STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157550	A. BUILDING B. WING	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE AT HOME INC	8929 BROADWAY, MERRILLVILLE, IN, 46410

(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 was a post condition revisit survey for Providence at Home conducted by the Indiana Department of Health. Survey Dates: 3/7/2022, 3/8/2022, 3/9/2022, 3/10/2022, and 3/11/2022 Facility ID: 003435 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings. Providence At Home Inc., is precluded from providing its own home health aide training and competency evaluation for a period of two years from 1/25/2022 - 1/24/2024, due to being found out of compliance with Conditions of Participation 42 CFR 484.60 Care Planning, Coordination of Care and Quality of Care. During this survey, Conditions of Participation 42 CFR 484.60 Care Planning, Coordination of Care and Quality of Care was found to be in compliance and 11 standard citations were found to be corrected. Quality Review Completed 03/25/2022	G0000		2022-04-08
N0000	Initial Comments	N0000		2022-04-08

	This was a re-licensure survey in conjunction with a federal post condition revisit survey, conducted by the Indiana Department of Health Survey Dates: 3/7/2022, 3/8/2022, 3/9/2022, 3/10/2022, and 3/11/2022 Facility: #003435			
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health and Providence At Home Inc, was found to be in compliance in accordance with 42 CFR 484.102. Survey Dates: 3/7/2022, 3/8/2022, 3/9/2022, 3/10/2022, and 3/11/2022 Facility ID: 003435	E0000		2022-04-08
G0442	Written notice for non-covered care 484.50(c)(8) Receive proper written notice, in advance of a specific service being furnished, if the HHA believes that the service may be non-covered care; or in advance of the HHA reducing or terminating on-going care. The HHA must also comply with the requirements of 42 CFR 405.1200 through 405.1204. Based on record review and interview, the home health agency failed to ensure all patients received proper written notice in advance of terminating services for 1 of 1 discharged patient who received speech therapy (ST) services, from a total of 2 closed clinical records reviewed. (#7) The findings include: Record review of an agency policy titled "Patient Notification of Changes in Care" revised February 2022, stated "Purpose To define organization requirements for patient notification of changes in care & Policy The patient will be notified within 24 hours of any significant changes in the agreed-upon schedule or plan of care & Procedure & Plan of Care Changes 1. Whenever the plan of	G0442	What action will we take to correct the deficiency cited? Discharge Criteria and Process policy No. 2-042.1 was reviewed and updated to include 15 day discharge notice policy and procedure. Rehabilitative Care Services and Contents of the Clinical Record policy was reviewed and provided to staff for review. All actively employed staff with the exception of the home health aide will be reeducated individually and collaboratively regarding the updated Discharge Criteria and Process, Rehabilitative Care Services, and Contents of the Clinical Record Policy and the importance of 15 day discharge notification. Staff will also be educated on the expectation regarding documentation and discharge paperwork requirements. Who is responsible to implement the corrective action? Nurse Case Managers, Registered Therapists, and the Clinical Supervisor will be active participants in implementing the corrective action. The Home Health Administrator will	2022-04-08

	care is being changed, including services, frequencies, treatments, etc., the patient will be notified at the time of visit. Use the CMS Home Health Advanced Beneficiary when indicated. 2. Documentation of the notification will include: A. Date and time of notification & B. Specific changes in the plan of care & C. Patient response or acceptance &. Record review of an agency policy titled "Discharged Criteria and Process" revised April 2021, stated "Purpose To outline the process for discharging a patient from service ... Policy When the patient's plan of care changes and this change results in discharge from or reduction of services, the patient or his/her representative, as well as his/her primary physician, will be notified and involved in the planning decisions ...." Record review of an agency policy titled "Rehabilitative Care Services" revised April 2020, stated "Purpose To provide clinical direction to therapists providing direct patient care & Policy Qualified rehabilitation professionals will develop and implement the rehabilitation care plan with the patient, family, and caregivers & Discharge planning from services will be integrated into the functional rehabilitation assessment & All services will be provided in accordance with accepted standards of practice by or under the direction of a qualified physical, occupational, or speech therapist & Procedure & 7. Discharge planning will be integrated early in treatment based on ongoing assessments and stated expectation for achieving treatment goals and objectives. Criteria for discharge or termination of services may vary based on age, disability, treatment setting, and the plan for professional services. (See Discharge Criteria and Process &) &. Record review of an agency policy titled "Contents of the Clinical Record" revised December 2015, stated "Purpose To outline the requirements for and components of a clinical record & Policy A clinical record will be maintained for each patient receiving care. The clinical record will contain sufficient information to identify the patient, describe the patient s problems and needs, justify care, accurately document care provided and results in detail, and facilitate continuity of care among organization and contract personnel & Procedure 1. The		monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring system we will put into place to ensure implementation and effectiveness of this corrective action plan? Upon admission, a reminder will be added to the week containing the visit 15 days prior to discharge so staff is aware to get paperwork completed. Clinical Supervisor will monitor 100% of discharged patients for appropriate discharge paperwork including 15 day notice and discharge instructions.	

following information will be available in the clinical record, as applicable to care and services provided: & Q. Statement of any changes in the patient s condition related to care and service & BB. Documentation of the assessment data collected, actions and interventions performed, and patient response to care provided &.

Clinical record review on 3/11/2022, for patient #7, start of care 7/19/2021, diagnosis of aphasia [loss of ability to understand or express speech, caused by brain damage], evidenced an agency document titled "Home Health Care Certification and Plan of Care" for certification period 1/15/2022 - 3/15/2022, signed by the physician on 1/24/2022. This document had an area subtitled "Orders/Treatments" which stated "Discipline Orders ... Speech Therapy; 2 wk 6 wk [twice a week for 6 weeks]; Beginning during week of 1/16/2022 - Ending on 2/26/2022 ... Additional Services ... The primary reason the patient is being seen by home health is decreased verbal expression, visual neglect and decreased auditory processing. It is anticipated that the patient will continue needing home health services for the anticipated length of time of 60 days ...."

Record review evidenced an agency document titled "Prep Notes Communication" created by Speech Therapist (ST) H on 2/25/2022. This document stated "... The patient continues to participate well during therapy and [his/her] overall conversational skills continue to improve. Discharge plans discussed with patient. Plan discharge next week ...."

Record review evidenced an agency document titled "Discharge OASIS [Outcome and Assessment Information Set]"dated 3/1/2022, and signed by ST H. This document stated "(M0906) Discharge/Transfer/Death Date- ... 3/1/2022 ...." Record review failed to evidence documentation of a Home Health Change of Care Notice.

During an interview on 3/11/2022, at 10:40 AM, clinical manager A indicated a 15-day discharge notice would be documented in the patient's visit notes and a Notice of Medicare Non-Coverage is signed by the patient at that time.

N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.	N0488	What action will we take to correct the deficiency cited? Discharge Criteria and Process policy No. 2-042.1 was reviewed and updated to include 15 day discharge notice policy and procedure. Rehabilitative Care Services and Contents of the Clinical Record policy was reviewed and provided to staff for review. All actively employed staff with the exception of the home health aide will be reeducated individually and collaboratively regarding the updated Discharge Criteria and Process, Rehabilitative Care Services, and Contents of the Clinical Record Policy and the importance of 15 day discharge notification. Staff will also be educated on the expectation regarding documentation and discharge paperwork requirements. Who is responsible to implement the corrective action? Nurse Case Managers, Registered Therapists, and the Clinical Supervisor will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring system we will put into place to ensure implementation and effectiveness of this corrective action plan? Upon admission, a reminder will be added to the week containing the visit 15 days prior to discharge so staff is aware to get paperwork completed. Clinical Supervisor will monitor 100% of discharged patients for appropriate discharge paperwork including 15 day notice and discharge instructions.	2022-04-08

Based on record review and interview, the home health agency failed to develop and implement a policy to include a 15-day discharge notice.

The findings include:

Record review of an agency policy titled "Discharged Criteria and Process" revised April 2021, stated "Purpose To outline the process for discharging a patient from service ... Policy When the patient's plan of care changes and this change results in discharge from or reduction of services, the patient or his/her representative, as well as his/her primary physician, will be notified and involved in the planning decisions ...."

Record review of an agency policy titled "Discharged Planning" reviewed February 2022, stated "Purpose To promote patient independence, safety, and use of available community resources prior to patient discharge from the organization ... Patients will not be discharged without appropriate preparation. The patient's continuing care needs will be assessed on an ongoing basis, as well as at discharge. Information will be provided to assist the patient in his/her discharge, including referral and transfer ... 2. Clinicians will assist patients regarding their discharge by: A. Consulting with the patient and family/caregiver regarding plans for discharge from the organization ... C. Consulting with the patient and family/caregiver regarding the provision if discharge information ... E. Coordinating discharge with the patient's physician ... 4. All communication and information regarding discharge planning will be documented in the clinical record ....

Record review failed to evidence a discharge policy or process to include a 15-day discharge notice prior to the patients' discharge from the home health agency.

During an interview on 3/11/2022, at 10:40 AM, when queried how the patients are made aware of the 15 day discharge notice, clinical manager A indicated discharge planning begins upon admission and it should be documented in the visit notes. She also indicated the patient's receive a Home Health Non-Coverage form prior to discharge.

N0490	Q A and performance improvement 410 IAC 17-12-2(k) Rule 12 Sec. 2(k) A home health agency must continue, in good faith, to attempt to provide services during the fifteen (15) day period described in subsection (i) of this rule. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented. Based on record review and interview, the home health agency failed to ensure every patient received a 15-day notice prior to being discharged for 1 of 1 patient who received Speech Therapy services only, from a total of 2 discharged clinical records reviewed. (#7) The findings include: Record review of an agency policy titled "Discharged Criteria and Process" revised April 2021, stated "Purpose To outline the process for discharging a patient from service ... Policy When the patient's plan of care changes and this change results in discharge from or reduction of services, the patient or his/her representative, as well as his/her primary physician, will be notified and involved in the planning decisions ...." Record review of an agency policy titled, "Discharged Planning" reviewed February 2022, stated "Purpose To promote patient independence, safety, and use of available community resources prior to patient discharge from the organization ... Patients will not be discharged without appropriate preparation. The patient's continuing care needs will be assessed on an ongoing basis, as well as at discharge. Information will be provided to assist the patient in his/her discharge, including referral and transfer ... 2. Clinicians will assist patients regarding their discharge by: A. Consulting with the patient and family/caregiver regarding plans for discharge from the organization ... C. Consulting with the patient and family/caregiver regarding the provision if	N0490	What action will we take to correct the deficiency cited? Discharge Criteria and Process policy No. 2-042.1 was reviewed and updated to include 15 day discharge notice policy and procedure. Rehabilitative Care Services and Contents of the Clinical Record policy was reviewed and provided to staff for review. All actively employed staff with the exception of the home health aide will be reeducated individually and collaboratively regarding the updated Discharge Criteria and Process, Rehabilitative Care Services, and Contents of the Clinical Record Policy and the importance of 15 day discharge notification. Staff will also be educated on the expectation regarding documentation and discharge paperwork requirements. Who is responsible to implement the corrective action? Nurse Case Managers, Registered Therapists, and the Clinical Supervisor will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring system we will put into place to ensure implementation and effectiveness of this corrective action plan? Upon admission, a reminder will be added to the week containing the visit 15 days prior to discharge so staff is aware to get paperwork completed. Clinical Supervisor will monitor 100% of discharged patients for appropriate discharge paperwork including 15 day notice and discharge instructions. With regard to patient #7, discharge instructions and 15 day discharge notice are in patient's medical record.	2022-04-08

discharge information ... E. Coordinating discharge with the patient's physician ... 4. All communication and information regarding discharge planning will be documented in the clinical record ...."

Record review of an agency policy titled "Rehabilitative Care Services" revised April 2020, stated "Purpose To provide clinical direction to therapists providing direct patient care & Policy Qualified rehabilitation professionals will develop and implement the rehabilitation care plan with the patient, family, and caregivers & Discharge planning from services will be integrated into the functional rehabilitation assessment & All services will be provided in accordance with accepted standards of practice by or under the direction of a qualified physical, occupational, or speech therapist & Procedure & 7. Discharge planning will be integrated early in treatment based on ongoing assessments and stated expectation for achieving treatment goals and objectives. Criteria for discharge or termination of services may vary based on age, disability, treatment setting, and the plan for professional services. (See Discharge Criteria and Process &) &.

Record review of an agency policy titled "Contents of the Clinical Record" revised December 2015, stated "Purpose To outline the requirements for and components of a clinical record & Policy A clinical record will be maintained for each patient receiving care. The clinical record will contain sufficient information to identify the patient, describe the patient s problems and needs, justify care, accurately document care provided and results in detail, and facilitate continuity of care among organization and contract personnel & Procedure 1. The following information will be available in the clinical record, as applicable to care and services provided: & Q. Statement of any changes in the patient s condition related to care and service & BB. Documentation of the assessment data collected, actions and interventions performed, and patient response to care provided &.

Clinical record review on 3/11/2022, for patient #7, start of care 7/19/2021, diagnosis of aphasia [loss of ability to understand or express speech, caused by brain damage], evidenced an agency document titled "Home Health Care Certification and Plan of Care"

	for certification period 1/15/2022 - 3/15/2022, signed by the physician on 1/24/2022. This document had an area subtitled "Orders/Treatments" which stated "Discipline Orders ... Speech Therapy; 2 wk 6 wk [twice a week for 6 weeks]; Beginning during week of 1/16/2022 - Ending on 2/26/2022 ... Additional Services ... The primary reason the patient is being seen by home health is decreased verbal expression, visual neglect and decreased auditory processing. It is anticipated that the patient will continue needing home health services for the anticipated length of time of 60 days ...." Record review evidenced an agency document titled "Prep Notes Communication" created by Speech Therapist (ST) H on 2/25/2022. This document stated "... The patient continues to participate well during therapy and [his/her] overall conversational skills continue to improve. Discharge plans discussed with patient. Plan discharge next week ...." Record review evidenced an agency document titled "Discharge OASIS [Outcome and Assessment Information Set]"dated 3/1/2022, and signed by ST H. This document stated "(M0906) Discharge/Transfer/Death Date- ... 3/1/2022 ...." Record review evidenced discharge planning began one week prior to discharge. Record review failed to evidence the patient received a 15-day discharge notice. During an interview on 3/11/2022, at 10:40 AM, when queried how patients were made aware of the agency's 15 discharge notice policy, clinical manager A indicated discharge planning begins upon admission and would be documented in the skilled visit notes. She indicated the documentation would include the anticipated date of discharge, education that was provided, and who to follow up with after discharge.			
G0536	A review of all current medications 484.55(c)(5)	G0536	What action will we take to correct the deficiency cited? All actively employed staff field staff with the exception of the home health aide will reeducated individually and collaboratively	2022-04-08

	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. Based on observation, record review, and interview, the home health agency failed to ensure a review of all current medications was performed for 1 of 3 patients where a home visit was conducted. (#3) The findings include: Record review of an agency policy titled "Medication Profile" reviewed February 2022, stated "Purpose To define the use of the medication profile in evaluating a patient s medication regimen & Policy Patients receiving medications will have a current, accurate medication profile in the clinical record & Procedure & 4. During subsequent home visits, the medication profile will be used as a care planning and teaching guide to ensure that the patient and family/caregiver, as well as other clinicians, understand the medication regimen. This includes, but will not be limited to: & B. Using the medication profile to teach the purpose of medication, dosages, routes, administration times, side effects, and contraindications &. " Record review of an agency policy titled "Contents of the Clinical Record" revised December 2015, stated "Purpose To outline the requirements for and components of a clinical record & Policy A clinical record will be maintained for each patient receiving care. The clinical record will contain sufficient information to identify the patient, describe the patient s problems and needs, justify care, accurately document care provided and results in detail, and facilitate continuity of care among organization and contract personnel & Procedure 1. The following information will be available in the clinical record, as applicable to care and services provided: & BB. Documentation of the assessment data collected, actions and interventions performed, and patient response to care provided & CC. Current medication profile, including prescription and nonprescription medications, herbal products and home remedies, dose, frequency, route of administration, and new, changed, or discontinued medications &. Observation of a home visit was conducted		Contents of the Clinical Record Policy. Education will also be provided to staff regarding the important of maintaining a current medication profile to include: prescription and nonprescription medications, herbal products, home remedies and any topical or wound care treatments including wound washes or treatments, and skin care products. Clinical Documentation Review Coordinator will audit all admissions, resumption of care, recertification documents to ensure they are complete and current. Who is responsible to implement the corrective action? Nurse Case Managers, Licensed Practical Nurses, Registered Therapists, Clinical Supervisor and the Clinical Documentation Review Coordinator will all be active participants in implementing the corrective plan. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective plan? Clinical Documentation Review Coordinator will audit all admissions, resumption of care, recertification documents to ensure they are complete and current. Members of the Quality team will audit 10% of monthly to assure that medication reconciliation is completed and documented accurately at each comprehensive assessment and when made aware of medication changes or concerns. Chart audit results will be discussed at the QAPI meeting to assess if processes have improved to the required level, and what deficiencies remain. Further deficiencies will be addressed individually with staff on a ongoing basis to monitor and ensure compliance.	

	on 3/10/22 at 9:00 AM, with patient #3, start of care 2/11/2022, and registered nurse (RN) G. At 9:05 AM, RN G performed hand hygiene, donned new gloves, and applied a wound cleanser from a blue bottle to the patient's left calf, then completed the dressing change to the left leg. At 9:14 AM, RN G began the wound care to the patient's right calf area. After RN G removed the old dressing and performed proper hand hygiene, the solution from the blue bottle was applied the wound on the right lower extremity. The patient's caregiver indicated the solution in the blue bottle was called Vashe Wound Solution (solution containing hypochlorous acid used for debriding, cleansing, and removing foreign material from wounds) and it was purchased online at a good price. At 9:35 AM, the patient's medication list was reviewed and failed to evidence Vashe Wound Solution with the instructions for use. During the entrance conference interview on 3/7/2022, at 10:02 AM, clinical manager A indicated new patient medications found in the home or reported by the patient would get added to the MAR (medication administration record), which would create an order for the medication for the doctor to review, and the medication would be added to the medication list in the patient's home. She indicated the drug regimen review was performed at every visit. 410 IAC 17-14-1(a)(1)(B)			
G0574	Plan of care must include the following 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;	G0574	What action will we take to correct the deficiency cited? All actively employed field staff with the exception of the home health aide, will be reeducated individually and collaboratively regarding the importance of patient specific, individualized orders. Standing PICC orders have been updated and education provided to skilled nurses. Wound care order writing and documentation education provided to skilled nurses. Patient provided care plans will be updated as warranted every visit if indicated, education provided to all actively employed field staff regarding the patient provided plan of care. Who is responsible to implement the corrective action?	2022-04-08

	(viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the home health agency failed to ensure the plan of care was individualized to meet the needs for 2 of 3 patients where a home visit was conducted, from a total of 5 active clinical records reviewed. (#1, #3) The findings include: 1. Record review of an agency policy titled Physician Participation in Plan of Care revised December 2015, stated Policy & The attending physician will certify that medical, skilled, rehabilitation, and social services provided by the organization are medically required for the patient & Procedure 1. Physician (or other authorized licensed independent practitioner) orders will be individualized, based on patient s needs, and include: & B. Treatments and/or procedures needed, including type, frequency, duration, and goals & C. Medications to be administered and/or monitored & 2. Orders are reviewed for appropriateness and accuracy before care, treatment, and services are provided & 7. Orders will be reviewed and revised by the patient s physician (or other authorized licensed independent practitioner) based on: A. Changes in diagnosis or treatment, including procedures, medications and equipment &. 2. Clinical record review on 3/11/2022, for patient #3, start of care 2/11/2022, diagnosis of cellulitis (bacterial skin infection),		Nurse Case Managers, Licensed Practical Nurses, Registered Therapists, Clinical Supervisor and the Clinical Documentation Review Coordinator. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? The Quality improvement team will audit 10% of active patient charts monthly to ensure these standards are met and compliance is achieved. Chart audits will will be performed on a on-going basis to monitor continued compliance. Results will be discussed at the QAPI meetings to assess if processes have improved to the required level and what deficiencies will be addressed with individual staff members as warranted.	

Health Care Certification and Plan of Care" which was signed by the physician on 2/22/2022. This document had an area subtitled "Orders/Treatments" which stated "Discipline Orders ... Skilled Nursing; 2 wk 5 wk [twice a week for 5 weeks] ... Change PICC [peripherally inserted central catheter] Line dressing once a week ... Change caps to each lumen [tubing connected to the PICC line] once a week using sterile technique ... Interventions ... SN [skilled nurse]: Change IV [intravenous] tubing every 24 hours ...." Review of the clinical record failed to evidence the PICC line caps were changed weekly. Review evidenced the SN made visits to the patient's home 2 times weekly. Record review failed to evidence IV tubing was changed every 24 hours. Review evidenced the orders on the plan of care were not individualized specific to the patient s needs as evidenced during the interview with the clinical manager.

During an interview on 3/11/2022, at 10:56 AM, clinical manager A indicated the SN would teach family/caregiver to change IV tubing as directed on the plan of care.

During an interview on 3/11/2022, at 11:08 AM, clinical manager A indicated the orders for IV (intravenous) medications were standard orders (not individualized). She indicated pharmacies have not been sending the antiseptic caps for the PICC lines because they were too costly.

3. Clinical record review on 3/11/2022, for patient #1, start of care 2/10/2022, primary diagnosis of spinal stenosis (narrowing of the spinal canal), evidenced an agency document titled "Home Health Care Certification and Plan of Care" which was signed by the physician on 2/21/2022. This document had an area subtitled "Orders/Treatments" which stated "Interventions ... SN: Perform wound care/dressing change: cleanse wound with normal saline, pat dry, apply calcium alginate with silver, cover with foam boarder dressing, change three times a week and as needed. Caregiver/patient to perform in absence from nurse ...." Review of this document failed to evidence the wound care order was individualized to include the location of the wound. Review failed to evidence the plan of care was individualized to include the as needed indications when the dressing should have been changed.

	During an interview on 3/11/2022, at 10:46 AM, clinical manager A indicated the location of the wound should be on the plan of care orders. 410 IAC 17-13-1(a)(1)(i-xiii)			
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Based on record review and interview, the home health agency failed to ensure the plan of care was revised to disclose current, accurate patient information for 1 of 1 patient with a resumption of care (ROC), from a total of 5 active clinical records reviewed. (#2) The findings include: Record review of an agency policy titled Physician Participation in Plan of Care revised December 2015, stated Policy & The attending physician will certify that medical, skilled, rehabilitation, and social services provided by the organization are medically required for the patient & Procedure 1. Physician (or other authorized licensed independent practitioner) orders will be individualized, based on patient s needs, and include: & B. Treatments and/or procedures needed, including type, frequency, duration, and goals & C. Medications to be administered and/or monitored & 7. Orders will be reviewed and revised by the patient s physician (or other authorized licensed independent practitioner) based on: A. Changes in diagnosis or treatment, including procedures, medications and equipment & E. Changes in diagnoses or treatment, including procedures, medications, and equipment &. Record review of an agency policy titled "Contents of the Clinical Record" revised December 2015, stated "Purpose To outline the requirements for and components of a clinical record & Policy & The clinical record will contain sufficient information to identify the patient, describe the patient s	G0592	What action will we take to correct the deficiency cited? All patients will be provided a copy of their plan of care upon admission and at recertification of services. All actively employed field staff with the exception of the home health aide will be reeducated individually and collaboratively regarding the importance of accurate and current patient provided plan of care. Field staff will update Plan of Care every visit if indicated. Clinical Supervisor will complete monthly supervisory visits to ensure staff compliance. Who is responsible to implement the corrective action? Nurse Care Managers, Licensed Practice Nurses, Licensed Therapists, Clinical Supervisor, Clinical Documentation Review Coordinator will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure these deficiencies are corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Clinical Documentation Review Coordinator will provide clinicians with patient copy of their plan of care that will be given to clinicians to return to patient folders. Clinical Supervisor will complete monthly supervisory visits to ensure staff compliance.	2022-04-08

problems and needs, justify care, accurately document care provided and results in detail, and facilitate continuity of care among organization and contract personnel & Procedure 1. The following information will be available in the clinical record, as applicable to care and services provided: & R. Care planning activity based on patient s problem and needs & CC. Current medication profile, including prescription and nonprescription medications, herbal products and home remedies, dose, frequency, route of administration, and new, changed, or discontinued medications &.

Record review of an agency policy titled Reassessments/Recertification reviewed in April 2020, stated Purpose To outline the requirements for ongoing updates to the comprehensive assessment (reassessments) and recertification & Policy & The total plan of care must be renewed at least every 60 days, or more often as warranted by the condition of the patient. Any assessment findings that suggest a need to alter the plan of care will be reported to the patient s physician & Procedure & 4. Each patient will be reassessed using a comprehensive OASIS [Outcome and Assessment Information Set] assessment tool for the review and revision of the plan of care when: & A. The patient returns home after an inpatient admission lasting 24 hours or longer for any purpose other than diagnostic testing & 8. The updated Home Health Certification and Plan of Care will be prepared and sent to the physician for review and signature in a timely manner &.

Record review of an agency policy titled "Contents of the Clinical Record" revised December 2015, stated "Purpose To outline the requirements for and components of a clinical record & Policy A clinical record will be maintained for each patient receiving care. The clinical record will contain sufficient information to identify the patient, describe the patient s problems and needs, justify care, accurately document care provided and results in detail, and facilitate continuity of care among organization and contract personnel & Procedure 1. The following information will be available in the clinical record, as applicable to care and services provided: & Q. Statement of any changes in the patient s condition related to care and service & BB. Documentation of

interventions performed, and patient response to care provided &.

Clinical record review on 3/11/2022, for patient #2, start of care 2/9/2022, evidenced an agency document titled Home Health Care Certification and Plan of Care for certification period 2/9/2022 4/9/2022, diagnoses include but were not limited to a surgical wound, chronic obstructive pulmonary disease [COPD], and pulmonary fibrosis. This document was signed by the physician on 2/22/2022 and had an area subtitled Medications which stated & ascorbic acid [vitamin C] 500 mg [milligrams] oral capsule; Take 1 cap(s) [capsule(s)] orally once a day for supplement & Oxycodone Hydrocholoride [opioid pain medication] 15 mg oral tablet; Take 1 tab(s) [tablet(s)] oral every 4 hours as needed for pain &. This document was indicated to be the current plan of care by clinical manager A on 3/9/2022.

Record review evidenced an agency document titled Verbal Order from 2/23/2022, and signed by the physician on 3/3/2022. This document stated 1: Resume HHC [home health care] services. Patient discharged from [Entity A] on 2/22/22 & 2: ROC 2/23/22 Patient was hospitalized at [Entity A] from 2/16/22 2/22/22 for new onset atrial fibrillation with rapid ventricular response [irregular, rapid heartbeat] & Plan of care and medications to continue as previously ordered with the addition of Digoxin [medication used to treat heart failure and heart rhythm problems] 125 mcg [micrograms] orally daily &.

Record review evidenced an agency document titled Verbal Order which was signed by RN F on 2/23/2022. This document stated 1: Digox [digoxin] 125 mcg (0.125 mg) oral tablet; Take 1 tab(s) orally once a day for chf [congestive heart failure], af [atrial fibrillation] & Start Date: 2/23/2022 & 2: Aide / 2 wk 3 wk [twice a week for 3 weeks]; 1 wk 4 wk [once a week for 4 weeks]; - read back and confirmed & Start Date: 2/23/2022 & 4. Discontinue: effective 2/23/2022 ascorbic acid 500 mg oral capsule & 5. Discontinue: effective 2/23/2022 oxycodone Hydrochloride 15 mg oral capsule &. This document was signed by the physician on 3/1/2022. Record review of the plan of care evidenced ascorbic acid 500 mg

	listed as an active medication. Review failed to evidence Digox was added to the active medication list. Review of the plan of care failed to evidence the patient had a history of atrial fibrillation. Record review failed to evidence the current plan of care was a current and accurate description of the patient s pertinent diagnoses and medications. During an interview on 3/7/2022, at 10:02 AM, clinical manager A stated the agency considers the 485 (Home Health Care Certification and Plan of Care) to follow as the plan of care. During an interview on 3/11/2022, at 10:42 AM, clinical manager A indicated the process to update the plan of care after orders are added or discontinued would include making corrections to the plan of care and then send to the physician for a signature.			
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 home health agency failed to coordinate care delivery to ensure the patient's needs were met for 1 of 1 patient who had a resumption of care (ROC), from a total of 5 active clinical records reviewed. (#2) The findings include: Record review of an agency document titled Care Coordination revised February 2022, stated Purpose To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services & Policy Each patient will be assigned a Case Manager upon admission by the Clinical Supervisor or designee. It will be the responsibility of the Case Manager to facilitate communication about changes in the patient status among assigned personnel & Timely and ongoing communication is the responsibility of each team member, will be appropriate to the needs and abilities of the patient, and will be relevant to the care provided. The clinicians responsible for facilitating communications	G0608	What action will we take to correct the deficiency cited? All actively employed field staff were reeducated individually and collaboratively regarding the importance of care coordination and the proper missed visit process including documentation of missed visits. Clinical Supervisor will monitor 100% of home health aide missed visits to ensure compliance. Clinical Documentation Review Coordinator will monitor 100% of patient ordered frequencies to ensure compliance. Who is responsible to implement the corrective action? All actively employed field staff, Clinical Supervisor and the Clinical Documentation Review Coordinator. What is the monitoring process we will put into place to ensure compliance and effectiveness of this corrective action plan? Clinical Supervisor will monitor 100% of home health aide missed visits to ensure compliance. Clinical Documentation Review Coordinator will	2022-04-08

	about changes in the patient s status among the assigned personnel & Procedure 1. The Clinical Supervisor or designee will assign each case to a Case Manager, based on the patient s need and level of care required, geographic area, and qualifications of organization personnel needed & 4. Care coordination will include, but not be limited to: & A. Regularly occurring telephone or email communication among team members & C. Timely documentation of coordination of care activities & 5. Organization personnel will communicate changes in a timely manner via telephone, one to-one meetings, case conferences and home visits. Documentation of all communications will include: the date and time of communication, individuals involved with the communication, information discussed, and the outcome of the communication & 6. Written evidence of care coordination may be found in the plan of care, case conference summary forms, or clinical notes in the patients clinical record &. Record review of an agency policy titled Missed Visits Policy revised February 2022, stated Purpose To promote the safety and well-being of patients receiving services, and to provide guidelines for communication and documentation when a missed visit occurs which modifies the frequency of visits ordered by the physician & Definition of Missed Visit & A missed visit modifies the frequency of visits ordered by the physician. If the visits cannot be rescheduled within the week it was missed, it is considered a missed visit &. Clinical record review on 3/11/2022, for patient #2, start of care 2/9/2022, evidenced an agency document titled Home Health Care Certification and Plan of Care for certification period 2/9/2022 4/9/2022, and signed by the physician on 2/22/2022. This document had an area subtitled Orders/Treatments which stated, Discipline Orders & Aide; 1 wk 1 wk [once a week for one week]; 2 wk 4 wk [twice a week for 4 weeks]; 1 wk 4 wk [once a week for 4 weeks] &. Record review evidenced an agency document titled Verbal Order which was signed by RN F on 2/23/2022. This document stated & Start Date: 2/23/2022 & 2: Aide / 2 wk 3 wk [twice a week for 3 weeks]; 1 wk 4 wk [once a week for 4		monitor 100% of patient ordered frequencies to ensure compliance.	

	weeks]; - read back and confirmed & Start Date: 2/23/2022 &. Review of this document evidenced the skilled nurse confirmed the order for home health aide (HHA) services to resume on 2/23/2022. Record review evidenced an agency document titled Aide Visit Note which was electronically signed by HHA I on 2/25/2022. This document stated Date of Visit 2/24/2022 & Visit Plan No Visit Made & Reason Visit Not Made: Other Schedule Conflicts & Narrative ... Note: Was not communicated that pt [patient] was ready to be seen by the aide &. Record review failed to evidence the HHA was notified of the patient s return to services. Record review failed to evidence the visit was made up before the week ending on 2/26/2022. Review evidenced the lack of care coordination resulted in a missed visit for the patient. During an interview on 3/11/2022, at 10:43 AM, clinical manager A indicated staff should access their patient s calendars the evening before to confirm their schedules for the next day. During an interview on 3/11/2022, at 10:49 AM, clinical manager A indicated the missed HHA visit was a result of an error entering the frequencies of HHA visits for the week of 2/23/2022. 410 IAC 17-14-1(a)(1)(F)			
G0620	Other pertinent instructions 484.60(e)(4) Any other pertinent instruction related to the patient's care and treatments that the HHA will provide, specific to the patient's care needs. Based on observation, record review and interview, the home health agency failed to ensure detailed instructions pertinent to the patient s care were provided for 1 of 1 patient with home health aide services, from a total sample of 5 active clinical records reviewed. (#2) The findings include: Record review of an agency policy titled Rights/Responsibilities reviewed February 2022, stated Purpose To encourage	G0620	What action will we take to correct the deficiency cited? All actively employed field staff were reeducated individually and collaboratively regarding the importance of patient provided care plans. Education was provided to update patient provided care plans every visit. The development of the home health aide care plan will include patient specific detailed tasks with frequency. The home health aide will be educated on the patient provided care plan if an incident prohibits access to their EMR, that will be kept in the patient provided folder. Who is responsible to implement the corrective action?	2022-04-08

	responsibilities, to provide guidelines to assist patients making decisions regarding care, and to support active participation in care planning & Policy Each patient will be an active, informed participant in care planning & Procedure 1. The patient will be informed upon admission and, as needed, of: & B. The goals of care, the interventions that support these goals and the identification of staff providing service & D. The right to be informed of his/her condition, participate in all aspects of care , and the right to refuse al or part of his/her care to the extent permitted by law &. Review of an agency policy titled Home Health Aide Plan of Care reviewed April 2020, stated Purpose To define the process for the development and use of the home health aide [HHA] plan of care & Policy Each patient receiving home health aide services will have an individualized plan developed and utilized to direct care performed by the assigned aide & Procedure & 2. The home health aide plan of care will be individualized to the specific patient and will include at least: A. Type of services/procedures to be provided & H. Specific procedure(s) to be performed, including amount, frequency, and duration & 6. The home health aide plan of care will be reviewed with the patient to ensure understanding of the aide s role in the home &. An observation of a home visit was conducted on 3/9/2022, at 4:00 PM, for patient #2, start of care 2/9/2022, with Registered Nurse (RN) F. At the beginning of the visit, RN F indicated she placed a plan of care in the patient s home folder. At 4:27 PM, the patient s home folder was reviewed to ensure all pertinent information for accurate delivery of services, including but not limited to a home health aide (HHA) care plan. Review of the home folder failed to evidence a HHA care plan to include specific tasks that were provided by the agency. Observation failed to evidence all pertinent information was provided to the patient. Clinical record review on 3/11/2022, for patient #2, primary diagnosis of an abdominal surgical wound, evidenced an agency document titled Home Health Care Certification and Plan of Care for certification period 2/9/2022 4/9/2022, and		All actively employed filed staff, Clinical Supervisor and the Clinical Documentation Review Coordinator will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Quality improvement team will audit 10% of active patient records to ensure these standards are met and compliance is achieved. Results will be discussed at the QAPI meeting to assess if processes have improved to the required level and what deficiencies remain. Chart audits will be performed on an on going basis to monitor continued compliance. Further deficiencies will be addressed with individual staff members as warranted. Home health aide care plan will be reviewed at initiation of home health aide services to ensure compliance.	

	document had an area subtitled Orders/Treatments which stated, Discipline Orders & Aide; 1 wk 1 wk [once a week for one week]; 2 wk 4 wk [twice a week for 4 weeks]; 1 wk 4 wk [once a week for 4 weeks] & Interventions & Aide: Elimination: Incontinent Care & Aide: Hygiene: Bath: Bed & Aide: Hygiene: Skin care &. This document was indicated to be the HHA care plan on 3/9/2022, by clinical manager A. Review failed to evidence pertinent details for incontinent care to include but not limited to frequency and specific details for cleaning the perineal area [pertaining to the area between the thighs, bounded by the anus and either scrotum for males or the vagina for females]. Review failed to evidence pertinent details of a bath to include but not limited to frequency, and specific tasks such as shampoo hair and/or shave. Review of this document failed to evidence pertinent information to include but not limited to frequency of skin care and specific tasks such as apply lotion and/or frequent turns. During an interview on 3/8/2022, at 10:02 AM, clinical manager A indicated clinicians would document directly to the patient care plans with their tablet via the electronic medical record (EMR). During an interview on 3/11/2022, at 10:41 AM, clinical manager A was queried how clinicians would know which tasks to perform if the EMR was down or unable to access in a patient s home. She indicated the plan of care should be in every patient s home.			
G0704	Responsibilities of skilled professionals 484.75(b) Standard: Responsibilities of skilled professionals. Skilled professionals must assume responsibility for, but not be restricted to, the following: Based on record review and interview, the skilled nurse failed to ensure professional practices for the resumption of care was followed as directed by the primary care physician in 1 of 1 clinical record reviewed with resumption of care (ROC), out of a total of 5 active clinical records reviewed. (#2)	G0704	What action will we take to correct the deficiency cited? All actively employed field staff were reeducated individually and collaboratively regarding the importance of care coordination and the proper missed visit process including documentation of missed visits. Clinical Supervisor will monitor 100% of home health aide missed visits to ensure compliance. Clinical Documentation Review Coordinator will monitor 100% of patient ordered frequencies to ensure compliance.	2022-04-08

The findings include:

Record review of an agency document titled Care Coordination revised February 2022, stated Purpose To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services & Policy Each patient will be assigned a Case Manager upon admission by the Clinical Supervisor or designee. It will be the responsibility of the Case Manager to facilitate communication about changes in the patient status among assigned personnel & Timely and ongoing communication is the responsibility of each team member, will be appropriate to the needs and abilities of the patient, and will be relevant to the care provided. The clinicians responsible for facilitating communications about changes in the patient s status among the assigned personnel & Procedure 1. The Clinical Supervisor or designee will assign each case to a Case Manager, based on the patient s need and level of care required, geographic area, and qualifications of organization personnel needed & 4. Care coordination will include, but not be limited to: & A. Regularly occurring telephone or email communication among team members & C. Timely documentation of coordination of care activities & 5. Organization personnel will communicate changes in a timely manner via telephone, one to-one meetings, case conferences and home visits. Documentation of all communications will include: the date and time of communication, individuals involved with the communication, information discussed, and the outcome of the communication & 6. Written evidence of care coordination may be found in the plan of care, case conference summary forms, or clinical notes in the patients clinical record &.

Record review of an agency policy titled Staffing and Scheduling revised February 2022, stated Purposed To ensure continuity of care for all patients while receiving home health services. To define the organization s expectation for communication between clinicians and the office & Policy & Clinicians will contact the office daily to confirm their schedules and caseload, and to receive reports on patients & Procedure & 1. The Clinical Supervisor will review the patient census and staffing levels on a daily basis and will make patient assignments which consider: & G. Previous organization

Who is responsible to implement the corrective action?

All actively employed field staff, Clinical Supervisor and the Clinical Documentation Review Coordinator.

What is the monitoring process we will put into place to ensure compliance and effectiveness of this corrective action plan?

Clinical Supervisor will monitor 100% of home health aide missed visits to ensure compliance. Clinical Documentation Review Coordinator will monitor 100% of patient ordered frequencies to ensure compliance.

personnel assigned to case & 2. The clinical Supervisor will consult the Clinical Director or Executive Director/Administrator regarding any daily staffing issues that cannot be resolved & 4. Clinicians will communicate with the office to verify that all planned visits for the day were made, to report availability for the next day, and to receive reports on admission or changes for the next day s schedule &.

Clinical record review on 3/11/2022, for patient #2, start of care 2/9/2022, evidenced an agency document titled Verbal Order which was signed by RN F on 2/23/2022. This document stated & Start Date: 2/23/2022 & 2: Aide / 2 wk 3 wk [twice a week for 3 weeks]; 1 wk 4 wk [once a week for 4 weeks]; - read back and confirmed & Start Date: 2/23/2022 &. Review of this document evidenced the skilled nursed confirmed the order for home health aide (HHA) services to resume on 2/23/2022.

Record review evidenced an agency document titled Aide Visit Note which was electronically signed by HHA I on 2/25/2022. This document stated Date of Visit 2/24/2022 & Visit Plan No Visit Made & Reason Visit Not Made: Other Schedule Conflicts & Narrative ... Note: Was not communicated that pt [patient] was ready to be seen by the aide &. Record review failed to evidence the HHA was notified of the patient s return to services by the skilled nurse. Review failed to evidence the skilled nurse followed the agency policy for coordination of care services. Review failed to evidence the skilled nurse assumed responsibility for the patient's care as ordered by the physician.

During an interview on 3/11/2022, at 10:43 AM, clinical manager A indicated staff should access the patient calendars the evening before the visit to check their schedules.

During an interview on 3/11/2022, at 10:49 AM, when queried who was responsible for the patient's missed visit, clinical manager A indicated it was an error of the frequency of visits entry for the first week following ROC by the skilled nurse.

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