STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157662	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/11/2024
NAME OF PROVIDER OR SUPPLIER ONE HOME HEALTH, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 833 W LINCOLN HWY, SUITE 300, SCHERERVILLE, IN, 46375		

(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
E0000	Initial Comments An Emergency Preparedness Revisit Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 for Home Health Providers and Suppliers. Survey Dates: January 10, 2023, and January 11, 2024. Active Census: 56 At this Emergency Preparedness survey, One Home Health, LLC was found to be in compliance with Conditions of Participation 42 CFR 484.102: Emergency Requirements for Medicare and Medicaid Participating Providers and Suppliers QR: 01/19/24	E0000		
G0000	INITIAL COMMENTS This was a Federal Post	G0000		

Condition Revisit for a Federal Recertification and State Re-licensure of a Home Health Provider.

Survey Dates: 01/10/2024-01/11/2024

12-month unduplicated skilled admissions: 721

During this revisit 1 condition level and 6 standard level deficiencies were determined to be corrected, and 4 standard level deficiencies were recited.

The deficiency report reflects state findings cited in accordance with 410 IAC 17.

Based on the Condition-level deficiency during the November 8, 2023, survey, your home health agency was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 10/11/2023. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning 11/08/2023 and continuing through

	11/08/2025. 01/16/2024 A1			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview the home health agency failed to ensure that each patient received an individualized written plan of care that would specify the care and services necessary to meet the patient-specific needs identified in the comprehensive assessment in 1 of 1 patient with a resumption of care after 01/02/2024 (Patient #17). Findings include: Based on record review and interview the home health agency failed to ensure that each patient received an	G0572	Clinicians were educated on 1/29/24 to promptly alert physicians on anychanges in the patient’s condition or outcomes that are not being achieved andif the plan of care should be altered. Physician should be contacted to obtaina new order for medication if patient is stating pain levels are elevated andno medication is prescribed for patient in plan of care. Assistants are alsoable to report any changes to therapist or nursing supervisor. 100% of chartswill be reviewed by Clinical Director/Administrator and Intake Manager until100% compliance is met to ensure coordination between clinicians and physicianson any change of status, notification of pain ongoing or rating 6 or higher ona scale of 1-10. Once threshold is met 10% audit will be conducted quarterly byQAPI.	2024-02-02

care that would specify the care and services necessary to meet the patient-specific needs identified in the comprehensive assessment in 1 of 1 patient with a resumption of care after 01/02/2024 (Patient #17).

Findings include:

A review of a policy dated April 2020, titled, "Care Planning Process," indicated an individualized patient specific plan of care would include patient specific interventions and education.

A review of a policy dated April 2020, titled, "Physician Participation In Plan of Care," indicated the physician orders will be individualized based on the patient's needs.

A review of an initial comprehensive assessment dated 12/08/2023, indicated the patient had a diagnosis of stomach cancer and had a new peg tube (tube into the stomach to provide nutrition and medication).

A review of the plan of care for certification period 12/08/2023-02/05/2024

	are to report pain if greater than 6 on a 0-10 scale (0 being no pain and 10 being worst pain). A review of the plan of care failed to evidence any pain medication was ordered. During an interview on 01/11/2024, at 2:00 PM, the Administrator indicated the parameters set for a physician being notified of pain greater than 6 are a standard protocol for every patient and could be individualized if needed. During an interview on 01/11/2024, at 12:20 PM, physician 5, the plan of care physician, indicated the cancer physician should set the pain rating for the patient and he/she had not received a call from the home health agency regarding the patient's pain or pain rating to be individualized.			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being	G0590	Clinicians educated on 1/29/24 to promptly alert physicians on anychanges in the patient's condition such as rating pain as a 6 or greater on ascale of 1-10 and patient has no pain medication ordered as well as outcomesthat are not being achieved and if the plan of care needs to be altered. Physicianshould be contacted to obtain a new order and order should be entered. 100% ofcharts reviewed by Clinical Director/Administrator and Intake Manager until100% compliance is met to	2024-02-02

	achieved and/or that the plan of care should be altered. Based on record review and interview the home health agency failed to alert the physician to changes in the patient's condition in 1 of 1 clinical record reviewed where a patient experienced a change in condition (Patient #17). Findings include: A review of a job description dated 12/2018, titled, "Registered Nurse," indicated the registered nurse would report significant changes in the patient status to the physician and other members of the team in a timely manner consistent with the patient's needs. A review of a policy dated April 2020, titled, "Ongoing Assessment," indicated the scope and intensity of ongoing assessment will be determined by the diagnoses, condition, and the clinician will assess for pain status. A review of an initial comprehensive assessment dated 12/08/2023, indicated Patient #17's had a diagnosis of stomach cancer with a recent g-tube (tube into stomach to provide nutrition and medication) insertion, and had a		ensure care coordination between clinician's andphysicians on any change in status. Once threshold is met a 10% audit will beconducted quarterly by QAPI.	

pain level of 0 (on a 0-10 pain scale with 0 no pain and 10 worst pain).

A review of a registered nurse visit dated 12/11/2023, indicated the patient's pain level was at a 5 with the location of the pain in the abdomen described as aching and cramping.

A review of a registered nurse visit dated 12/14/2023, indicated the patient's pain level was at a 5 with complaints of abdominal cramps and heartburn and the patient did not have any medications prescribed for heartburn.

A review of the registered nurse visit notes dates 12/11/2023 and 12/14/2023 failed to evidence the physician was notified of the patient's pain.

A review of hospital 4's history and physical dated 11/22/2023, indicated the patient was on Dilaudid (pain medication) intravenously (medications delivered through vein) every 4 hours and Protonix (heartburn medication) intravenous twice per day during the patient's hospital stay.

	A review of the plan of care for certification period 12/08/2023-02/05/2024 failed to evidence the patient had any pain medication or heartburn medication prescribed. During an interview on 01/11/2024, at 10:50 AM, registered nurse 2 indicated the physician should be notified if a patient was having pain and did not have pain medication prescribed. During an interview on 01/11/2024, at 12:20 PM, physician 5, the plan of care physician, indicated the patient's pain medication needs should be addressed by the patient's cancer doctor			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the home health agency failed to integrate services to assure the identification of patient	G0606	Educationwas provided on 1/29/24 to clinicians coordinating its services with otherhealth providers serving the patient. Clinicians were educated on reporting tophysician any pain level of 6 or higher and addressing any new orders receivedfrom physician due to elevated pain level. Plan of care to be updated according to physician to assure patients'needs and factors that	2024-02-02

	needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines in 1 of 2 clinical records reviewed with physical and occupational therapies (Patient #17). Findings include: A review of a job description dated 12/2018, titled, "Registered Nurse," indicated the registered nurse would report changes and information necessary to modify and update the care plan to reflect progress towards goals. A review of an undated job description received on 01/11/2024, titled, "Physical Therapist," indicated the physical therapist would communicate plans and changes to the physician and to the client Case Manager and other caregivers through the care plan, progress notes, and participation in care conferences. A review of an occupational therapist note dated 12/11/2023, indicated Patient #17's pain level was 5 on a pain scale of 0-10 (0 being no pain and 10 being worst pain), reported discomfort in the		could affect patients' safety and treatmenteffectiveness are being identified and coordination of care is being providedby all disciplines managing care of patient. 100% of charts were reviewed byClinical Director/Administrator and Intake manager until 100% compliance is metto show evidence of communication/coordination of care with other health careproviders. Oncethreshold is met a 10% chart audit will be conducted quarterly by QAPI toensure deficiencies do not recur.	

abdomen (stomach area) with the patient grimacing at times, and medication helped relieve the pain.

A review of physical therapy assistant 3 note dated 12/12/2023, indicated Patient's pain level was a 4 to the abdomen, Patient's caregiver reported Patients' stomach hurt all the time, Patient presented with grimacing and bracing, and medication helped relieve the pain.

A review of physical therapy assistant 3 note dated 12/14/2023, indicated Patient's pain level was a 5 to the abdomen and medication helped relieve the pain.

A review of occupational therapy assistant 1 note dated 12/14/2023, indicated Patient's pain level was a 6 to the abdomen with grimacing and initially refused therapy due to too much abdominal discomfort and medication helped relieve the pain.

A review of a registered nurse visit dated 12/11/2023, indicated Patient's pain level was at a 5 with the location of

described as aching and cramping.

A review of a registered nurse visit dated 12/14/2023, indicated Patient's pain level was at a 5 with complaints of abdominal cramps and heartburn and Patient did not have any medications prescribed for heartburn.

A review of the registered nurse visit notes dated 12/11/2023 and 12/14/2023 failed to evidence the physician was notified of Patient's pain.

A review of the plan of care for the certification period 12/08/2023 - 02/05/2024, failed to evidence pain medication or heartburn medication was prescribed for Patient.

A review of the therapy notes dated 12/11/2023, 12/12/2023, and 12/14/2023 failed to evidence the registered nurse or the physician was notified of Patient's complaints of abdominal pain and cramping.

During an interview on 01/11/2024, at 1:10 PM, occupational therapist assistant 1 indicated Patient's family

	with translation and was not able to answer questions regarding medications and the agency's protocol was to notify the physician if the pain level was greater than 6 on a 0-10 scale. During an interview on 01/11/2024, at 12:15 PM, physical therapy assistant 3 indicated Patient was having pain to the peg tube site (tube to the stomach for nutrition and medications), unsure if Patient was taking pain medications, and would notify the physician if the pain level was greater than 7 per the agency protocol. During an interview on 01/11/2024, at 10:50 AM, registered nurse 2 indicated the physician should be notified if a patient was having pain and did not have pain medication prescribed. During an interview on 01/11/2024, at 12:20 PM, physician 5 indicated he/she had not received a call from the home health agency regarding Patient's pain, Patient was taking Tylenol for pain and any further pain medication would need to be prescribed by the			

	oncologist. During an interview on 01/11/2024, at 2:15 PM, the Administrator indicated Patient's pain level should be reported to the physician based on Patient's behavior and their ability to participate in therapy and further relayed that the physical therapists (PT) and PT assistants are able to notify the physician if required.			
N0000	Initial Comments This visit was for a State Re-licensure Revisit Survey of a Home Health provider. Survey Dates: 01/10/2024-01/11/2024 12 month Unduplicated Skilled Admissions: 721 This deficiency report reflects State Findings cited in accordance with 410 IAC 17.	N0000		
N0470	Home health agency administration/management	N0470	100 % of current/active charts	2024-02-02

	410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on record review and interview the home health agency failed to implement policies and procedures for the control of communicable diseases in 1 of 1 clinical records reviewed with a diagnosed flu virus (Patient #17). Findings include: Based on record review and interview the home health agency failed to implement policies and procedures for the control of communicable diseases in 1 of 1 clinical records reviewed with a diagnosed flu virus (Patient #17). Findings include: A policy dated April 2020, titled, "Evaluating and Maintaining Records of Infections Among Patients," indicated all patients with a new, actual, or suspected infection will have a patient		are being reviewed by ClinicalDirector/Administrator for the next 30 days to ensure all patients with new, suspected, reportable communicable infections, admission to hospital due to an infection or actual infection report completed within24 hours of discovery. This will include any new, actual, or suspected infection that isclinically observed by personnel, admission to hospital for infection, reportablecommunicable infections reported/diagnosed, or a new antibiotic is ordered. Clinical Director/Administrator will be monitoring new or suspected Infections,recent hospitalization due to infection, start of antibiotic, admission tohospital due to actual or suspected infection, or reportable communicableinfection that is identified/ diagnosed during case conference and	

	infection reported completed within 24 hours of discovery, and the infection identification patient report form would be completed when a patient was admitted to a hospital due to an actual or suspected infection, or a reportable communicable infection was identified. The clinical record for Patient #17 indicated a start of care date of 12/08/2023. The record included a coordination note, dated 01/08/2024, which indicated Patient was admitted to the hospital from 12/18/2023 to 12/28/2023. The hospital's history and physical, dated 12/17/2023, indicated Patient was hospitalized after diagnosed with Influenza A and Tamiflu (anti-virus medication) was prescribed in the hospital. A review of the Quality Improvement Event Summary dated 12/08/2023 to 01/10/2024 failed to evidence Patient's infection was documented on an infection control report. During an interview on 01/11/2024, at 2:31 PM, the Administrator indicated		havingclinicians enter QI report if needed within 24 hours of discovery, Target threshold is 100% once 100% compliance is met then QAPI will be performing quarterly chart audits to ensure deficiency does not recur on any new, actual, or suspected infection is clinically observed, by personnel, admission to hospital for infection, communicable infections reported/diagnosed, or a new antibiotic is ordered. Education was provided to the staff on 1/29/24 on infection control and documenting an infection report on any new admission to hospital for infection or a reportable communicable infection is identified.	

	according to the agency's policy a quality improvement report should have been completed for a patient diagnosed with Influenza A.			
N0486	Q A and performance improvement 410 IAC 17-12-2(h) Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review and interview, the home health agency failed to integrate services to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines in 1 of 2 clinical records reviewed with physical and occupational therapy (Patient #17). Findings include: Based on record review and interview, the home health agency failed to integrate services to assure the identification of patient needs	N0486	**Education was provided on 1/29/24to clinicians coordinating its services with other health providers serving thepatient. Clinicians were educated on reporting to physician any pain level of 6or higher and addressing any new orders received from physician due to elevatedpain level. Plan of care to be updatedaccording to physician to assure patients' needs and factors that could affect patients'safety and treatment effectiveness are being identified and coordination ofcare is being provided by all disciplines managing care of patient. 100% ofcharts were reviewed by Clinical Director/Administrator and Intake manageruntil 100% compliance is met to show evidence of communication/coordination ofcare with other health care providers.**	2024-02-02

	patient safety and treatment effectiveness and the coordination of care provided by all disciplines in 1 of 2 clinical records reviewed with physical and occupational therapy (Patient #17). Findings include: A review of a job description dated 12/2018, titled, "Registered Nurse," indicated the registered nurse would report changes and information necessary to modify and update the care plan. A review of an undated job description received on 01/11/2024, titled, "Physical Therapist," indicated the physical therapist would communicate plans and changes to the physician and to the client Case Manager and other caregivers through the care plan, progress notes, and participation in care conferences. A review of an occupational therapist note dated 12/11/2023, indicated Patient #17's pain level was 5 on a pain scale of 0-10 (0 being no pain and 10 being worst pain), reported discomfort in the		**Oncethreshold is met a 10% chart audit will be conducted quarterly by QAPI toensure deficiencies do not recur.**	

	abdomen (stomach area) with the patient grimacing at times, and medication helped relieve the pain. A review of physical therapy assistant 3 note dated 12/12/2023, indicated the patient's pain level was a 4 to the abdomen, the patient's caregiver reported the patient stomach hurts all the time, patient presented with grimacing and bracing, and medication helped relieve the pain. A review of physical therapy assistant 3 note dated 12/14/2023, indicated the patient's pain level was a 5 to the abdomen and medication helped relieve the pain. A review of occupational therapy assistant 1 note dated 12/14/2023, indicated the patient's pain level was a 6 to the abdomen with grimacing and initially refused therapy due to too much abdominal discomfort and medication helped relieve the pain. A review of a registered nurse visit dated 12/11/2023, indicated the patient's pain level			

	the pain in the abdomen described as aching and cramping. A review of a registered nurse visit dated 12/14/2023, indicated the patient’s pain level was at a 5 with complaints of abdominal cramps and heartburn and the patient did not have any medications prescribed for heartburn. A review of the registered nurse visit notes dates 12/11/2023 and 12/14/2023 failed to evidence the physician was notified of the patient's pain. A review of the plan of care for certification period 12/08/2023-02/05/2024, failed to evidence pain medication or heartburn medication prescribed for the patient. A review of the therapy notes dated 12/11/2023, 12/12/2023, and 12/14/2023 failed to evidence the registered nurse or the physician were notified of the patient’s complaints of abdominal pain and cramping. During an interview on 01/11/2024, at 10:50 AM, registered nurse 2 indicated the			

	patient was having pain and did not have pain medication prescribed. During an interview on 01/11/2024, at 1:10 PM, occupational therapist assistant 1 indicated the patient's family member had some difficulty with translation and was not able to answer questions regarding medications and the agency's protocol was to notify the physician if the pain level was greater than 6 on a 0-10 scale. During an interview on 01/11/2024, at 12:15 PM, physical therapy assistant 3 indicated the patient was having pain to the peg tube site (tube to the stomach for nutrition and medications), unsure if patient was taking pain medications, would notify the physician if the pain level was greater than 7 per the agency protocol. During an interview on 01/11/2024, at 12:20 PM, physician 5 indicated he/she had not received a call from the home health agency regarding the patient's pain, the patient was taking Tylenol for pain and			

	any further pain medication would need to be prescribed by the cancer doctor. During an interview on 01/11/2024, at 2:15 PM, the Administrator indicated the patient's pain level should be reported to the physician based on the patient's behavior and if able to participate in therapy and the physical therapy assistants and physical therapists are able to notify the physician if required.			
N0522	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview the home health agency failed to ensure that each patient received an individualized written plan of care that would specify the care and services necessary to meet the patient-specific needs	N0522	Clinicians were educated on 1/29/24to pain parameters and when to notify physician of pain rating greater then 6on a scale of 1-10. The Clinical Director/Administratorand Intake manager audited 100% of all active/current charts and will continueto audit until 100% compliance is met. If deficiencies were cited clinicianswere educated via HIPPA compliant tiger connect on said deficiency withcorrected additions needed to show compliance. Pain is being added to HCHBVital signs documentation as a mandatory	2024-02-02

	identified in the comprehensive assessment in 1 of 3 patient records reviewed with an initial comprehensive assessment completed after 12/08/2023 (Patient #17). Findings include: Based on record review and interview the home health agency failed to ensure that each patient received an individualized written plan of care that would specify the care and services necessary to meet the patient-specific needs identified in the comprehensive assessment in 1 of 3 patient records reviewed with an initial comprehensive assessment completed after 12/08/2023 (Patient #17). Findings include: A review of a policy dated April 2020, titled, “Care Planning Process,” indicated an individualized patient specific plan of care would include patient specific interventions and education. A review of a policy dated April 2020, titled, “Physician Participation In Plan of Care,”		documented vital sign and if patientrating is 6 or greater a alert will be sent to clinician/clinical director andcoordination note will be entered to show coordination of care with physician. Once100% of all charts are in compliance a quarterly audit will be conducted byQAPI to ensure deficiency will not recur	

will be individualized based on the patient's needs.

A review of an initial comprehensive assessment dated 12/08/2023, indicated the patient had a diagnosis of stomach cancer and had a new peg tube (tube into the stomach to provide nutrition and medication) and denied having pain.

A review of the plan of care for certification period 12/08/2023-02/05/2024 indicated licensed professional to report pain if greater than 6 on a 0-10 scale (0 being no pain and 10 being worst pain).

A review of the plan of care failed to evidence any pain medication was ordered.

During an interview on 01/11/2024, at 2:00 PM, the Administrator indicated the parameters set for a physician being notified of pain greater than 6 are a standard protocol for every patient and could be individualized if needed.

During an interview on 01/11/2024, at 12:20 PM, physician 5, the plan of care physician, indicated the cancer

	physician should set the pain rating for the patient and he/she did not receive a call from the home health agency regarding the patient's pain or pain rating to be individualized.			
N0527	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on record review and interview the home health agency failed to alert the physician to changes in the patient's condition in 1 of 1 clinical records where a patient experienced a change in condition (Patient #17). Findings include: A review of a job description dated 12/2018, titled, "Registered Nurse," indicated the registered nurse would	N0527	Clinicians were educated on 1/29/24 to promptly alert physicians on anychanges in the patient's condition or outcomes that are not being achieved andif the plan of care should be altered. Physician should be contacted to obtaina new order for medication if patient is stating pain levels are elevated andno medication is prescribed for patient in plan of care. Assistants are alsoable to report any changes to therapist or nursing supervisor. 100% of chartswill be reviewed by Clinical Director/Administrator and Intake Manager until100% compliance is met to ensure coordination between clinicians and physicianson any change of status, notification of pain ongoing or rating 6 or higher ona scale of 1-10. Once threshold is met 10% audit will be conducted quarterly byQAPI.	2024-02-02

patient status to the physician and other members of the team in a timely manner consistent with the patient's needs.

A review of a policy dated April 2020, titled, "Ongoing Assessment," indicated the scope and intensity of ongoing assessment will be determined by the diagnoses, condition, and the clinician will assess for pain status.

A review of an initial comprehensive assessment dated 12/08/2023, indicated Patient #17's had a diagnosis of stomach cancer with a recent g-tube (tube into stomach to provide nutrition and medication) insertion, and had a pain level of 0 (on a 0-10 pain scale with 0 no pain and 10 worst pain).

A review of a registered nurse visit dated 12/11/2023, indicated the patient's pain level was at a 5 with the location of the pain in the abdomen described as aching and cramping.

A review of a registered nurse visit dated 12/14/2023, indicated the patient's pain level

abdominal cramps and heartburn and the patient did not have any medications prescribed for heartburn.

A review of the registered nurse visit notes dates 12/11/2023 and 12/14/2023 failed to evidence the physician was notified of the patient's pain.

A review of hospital 4's history and physical dated 11/22/2023, indicated the patient was on Dilaudid (pain medication) intravenously (medications delivered through vein) every 4 hours and Protonix (heartburn medication) intravenous twice per day during the patient's hospital stay.

A review of the plan of care for certification period 12/08/2023-02/05/2024 failed to evidence the patient had any pain medication or heartburn medication prescribed.

During an interview on 01/11/2024, at 10:50 AM, registered nurse 2 indicated the physician should be notified if a patient was having pain and did not have pain medication prescribed.

During an interview on

	01/11/2024, at 12:20 PM, physician 5, the plan of care physician, indicated the patient's pain medication needs should be addressed by the patient's cancer doctor.			
N0544	Scope of Services 410 IAC 17-14-1(a)(1)(E) Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on record review and interview, the Registered Nurse failed to document complete clinical notes including wound assessment in 1 out of 2 active patients reviewed with a surgical wound (Patient #16). 410-IAC-17-14-1(a)1(E) The findings include: 1. A review of policy, "Wound Care," revised April 2020, evidenced "At each visit the patient's skin will be assessed. At each dressing change the wound will be assessed and documentation. At least every	N0544	Clinicians were educated on1/29/24 on completing accurate clinical notes that include ongoing assessmentof non-removable dressings, ostomy site/device/stoma, and the status ofdressings. Every week wound assessmentand documentation will be completed and clients' records will show systematicassessment, planning intervention, and evaluation. Wound assessment will beperformed every visit. 100%of charts will be audited by Clinical Director/Administrator and Intake Manageruntil 100% compliance is met to ensure ongoing assessment is being completed.Once threshold is met a 10% audit will be conducted quarterly by QAPI.	2024-02-02

and documentation will include measurement of length, width, depth and undermining and tunneling if present."

2. A review of agency's Registered Nurse job description, revised 12/2018, evidenced "the Registered Nurse...communicates/documents observations and assessments. Maintains client records showing systematic assessment, planning intervention, and evaluation."

3. The clinical record for Patient #16, included a plan of care, initiated 12/03/23 with orders for skilled nurse visits weekly, to educate patient and caregiver regarding new ostomy site and to assess and monitor ostomy and change dressings as needed.

The record included skilled nurse visit notes dated 01/05/24 and 01/09/24 that each failed to evidence the ostomy was assessed. Each visit note indicated the wound was over by a non-removable dressing.

4. During an interview beginning on 1/11/24 at 2:54 pm, Administrator indicated the

	performed with every nurse every visit.			
N0567	Scope of Services 410 IAC 17-14-1(c)(6) Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel; Based on record review and interview, the agency failed to ensure physical and occupational therapists consulted with other home health agency personnel responsible for the patient in 1 of 2 active clinical records reviewed with a patient receiving physical therapy and occupational therapy (Patient #17). The findings include: Based on record review and interview, the agency failed to ensure physical and occupational therapists consulted with other home health agency personnel responsible for the patient in 1 of 2 active clinical records	N0567	Education was provided on 1/29/24 to therapists that they will reviewand update the patients plan of care according to the patients need. Therapists will communicate plans and changesto physician and case manager through the plan of care, progress note, and caseconference. If patient is not participating in therapy physician and casemanager will be made aware and physician will be notified by patients casemanager and any changes in plan of care will be documented. 100% of allactive/current patients will have case conference with Clinical Director until100% compliance is met Once threshold is met a 10% audit will be conducted byQAPI quarterly.	2024-02-02

reviewed with a patient receiving physical therapy and occupational therapy (Patient #17).

A review of an undated job description received on 01/11/2024, titled, “Physical Therapist,” indicated the physical therapist would communicate plans and changes to the physician and to the client Case Manager and other caregivers through the care plan, progress notes, and participation in care conferences.

A review of a policy dated April 2020, titled, "Scope of Services," indicated rehabilitative therapies provided by a certified physical or occupational therapist would include coordinating services in consultation with home health staff.

A review of an occupational therapist note dated 12/11/2023, indicated Patient #17’s pain level was 5 on a pain scale of 0-10 (0 being no pain and 10 being worst pain), reported discomfort in the abdomen (stomach area) with

	and medication helped relieve the pain. A review of physical therapy assistant 3 note dated 12/12/2023, indicated the patient's pain level was a 4 to the abdomen, the patient's caregiver reported the patient stomach hurts all the time, patient presented with grimacing and bracing, and medication helped relieve the pain. A review of physical therapy assistant 3 note dated 12/14/2023, indicated the patient's pain level was a 5 to the abdomen and medication helped relieve the pain. A review of occupational therapy assistant 1 note dated 12/14/2023, indicated the patient's pain level was a 6 to the abdomen with grimacing and initially refused therapy due to too much abdominal discomfort and medication helped relieve the pain.			

A review of the plan of care for certification period 12/08/2023-02/05/2024, failed to evidence pain medication or heartburn medication prescribed for the patient.

A review of the patient's medication list received on 01/11/2024, failed to evidence pain medication or heartburn medication prescribed for the patient.

A review of the therapy notes dated 12/11/2023, 12/12/2023, and 12/14/2023 failed to evidence the registered nurse or the physician were notified of the patient's complaints of abdominal pain and cramping.

During an interview on 01/11/2024, at 1:10 PM, occupational therapist assistant 1 indicated the patient's family member had some difficulty with translation and was not able to answer questions regarding medications and the agency's protocol was to notify the physician if the pain level was greater than 6 on a 0-10 scale.

During an interview on 01/11/2024, at 12:15 PM, physical therapy assistant 3

indicated the patient was having pain to the peg tube site (tube to the stomach for nutrition and medications), unsure if patient was taking pain medications, would notify the physician if the pain level was greater than 7 per the agency protocol.

During an interview on 01/11/2024, at 2:15 PM, the Administrator indicated the patient's pain level should be reported to the physician based on the patient's behavior and if able to participate in therapy and the physical therapy assistants and physical therapists are able to notify the physician if required.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robyn Vescovi	Administrator/Clinical Director	2/20/2024 2:54:23 PM