans of care were developed, implemented, and updated per the individualization of the patient for 5 of 5 active records reviewed (# 1, 2, 3, 4, 5), in a total sample of 10. Findings include: 1. An undated agency policy titled "clinical manager," Policy#B-105 stated ""POLICY ... This position provides clinical oversight over all client care services and staff ... SPECIAL INSTRUCTIONS:4. The oversight provided by the clinical manager(s) [director of nursing] includes ... e. assuring the development, implementation, and updates to the individualized plans of care...." 2. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification period of 10/23/20-12/21/20 which indicated diagnoses of benign prostatic hyperplasia with lower urinary tract symptoms,	G 968		

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hyperlipidemia, and type 2 diabetes, and a functional limitation of paralysis (failed to evidence to what area). The summary indicated the patient had a previous traumatic brain injury, headaches, left sided weakness, and short-term memory loss. Additionally there were medications, but not limited to, calcium with vitamin D (supplement), divalproex (commonly used for seizures or mental illness disorders), docusate (for constipation), fluticasone nasal spray (used for allergies), levothyroxine (used for thyroid dysfunction), loratadine (used for allergies), quetiapine (used for mental illness, typically bipolar and schizophrenia), sertraline (used for depression), and acetaminophen, naproxen, and ibuprofen (all pain medications). Lastly, it identified goals as "client will verbalize understanding of proper use of pain medication by the end of the care period. Neuro [neurological] status will be within normal limits and free from S&S [signs and symptoms] of complications or further deterioration. The client will be free from falls during the care period. The client will be free from injury during care period."

During a home visit completed on 10/29/20 at 8:00 AM, patient #1 was observed having left side paralysis of upper and lower extremities, patient lived in a group home with staff there and available, and the use of a toilet riser when using the bathroom.

A recertification comprehensive assessment was completed on 10/22/20 by the director of nursing. The assessment stated, "Client has history of traumatic brain injury and gets occasional headaches," was on a regular diet (should be on a diabetic diet).

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Patient #1's plan of care failed to evidence diagnoses, but not limited to, traumatic brain injury, headaches, left sided hemiplegia (paralysis), short term memory loss, pain (or disorder that causes pain), seizures and/or mental illness (whichever divalproex was being used for), allergies, hypothyroidism (thyroid dysfunction), and depression. The plan of care also failed to evidence a diabetic diet (also known as no concentrated sweets) due to the patient having diabetes and being on 2 diabetic oral medications (metformin and myrbetric), if the patient had any food or drug allergies, any goals and interventions related to all the medications and diagnoses above, patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient and caregiver education to facilitate timely discharge, patient specific interventions and education, durable medical equipment (DME) of a toilet riser, advance directive information, and information regarding the group home living and guardian with contact information.

3. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 8/27/20-10/25/20 which indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 3 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), meal preparation, set up assist, bathing, dressing, and light housekeeping.

The consent form on admission, dated 8/27/20

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indicated "the anticipated apple tree home health care services and frequency to be provided," was skilled nursing 1 hour weekly, home health aide 2 hours a day, and waiver 3 times a week.

A office visit encounter from the patient's physician dated 8/14/20 indicated the patient had diagnoses of COPD (chronic obstructive pulmonary disease), hypertension, history of hypercholesterolemia, history of myocardial infarction, history of right hand fracture, gouty arthritis, arthritis, and compression fractures.

A recertification comprehensive assessment was completed on 10/25/20 by the director of nursing stated the assessment "conclusions" were "skilled intervention needed," but failed to evidence what was needed for the patient.

Patient #2's plan of care failed to evidence diagnoses, but not limited to, COPD, hypertension (high blood pressure), history of hypercholesterolemia (high cholesterol), history of myocardial infarction (heart attack), history of right hand fracture, gouty arthritis, arthritis, and compression fractures. The plan of care also failed to evidence a diet order, waiver discipline, frequency and duration with tasks to be completed, any measurable and interventions related to all the diagnoses above, patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient and caregiver education to facilitate timely discharge, patient specific interventions and education, and advance directive information.

4. The clinical record of patient #3 was reviewed on 10/28/20 and indicated a start of care date of

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5/14/20. The record contained a plan of care for the certification period of 9/18/20-11/16/20 which indicated the medication, but not limited to, "toujeo [injectable medication used for diabetes]300/10 units daily subcutaneous " diagnoses of lupus, type II diabetes, hypertension, and orders for a registered nurse every other week for med set up, assessment, and aide and skilled nurse supervision as well as HHA 3 hours, 5 days per week for personal care, range of motion, ambulation, meal prep.

An office note dated 5/12/20 from the patient's physician indicated the patient had diagnoses, but not limited to, iron deficiency anemia, gastric bypass status for obesity, and osteopenia.

A recertification comprehensive assessment was completed on 9/15/20 by assessed the nutritional risk as a "0" but the patient eats alone most of the time (she lives by herself and would give her 5 points), and takes 3 or more prescribed or over the counter medications daily which would give her an additional 5 points), thus the nutritional assessment was incorrect. Furthermore, the patient has diabetes, and had a gastric bypass surgery, all which would affect nutritional status.

Patient #3's plan of care failed to evidence diagnoses, but not limited to, iron deficiency anemia, gastric bypass status for obesity, and osteopenia. The plan of care also failed to evidence a diet order which matched the assessment, waiver discipline, frequency and duration with tasks to be completed, any measurable goals and interventions related to all the diagnoses above, patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient

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education to facilitate timely discharge, patient specific interventions and education, and advance directive information.

5. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated SN orders once per month for aide supervisory visits and head to toe assessment, and HHA orders for 9 hours per day, 5 days per week to assist with ADL's, IADL's and "monitoring disease process."

A comprehensive recertification assessment was documented on 10/22/20 by the director of nursing (DON). The assessment stated the patient has dysphasia, order for "SN to instruct on daily/weekly weights and recordings," the patient had nausea/vomiting, the presence of a peg tube.

During an interview on 11/2/20 at 12:53 PM, the mother of patient #4 stated the patient currently stayed with grandmother and came to her house every other weekend, that the patient can has a gastrostomy tube (G-tube), but can have small things by mouth such as capri sun or small snacks and the aide assists the patient when taking things in orally. After a conversation with the mother, a call was placed to the grandmother at 1:03 PM. She indicated the patient had a g-tube which al meds and feeding go through and that the patient's grandfather managed it during the day due to being off work and aides were not helping with that. Stated the G-tube had to be in pave to get the patient's weight up to 70 lbs. The patient required a surgery for Scoliosis (curvature of the spine), but the physicians would not do the surgery until the patient's weight had reached and

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maintained at 70 pounds.

A physician's "final report," from the hospital dated 6/21/20 indicated the patient had been hospitalized for malnutrition and failure to thrive. The patient was discharged with a new pump for the feeding that stated "Pediasure 1.0 420 ml via pump over 1 hour 4 times per day" the patient required AFO's to be taken to an outpatient vendor to be readjusted. Additionally, it stated the patient had "No free water needs but may flush meds with free water. [patient] may eat pureed foods and honey thick liquids by mouth." Lastly, the physician had diagnoses listed as "schizencephaly, hydrocephalus, scoliosis, failure to thrive, tetraplegic cerebral palsy, constipation, GER [gastroesophageal reflux] with vomiting."

Patient #4's plan of care (and all care plans since hospitalization in June 2020) failed to evidence diagnoses, but not limited to, schizencephaly, hydrocephalus, scoliosis, failure to thrive, tetraplegic cerebral palsy, constipation, and GER. The plan of care also failed to evidence a pureed diet with thickened liquid order, orders for feeding (whether bolus or continuous), water/flush orders for G-tubes, the DME of a carseat, AFO's, type of pump and specific supplies for g-tube feedings, safety measures of aspiration precautions (due to dysphasia), daily weight orders or vital sign parameters to notify the physician, any measurable goals and interventions related to all the diagnoses above, patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient education to facilitate timely discharge, patient specific interventions and education, and advance directive information.

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6. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated HHA orders for 2 hours per day, 4 days per week for personal care, meal preparation, light housekeeping, and weight log at each visit, that the patient had "COPD [chronic obstructive pulmonary disease] with oxygen use at 2L[liters]," and goals stated "client will verbalize understanding of proper use pain medication by the end of the care period. Neuro status will be free of S&S [signs and symptoms] of complications or further deterioration client will be free from falls during the care period. Client will remain safe in home while home health aide is present."

A physician office note dated 9/12/17 stated the patient had a past medical history of, but not limited to, arteriovenous malformation of the stomach, bursitis of the left shoulder, coronary artery disease, COPD with asthma, deafness, vitamin D deficiency, hypertension, hyperlipidemia, microcytic anemia, morbid obesity, and unstable angina.

Patient #5's plan of care failed to evidence diagnoses of arteriovenous malformation of the stomach, bursitis of the left shoulder, coronary artery disease, COPD with asthma, deafness, vitamin D deficiency, hypertension, hyperlipidemia, microcytic anemia, morbid obesity, unstable angina, daily weight parameters to notify the physician, any measurable goals and interventions related to all the diagnoses above, patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient education to

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G 968	Continued From page 139 facilitate timely discharge, patient specific interventions and education, and advance directive information. IAC 410 17-4-1(a)(1)(c)	G 968		
G1008	Clinical records CFR(s): 484.110 Condition of participation: Clinical records. The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically. This CONDITION is not met as evidenced by: Based on record review and interview, the agency failed to ensure staff documentation was not copy and pasted each visit to ensure it met documentation standards for 2 of 5 active records reviewed (#1,5), failed to complete a discharge summary and sent to the primary practitioner (See Tag G 1022), failed to ensure staff visits were authenticated to ensure the visits occurred when they were documented (See Tag G 1024), and ailed to ensure all clinical records were safeguarded against loss or unauthorized use (See Tag G 1028). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.110 Clinical Records.	G1008		

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G1008	Continued From page 140 In regards to G 1008, findings include: 1. The clinical record of patient #1 was reviewed on 10/27/20 and indicated a start of care date of 7/11/17. The record contained a plan of care for the certification periods of 8/24/20-10/22/20 and 10/23/20-12/21/20 both which were identical with the exception of the dates of the certification period and indicated orders for skilled nursing (SN) 1 time per week for medication set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 12 hours per day for 7 days a week for personal activities of daily living (ADL), instrumental activities of daily living (IADL), around the clock supervision, meal preparation, set up, assist, bathing, dressing, and light housekeeping. Recertification comprehensive assessments completed on 8/20/20 and 10/22/20 by the director of nursing contained copy/pasted information as evidenced by: Both stated "client has history of traumatic brain injury and gets occasional headaches," "client does not have current orders for glucose checks. Writer reached out to [person B] today for orders regarding checks and frequency," and stated last bowel movement was "6/23/20" (4 months prior). 2. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated orders for skilled nursing (SN) once per week for medication set up and assessment as well as HHA 2 hours per day, 4 days per week for personal care, meal preparation, light housekeeping, and weight log at each visit.	G1008		

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G1008	Continued From page 141 Skilled nurse visits were completed by the director of nursing on 9/10/20-10/22/20. All the visits were marked as the cardiovascular system was "WNL (within normal limits)," the morning (AM) blood sugar reading was 150 every visit, the date of the last bowel movement was 9/8/20 on every visit documented, and interventions completed at all visits were "diabetic monitoring care check bs [blood sugar] daily ... diet teaching reg [regular]."	G1008		
G1022	Discharge and transfer summaries CFR(s): 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. This ELEMENT is not met as evidenced by: Based on record review, the agency registered nurse (RN) failed to complete a discharge summary and sent to the primary practitioner for 3 of 3 discharged records reviewed (#8, 9, 29). Findings include: 1. The entire clinical record provided by the	G1022		

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G1022	Continued From page 142 agency for patient #8 was reviewed on 11/2/20 which indicated a start of care date of 7/18/19, and unknown discharge date. The agency failed to complete and send a discharge summary. 2. The clinical record of patient #9 was reviewed on 11/2/20. The record contained several start of care and discharge dates combined into one record. The last admission consents and plan of care was completed with a start of care date of 11/14/19. A discharge OASIS assessment was completed on 12/6/19. The agency failed to complete and send a discharge summary. 3. The clinical record of patient #29 was reviewed on 11/2/20, which indicated a start of care date of 7/18/19, and unknown discharge date. The agency failed to complete and send a discharge summary.	G1022		
G1024	IAC 410 17-15-1(a)(6) Authentication CFR(s): 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure staff visits were authenticated to ensure the visits occurred when they were documented for 2 of 5 active records reviewed (#4, 5), in a total sample of 10.	G1024		

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Findings include:

1. An undated agency policy titled "clinical documentation," Policy# C-680 stated " ...PURPOSE: To ensure that there is an accurate record of the services provided ...."

2. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated SN orders once per month for aide supervisory visits and head to toe assessment, and HHA orders for 9 hours per day, 5 days per week to assist with ADL's, IADL's and "monitoring disease process."

A comprehensive recertification assessment was documented on 10/22/20 by the director of nursing (DON).

During an interview on 11/2/20 at 1:03 PM, a caregiver for patient #4 stated there had not been a nurse to visit the patient in over a month. Furthermore, they stated a nurse called last week and left a voicemail which indicated they needed to come assess the patient, but if the family did not want a visit made that family could call and give the information to the nurse over the phone. The family was upset and stated the "patient needs assessed," and they were going to call the nurse back and make sure a nurse went to the home and completed an assessment.

3. The clinical record of patient #5 was reviewed on 10/30/20 and indicated a start of care date of 9/20/17. The record contained a plan of care for the certification period of 9/4/20-11/2/20 which indicated HHA orders for 2 hours per day, 4 days

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APPLE TREE HOME HEALTH CARE SERVICES, LLC	5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G1024	Continued From page 144 per week for personal care, meal preparation, light housekeeping, and weight log at each visit. On visits documented from 9/27/20-10/17/20, the HHA documented tasks completed, visits were signed, but they failed to evidence how many hours/what times the visit was conducted (not authenticated). IAC 410 17-15-1(a)(7)	G1024		
G1028	Protection of records CFR(s): 484.110(d) Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure all clinical records were safeguarded against loss or unauthorized use for 20 of 20 partial or full missing records (#4, 5, 9, 20, 21, 22, 23, 24, 25, 26, 28, 31, 32, 34, 35, 36, 37, 39, 40, and 41). Findings include: 1. An undated agency policy titled "Clinical records/medical record retention," Policy #C-870 stated "POLICY: ...A clinical record will be maintained for very client receiving home health services. All client information shall be regarded as confidential and available only to authorized users. ...PURPOSE: ...To safeguard the integrity of information maintained in clinical and billing	G1028		

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G1028	Continued From page 145	G1028		

records ...SPECIAL INSTRUCTIONS: Clinical record: 1. A confidential clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every client receiving home health services ...9. Since the clinical record is a legal document, no form may be removed or destroyed once it is filed within the chart... Retention of records: 1. clinical records shall be retained for six (6) years ...."

2. A required state form was completed by the alternate administrator which indicated the unduplicated census for the last 12 months was 23 (16 home health aide only, 3 personal service only, and 4 skilled patients).

3. During the entrance conference on 10/26/20 at 1:05 PM, the alternate administrator was given a list of items to submit. The list included (but not limited to), active patient census list, and a list of all discharged patients since the last survey (12/20/17).

4. The agency active census list revealed the active patients were #1, 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 27.

5. The agency discharge list revealed the discharged patients were # 8, 9, 13, 14, 15, 16, 17, 29, 30, 33, and 38.

6. Review of the previous survey roster revealed patient # 20, which was not listed on either patient lists provided.

7. Review of billing documents from June 2018 to October 2020, revealed billing to Medicaid for patients # 22, 23, 24, 25, 26, 39.

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8. A document provided by previous employee R contained a list of patients the agency serviced from billing and scheduling documentation (but not limited to) patients # 21, 23, and 25 (not on either list from the agency).

9. An email that was sent by person D to the administrator and employee EE on 11/24/18 at 7:59 PM, was reviewed and contained a quality review document titled "285/certification review Q.A [quality assurance] chart," that listed patients # 31, 32, 34, 35, 36, 37, 40, and 41 (none were listed on the agency's census/discharge lists), had a spot for "Y" for yes and "N" for no and stated "auditor signature: [employee EE] each certification period needs audited. Each item missing needs corrected and a note made on how corrected."

10. During record review of the clinical record for patient #4 on 10/30/20 it indicated a start of care date of 4/22/20. The last page of the orders section of the hard chart revealed a plan of care with a start of care date of 8/24/18 with a certification period of 2/16/20-4/14/20. The record failed to evidence any other documents in the chart for that timeframe. The alternate administrator was questioned on the whereabouts of the older record on 10/30/20 at 1:20 PM. The alternate administrator indicated the record was not in the office. Requested she contact the administrator to see if he knew the whereabouts of the record. Six minutes later she stated the administrator was looking for it. No record prior to the current start of care was ever submitted for review.

11. During record review of the clinical record for

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patient #5 on 10/30/20 it indicated a start of care date of 9/20/17 with a plan of care dated 9/4/20-11/2/20. The client profile in the electronic medical record stated the start of care date was 9/20/17. The "financial responsibility and assignment of benefits,"consent in the hard chart of the medical record was dated and signed by the patient on 6/17/18. The "home health beneficiary notice," was signed and dated by the patient on 6/17/18. The "client rights and responsibilities," was dated and signed by the patient on 2/18/18. The "revised admission and discharge policy," was dated and signed by the patient on 6/17/18. The "consent for the use and disclosure of protected health information, was dated and signed by the patient on 6/17/18. The record failed to evidence any documents in the record from 9/20/17 to 2/18/18. The alternate administrator was questioned regarding the missing documentation on 10/30/20 at 2:00 PM. She stated when the previous administrator left there had been documents which were shredded, and indicated when the office was moved from Fort Wayne to Indianapolis some were found but there were gaps in services.

12. The clinical record of patient #9 was reviewed on 11/2/20 and indicated a start of care date of 11/14/19 and a discharge date of 12/6/19. The record contained a plan of care for the certification period of 11/14/19-1/12/20 which indicated orders for HHA 12 hours per day for the certification period for personal care, meal preparations, and light housekeeping. The record failed to evidence any HHA visits or start of care consents for the certification period.

13. An interview was completed on 11/2/20 at 11:17 AM and 11/10/20 at 8:35 AM with patient

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#21. The patient stated they were a patient with the agency from approximately March 2019-August 2019 and received HHA and SN services. An email was received on 11/20/20 which contained admission, discharge, plan of care, and assignment sheet documents for patient #21 while under the care of Apple tree. The documents were Apple tree documents which failed to be evidenced at the agency while on survey.

14. During an interview on 10/26/20 at 2:18 PM, the alternate administrator was asked if all records were present in the office. She indicated the majority of records were in the office and the administrator had a storage in Fort Wayne, but he could bring them to the office if they were needed.

During an interview on 11/5/20 at 9:19 AM, the administrator was asked if all agency records were in the office, he stated "yes." He was then asked if there was a storage facility in Fort Wayne (per the alternate administrator). He stated the storage facility was his garage. He was asked if there were currently any records there which he stated, "not that I know of." The administrator was then given the names of patients #20, 21, 22, 23, 24, 25, 26, 28, 31, 32, 34, 35, 36, 37, 39, 40, and 41 and asked if any of those patients were or had ever been patients of the agency. He stated none had ever been patients. When questioned why the names of the patients were found on documents retained from previous employees, previous surveys, or billing the administrator stated patient #20 was "never a client because that was my auntie." The clinical record was shown to him from the Indiana Department of Health database from the last survey as a part of

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G1028	Continued From page 149 the chosen sample of patients reviewed. After more questioning of specific patients he indicated that patient #21 was a family member of a board member and had been a previous patient, but indicated he did not know where the records were. Then changed his answer by stating there could be records in his garage. When asked how confident he was that their were records in the garage he stated "I am very confident that there could be" due to boxes in the garage from when he moved. When asked how secure, protected and confidential the records would be from family, visitors, or damage he indicated they would be very secure and protected. 410 IAC 17-15-1(c)	G1028		