STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157318	A. BUILDING B. WING	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED HOME HEALTH CARE, INC	6920 PARKDALE PLACE, SUITE 110, INDIANAPOLIS, IN, 46254

(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
G0000	This visit was for the investigation of 2 Federal and State Complaints of a Home Health Agency. Survey Dates: 11/30/21, 12/1/21, 12/2/21, 12/3/21, and 12/6/21. Complaint: 61324 - Substantiated with related and unrelated findings Complaint 61292 - Substantiated with related and unrelated findings Facility ID: IN005731 This deficiency report reflects State Findings in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Quality Review by Area 3 on 1-3-2022	G0000	POC accepted on 2/22/2022 Deborah Franco	2022-03-18
G0412	Written notice of patient's rights 484.50(a)(1)(i) (i) 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. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities; Based on record review and interview, the agency failed to ensure patients received and had an understanding of Patient Rights for 5 of 8	G0412	1. HHA to use newly developed SOC handout which will include a link to patient handbook. Said handbook will include agency overview, patient rights and responsibilities, transfer/discharge policy, privacy policy, advanced directive information, and	2022-02-01

	6, 7, and 8) Findings include: 7. A review of admission paperwork on 12/01/2021, for patient #1 revealed the Acknowledgement of Information was digitally signed and dated on 11/17/2021, by the patient with nothing checked on the forms. 8. A review of admission paperwork on 12/02/2021, for patient #8 revealed the Acknowledgement of Information was digitally signed and dated on 11/13/2021, by the patient with nothing checked on forms. 410 IAC 17-12-3(a)1(A)(B) 1. Review of Policy titled "Admission Documents 2-004.1," dated April 2015 stated, "[Entity #D] will provide written admission document prior to or at initiation of home care services including: ...3. ...including a description of an individual's right under state law ....and how such rights are implemented by the organization." "Procedure...3. The admission information will be left in the patient's home." 2. A document entitled "Home Health Admission Service Agreement," section of the document entitled 'Acknowledgement of Information' stated, "I have received verbal and written information on the following: ... Patients' Rights and Responsibilities ... " These forms contained checkmark boxes which were to be marked to verify each item was discussed with the patient/patient representative.		safety information. SOC handout will also include site administrator contact information, Indiana Department of Health contact information, Medicare contact information, blank spaces for our clinical team to fill in their contact information and our 24 hour nursing line number. Service agreement will be signed via DocuSign at time of SOC, while reviewing all information in our patient handbook. Said service agreement, along with the 485 will be mailed from office to patient. 2. Summit has a dedicated staff member that calls every patient following their SOC to ensure they are receiving the care they expect. During this care call, we will have said staff member confirm that each patient has a SOC handout. If a patient does not have this handout, said staff member will contact those listed in #3 to correct the issue. 3. Regional Director and Site Administrator 4. All parties will be educated and this deficiency will be corrected by 02/01/2022	

3. A review of admission paperwork on 12/02/2021, for patient #5 revealed the Acknowledgement of Information was digitally signed and dated on 10/20/2021, by the patient with nothing checked on the forms.

4. A review of admission paperwork on 12/02/2021, for patient #6 revealed the Acknowledgement of Information was digitally signed and dated on 11/26/2021, by the patient with nothing checked on the forms.

5. A review of admission paperwork on 12/03/2021, for patient #7 revealed the Acknowledgement of Information was digitally signed and dated on 11/20/2021, by the patient with nothing checked on the forms.

6. On 11/30/21 at 3:00 PM, the Alternate Administrator, indicated the admission packet was now being emailed to the patient on the day of Admission, and the admitting clinician reviews this with the patient at that time, the patient then signed consents on the clinician's device. When queried as to whether any hard copies of patient rights were left in the home, the Alternate Administrator indicated a magnet was left in the home upon admission. He also indicated that the magnet contained the Agency phone number as well as information on how to reach the Administrator, State Hotline Number, and a handwritten medication list was also left in the patients' home.

On 12/6/21 at 12:20 PM, patient #7 indicated he /she had not received a copy of the Admission packet from the agency. When queried as to whether the agency had emailed this to him/her, the patient indicated the Agency had not. Patient #7 stated, "I haven't seen anything yet." Patient 7 indicated not knowing who the Administrator was or how to contact him/her, and also stated did not have the agency's phone number, and in fact needed it to reach his/her therapist over the weekend to verify today's therapy visit time, but did not have a contact number to call.

On 12/6/21 at 3:52 PM, the Alternate Administrator, indicated he had reviewed clinical records where DocuSign was utilized to obtain

	patients' signatures during admission, and he indicated checkmark boxes were blank on those as well. He indicated he discovered marking the boxes was 'optional' for the clinicians, and although clinicians had the ability to perform the task of checking off boxes, found they were not doing so.			
G0414	HHA administrator contact information 484.50(a)(1)(ii) (ii) Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints. Based on record review and interview, the agency failed to ensure patients understood and had received in writing, the phone number and the name of the Administrator in 7 of 8 active and discharged clinical records. (Patients # 1, 2, 4, 5, 6, 7, and 8) Findings include: 6. The clinical record review of patient #1 on 12/01/2021, failed to evidence documentation of patient's receipt of contact information for the Home Health Agency's Administrator, to include the Administrator's name. 7. The clinical record review of patient #2 on 12/03/2021, failed to evidence documentation of patient's receipt of contact information for the Home Health Agency's Administrator, to include the Administrator's name. 8. The clinical record review of patient #4 on 12/01/2021, failed to evidence documentation of patient's receipt of contact information for the Home Health Agency's Administrator, to include the Administrator's name. 9. The clinical record review of patient #8 on	G0414	1. 1. HHA to use newly developed SOC handout which will include a link to patient handbook. Said handbook will include agency overview, patient rights and responsibilities, transfer/discharge policy, privacy policy, advanced directive information, and safety information. SOC handout will also include site administrator contact information, Indiana Department of Health contact information, Medicare contact information, blank spaces for our clinical team to fill in their contact information and our 24 hour nursing line number. Service agreement will be signed via DocuSign at time of SOC, while reviewing all information in our patient handbook. Said service agreement,	2022-02-01

	patient's receipt of contact information for the Home Health Agency's Administrator, to include the Administrator's name. 1. Review of Policy titled "Admission Documents 2-004.1," dated April 2015, stated, "[Entity 3D] will provide written admission document prior to or at initiation of home care services including: ...4. Information describing the organization's grievance procedure which includes the names of contacts, phone numbers, ... and mechanism(s) for communicating problems." 2. The clinical record review of patient #5 on 12/02/2021, failed to evidence documentation of receipt of contact information for the Home Health Agency's Administrator, including the Administrator's name. 3. The clinical record review of patient #6 on 12/02/2021, failed to evidence documentation of receipt of contact information for the Home Health Agency's Administrator, including the Administrator's name. 4. The clinical record review of patient #7 on 12/03/2021, failed to evidence documentation of receipt of contact information for the Home Health Agency's Administrator, including the Administrator's name. 5. On 11/30/21 at 3:00 PM, the Alternate Administrator, stated the admission packet was now being emailed to the patient on the day of Admission, and the admitting clinician reviews this with the patient at that time, the patient then signs consents on the clinician's device. The Alternate Administrator stated a magnet with the Agency's phone number as well as information on how to reach the Administrator was left in the home. On 11/30/2021, at 3 PM, one of the above magnets was requested for review. On 12/6/2021, at 2:35 PM, one of the above magnets was requested for review. The agency failed to provide a magnet for review. It could not be determined the agency magnet met the agency's policy requirements		along with the 485 will be mailed from office to patient. 2. All staff to be educated on documenting delivery of SOC packet, along with patient response. 2. Summit has a dedicated staff member that calls every patient following their SOC to ensure they are receiving the care they expect. During this care call, we will have said staff member confirm that each patient has a SOC handout. If a patient does not have this handout, said staff member will contact those listed in #3 to correct the issue. QA will audit charts for this information. If documentation is missing, QA will return the note to the clinician to review and correct if information was delivered. 3. Regional Director and Site Administrator 4. All parties will be educated and this deficiency will be corrected by 02/01/2022	

	above. In an interview on 12/6/21 at 12:20 PM, patient #7 stated that he had not received a copy of the Admission packet from the agency. When queried as to whether the agency had instead emailed this to him/her, the patient stated, "I haven't seen anything yet". The patient stated not knowing who the Administrator was or how to contact him, and also stated did not have the agency's phone number. Patient #7 stated having needed to reach the Therapist over the weekend to verify today's therapy visit time but could not as the patient did not have a contact number to call.			
G0416	OASIS privacy notice 484.50(a)(1)(iii) (iii) An OASIS privacy notice to all patients for whom the OASIS data is collected. Based on record review and interview the age,ncy failed to ensure Outcome and Assessment Information Set (OASIS) privacy notice and rights were provided to patients/caregivers at the start of care and failed to ensure education of OASIS rights was documented in 5 (Patients # 1, 5, 6, 7, and 8) of 5 patients who had received skilled care, out of a total sample of 8 patients. Findings include: 6. A review of admission paperwork on 12/01/2021 for patient #1 evidenced a start of care date of 11/17/2021, and failed to evidence OASIS patient rights had been provided to patient #1. Patient #1 had received skilled nursing and physical therapy services. 7. A review of admission paperwork on 12/02/201 for patient #8 evidenced a start of care date of 11/13/2021, and	G0416	1. HHA to use newly developed SOC handout which will include a link to patient handbook. Said handbook will include agency overview, patient rights and responsibilities, transfer/discharge policy, privacy policy, advanced directive information, and safety information. SOC handout will also include site administrator contact information, Indiana Department of Health contact information, Medicare contact information, blank spaces for our clinical team to fill in their contact information and our 24 hour nursing line number. Service agreement will be signed via DocuSign at time of SOC, while reviewing all information in our patient handbook. Said service agreement, along with the 485 will be mailed from	2022-02-01

	failed to evidence OASIS patient rights had been provided to patient #8. Patient #8 had received skilled nursing and occupational therapy services. 1. Review of Policy titled "Admission Documents 2-004.1," dated April 2015, states "Purpose - To ensure organizational compliance with the Patient Bill of Rights and regulatory requirements." This policy also states, "3. The admission information will be be left in the patient's home." A document entitled "Home Health Admission Service Agreement," section of the document entitled "Acknowledgement of Information" stated, "I have received verbal and written information on the following:" The document failed to evidence OASIS rights and privacy notice. 2. A review of admission paperwork on 12/02/2021, for patient #5 evidenced a start of care date 10/20/2021, and failed to evidence OASIS patient rights had been provided to patient #5. Patient #5 had received skilled nursing, physical therapy, and occupational therapy services. 3. A review of admission paperwork on 12/02/2021, for patient #6 evidenced a start of care date 11/26/2021, and failed to evidence OASIS patient rights had been provided to patient #6. Patient #6 had received skilled nursing and physical therapy services. 4. A review of admission paperwork on 12/03/2021 for patient #7 evidenced a start of care date of 11/20/2021, and failed to evidence OASIS patient rights had been provided to patient #7. Patient #7 had received skilled nursing and physical therapy services. 5. On 11/30/21 at 3:00 PM, in an interview with Alternate Administrator, he indicated the		office to patient. 2. Summit has a dedicated staff member that calls every patient following their SOC to ensure they are receiving the care they expect. During this care call, we will have said staff member confirm that each patient has a SOC handout. If a patient does not have this handout, said staff member will contact those listed in #3 to correct the issue. 3. Regional Director and Site Administrator 4. All parties will be educated and this deficiency will be corrected by 02/01/2022	

	patient on the day of Admission, and the admitting clinician reviews this with the patient at that time, the patient then signs consents on the clinician's device. The Alternate Administrator stated that a magnet with the Agency's phone number, as well as information on how to reach the Administrator, State Hotline Number, and handwritten medication list were left in the home upon admission. No paper/hard copies of the agency Administrator's name was left in the home. In an interview on 12/6/21 at 12:20 PM, patient #7 stated he/she had not received a copy of the Admission packet from the agency. When queried as to whether the agency had emailed this to him/her, patient #7 stated, "I haven't seen anything yet".			
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the agency failed to document services and care including the frequency of visits, ensuring the patients and family/caregivers were consulted and consented to planned services and care in 5 of 8 active and discharged clinical records. (Patients #1, 5, 6, 7, and 8) Findings include:	G0434	1. 1. HHA to use newly developed SOC handout which will include a link to patient handbook. Said handbook will include agency overview, patient rights and responsibilities, transfer/discharge policy, privacy policy, advanced directive information, and safety information. SOC handout will also include site administrator contact information, Indiana Department of Health contact information, Medicare contact information, blank spaces for our clinical team to fill in their contact information	2022-02-01

	4. A review of admission paperwork on 12/01/2021 for patient #1 revealed the Admission Agreement was digitally signed and dated on 11/17/2021 by the patient with the type and frequency for the Service(s) provided left blank. 5. A review of admission paperwork on 12/02/2021, for patient #8 revealed the Admission Agreement was digitally signed and dated on 11/13/2021 by the patient, and the type and frequency for the Service(s) provided had been left blank. 410 IAC 17-12-3(b)(2)(D)(i) 410 IAC 17-12-3(b)(2)(D)(ii) 410 IAC 17-12-3(b)(2)(D)(iii) 1. A policy titled "Informed Consent/Refusal of Treatment 2-005.1," dated April 2015 indicated, "Purpose: To obtain written consent for care during the admission process and to communicate the organization's process for informing patients and family/caregivers regarding services as well as involving patients in the care/service planning process....4. During the admission visit, the patient or authorized representative will sign the organization's written consent for care/services."		and our 24 hour nursing line number. Service agreement will be signed via DocuSign at time of SOC, while reviewing all information in our patient handbook. Said service agreement, along with the 485 will be mailed from office to patient. 2. All staff to be educated on proper completion of service agreements. Leadership team adjusting services agreement template in docusign to ensure proper completion. (training initiated week of 12/05/21). 2. Summit has a dedicated staff member that calls every patient following their SOC to ensure they are receiving the care they expect. During this care call, we will have said staff member confirm that each patient has a SOC handout. If a patient does not have this handout, said staff member will contact those listed in #3 to correct the issue. Regional Director will audit each service agreement for the first 30 days and then proceed to spot checking for proper completion of service agreements. 3. Regional Director and Site Administrator	

	A policy titled "Admission Documents 2-004.1," dated April 2015, indicated, "[Entity #D] will provide written admission documents prior to or at the initiation of home care services." Section titled 'Procedure' states, "1. Appropriate documents will be included in admission folder bearing the [Entity #D] name...2. The admission information will be reviewed with the patient and/or family a the start of care visit...3. The admission information will be left in the patient's home." Entity D was an outside provider, not the name of this agency. 2. A review of admission paperwork on 12/2/2021, for patient #5 revealed the Admission Agreement was digitally signed and dated on 10/20/2021, by the patient; however, the frequency for the Service(s) provided was left blank. A review of admission paperwork on 12/02/2021, for patient #6 revealed the Admission Agreement was digitally signed and dated on 11/26/2021, by the patient; however, the frequency for the Service(s) provided was left blank. A review of admission paperwork on 12/3/2021, for patient #7 revealed the Admission Agreement was digitally signed and dated on 11/20/2021, by the patient;however, the frequency for the Service(s) provided was left blank. 3. On 11/30/21 at 3:00 PM, in an interview with the Alternate Administrator, he indicated the admission packet was now being emailed to the patient on the day of Admission, and the admitting clinician reviews this with patient at that time, the patient then signs consents on the clinician's device. When queried as to whether any hard copies were left in the home, the Alternate Administrator indicated a magnet with the Agency's phone number, information on how to reach the Administrator, the State Hotline Number, and a handwritten medication list were what was left in the home upon admission. On 12/6/21 at 12:20 PM, in an interview patient #7 indicated that he /she had not received a copy of the Admission packet from the agency. When queried as to whether the agency had emailed this to him/her, patient #7 indicated that he/she had not, and stated "I haven't seen		4. All parties will be educated and this deficiency will be corrected by 02/01/2022	

	anything yet." On 12/6/21 at 3:52 PM, in an interview with the Alternate Administrator, he indicated he had also reviewed clinical records where DocuSign (a digital procedure) was utilized to obtain signatures during admission, and he indicated checkmark boxes were blank on those as well. He indicated having learned marking the boxes in the electronic clinical record was "optional" for clinicians, and although clinicians had the ability to perform the task of checking off boxes, they were not doing so.			
G0440	Payment from federally funded programs 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). Based on record review and interview, the agency failed to advise patients/families in writing of expected payment for services from Medicare, and of possible charges for services that may not be covered by insurance at the time of admission in 5 of 8 active and discharged clinical records. (Patients # 1, 5, 6, 7 and 8) Findings include: 4. A review of admission paperwork on 12/01/2021, for	G0440	1. 1. HHA to use newly developed SOC handout which will include a link to patient handbook. Said handbook will include agency overview, patient rights and responsibilities, transfer/discharge policy, privacy policy, advanced directive information, and safety information. SOC handout will also include site administrator contact information, Indiana Department of Health contact information, Medicare contact information, blank spaces for our clinical team to fill in their contact information and our 24 hour nursing line number. Service agreement will be signed via	2022-02-01

	patient #1 revealed the Home Health Admission Service Agreement and Advance Beneficiary Notice of Non-coverage were digitally signed and dated on 11/17/2021, by the patient, however; the boxes which identified the payment source had been left blank. The agency failed to identify a payment source. 5. A review of admission paperwork on 12/02/2021, for patient #8 revealed the Home Health Admission Service Agreement and Advance Beneficiary Notice of Non-coverage were digitally signed and dated on 11/13/2021, by the patient, however; the boxes which identified the payment source had been left blank. The agency failed to identify a payment source. 1. A review of Policy titled "Admission Criteria and Process - Policy No. 2-003.1," dated April 2015 stated, "7. Upon acceptance into service, the patient will be provided with an organization brochure and various educational materials providing the patient and family/caregiver with sufficient information on: ...D. Care costs, if any to be born by the patient." A review of Policy titled "Admission Documents - Policy No. 2-004.1," dated April 2015, revealed, "Purpose - to ensure organizational compliance with the Patient Bill of Rights and regulatory requirements...[Entity #D] will provide written admission documents prior to or at initiation of home care services including: 1. Information regarding billing policies and payment procedures at the time of admission and any subsequent changes within 30 days." Entity D was an outside agency, not this home health agency.		DocuSign at time of SOC, while reviewing all information in our patient handbook. Said service agreement, along with the 485 will be mailed from office to patient. 2. All staff to be educated on proper completion of service agreements. Leadership team adjusting services agreement template in docusign to ensure proper completion. (training initiated week of 12/05/21). 3. Remove ABN and HHCCN from service agreement template in Docusign to eliminate confusion. (Completed 01/05/2022) 2. Summit has a dedicated staff member that calls every patient following their SOC to ensure they are receiving the care they expect. During this care call, we will have said staff member confirm that each patient has a SOC handout. If a patient does not have this handout, said staff member will contact those listed in #3 to correct the issue. Jeff Degroote will audit each service agreement for the first 30 days and then proceed to spot checking for proper completion of service agreements, as	

	2. A review of admission paperwork on 12/02/2021, for patient #5 revealed the Home Health Admission Service Agreement and Advance Beneficiary Notice of Non-coverage were digitally signed and dated on 10/20/2021, by the patient, however; the boxes which identified the payment source had been left blank. The agency failed to identify a payment source. 3. A review of admission paperwork on 12/02/2021, for patient #6 revealed the Home Health Admission Service Agreement and Advance Beneficiary Notice of Non-coverage were digitally signed and dated on 11/26/2021, by the patient, however; the boxes which identified the payment source had been left blank. The agency failed to identify a payment source. 4. A review of admission paperwork on 12/3/2021 for patient #7 revealed the Home Health Admission Service Agreement and Advance Beneficiary Notice of Non-coverage were digitally signed and dated on 11/20/2021 by the patient, however; the boxes which identified the payment source had been left blank. The agency failed to identify a payment source. 5. On 11/30/21 at 3:00 PM, in an interview with the Alternate Administrator, he indicated that the admission packet was now being emailed to the patient on the day of Admission, and that the admitting clinician was supposed to review this with the patient at the visit. On 12/6/21 at 12:20 PM, patient #7 indicated that he/she had not received a copy of the Admission packet from the agency. When queried as to whether the agency had emailed Admission documents to him/her, the patient indicated the agency had not, and stated "I haven't seen anything yet." On 12/6/21 at 3:52 PM, in an interview with the Alternate Administrator, he indicated that he also reviewed clinical records where DocuSign was utilized to obtain signatures during admission and there was no documentation the above patients had been advised of payment sources or any money which might be the obligation of		well as no pre signed ABNs or HHCCNs. 3. Regional Director and Site Administrator 4. All parties will be educated and this deficiency will be corrected by 02/01/2022	

	the patient.			
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the agency failed to ensure the initial assessment visit was completed either within 48 hours of a referral, discharge from a facility, or to obtained a physician-ordered start of care date for 2 of 8 clinical records reviewed. (Patients 2 and 3) Findings include: 1. A review of an agency policy titled, "Initial and Comprehensive Assessment No 4-018.1," dated April 2015, revealed, "The initial assessment visit must be performed either within 48 hours of the referral, within 48 hours of the patient s return home, on the start of care date ordered by the physician (or other authorized licensed independent practitioner), or at the patient/family request with the approval of the physician." 2. A review of patient #2's clinical record was reviewed on 12/3/2021, revealed a referral date of 08/31/2021, and evidenced an assessment document titled OASIS dated 09/08/2021, item M0104 listed the referral date of 08/31/2021. The administrator had written a communication note in the record which documented the assessment was delayed due to the request of the patient on 09/08/2021. The record failed to evidence documentation a physician's verbal order that authorized the delay in conducting the initial assessment, and failed to evidence a physician ordered start of care date. 3. During an interview on 12/06/2021 at 2:15 PM, the Administrator stated the agency encouraged the clinicians to call the office when	G0514	1. Summit will obtain new (Eval and tx) SOC orders with every SOC. If the delay in SOC is >48 hours, we obtain a delay order from the signing physician. 2. QA will audit orders and contact those listed in #3 if issues are found, allowing us to correct said issues and operate within compliance. 3. Site Administrator 4. All parties will be educated and this deficiency will be corrected by 02/01/2022	2022-02-01

a patient start of care assessment was delayed so administrative personnel could obtain a physician's order.

4. The clinical record of patient #3 was reviewed on 12/1/12. On a document titled "OASIS," performed and dated 9/7/21, the date of 8/31/21, was recorded under M0104 (Referral date).

A review of an agency document titled 'Communication Note' dated 9/4/21, detailed an attempt by Nursing to perform a Start of Care visit, "Spoke with patient and set up time for admission today. However went to pt's [sic patient's] house, knocked on the door multiple times waited for approximately 20 mins. Attempted to call patient while there with no answer." Review of a 'Communication Note' dated 9/7/21, by Occupational Therapy, "Spoke with [Patient #3] today. He/she gives me a better number to reach her...He/she asks that we please try again to come see him/her. He/she is wanting and needing our services. He/she is sorry that he/she missed our nurse when she came out to see him/her." Review of the clinical record failed to evidence subsequent documentation the provider was notified of unsuccessful attempt to admit the patient, nor of an MD order to delay care.

In an interview on 12/1/21 at 1:51 PM, a representative of Physician #C for Patient #3, Person #B stated there was nothing in the provider's documentation related to the agency attempting to reach to the Physician "from 9/4 to 9/13/21 there were no calls on record from agency."

In an interview with the Administrator and the Alternate Administrator on 12/2/21, at 12:58 PM, indicated staff did not call the doctor for a delayed Start of Care, but rather the physicians were sent an order by fax to sign. When queried specifically as to whether the agency or clinicians were calling the Physician, the Administrator stated, "typically we'll fax." While checking their system to verify, the Alternate Administrator and the Administrator indicated in the case of Patient #3, the agency did not reach out to the physician to obtain authorization for a delayed Start of Care.

410 IAC 17-14-1(a)(1)(A)

G0526	Content of the comprehensive assessment 484.55(c) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: Based on record review and interview, the agency failed to ensure the comprehensive assessments were complete and accurately reflected the patient s health status to ensure the patients needs were being met in 2 of 8 records reviewed. (Patients 2 and 4) Findings include: 1. A review of an agency policy, "Initial and Comprehensive Assessment Policy No. 4-018.1," evidenced "...2. The comprehensive assessment for each patient must be completed in its entirety by a single clinician. ...B. A physical assessment, including blood pressure, temperature, pulse....other relevant date related to pertinent physical findings of common symptoms...C. Patient's functional status, including but not limited to, the degree of self-care, and the amount and level of assistance needed ... " 2. A review of patient #2's clinical record on 12/3/2021, which contained a plan of care for the certification period of 11/07/2021 through 01/05/2021, and revealed diagnoses of Weakness, CKD (chronic kidney disease) stage 4, retention of urine, and history of urinary tract infections The patient had received Physical Therapy. A review of a document titled "OASIS Start of Care" completed on 09/08/2021, revealed a start of care 09/08/2021, under History and Diagnoses, temperature was left blank and CKD, Urinary Incontinence and Recent/Frequent UTI were checked, Elimination status GU was checked WNL, question M1600 "Has this patient been treated for a Urinary Tract infection in the past 14 days?" was checked No. M1610 Urinary Incontinence or Urinary Catheter Presence, No for incontinence or catheter was checked. Functional limitations were marked Ambulation and hearing and Sensory Status	G0526	1. Mandate Temp, BP, RR, HR, and O2 with every visit. 2. QA will audit documentation and contact those listed in #3 if issues are found, allowing us to correct said issues and operate within compliance. 3. Regional Director and Site Administrator 4. All parties will be educated and this deficiency will be corrected by 02/01/2022	2022-02-01

	comprehensive assessment failed to document an accurate assessment of the patient's health status because patient #2 had a foley catheter, the patient's temperature was not documented, and and the assessment failed to document the patient's history of urinary tract infections. 3. A review of patient's #4 clinical record on 12/01/2021, which contained a plan of care with a certification period of 07/23/2021 through 09/20/2021, and revealed diagnoses of UTI (urinary tract infection), nausea and vomiting, Pancreas Transplant, and Type 1 Diabetes Mellitus (a chronic condition in which the pancreas produces little or no insulin). A review of a document titled "OASIS (Outcome and Assessment Information Set used to collect a complete medical history of the patient) Start of Care", dated 07/23/2021 at 12:02 PM\, evidenced Item M104 Date of Referral was left blank. Under Elimination status, GU (Genitourinary, pertaining to the genital and urinary systems), which was checked within normal limits with urine clear and yellow. Under Title (M1600) Has this patient been treated for a Urinary Tract Infection in the past 14 days? This was checked No. Review of the physician's referral dated 7-15-2021, evidenced patient #4 had a urinary tract infection. The assessment failed to give an accurate description of the patient's health status because patient #4 had just been discharged from the hospital where he/she had been treated for a urinary tract infection. 410 IAC 17-15-1(a)			
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	G0572	1. 1. Summit will obtain new (Eval and tx) SOC orders with every SOC. If the delay in SOC is >48 hours, we obtain a delay order from the signing	2022-02-01

	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 agency failed to ensure the plan of care was established/reviewed in conjunction with the attending physician for 7 of 8 records reviewed. (#1, 2, 3, 5, 6, 7, and 8) Findings include: 1. A review of an agency policy titled, "Verification of Physician Orders Policy No 4-003.1" dated, April 2015, revealed, "accurate physician orders are obtained &under subtitle Policy; Orders will be obtained from a licensed physician &for care and services to be provided &A qualified individual will review each order before care is provided." 2. A review of an agency policy titled, "Physician Participation in Plan of Care Policy No. 4-002.1," dated April 2015 revealed, "guidelines for the physician s participation & under subtitle Procedure 2. The attending physician s verbal orders will be obtained at the time the plan of care is established." 3. A review of the clinical record of patient #1, evidenced a start of care date of 11/17/2021, which contained a plan of care for the certification period of 11/17/2021 to 01/152022, with orders for skilled nursing, PT (physical therapy), and OT (occupational therapy). A review of visit notes evidenced skilled nursing visit was made on 11/22/2021, PT visits were made on 11/22/2021, 11/24/2021, and 11/30/21, OT visit was made on 11/30/2021. A review of the clinical record failed to evidence a verbal order had been obtained prior to furnishing care visits. A review of the plan of care evidenced the physician had not signed the plan of care. The plan of care failed to evidence it was developed in conjunction with the attending physician.		physician. 2. Clinicians to be educated to contact the signing physicians office to notify of plan of care (including freq and goals), as well as documenting who they spoke with and the time, or if voicemail was left. 2. QA will audit orders and contact those listed in #3 if issues are found, allowing us to correct said issues and operate within compliance. 3. Site Administrator 4. All parties will be educated and this deficiency will be corrected by 02/01/2022	

4. A review of the clinical record of patient #2, evidenced a start of care date of 09/08/2021, which contained a care plan for the certification period of 11/07/2021 to 01/05/2021, with orders for physical therapy.

A review of visit notes evidenced the physical therapy made care visits on 11/12/2021, 11/17/2021, 11/24/2021, and 12/01/2021.

A review of the clinical record failed to evidence a verbal order had been obtained prior to furnishing care visits.

A review of the plan of care evidenced the physician had not signed the plan of care. The plan of care failed to evidence it was developed in conjunction with the attending physician.

5. A review of the clinical record of patient #8, evidenced a start of care date of 11/13/2021, which contained a care plan for the certification period of 11/13/2021 to 01/11/2021, with orders for skilled nursing and occupational therapy.

A review of visit notes evidenced care visits were made by skilled nursing on 11/16/2022, 11/22/2021, 11/26/2021, 12/01/2021, and 12/03/2021; an occupational therapy visit was made on 11/22/2021.

A review of the clinical record failed to evidence a verbal order had been obtained prior to furnishing care visits.

A review of the plan of care evidenced the physician had not signed the plan of care. The plan of care failed to evidence it was developed in conjunction with the attending physician.

6. A review of the clinical record of patient #3, evidenced a start of care date 9/07/2021and contained a plan of care with a certification period of 9/07/2021 to 10/26/2021, with orders for Skilled Nursing, Physical Therapy and Occupational Therapy.

A review of the clinical record failed to evidence verbal order had been obtained prior to furnishing care visits.

Review of of visit notes evidenced the Occupational Therapy made care visits on 9/21/2021, 10/06/2021, 10/13/2021, 10/20/2021, and 11/03/2021.

A review of the OT evaluation completed 9/09/2021, revealed the physician had not yet signed the plan of care. Therefore the plan of care failed to evidence it was developed in conjunction with the attending physician.

7. A review of the clinical record for Patient #5 evidenced a start of care date of 10/20/2021, and contained a plan of care with a certification period of 10/20/2021 through 11/30/2021, with orders for Physical Therapy and Occupational Therapy.

A review of the clinical record failed to evidence a verbal order had been obtained prior to furnishing care visits.

Review of visits notes evidenced the Physical Therapy made visits on 10/28/2021, 11/02/2021, 11/09/2021, 11/18/2021, and 11/23/2021.

Review of visits evidenced Occupational Therapy made visits on 10/29/2021, and 11/01/2021.

A review of the plan of care evidenced the physician had not yet signed the plan of care. Therefore, the plan of care failed to evidence it was developed in conjunction with the attending physician.

8. A review of the clinical record of Patient #6, evidenced a start care date of 11/26/2021 and contained a plan of care with a certification period of 11/26/2021 through 1/24/2022, with orders for Skilled Nursing and Physical Therapy.

A review of clinical record failed to evidence a verbal order had been obtained prior to furnishing care visits.

Review of visit notes evidenced that Skilled Nursing had made a subsequent care visit on 12/02/2021.

A review of the plan of care evidenced that the physician had not yet signed the plan of care. Therefore, the plan of care failed to evidence it was developed in conjunction with the attending physician.

9. A review of the clinical record of Patient #7 evidenced a start of care of 11/20/2021, and contained a plan of care with a certification period of 11/20/2021 through 1/18/2022 with orders for Skilled Nursing and Physical Therapy.

A review of clinical record failed to evidence a verbal order had been obtained prior to furnishing care visits.

Review of visit notes evidenced the Physical Therapist made care visits on 11/30/2021, and 12/02/2021.

A review of the plan of care evidenced that the physician had not yet signed the plan of care. Therefore, the plan of care failed to evidence it was developed in conjunction with the attending physician.

10. In an interview on 12/06/2012 at 11:47 AM, Physical Therapist #O indicated that rather than reaching out to the attending physician directly, she would call or email the office and have the nurse in the agency's office (Administrator/Clinical Manager) reach out to MD for orders.

Therapist also indicated that if she was familiar with Physician, she would then reach out herself for orders, and further indicated this contact was not documented in communication notes, but

	would be documented in Physician Orders or in a narrative note. In an interview on 12/06/2021 at 12:34 PM, when queried as to who calls the Physician after the Start of Care for verbal orders Registered Nurse (RN) employee #N stated, "I don't know". She further indicated that she has not been given instruction to call to Physician for this, but is aware that the Plan of Care does get faxed to MD for signature. During an interview on 12/16/2021 at 2:17 PM the Regional Managing Director, Employee #P, indicated that the agency's practice was not to call attending physician for Plan of Care orders or Evaluation orders contemporaneously with visits being made, but rather to wait for the MD signature to come back on Plan of Care/485 document. 410 IAC 17-13-1(a)			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the agency failed to ensure services were provided only upon a physician's order in 7 of 8 clinical records reviewed. (Patients #1, 2, 3, 5, 6, 7, and 8) Findings include: 1. A review of an agency policy titled, "Verification of Physician Orders Policy No 4-003.1," dated April 2015, revealed, "accurate physician orders are obtained &under subtitle Policy; Orders will be obtained from a licensed physician &for care and services to be provided &A qualified individual will review each order before care is provided." 2. A review of an agency policy titled "Physician	G0580	1. 1. Summit will obtain new (Eval and tx) SOC orders with every SOC. If the delay in SOC is >48 hours, we obtain a delay order from the signing physician. 2. Clinicians to be educated to contact the signing physicians office to notify of plan of care (including freq and goals), as well as documenting who they spoke with and the time, or if voicemail was left. 2. QA will audit orders and	2022-02-01

	dated April 2015 revealed, "guidelines for the physician s participation &Procedure... B. Treatment and/or procedures needed, including type, frequency, duration, and goals...Procedure 2. The attending physician s verbal orders will be obtained at the time the plan of care is established." 3. A review of the clinical record of patient #1, evidenced a start of care date of 11/17/2021, which contained a plan of care for the certification period of 11/17/2021 to 01/15/2022, with orders for (SN) Skilled nursing, PT (physical therapy), and OT (occupational therapy.) Review of visit notes evidenced the SN made care visits on 11/22/2021 and 11/22/2021. Review of visit notes evidenced by PT made care visits on 11/22/2021, 11/24/2021, and 11/30/21. Review of visit notes evidenced by OT made a care visit on 11/30/2021. A review of the clinical record failed to evidence a verbal order had been obtained prior to furnishing the above care visits. A review of the plan of care evidenced the physician had not signed the plan of care. All care visits provided above had been furnished without physician orders. 4. A review of the clinical record of patient #2, evidenced a start of care date of 11/13/2021, which contained a plan of care for the certification period of 11/13/2021 to 01/11/2022, with orders for PT (physical therapy.) Review of visit notes evidenced by PT made care visits on 11/12/2021, 11/17/2021, and 11/24/21. A review of the clinical record failed to evidence a verbal order had been obtained prior to furnishing the above care visits. A review of the plan of care evidenced the physician had not signed the plan of care. All care visits provided above had been furnished without physician orders. 5. A review of the clinical record of patient #8, evidenced a start of care date of 11/13/2021,		contact those listed in #3 if issues are found, allowing us to correct said issues and operate within compliance. 3. Site Administrator 4. All parties will be educated and this deficiency will be corrected by 02/01/2022	

certification period of 11/13/2021 to 01/11/2022, with orders for SN and OT. Review of visit notes evidenced by SN made a care visit on 11/16/2021. Review of visit notes evidenced by OT made a care visit on 11/30/2021.

A review of the clinical record failed to evidence a verbal order had been obtained prior to furnishing the above care visits.

A review of the plan of care evidenced the physician had not signed the plan of care. All care visits provided above had been furnished without physician orders.

5. A review of the clinical record of patient #3, evidenced a start of care date of 9/07/2021 and contained a plan of care with a certification period of 9/07/2021 to 10/26/2021, with orders for Skilled Nursing, Physical Therapy, and Occupational Therapy.

Review of visit notes evidenced that Occupational Therapy made care visits on 9/21/2021, 10/05/2021, 10/13/2021, 10/20/2021, and 11/03/2021.

A review of the clinical record failed to evidence a verbal order had been obtained prior to furnishing the above care visits.

A review of the plan of care, failed to evidence the physician's signature. All OT care visits had been furnished without physician orders.

6. A review of the clinical record for Patient #5, evidenced a start of care of 10/20/2021 and contained a certification period of 10/20/2021 through 11/30/2021, with orders for Physical Therapy and Occupational Therapy.

Review of visit notes evidenced that Physical Therapy made care visits on 10/28/2021, 11/02/2021, 11/09/2021, 11/18/2021, and 11/23/2021.

	Review of visit notes evidenced that Occupational Therapy made care visits on 10/29/2021, and 11/01/2021. A review of the clinical record failed to evidence a verbal order had been obtained prior to furnishing the above care visits. A review of the plan of care failed to evidence the physician's signature or the recommended treatment plan on the OT evaluation. The care visits above had been furnished without physician orders. 7. A review of the clinical record of Patient #6, evidenced a start of care date of 11/26/2021, and contained a certification period of 11/26/2021 through 1/24/2022, with orders for Skilled Nursing and Physical Therapy. Review of visit notes evidenced that Skilled Nursing made a care visit on 12/02/2021. A review of the clinical record failed to evidence a verbal order had been obtained prior to furnishing the above care visits. A review of the plan of care evidenced the physician had not yet signed the plan of care nor the treatment plan on the OT evaluation. The care visit above had been furnished without physician orders. 8. A review of the clinical record of Patient #7 evidenced a start of care date of 11/20/2021 and contained a plan of care with a certification period of 11/20/2021 through 1/18/2022, with orders for Skilled Nursing and Physical Therapy. Review of visit notes evidenced that Physical Therapy made care visits 11/30/2021 and 12/02/2021. A review of the clinical record failed to evidence a verbal order had been obtained prior to			

	furnishing the above care visits. A review of the plan of care evidenced the physician had not yet signed the plan of care nor the Physical Therapy Evaluation order. All Physical Therapy care visits made subsequent to the Physical Therapy Evaluation visit dated 11/22/2021, failed to evidence they were provided under physician orders. 9. In an interview on 12/06/2012 at 11:47 AM, Physical Therapist #O indicated that rather than reaching out to the attending physician directly, she would call or email the office and have the nurse in the agency's office (Administrator/Clinical Manager) reach out to attending physician for orders. Therapist also indicated that if she was familiar with physician, she would then reach out herself for orders, and further indicated this contact is not documented in communication notes but would be documented in Physician Orders or in a narrative note. In an interview on 12/06/2021 at 12:34 PM, when queried as to who calls the Physician after the Start of Care for verbal orders Registered Nurse (RN) employee N stated, "I don't know". Employee N, RN, further indicated that she had not been given instruction from agency to call to the Physician for verbal orders during or after a start of care visit, but was aware that the Plan of Care (POC) does get faxed to attending physician for signature once POC is completed. During an interview on 12/16/2021 at 2:17 PM the Managing Director indicated that the agency's practice was not to call attending physician for Plan of Care orders or Evaluation orders, subsequent to those visits being made, but rather to wait for attending physician signature to come back on Plan of Care/485 document. 410 IAC 17-13-1(a)			
G0588	Reviewed, revised by physician every 60 days	G0588	1. Educate all clinical staff when MSW consult is	2022-02-01

	484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner 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. Based on record review and interview, the agency failed to ensure the individualized plan of care was reviewed and revised in conjunction with the ordering physician as frequently as the patient's condition or needs warranted in 4 of 8 patient record reviews. (Patients 3, 6, 7, and 8) Findings include: 2. A review of patient's #8 clinical record on 12/2/21, which contained a plan of care for the certification period of 11/13/2021 to 01/11/2022, with diagnoses included but not limited to Pressure ulcer of sacral region, stage 3, Malignant neoplasm of rectum, and Encounter for attention to colostomy. Orders were updated from skilled nursing from 1 time a week to 3 times a week for wound care and colostomy care on 11/22/2021. OT (occupational therapy) orders were 1 time a week for 4 weeks. A review of the OT evaluation evidenced it was completed on 11/17/2021, and revealed in the Evaluation Assessment Summary, the spouse is having a difficult with ostomy care. The patient has a doctor appointment that afternoon and have instructed spouse to have PCP look at the patient s ostomy site and see if the PCP can refer them to an ostomy sure as skin all around stoma is extremely irritated and bleeding in certain places & A review of a document titled office visit, encounter date of 11/24/2021, with the patient s family physician, revealed the physician documented the patient s spouse had been hospitalized the prior night, the patient s other family member had taken the patient to the scheduled MD appointment, requesting respite care or home health to be able to increase their visits. The MD phoned the agency, and requested additional care visits. The agency denied the request. During a phone interview on 12/06/2021, at 12:15 PM, employee K, the registered nurse		needed. Educate clinical staff when/why to contact ADON team, when to contact MD. Document that these have been completed and why. If unsure, staff to contact ADON team or Jeff DeGroote for guidance. 2. QA will audit documentation and contact those listed in #3 if issues are found, allowing us to correct said issues and operate within compliance. 3. Regional Director and Site Administrator 4. All parties will be educated and this deficiency will be corrected by 02/01/2022	

told staff 3 times a week was the maximum number of visits we can schedule.

During a phone interview on 12/06/2021, at 3:19 PM, with employee J, staff RN for patient #8, who confirmed he/she knew about the phone call from the physician requesting additional daily visits, but stated the agency couldn t justify daily visits with the possibility of the need of visits being made during the middle of the night while the spouse was hospitalized with the insurance, and the agency had requested a short term respite stay, but the patient had refused.

1. A review of the clinical record of Patient #3 on 12/1/21, contained a plan of care for a certification period of 9/7/21 through 10/26/21, which revealed a diagnoses of new-onset stroke (damage to the brain from interruption to the blood supply) with recent rehab stay, multiple sclerosis (disease in which the immune system eats away at the protective covering of nerves) and diabetes mellitus (a chronic condition that affects the way the body processes sugars). The patient received Skilled Nursing, Physical Therapy, Occupational Therapy and Speech Therapy services.

A review on 12/3/21 of patient #3 clinical record evidenced a Physical Therapy re-evaluation visit, dated 12/2/21, failed to evidence documentation of change in caregiver status (recent glaucoma surgery which rendered caregiver/spouse temporarily blind) or change in patient caregiver's ability to provide support to patient.

Review of the clinical record failed to evidence the attending physician had been contacted to update patient #3's plan of care.

In an interview on 12/3/21 at 9:13 AM, Patient #3 indicated a female clinician had visited the home yesterday for a re-evaluation, and the patient reported to the clinician the spouse, who was the patient's main caregiver, had recently undergone glaucoma surgery and has been rendered essentially blind for the next few weeks. The patient indicated more help was needed with everything now since they cannot care for each other.

In an interview on 12/6/21 at 11:47 AM,

	informed him/her the spouse, who is also the patient's primary caregiver, just had surgery for glaucoma and would be rendered effectively blind for 2-3 weeks, Therapist #O stated, "[he/she] did actually." In an interview with the Administrator on 12/3/21 at 3:52 PM, the above findings related to patient #3 were verified. The Administrator indicated she was unaware of the change in the patient's caregiver status and available supports. The Administrator indicated she would have expected to have seen something documented in the clinical record and/or received a call from the Physical Therapist to request MD order be written for Social Work Evaluation. 6. The clinical record of Patient #6 was reviewed on 12/2/21, and contained a plan of care with a start date of 11/26/21, and certification period of 11/26/21 through 1/24/22, revealed a diagnosis of Covid (A highly contagious respiratory disease caused by the SARS-CoV-2 virus), Pneumonia (infection of the lungs that can cause mild to severe illness) and Atrial Fibrillation (an irregular and often very rapid heart rhythm (arrhythmia) that can lead to blood clots in the heart). The patient was receiving Skilled Nursing and Physical Therapy services. Review of this record on 12/2/21, evidenced a Physical Therapy note dated 11/30/21, titled 'PT Evaluation' which stated, "Son questioning the need for O2 [oxygen] as patient only wearing at night at times; encouraged to ask at next appt." Clinical record failed to evidence documentation of communication with other interdisciplinary team members and with attending physician, to make them aware of patient #6's new assessment findings. The Physical Therapist failed to revise the plan of care and failed to evidence the PT had contacted the attending physician with the family member's concern. 7. The clinical record of Patient #7 was reviewed on 12/3/21 and contained a plan of care with a start date of 11/20/21, and certification period of 11/20/21 through 1/18/22, revealed a diagnosis of Chronic Obstructive Pulmonary Disease(a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and Diabetes Mellitus (a chronic condition that affects the way the body processes sugars) and was receiving Skilled Nursing and Physical Therapy services.			

	Review of this record on 12/3/21, evidenced a Physical Therapy note dated 11/22/21 and titled "PT Evaluation Addendum Page" stated, "Called pt. daughter in law {anonymous} to edu on pt. need for use of O2 at present due to desaturation and SOB (shortness of breath). Edu on encouraging pt. to use SPC (single point cane) for all ambulation around the home. {daughter in law} agreeable. Per {daughter in law}, pt, has f/u appointment with PCP (Primary Care Physician) tomorrow and {daughter in law} will let {PCP} know of these recommendations." Further review of the record failed to evidence documentation of communication with other team interdisciplinary members or with the attending physician, to update others in relation to patient new assessment findings. The therapist failed to contact the physician to report shortness of breath and to receive any new orders. 410 IAC 17-13-1(a)(2)			
G0608	Coordinate care delivery 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. Based on record review and interview, the agency failed to ensure coordination of care occurred between interdisciplinary team members and the attending physician, in order to meet the changing needs of the patient in 3 (Patients #3, 5, and 6) of 8 patient's whose clinical record was reviewed. Findings include: 1. The clinical record of Patient #3 was reviewed on 12/1/21, and contained a plan of care with a start of care date of 9/7/21, and certification period of 9/7/21 through 10/26/21, which revealed a diagnosis of new-onset stroke (damage to the brain from interruption to the blood supply) with recent rehabilitation facility stay, multiple sclerosis (disease in which the immune system eats away at the protective covering of nerves) and diabetes mellitus (a chronic condition that affects the way the body processes sugars). The patient was receiving	G0608	1. Educate all clinical staff when MSW consult is needed. Educate clinical staff when/why to contact ADON team, when to contact MD, and to share status updates with the treating clinical team. Document that these have been completed and why. If unsure, staff to contact ADON team or Jeff DeGroote for guidance. 2. QA will audit documentation and contact those listed in #3 if issues are found, allowing us to correct said issues and operate within compliance. 3. Regional Director and Site Administrator 4. All parties will be educated and this	2022-02-01

	Skilled Nursing and Physical Therapy services. A review on 12/3/21, of patient #3 clinical record evidenced a Physical Therapy re-evaluation visit note, dated 12/2/21, which failed to evidence documentation of the change in caregiver status (recent glaucoma surgery which rendered caregiver/spouse temporarily blind) and of the caregiver's inability to provide support to Patient #3. In an interview on 12/3/21 at 9:13 AM, Patient #3 indicated a female clinician had visited the home yesterday for a re-evaluation and the patient had reported to the clinician the spouse, who is the patient's main caregiver, had recently undergone glaucoma surgery and has been rendered essentially blind for the next few weeks. Patient #3 indicated more help was needed with everything now because the patient and caregiver cannot care for each other. Review of the clinical record failed to evidence documentation of communication between interdisciplinary team members to inform them of patient #3's change in support and caregiver assistance. The therapist failed to contact the MD to coordinate care. In an interview on 12/6/21 at 11:47 AM, with Physical Therapist #O, when queried if patient #3 had informed her that the spouse, who was also the patient's primary caregiver, had recently undergone surgery for glaucoma and would be rendered effectively blind for 2-3 weeks, Physical Therapist #O stated, "[he/she] did actually." Employee #O also indicated that the physician had not been contacted. In an interview with the Administrator on 12/3/21 at 3:52 PM, the concerns related to patient #3 were addressed. The Administrator indicated she was unaware of any change in the patient's caregiver status and available supports. The Administrator indicated she would have expected to have seen something documented in the clinical or received a call from Physical Therapist to request an MD order be written for Social Work Evaluation. 2. The clinical record of Patient #6 was reviewed		deficiency will be corrected by 02/01/2022	

start date of 11/26/21, and certification period of 11/26/21 through 1/24/22, revealed a diagnosis of Covid (A highly contagious respiratory disease caused by the SARS-CoV-2 virus), Pneumonia (infection of the lungs that can cause mild to severe illness) and Atrial Fibrillation (an irregular and often very rapid heart rhythm (arrhythmia) that can lead to blood clots in the heart). The patient was receiving Skilled Nursing and Physical Therapy services.

Review of this record on 12/2/21 evidenced a Physical Therapy note dated 11/30/21, titled 'PT Evaluation' which stated, "Son questioning the need for O2 as patient only wearing at night at times; encouraged to ask at next appt." Clinical record failed to evidence documentation of communication with other interdisciplinary team members nor attending physician were made aware of patient's new assessment findings. Physical Therapist failed to contact MD with findings discovered during patient visit, but documented having asked the family to follow up with the attending physician.

3. The clinical record of Patient #7 was reviewed on 12/3/21, and contained a plan of care with a start date of 11/20/21, and certification period of 11/20/21 through 1/18/22, revealed a diagnosis of Chronic Obstructive Pulmonary Disease(a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and Diabetes Mellitus (a chronic condition that affects the way the body processes sugars) and was receiving Skilled Nursing and Physical Therapy services.

Review of this record on 12/3/21, evidenced a Physical Therapy note dated 11/22/21, and titled 'PT Evaluation Addendum Page' stated, "Called pt. daughter in law {anonymous} to edu on pt. need for use of O2 at present due to desaturation and SOB (shortness of breath). Edu on encouraging pt. to use SPC (single point cane) for all ambulation around the home. {daughter in law} agreeable. Per {daughter in law}, pt, has f/u appointment with PCP (Primary Care Physician) tomorrow and {daughter in law} will let {PCP} know of these recommendations." Further review of the record failed to evidence documentation of communication with other team interdisciplinary members

	therapist failed to contact MD with findings discovered during the patient visit, but deferred to the family to do so. 410 IAC 17-14-1(c)(6)			
G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on record review and interview, clinicians failed to document all pertinent data and completely assess patients receiving skilled services, and failed to ensure all clinicians discussed among the team members regarding changes in the patient s health status for 1 of 8 records reviewed (Patient #2). Findings include: 1. A review of a document titled, "American Physical Therapy Association", dated 2020, revealed "Preamble: ....Physical therapist pursue excellence in a professional scope of practice that includes optimizing physical function, health, quality of life...they provide a foundation for assessment of physical therapist practice... III. Patient and Client Management: Physical therapist practice incorporates all...clinical expertise,...make decisions regarding services...and health policy....C. The physical therapist examination: ...indicated other health needs of the patient or client, performs appropriate ...test, and measures,...Refers for additional services to meet the needs of the patient or client...The management plan includes a plan of care when physical therapist services are indicated to address a health condition." 2. A review of the clinical record of patient #2 was reviewed on 12/3/2021, which contained a plan of care for the certification period of 09/08/2021 through 11/06/2021, and revealed diagnoses of Weakness, CKD (chronic kidney disease) stage 4, retention of urine, and history of urinary tract infections. Patient #3 had received physical therapy, occupational therapy, and nursing services.	G0706	1. Mandate Temp, BP, RR, HR, and O2 with every visit. 2. QA will audit documentation and contact those listed in #3 if issues are found, allowing us to correct said issues and operate within compliance. 3. Regional Director and Site Administrator 4. All parties will be educated and this deficiency will be corrected by 02/01/2022	2022-02-01

	A review of the PT evaluation dated 09/08/2021, revealed the clinician failed to record the patient's temperature, failed to document patient #2 had a Foley catheter, and failed to document patient #2's history of a recent urinary tract infection. A review of a document titled D/C (discharge) Summary from entity E, an acute care hospital, dated 08/31/2021, evidenced patient #3 had been treated for a urinary tract infection and was to continue using a Foley catheter. During an interview with the administrator on 12/02/2021, at 12:15 PM, when queried related to the failure of the therapist to document the above, and follow up with other disciplines and the physician; the administrator indicated the therapist should have done so. 410 IAC 17-12-2(g)			
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and interview, the skilled clinicians failed to communicate with the attending physician involved in the plan of care related to the adequacy of the current plan of care for 1 of 8 patients (Patient #3) Findings include: A review of the clinical record of Patient #3 on 12/1/21, contained a plan of care for a certification period of 9/7/21 through 10/26/21, which revealed a diagnoses of new onset stroke (damage to the brain from interruption to the blood supply) with recent rehab stay, multiple	G0718	1. Educate all clinical staff when MSW consult is needed. Educate clinical staff when/why to contact ADON team, when to contact MD. Document that these have been completed and why. If unsure, staff to contact ADON team or Jeff DeGroote for guidance. 2. QA will audit documentation and contact those listed in #3 if issues are found, allowing us to correct said issues and operate within	2022-02-01

	eats away at the protective covering of nerves) and diabetes mellitus (a chronic condition that affects the way the body processes sugars). The patient was to receive Skilled Nursing 2 times per week for 1 week, 1 time per week for 1 week, and every other week for 6 weeks, Physical Therapy 1 time per for 1 week, 2 times per week for 6 weeks, 1 time per week for 1 week, Occupational Therapy 1 time per week for 4 weeks, and Speech Therapy 1 time per week for 1 week. A review on 12/3/21 of patient #3 clinical record evidenced a physical therapy re-evaluation visit, dated 12/2/21, and failed to evidence documentation of change in the caregiver's status (recent glaucoma surgery which rendered caregiver/spouse temporarily blind) or change in the patient caregiver's ability to provide support to the patient. Review of the clinical record failed to evidence the attending physician had been notified of the change in patient #3's needs. In an interview on 12/3/21 at 9:13 AM, Patient #3 indicated that a female clinician had visited the home yesterday for a re-evaluation and the patient reported to the clinician the spouse, who was the patient's main caregiver, had recently had glaucoma surgery and was essentially blind for the next few weeks. Patient #3 indicated more help was needed with everything since they cannot care for each other. In an interview on 12/6/21 at 11:47 AM, therapist #O, when asked if patient #3 had informed him/her the spouse, who is also patient's primary caregiver, just had surgery for glaucoma and would be rendered effectively blind for 2-3 weeks, Therapist #O stated, "[he/she] did actually." In an interview with the Administrator on 12/3/21 at 3:52 pm, the above findings related to patient #3 were verified. The Administrator indicated she was unaware of the change in patient #3's caregiver status and available supports. The Administrator indicated she would have expected to have seen something documented in the clinical record and/or received a call from the Therapist to request physician authorization for a Social Work Evaluation. 410 IAC 17-14-1(c)(3)		compliance. 3. Regional Director and Site Administrator 4. All parties will be educated and this deficiency will be corrected by 02/01/2022	

G0852	Information to the state survey agency 484.100(a) Standard: The HHA also must disclose the following information to the state survey agency at the time of the HHA's initial request for certification, for each survey, and at the time of any change in ownership or management: Based on record review and interview, the agency failed to notify the Indiana Department of Health of a change in ownership for 1 of 1 change in ownership. Findings include: 1. A review of the Indiana Department of Health (IDOH) database notes revealed a notice was sent to IDOH on 03/17/2021, requesting a name change from Preferred Home Health Care Inc to [Entity D] effective 02/24/2021, with a certificate of assumed business name document from the Secretary of State. Indiana Department of Health (IDOH) mailed a letter that requested additional documentation. 2. Review of an IDOH database, evidenced on 03/24/2021, IDOH received an email from person F, the Chief Operations Officer, with a copy of a CMS 855 (a form which home health agencies use to communicate and request action) dated 01/06/2021, was used for the CHOI (Change of Information) approved on 01/27/2021, and was not acceptable because it had not included a request for approval of a name change for the agency. IDOH replied by email, to the email address the agency provided, and requested the CMS 855 for a name change, an updated email address, and a document evidencing person F had was authorized to act on behalf of the home health agency. Review of an IDOH database failed to evidence agency had provided IDOH the required documents. 3. In an interview on 11/30/21 at 3:20 PM Alternate Administrator stated that Summit bought and finalized Preferred in August of 2020. He stated he had been attempting to reach someone at IDOH to finalize the name change. When queried, he was unable to recall the associated contact name.	G0852	Company attorney from Taft Law submitted COI with name change in 1/2021. The COI was accepted, however, the name change was not. After speaking with survey supervisor on 2/21/22, the site administrator will be submitting a new 855 to the Indiana Dept of Health, verifying address, phone number, and email address, while requesting a name change from Preferred Home Health Care to Summit Home Care. This deficiency will be corrected by 03/18/2022 pending approval times.	2022-03-18

	4. Review on 12/06/21 of Indiana Department of Health Data Base, entry dated 03/24/2021, IDOH received an email from Don Radlinski, COO with a copy of a CMS 855 dated 01/06/2021 that was used for the CHOI approved on 01/27/2021 and is not acceptable as it was not for a name change. A reply was sent via email, to don.radlinski.@summit-ortho.com requesting the CMS 855 for the name change, an updated email address, and a notice that he is their COO from the administrator. Data base failed to evidence the agency had provided the documentation requested on 3/24/2021. 410 IAC 17-10-1(d)			
G0942	Governing body 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. Based on record review and interview, the governing body failed to exercise its responsibility for the agency's management by having failed to amend policies with the name of an outside agency [entity D] to the agency name for 1of 6 policies reviewed. Findings include: 1. Review of Policy titled 'Admission Documents 2-004.1,' dated April 2015 revealed, "Purpose - To ensure organizational compliance with the Patient Bill of Rights and regulatory requirements. [Entity D] will provide written admission documents prior to or at initiation of home care services including: 1. Information regarding billing policies and payment procedures at the time of admission and any subsequent changes within 30 days & 3. including a description of an individual's right under state law,... and how such rights are implemented by the organization. 4. Information describing the organization's grievance	G0942	1. Update P&P and SOC packet to include Summit name. 2. Once completed, Summit will reissue these documents to all staff to ensure they are using the correct documentation. 3. Corp Clinical Director 4. All documents will be updated, all parties will be notified and this deficiency will be corrected by 02/01/2022	2022-02-01

	contacts, phone numbers, ... and mechanism(s) for communicating problems & Procedure 1. Appropriate documents will be included in admission folder bearing the Other Entity D name. 2. The admission information will be reviewed with the patient and/or family at the start of care visit. 3. The admission information will be left in the patient's home." The governing body failed to ensure this policy was in the name of this agency, not an outside entity. 2. On 11/30/21 at 3:20 PM, the Alternate Administrator indicated Entity D had bought Preferred Home Health Care and finalized the purchase in August of 2020. 410 IAC 17-12-1(b)			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the Administrator failed to execute all of their responsibilities for the day-to-day operations of the home health agency, for 1 of 1 Administrator. Findings include: 1. A review of Policy titled Admission Criteria and Process - Policy No. 2-003.1 dated April 2015 states, & "7. Upon acceptance into service, the patient will be provided with an organization brochure and various educational materials providing the patient and family/caregiver with sufficient information on: ...D. Care costs, if any to be born by the patient." The administrator failed to ensure the agency advised patients/families in writing of expected payment for services from Medicare and of possible charges for services that may not be covered by insurance at the time of admission. (See G 440) 2. Review of the Policy titled 'Admission Documents 2-004.1,' dated April 2015 revealed, "Purpose - To ensure organizational compliance with the Patient Bill of Rights and regulatory requirements. [Entity D] will provide written admission documents prior to or at initiation of home care services including: 1. Information	G0948	1. 1. HHA to use newly developed SOC handout which will include a link to patient handbook. Said handbook will include agency overview, patient rights and responsibilities, transfer/discharge policy, privacy policy, advanced directive information, and safety information. SOC handout will also include site administrator contact information, Indiana Department of Health contact information, Medicare contact information, blank spaces for our clinical team to fill in their contact information and our 24 hour nursing line number.	2022-02-01

	procedures at the time of admission and any subsequent changes within 30 days & 3. including a description of an individual's right under state law,... and how such rights are implemented by the organization. 4. Information describing the organization's grievance procedure which includes the names of contacts, phone numbers, ... and mechanism(s) for communicating problems & Procedure 1. Appropriate documents will be included in admission folder bearing the Other Entity D name. 2. The admission information will be reviewed with the patient and/or family at the start of care visit. 3. The admission information will be left in the patient's home." The Administrator failed to ensure patients received and had an understanding of Patient Rights. (See G 414) 3. A policy titled 'Informed Consent/Refusal of Treatment 2-005.1,' dated April 2015 revealed, "Purpose: To obtain written consent for care during the admission process and to communicate the organization's process for informing patients and family/caregivers regarding services as well as involving patients in the care/service planning process....4. During the admission visit, the patient or authorized representative will sign the organization's written consent for care/services. The Administrator failed to ensure staff documented services and care including the frequency of visits, in the admission consent forms. (See G 434) 4. A review of an agency policy titled, "Verification of Physician Orders Policy No 4-003.1" dated April 2015, revealed, & accurate physician orders are obtained &under subtitle Policy; Orders will be obtained from a licensed physician &for care and services to be provided &A qualified individual will review each order before care is provided." The Administrator failed to ensure the plan of care was established/reviewed in conjunction with the attending physician. (See G 572) 6. A review of an agency policy titled, "Initial and Comprehensive Assessment No 4-018.1," dated April 2015, revealed, "The initial assessment visit must be performed either within 48 hours of the referral, within 48 hours of the patient s return home, on the start of care date ordered by the physician (or other authorized licensed independent practitioner), or at the patient/family request with the approval of the physician. ... Procedure &2. The comprehensive assessment for each patient		Service agreement will be signed via DocuSign at time of SOC, while reviewing all information in our patient handbook. Said service agreement, along with the 485 will be mailed from office to patient. 2. Summit will obtain new (Eval and tx) SOC orders with every SOC. If the delay in SOC is >48 hours, we obtain a delay order from the signing physician. 3. Re-educate all clinical staff on head to toe assessments with every visit. 4. Mandate Temp, BP, RR, HR, and O2 with every visit. 2. Summit has a dedicated staff member that calls every patient following their SOC to ensure they are receiving the care they expect. During this care call, we will have said staff member confirm that each patient has a SOC handout. If a patient does not have this handout, said staff member will contact those listed in #3 to correct the issue. QA will audit orders and clinical documentation and contact those listed in #3 if issues are found, allowing us to correct said issues	

	clinician. ...B. A physical assessment, including blood pressure, temperature, pulse ...other relevant date related to pertinent physical findings of common symptoms...C. Patient's functional status, including but not limited to, the degree of self-care, and the amount and level of assistance needed ... " The Administrator failed to ensure the initial assessment visit was completed either within 48 hours of a referral, discharge from a facility, or to obtain a physician ordered start of care date failed to ensure the comprehensive assessments were complete and accurately reflected the patient s health status to ensure the patients needs were being met. (See G 514) 7. On 12/6/2021, at 3:52 PM, the Alternate Administrator indicated the duties of the administrator included ensuring the agency operated in compliance with federal and state requirements. 410 IAC 17-12-1 (c)(1)		and operate within compliance. 3. Regional Director and Site Administrator 4. All parties will be educated and this deficiency will be corrected by 02/01/2022	

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