STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K133	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D-BEST HOME CARE	2346 S LYNHURST DRIVE SUITE 600 , INDIANAPOLIS, Indiana, 46241

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G0000	INITIAL COMMENTS This survey was for a Federal Recertification and State Re-licensure survey in conjunction with a complaint of a Home Health Provider. The survey was partially extended and the agency's Administrator was notified on Thursday, September 3rd, 2021 at 3:47 pm. Survey dates: 8/31/21, 9/1/21, 9/2/21, and 9/7/21 Complaint # IN00294048/ 29377 - Substantiated, with findings. Facility # 013640 CNN # 15K133 Census: 8 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State findings. Quality Review Completed on 09/27/21 by Area 3	G0000		
G0536	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 agency failed to ensure they reconciled and identified all duplicate drug therapy and compliance with drug therapy for 1 of 7 clinical records reviewed (Patient #4). Findings include:	G0536		

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G0536	Continued from page 1 In a review of Policies and Procedures on 9-2-21 at 2:52 pm, in a document entitled, 'Assessment - Nursing' on page 5 of 7 states, 'A comprehensive review and history of prescribed, over-the-counter medications and herbal supplements, including: .....Duplicative drug therapy' [would be performed during nursing assessment]. The clinical record for patient #4, start of care 2-19-19, was reviewed and contained a plan of care for the certification period of 8-7-21 to 10-5-21, with orders for Home Health Aide services 10 hours per day for 7 days per week for 26 weeks. The plan of care indicated the patient's diagnoses were COPD (Chronic Obstructive Pulmonary Disease), schizoaffective disorder, congestive heart failure, diabetes mellitus, and glaucoma. The plan of care contained the following duplicated medications; A. "Brimonidine tartrate 0.15% instill one drop 3 times daily drops, gel or ointment for the eye (OPTHALMIC)" and "Brimonidine 0.15% opthalmic solution 1 drop TID drops, gel or ointment for the eye (OPTHALMIC)", (medication used to treat glaucoma) is found twice in the medication list, without instructions to administer to specific eye(s). B. "Sitagliptin 25 mg oral tablet 1 daily by mouth (PO)" and "Januvia 25 mg oral tablet 1 daily: Morning by mouth" (these are the same anti-diabetic drug, the former is the generic name, the later is the brand name). C. "Latanoprost 0.005% opthalmic solution 1 at bedtime, instill 1 drop in both eyes for the eye (OPTHALMIC)" and "Xalatan 0.005% opthalmic solution 1 drop QHS drops, gel or ointment for the eye (OPTHALMIC)" (these are the same medication used to treat increased pressure in the eye, the former is the generic name, the later is the brand name). D. "Escitalopram 10 mg oral tablet 1 daily morning by mouth (PO)" and "Escitalopram 10 mg oral tablet 1 tab daily by mouth (PO)", (medication for depression and generalized anxiety) are both found in the medication list contained within the plan of care. In an interview on 9-2-21 at 2:00 pm with Administrator and Clinical Manager were queried about the duplicate medications found in the plan of care for patient #4, both indicated that they were unaware of the duplicated medications listed. Signature of Clinical Manager appears on the Plan of Care and is dated 8-6-2021. 410 IAC 17-14-1(a)(1)(B)	G0536		

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G0536 G0546	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 agency failed to ensure the comprehensive assessment was updated and revised as frequently as the the patient's condition warrants due to a major decline or improvement in the patients; health status but no less than the last 5 days of every 60 days beginning with the start of care date. Agency failed to perform a timely Recertification visit for 1 of 5 active records. Findings include: Clinical record for Patient #2, Start of Care 7-1-21, was reviewed on 9/2/21 and contained a plan of care for the certification period of 7-1-21 to 8-29-21, with orders for skilled nursing for 10 hours per day, 3 days a week, for 26 weeks. Further review of the record failed to evidence that a comprehensive recertification assessment was completed within the last 5 days of the 60 day certification period. In an interview on 9-7-21 at 12:02pm, Clinical Manager confirmed the Recertification visit was indeed missed, was overdue, and has not been completed. IAC 17-14-1(a)(1)(B)	G0536 G0546		
G0572	Plan of care CFR(s): 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	G0572		

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G0572	Continued from page 3 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure services were provided as ordered on the plan of care and failed to consult the physician when the orders on the plan of care were modified due to missed visits for 1 of 5 active records reviewed. Findings include: 1. On 9/7/21 at 11:00 am Administrator was queried as to location of Missed Visit Policy, as Surveyor was unable to locate this in either of the two policy binders that Administrator had presented to surveyors. Administrator stated this is likely located elsewhere and attempted to locate policy. Administrator reported later in the day that the policy could not be found. In an agency policy entitled 'Scheduling Patient Visits' (revised 4/11/2016), page 1 stated, "the physician shall be contacted whenever changes to the type and/or frequency of patient visits are required based on patient needs." Page 2 stated, "Interim and/or verbal orders noting a change in visit type or frequency shall be signed and dated by the supervising Registered Nurse or Therapist and sent to physician for countersignature." 2. On 8/31/21 clinical record review of patient #1 revealed Start of Care date of 10/24/16, and Plan of Care dated 4/12/19 – 6/10/19 with Skilled Nursing visits ordered 3 times per week, Monday through Wednesday from 7:00 am to 4:30 pm, with "Skilled Nurse to follow child to school" from 12:00 pm to 4:30 pm. Calendar revealed the following missed visits; Week of 3/24/19 - missed visit 3/25/19 Week of 3/31/19 - missed visit 4/1/19. Week of 4/7/19 – missed visit 4/8/19.	G0572		

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G0572	Continued from page 4 Week of 4/14/19 – missed visit 4/15/19. Week of 4/21/19 missed visit 4/22/19. Further review of the clinical record for patient #1, revealed there were no notes present in the chart related to any communication between agency and staff, agency and caregiver, nor agency and physician's office regarding missed visits for the dates in question. On 9/1/21 at 12:41 pm, in an interview with Person #A (relative of Patient #1), he/she indicated the agency often cancelled or could not cover scheduled visits, causing him/her to lose two jobs. On 9/3/21 at 2:15 pm, in an interview with Person #C, case worker with community resource agency (Agency #D), confirmed that Person #A had lost "jobs" on account of the Home Health agency's inability to staff scheduled visits as ordered. 3. The clinical record for patient #2, start of care 7/1/21, was reviewed 9/1/21 and contained a plan of care for the certification period 7/1/21 to 8/29/21, a diagnosis cerebral palsy (a condition marked by impaired muscle coordination and/or other disabilities, typically caused by damaged to the brain before or at birth) and feeding difficulties included order for skilled nursing with two differing frequencies: 10 hours per day, 3 times per week, then later in the same document, order indicated 10 hours daily, 5 days per week. Week of 8/8/21 – missed visits 8/11/21, 8/12/21, and 8/13/21. Week of 8/15/21 – missed visits 8/22/21 and 8/23/21. Week of 8/22/21 – missed visit 8/24/31. On 9/1/21 at 2:03 pm, Person #B (relative of patient #2) was contacted regarding the matter of missed visits; 8/11/21, 8/12/21, 8/13/21 and 8/22/21, 8/23/21 and 8/24/21. Person #B stated patient #2's usual nurse went on vacation and person #B was subsequently informed by the agency that they could not cover the scheduled visits. When Administrator and Clinical Manager were	G0572		

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G0572	Continued from page 5 queried on 9/7/21 @ 12:50 pm as to why visits were not able to be covered for patient #2 and have previously stated that they themselves conducted patient visits as needed, as both Administrator and Clinical Managers are Nurse Practitioners, both indicated that it was Person #B's preference to have female nursing staff tend to his/her relative. Surveyor asked if this statement or communication was documented anywhere in the in the clinical record, neither Clinical Manager nor Administrator were able to answer this. There was no documentation found in the clinical record related to this matter. In a subsequent conversation with Person #B on 9/7/21 3:35 pm, when queried as to whether alternative nursing staff had been offered to cover missed nursing visits in question, Person #B stated "nope, nothing" had been offered. When queried as to whether the agency had offered any male nursing staff, Person #2 indicated that the agency had not made this offer either. Person #B stated further that he/she knows the two male nurses from the agency and in fact both have been in the home before and Person #B stated, "I would not have minded them coming" indicating he/she was already familiar with them. Person #B reiterated that no alternate staff had been offered to cover the missed visits for the dates in question. On 9/7/21 at 3:45pm, in a return phone call from Nurse #E, representative of Physician for Patient #2, stated that there was no record of telephone communication, nor any faxes from D-Best Home Care in relation to missed visits for Patient #2 pertaining to the dates in question. In an interview on 9/7/21 at 3:05pm, as Administrator informed surveyors he/she was not able to locate Missed Visit Policy, Clinical Manager verbalized the procedure for handling missed visits as follows; when agency is made aware of staff member not being able to keep/cover a visit, agency makes attempts to get the visit covered by another staff member, when they are not able to get coverage agency will notify caregiver/patient as well. Administrator was queried as to whom else would be contacted or notified of the missed visit, he/she indicated they were unaware that physician also needs to be notified of same. Clinical Manager stated the agency does in fact have a paper form that he/she indicated is supposed to be filled out and sent to physician to advise of missed visit, but stated	G0572		

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G0572	Continued from page 6 twice that this form is seldom used. When queried as to where this document would be located in the electronic medical record (EMR), neither Administrator nor DON are able to answer. Referring to agency's own policy dated 4/11/16 titled, 'Access and Maintenance of the Electronic Health Record' page 1 of 2, "D-Best Home Care HHA will create a complete electronic health record (EHR) for each patient. Images of the paper record are accepted into the secure electronic document system for archiving and access controls, consistent with all federal and state rules and regulations." Further review of the electronic clinical record for patient #2 revealed there are no entries in the section of the electronic clinical record entitled 'Communication' neither for the current, nor previous certification period. 410 IAC 17-13-1(a)	G0572		
G0574	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; (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	G0574		

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G0574	Continued from page 7 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 or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation and record review the agency failed to revise the plan of care to reflect current living status and information regarding updated diabetic management for 1 of 5 active records reviewed. The findings include: During a home visit on 9-2-21 at 8:00 a.m., the patient was observed to have a continuous glucose (blood sugar) monitoring device on the patient's right arm. Employee F, a home health aide, reported the patient is able to check his/ her blood sugar and that the aide writes the numbers down. A review of the patient's plan of care for the certification period of 7-8-21 through 9-5-21 contains no reference, instruction, or information related to the continuous glucose monitoring machine. 410 IAC 17-13-1(a)(1)(D)(ix)	G0574		