STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157597	A. BUILDING B. WING	02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE SOLUTIONS LLC	5250 E US 36 STE 710, AVON, IN, 46123

(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 a Federal Recertification and State Re-licensure survey of a Home Health Care Provider. Survey Dates: 1/27/22, 1/28/22, 1/31/22, 2/1/22, 2/2/22, 2/3/22, 2/7/22, and 2/9/2022 to receive return phone calls This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR completed by Area 3 on 2/24/2022	G0000	G 0000-Thank you to inform the Agency, Home Health Care Solutions, LLC of compliance of Emergency Preparedness Requirements.	2022-03-10
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 1/27/22, 1/28/22, 1/31/22, 2/1/22, 2/2/22, 2/3/22, 2/7/22, and 2/9/2022 to receive return phone calls At this Emergency Preparedness survey, Home Health Care Solutions, LLC., was found to have been in compliance with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, including staffing and the implementation of staffing during a pandemic at 42 CFR 484.102.	E0000	E 0000- Survey was completed on 2/9/2022 but Agency received the results of the Survey on 3/7/22 for Federal Recertification and State Re-Licensing of Home Health Care with finding cited and for the Provider Plan of Correction.	2022-03-10

	QR by Area 3 completed 2/24/2022			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessments were complete and accurately reflected the patients' status, including current health and functional status which was required to plan care to meet the patients' needs are being met in 12 (Patients 3, 5, 6, 7, 8, 11, 15, 16, 1, 2, 4, and 13) of 14 active records reviewed in a sample of 19. Findings include: 1. Review of an undated agency's policy titled, "Initial Assessment Policy Number: C310," revealed, "POLICY An initial patient assessment which accurately reflects the patient's current health status will be performed and documented in the patient's clinical record by an RN. The current versions of OASIS (Outcome and Assessment Information Set is a comprehensive assessment to collect information on nearly 100 items related to a home care recipient's information and service needs) data items are incorporated into the initial comprehensive assessment. PROCEDURE 1. During the initial comprehensive patient assessment...including at least: A. A physical assessment...B. Patient's functional status, including but not limited to, the degree of self-care, the amount and level of assistance needed...C. The patient's current medical and psychosocial status...D. Verification of the patient's primary physician E. Name of the hospital, community resources, or individual involved in the past and present care of the patient F. An evaluation of the home environment...G. Presence of any advance directives...H. Equipment and medical supplies presently in-home...J. Patient and family or Caregiver support systems. Identification of the presence of family and/or caregiver... O. Specific, individualized patient care needs/problems pertinent to the care being provided..."	G0528	**G 0528**- Agency reviewed all the findings for not meeting the element of Comprehensive assessment to address patient's current health, psychosocial, functional, and cognitive status and shared them with all clinical staff members. Most of these findings were shared during the exit meeting on 2/9/22 by the State Surveyors therefore we started educating the staff since 2/10/22, day after the survey was completed. Staff was educated and provided written information as well as two meetings to address all issues. Staff reported back understanding of the findings and education provided for the importance of complete comprehensive assessment. Agency QA Team was also educated to make sure to review each assessment and continue staff education to meet the guidelines and make sure all comprehensive assessment are fully complete and appropriate. Agency has created Performance Improvement Process (PIP) to address this issue by the QAPI Team. All new patient assessments will be reviewed 100% for the next 6 months to ensure that each comprehensive assessment is fully complete and accurately reflects the patient's status. This will include current health,	2022-03-10

	A review of an undated agency's policy titled, " On-Going Assessment Policy Number: C318," revealed, "POLICY The scope of ongoing assessments is determined by the patient's diagnosis, condition, desire for care...PROCEDURE 1. During each home revisit, each discipline further re-evaluates the patient...2. The nurse assesses each patient for: A. Blood pressure, pulse, respiration, temperature B. Lung sounds C. Overall respiratory status D. Cardiovascular status E. elimination (urinary and bowel) F. Skin integrity G. Presence of edema any area of body H. Pain management... I. Mental status J. Nutritional status K. Functional status M. Risk factors to contribute to patient falls M. Family and/or caregiver support, type, frequency N. Patient needs, problems or updates..."P. Compliance with medication regimen...Q. Description of intravenous access device including type, location, site description and any dressing used with device... 3. Reassessments should focus on: A. Patient's response to care B. Changes in patient condition C. Changes in patient diagnoses D. Changes in patients care environment or support systems...5. Based on the reassessments, a comprehensive assessment inclusive of OASIS date set elements will be done by the primary clinician ..." A review of an Agency's undated policy titled, "Patient Bill of Rights and Responsibilities," Policy Number: C306, revealed, "POLICY In support of the home care services philosophy of care...PROCEDURE ...4. The patient is informed at admission of: A. Information about the Agency and services provided...H. The right to a comprehensive assessment completed within 5 days of the start of care to include: The patient's current health, psychosocial functional, and cognitive status...The patient's primary caregiver(s), if any, and other available supports, including their willingness and ability to provide care, availability, and schedule ..."		psychosocial, functional, and cognitive status which was required to create appropriate plan of care to meet each patient’s need. All DME supplies are documented along with the supplier’s name and contact information. All other healthcare entities are documented with their contact information for collaboration of care. The formation of PIP was also shared with all Nursing and Therapy staff members. Monthly findings will be shared with the Director of Nursing (DON) and the Administrator. The Administrator will observe the findings and will continue to monitor all steps taken to correct the deficiency. At the end of the six months, the DON will share the findings with the Administrator and if there are any further steps needed, then proper steps will be taken to have 100% compliance. The DON will be responsible for collecting the results of the PIP to ensure 100% compliance by the end of the 6-month period starting on 3/10/22. If Agency does not achieve 100% compliance, then PIP will continue for another 3 months to achieve 100% compliance.	

A review of an Agency's undated policy titled, "Clinical Records," Policy Number: A220, revealed, "POLICY 1. A clinical record must...2. The clinical record will contain sufficient information...PROCEDURE 1. The minimum contents of the clinical record include: ... L. Identity of other individuals and organizations know to be involved in patient care. P. Pain assessment and pain management interventions. Q. Wound assessment with measurement and drainage amount and skin condition around it. R. Statement of any changes in patient's condition. S. Goals of care and plan of care... '

2. A review of the clinical record of patient #3, contained a comprehensive assessment dated 12/27/21, and revealed diagnoses Secondary malignant neoplasm of bone (bone cancer), Malignant neoplasm of unspecified site of left female breast (breast cancer), Neoplasm related pain (acute) (chronic) (pain related to cancer), Essential (primary) hypertension (when you have abnormally high blood pressure that's not the result of a medical condition. This form of high blood pressure is often due to obesity, family history and an unhealthy diet), Depression (feelings of severe despondency and dejection), unspecified, Anxiety(a nervous disorder characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior or panic attacks) disorder, unspecified.

The comprehensive assessment failed to evidence the patient's status of Herpes Zoster (Shingles) Vaccine: (left blank), Health Screening: left blank; had an advance care plan had been documented in the home health record: (left blank), A surrogate decision-maker had been documented in the home health record: (left blank), Is religion important to the patient: marked no, patient's religious preference: (left blank), Patient's primary source of emotion support: (left blank); Cardiovascular: Peripheral pulses: (left blank); and Medication Administration Record; Does patient have IV access: (left blank).

During a home visit scheduled for 1/28/22 at 10:20 AM, upon arrival; observed patient #3 at the dining room table reading their Bible.

The comprehensive assessment failed to evidence the patient received a complete and

	accurate assessment to include whether or not religion was important to the patient. 3. A review of the clinical record of patient #5, revealed a comprehensive assessment dated 12/26/21, which evidenced diagnoses Encounter for fitting and adjustment of urinary device, encounter for attention to cystostomy (formation of an opening into the urinary bladder by surgical incision), mixed incontinence, Multiple Sclerosis (a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue), Chronic Kidney Disease Stage 3 (means you have an eGFR [estimated glomerular filtration rate] between 30 and 59. An eGFR between 30 and 59 means that there is some damage to your kidneys and they are not working as well as they should), Generalized anxiety (a nervous disorder characterized by a state of excessive uneasiness and apprehension) disorder, Dependence on a wheelchair, and Personal history of urinary (tract) infections. The comprehensive assessment indicated Patient 5 required 24-hour care yet failed to identify how 24 hour care was provided and failed to identify Supportive Assistance (names of organizations providing assistance.)			

During a telephone interview on 2/4/22 at 4:21 PM with patient #5, the patient stated they were receiving services from 2 other entities, N and O for housekeeping and personal care, as well as family members.

The comprehensive assessment failed to evidence the patient received a complete and accurate assessment.

4. A review of the clinical record of patient #6, revealed a comprehensive assessment dated 12/17/21, which evidenced diagnoses Diabetes Mellitus (A group of diseases that result in too much sugar in the blood, high blood glucose), Unilateral primary osteoarthritis (It occurs when the protective cartilage that cushions the ends of the bones wears down over time), left knee, Non-pressure chronic ulcer right foot (a damaged area on the foot that either does not heal or keeps returning) , essential hypertension (when you have abnormally high blood pressure that's not the result of a medical condition. This form of high blood pressure is often due to obesity, family history and an unhealthy diet), atherosclerosis heart disease (when thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of the arteries close to your heart) , Hyperlipidemia (your blood has too many lipids or fats, such as cholesterol and triglycerides), unspecified, obesity, unspecified, and Body mass index (BMI) (a weight-to-height ratio, calculated by dividing one's weight in kilograms by the square of one's height in meters and used as an indicator of obesity and underweight) 37.0-37.9.

	The comprehensive assessment failed to evidence the patient's health screening, it was left blank; failed to identify wound on Integumentary status and failed to identify Supportive Assistance, the name of entity caring for wound, failed to accurately identify how long patient was receiving insulin and whether patient was able to correctly draw up and administer insulin, and failed to identify Diabetic Supplies on the DME (Durable Medical Equipment) list. During a home visit on on 1/30/22 at 2:30 PM, this writer queried the patient as to whom administers insulin, the patient stated, "I do and I check my blood sugars 5 times a day". The comprehensive assessment failed to evidence the patient received a complete and accurate assessment. 5. A review of the clinical record of patient #7, revealed a comprehensive assessment dated 11/9/21, which evidenced diagnoses Pressure ulcer (injuries to skin and underlying tissue resulting from prolonged pressure on the skin) of right heel stage 4, Type 2 diabetes mellitus (an impairment in the way the body regulates and uses sugar (glucose) as a fuel), acute osteomyelitis (the clinical term for a new infection in bone), right ankle and foot, Type 2 Diabetes Mellitus with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes), Type 2 Diabetes with diabetic peripheral angiopathy (a blood vessel disease caused by high blood sugar levels) without gangrene (a dangerous and potentially fatal condition that happens when the			

	blood flow to a large area of tissue is cut off), Chronic Kidney Disease stage 5 (the kidneys are getting very close to failure or have completely failed), Dependence on renal dialysis (Dialysis does the work of your kidneys, removing waste products and excess fluid from the blood), Obstructive sleep apnea (occurs when the muscles that support the soft tissues in your throat, such as your tongue and soft palate, temporarily relax. When these muscles relax, your airway is narrowed or closed, and breathing is momentarily cut off), Obesity, Body mass index [BMI] (a weight-to-height ratio, calculated by dividing one's weight in kilograms by the square of one's height in meters and used as an indicator of obesity and underweight) 30.0-30.9, Long term use of insulin, and Long term use of aspirin. The comprehensive assessment failed to evidence the patient's status of Herpes Zoster (Shingles) Vaccine: (left blank), Health Screening was blank, had an advance care plan had been documented in the home health record: (left blank), A surrogate decision-maker had been documented in the home health record: (left blank), Supportive Assistance: (Names of organizations providing assistance) left blank, Integumentary Status, skin color left blank; Cardiovascular Status left blank, Nutritional Health Screen, failed to identify ulcer; and failed to accurately identify all DME supplies. The comprehensive assessment failed to evidence the patient received a complete and accurate assessment.			

	6. A review of the clinical record of patient #8, revealed a comprehensive assessment dated 12/31/21, which evidenced diagnoses Encounter for fitting and adjustment of urinary device, other hydronephrosis (swelling of one or both kidney), Multiple sclerosis(a potentially disabling disease of the brain and spinal cord [central nervous system]), Neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), functional quadriplegia(paralysis of all four limbs), Trigeminal neuralgia (a condition characterized by pain coming from the trigeminal nerve, which starts near the top of the ear and splits in three, toward the eye, cheek and jaw), Generalized anxiety disorder (a nervous disorder characterized by a state of excessive uneasiness and apprehension), Hyperlipidemia (your blood has too many lipids [fats], such as cholesterol and triglycerides), Major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning), Gastro-esophageal reflux disease (occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach [esophagus]) without esophagitis, presence of neurostimulator (a device is implanted and programmed that delivers electrical stimulation to specific parts of the patient's brain, spinal cord or peripheral nervous system to help treat various conditions, including chronic pain, movement disorders, epilepsy and Parkinson's disease), dependence on supplemental oxygen, dependence on wheelchair, personal history of malignant neoplasm of cervix (cancer that occurs in the cells of the cervix),			

Colostomy (an opening in the large intestine, or the surgical procedure that creates one. The opening is formed by drawing the healthy end of the colon through an incision in the anterior abdominal wall and suturing it into place), personal history of nicotine, and a personal history of urinary tract infections.

The comprehensive assessment failed to assess Respiratory status, lung sounds, and failed to identify patient using oxygen, a Port IV access was identified with last dressing change of 12/27/21, yet failed to reveal the entity that was managing the port. Employee E documented, "HHA (home health aide) completing personal care and ready for catheter care," yet failed to identify Supportive Assistance (names of organizations providing assistance).

The comprehensive assessment failed to evidence the patient received a complete and accurate assessment.

7. A review of the clinical record of patient #11, revealed a comprehensive assessment dated 12/30/21, which evidenced diagnoses Type 2 Diabetes Mellitus (an impairment in the way the body regulates and uses sugar[(glucose] as a fuel) with foot ulcer (an open sore or wound that occurs in approximately 15 percent of patients with diabetes, and is commonly located on the bottom of the foot), Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed, Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed, Type 2 diabetes with diabetic peripheral

	angiopathy (a blood vessel disease caused by high blood sugar levels) without gangrene (a dangerous and potentially fatal condition that happens when the blood flow to a large area of tissue is cut off), Venous insufficiency (Improper functioning of the vein valves in the leg, causing swelling and skin changes) (chronic)(peripheral), Essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition. This form of high blood pressure is often due to obesity, family history and an unhealthy diet), Unspecified atrial fibrillation (the heart's upper chambers[the atria] beat chaotically and irregularly out of sync with the lower chambers [the ventricles] of the heart), Restless legs syndrome (A condition characterized by a nearly irresistible urge to move the legs, typically in the evenings), Gout (a common and complex form of arthritis, that's characterized by sudden, severe attacks of pain, swelling, redness and tenderness in one or more joints, most often in the big toe), Long term use of oral hypoglycemic drugs, Long term use of aspirin, and Long term use of anticoagulants. The comprehensive assessment failed to document Supportive Assistance: Names of organizations providing assistance yet patient received weekly wound care from entity K, Integumentary Status: No was marked for using pressure-relieving device(s) yet patient receives weekly felt off-loading foam padding dressings bilaterally to feet for pressure-relieving from entity K, and DME supplies failed to identify diabetic and incontinence supplies.			

The comprehensive assessment failed to evidence the patient received a complete and accurate assessment.

8. A review of the clinical record of patient #15, revealed a re-certification comprehensive assessment dated 12/30/21, which evidenced diagnoses Pressure Ulcer Ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) of sacral (lying near the sacrum the sacral region of the spinal cord) region, stage 4; Pressure ulcer of right heel, stage 3; Pressure ulcer of left heel, unstageable; Open wound, right lower leg; Hypertensive chronic kidney disease, stage 4 (the kidneys are moderately or severely damaged, the last stage before kidney failure), Myelodysplastic syndrome (a group of disorders caused by blood cells that are poorly formed or don't work properly), and Personal history of malignant melanoma of skin (skin cancer).

The comprehensive assessment failed to identify Supportive Assistance: Names of organizations providing assistance, pressure-relieving device(s), and failed to identify incontinence supplies on the DME supply list.

A review of a skilled nursing visit noted dated 1/11/22, employee H, documented patient is sitting in bed on a waffle mattress and had a horseshoe seat cushion and a waffle cushion to protect spine for pressure relief, and the patient had an appointment scheduled at entity K later in the week..

The comprehensive assessment failed to

accurate assessment.

9. A review of the clinical record of patient #16, revealed an re-certification comprehensive assessment dated 2/4/22, which evidenced diagnoses Facture of 7th cervical vertebrae, Spondylosis with radiculopathy (causes pressure on the surrounding nerves there may be numbness, tingling or pain radiating into the chest, ribs, or abdominal areas), cervical region; Chronic pain syndrome, Rheumatoid arthritis (a form of arthritis that causes pain, swelling, stiffness and loss of function in your joints), and Restless legs syndrome(A condition characterized by a nearly irresistible urge to move the legs, typically in the evenings).

The comprehensive assessment indicated the Intensity of pain was at "0" ("no hurt") and relief rating of pain, i.e., pain level after medications was "0", Frequency of pain interfering with patient's activity or movement was marked that patient has no pain. Cardiovascular edema was blank, yet documented in Physical assessment that edema was "present, dependent, location mild edema in both LE (lower extremities)". It was documented the Patient Strengths were "motivated learner", Conclusions that "skilled intervention needed" yet, Skilled Intervention Assessment/Instruction/Performance were left blank.

A review of a document in the clinical record titled, "Physician Orders" dated 09/22/21 from entity L, revealed additional diagnoses of Unspecified protein-calorie malnutrition,

Unspecified cord compression, migraine w/o aura, not intractable, w/o status migraine, and anxiety disorder, unspecified.

The comprehensive assessment failed to evidence the patient received a complete and accurate assessment.

10. During a telephone interview on 2/2/22, Employee E stated that patient #8 had a port, and went to entity S, weekly for care of the port and flushes, and stated not knowing exactly why the patient had the port, but the patient had received antibiotics through the port in the past.

11. A review of the clinical record for Patient #1, revealed a comprehensive assessment dated 12/8/21 with diagnoses that included, but were not limited to: Stage 4 Sacral Pressure Ulcer (full thickness skin and tissue loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as ligaments, tendons, muscle and or bone) Atrioventricular heart block, second degree (when the electrical signals that tell your heart to contract don't always pass between the top and bottom chambers of your heart like they should. This causes an abnormal heart beat (arrhythmia)). Hypertension (high blood pressure), Heart Failure (when the heart muscle doesn't pump blood as well as it should). Skilled nursing visit frequency for wound care was written as: 2 times per week for 1 week, then 3 times for 8 weeks.

The comprehensive assessment failed to evidence patient #1's health status in regard to their wound. In a section of the OASIS (Outcome and Assessment Information Set, a patient specific, standardized assessment used in Medicare home health care to plan care, determine reimbursement, and measure quality) titled 'Integumentary Status', question, "Is patient using pressure relieving device(s)?" is marked "No". The next section, titled 'Comments', was left blank. Narrative from this same document failed to evidence any further explanation for reason for lack of a pressure-relieving device for a patient with a

stage 4 sacral pressure ulcer. Assessment further revealed a wound measurement of: 4 centimeters wide x 2 centimeters long x 2 centimeters in depth. Goal for this Comprehensive Assessment stated, "wound will decrease in size by 50 % by 2/5/22."

In a subsequent comprehensive assessment, a recertification OASIS dated 2/4/22, wound measurement was 5 centimeters wide x 3 centimeters long x 2 centimeters deep. In a section titled integumentary Status, the question, "Is patient using pressure relieving device(s)?" is marked "No". The next section, titled 'Comments', was left blank. Narrative of this same document failed to evidence any further explanation of lack of a pressure-relieving device for a patient with stage 4 sacral pressure ulcer, in light of the fact the wound measured larger than previous comprehensive assessment dated 12/6/21. Narrative of this same comprehensive assessment failed to evidence documentation of the reason for degradation of the wound, failed to evidence physician had been notified, and failed to evidence a change in wound care orders had been sought or attempts made to request changes be made to wound care orders. The goal for this Comprehensive Assessment stated, "wound will decrease in size by 50% by 2/5/22, (which was the identical date and time frame as the prior Comprehensive Assessment dated 12/6/21).

On 2/7/22 attempted a telephone interview with Nurse #K, who is listed as RNCM (Registered Nurse Case Manger) for Patient #1, left a voice message with callback number. Did not receive a call back from Nurse #K.

The comprehensive assessment of Patient #1 failed to evidence the patient received a complete and accurate assessment.

12. A review of clinical record for Patient # 2, revealed a comprehensive assessment dated 1/4/22 with diagnoses which included, but were not limited to: Chronic venous status ulcers of right and left lower extremities (also known as nonhealing wounds, are open wounds occurring around the ankle or lower leg. They do not heal for weeks or months, and occasionally persist longer), venous insufficiency (when your veins have trouble sending blood from your limbs back

back properly to the heart, causing blood to pool in the veins of one's legs), lymphedema

(build-up of fluid in soft body tissues when the lymph system is damaged or blocked. The lymph system is a network of lymph vessels, tissues, and organs that carry lymph throughout the body. Lymphedema occurs when lymph is not able to flow through the body the way that it should), hypertension (high blood pressure), History of Covid infection (a highly contagious respiratory disease caused by the SARS-CoV-2 virus). Skilled nurse was providing wound care 2 times per week for 8 weeks, then 1 time per week for one week.

During a home visit on 1/28/22 at 9:00 AM, patient #2 and spouse indicated patient had been hospitalized approximately one year ago due to Covid, and had been placed on a ventilator for 14 days. They collectively indicated patient was not expected to survive. The comprehensive assessment failed to evidence the severity and gravity of the prior Covid infection.

During the same home visit on 1/28/22, Nurse #J and patient #2 indicated the patient's recurrences of breast cancer have caused setbacks in wound healing, or/and exacerbations in healed wounds. The comprehensive assessment failed to evidence a history of breast cancer and subsequent recurrences of the breast cancer.

The comprehensive assessment of Patient #2 failed to evidence the patient received a complete and accurate assessment.

13. A review of the clinical record for Patient #4, revealed a comprehensive assessment dated 1/4/22, with diagnoses which included, but were not limited to: Stage 4 right buttock pressure ulcer (full-thickness skin and tissue loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as ligaments, tendons, muscle and or bone),

Multiple Sclerosis (a disease that can affect your brain and spinal cord, and can cause problems with vision, balance, muscle control), a suprapubic catheter (a type of urinary catheter that is left in place. Rather than being inserted through your urethra, the catheter is inserted through a hole in the abdomen and then directly into the bladder, in order to empty the bladder of urine), colostomy (an operation that redirects the colon from its normal route, down toward the anus, to a new opening in the abdominal wall), contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right and left legs, dependence on a wheelchair. The comprehensive assessment indicated skilled nursing was providing wound care/wound vacuum changes to the sacral pressure ulcer 3 times per week for 8 weeks.

During home visit on 1/31/22 at 10:00 AM, a suspected deep tissue injury was noted to the left heel. Additionally, patient #4's spouse also indicated that another wound was being tended to by Nurse #J on the right posterior leg. The comprehensive assessment dated 1/14/22, performed and completed by Nurse #L failed to evidence documentation of the presence of the left heel wound and failed to evidence documentation of the presence of a right leg wound.

During a review of the clinical record on 1/31/22, undated and untitled photos of the left heel wound and of the right posterior leg wound were present in the clinical record.

The comprehensive assessment failed to evidence documentation of both wounds, and failed to evidence measurements of both wounds, failed to evidence documentation of verbal communication to the physician of discovery of the two wounds, and failed to evidence verbal orders were requested for wound care for either of the two wounds.

On 1/31/22 at 3:18 PM, in a telephone interview with Nurse #L, RNCM for patient #4, when queried as to whether she was aware that the

"No, [Nurse #J] did not make me aware." when queried as to whether she was aware of wound to the left heel, she indicated she was unsure if she had been made aware of that wound. She accessed her laptop during our call to view the photos as well, and indicated this left heel wound appeared to be "unstageable" in her opinion.

The comprehensive assessment of Patient #4 failed to evidence the patient received a complete and accurate assessment.

14. A review of the clinical record for patient #13, revealed a comprehensive assessment dated 12/2/21, with diagnoses that included, but were not limited to: Stage 4 Sacral Pressure Ulcer (full-thickness skin and tissue loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as ligaments, tendons, muscle and or bone), Stage 4 Pressure Ulcer of left buttock, Stage 4 Pressure Ulcer of right buttock, quadriplegia, a suprapubic catheter (is a type of urinary catheter that is left in place. Rather than being inserted through your urethra, the catheter is inserted through a hole in the abdomen and then directly into the bladder, in order to empty the bladder of urine), colostomy (an operation that redirects the colon from its normal route, down toward the anus, to a new opening in the abdominal wall), dependence on a wheelchair. Skilled Nurse to provide wound care 1 time per week for 1 week, 5 times per week for 8 weeks, 1 time per week for 1 week.

A review of the comprehensive assessment dated 12/2/21, revealed under a section titled 'Musculoskeletal'

"Patient is quadriplegic and requires assistance for all activities". Under the section titled 'Order for Discipline and

Treatment', "HHA: offered and declined". The Comprehensive Assessment failed to evidence how assistance was being provided and how the patient's needs were being met.

On 2/1/22 at 9:00 AM, during a home visit, an aide was present in the home. The aide was not an employee of Home Health Care Solutions, LLC. The Clinical Manager was present for the visit as well and asked Patient #13 about the aide's services. The patient answered there had been some discontentment with the previous attendant care agency and now has had a new company providing aides, "since December." The agency was unaware of this and when later queried, the Clinical Manager responded there was a note in the clinical record regarding attendant care. "from June." Upon further review, the note was dated June 16th of 2020, and failed to evidence documentation of collaboration between the two agencies. Patient #13's family also provided considerable assistance. The comprehensive assessment failed to evidence documentation of all available and participating caregivers.

In a telephone interview on 2/1/22 at 2:35 PM, Nurse #P with Dr. #Q of wound care center #R, informed there have been no new orders for wound care given by their center, nor record of the agency requesting new wound care orders since August 20, 2021. States Patient #13 was last seen by their office on 1/11/22 and there were plans for surgery to address the wounds but informed that currently, all surgeries are on hold, not related to COVID, but rather to lack of staffing. The comprehensive assessment failed to evidence documentation of this most recent physician visit and future plans for addressing the patient's wounds.

In a telephone interview on 2/7/22 at 2:42 PM, the agency's wound care resource nurse, Nurse #M, stated part of her duties can involve reaching out to wound care centers to suggest changes to wound care if needed. When queried as to the lack of documentation of clinicians contacting the physician for change in wound care orders when a wound is not showing progress, Nurse #M states she has called the wound care center herself regarding Patient #13 and tried to get treatment changed, states wound care center was not open to change. When asked where these communications or attempts would be documented, as there are none currently, Nurse #M answered that she knows the nurses talk with the wound care center but, "can't remember if they wrote a note." When queried as to whether KCI (a wound vacuum company) had been asked to consult on patient #13's case, Nurse #M stated, "I don't know". Additionally, she informs she has just accepted a position at a hospital and will not be seeing the agency's patients or 'co-treating' anymore. The comprehensive assessment failed to evidence documentation of wound baseline, wound progress, attempts to reach out to physician for additional wound care orders, and upcoming plans and/or proposed interventions for the wound.

The comprehensive assessment of Patient #13 failed to evidence the patient received a complete and accurate assessment.

15. In an interview on 2/1/22 at 4:55 PM, Clinical Manager agreed that nursing documentation should provide enough patient information a following nurse should be able to 'pick up' where previous 'nurse 'left off' (in regards to knowing patient status and following treatment plan).

16. In an interview on 2/7/22 at 4:02 PM, the administrator and nursing supervisor were notified of the concerns in relation to failure of comprehensive assessments to reflect a complete and accurate health status of patients. An opportunity was provided to the agency to ask any questions or submit any additional information for consideration. Nothing further was presented for review.

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

	410 IAC 17-14-1(a)(1)(B)			
G0530	Strengths, goals, and care preferences 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview, the agency failed to ensure comprehensive assessments contained patient stated goals and care preferences in 14 (Patients 3, 5, 6, 7, 8, 11, 15, 16, 1, 2, 4, 10, 12, 13) of 14 active records reviewed in a sample of 19. 1. A review of an agency undated policy titled, "Patient Bill of Rights and Responsibilities" Policy Number: C306, revealed, "POLICY In support of the home care services philosophy of care...PROCEDURE ...4. The patient is informed at admission of: A. Information about the Agency and services provided...H. The right to a comprehensive assessment completed within 5 days of the start of care to include: The patient's current health, psychosocial...The patient's strengths, goals, and care preferences, including information that may be used to demonstrate..." Review of an undated agency's policy titled, "Initial Assessment Policy Number: C310", revealed, "POLICY An initial patient assessment which accurately reflects the patient's current health status will be performed and documented in the patient's clinical record by an RN. The current versions of OASIS (Outcome and Assessment Information Set is a comprehensive assessment to collect information on nearly 100 items related to a home care recipient's information and service needs) data items are incorporated into the initial comprehensive assessment. PROCEDURE 1. During the initial comprehensive patient assessment...including at least: A. A physical assessment...B. Patient's functional status...C. The patient's current medical and psychosocial status...D. Verification of the patient's primary physician E. Name of the hospital, community resources, or individual involved in the past and present care of the patient F. An evaluation of the home environment...G. Presence of any advance directives...H. Equipment and medical	G0530	**G 0530**- Agency reviewed all findings regarding, not meeting the element of including patient's strength, goal, and care preference, including information that may be used to demonstrate the patient's progress towards achievement of goals identified by the patient and the measurable outcomes identified by the HHA. Findings addressed and clued patient stated goals and patient preference were not documented appropriately. This information was also shared with the Agency during the exit meeting by the Surveyors on 2/9/22. Since then, Agency has educated all nursing and therapy staff and provided them with written information regarding patient specific goals and outcomes of each care provided by HHA. Appropriate documentation of patient stated goals and outcomes and patient care preference of services, time of visits or other care related preference to be appropriately documented and taken in account when creating patient specific plan of care. Staff was also provided Agency's policies "Initial Assessment Policy Number: C310 and "Patient Bill of Rights and Responsibilities Number: C306 again for review. Each assessment and plan of care will be reviewed by the QA team, Rehab Director under the	2022-03-10

	support systems. Identification of the presence of family and/or caregiver... O. Specific, individualized patient care needs/problems...3. A plan of care is developed from the information gathered during the initial assessment to determine: A. Patient problems and their medical, nursing, rehabilitative, social and discharge planning needs B. Patient goals and desired outcomes... " 2. A review of the clinical record of patient #3, revealed a start of care date of 12/27/21, that contained a plan of care for the certification period of 12/27/21to 2/24/22, which evidenced diagnoses diagnoses Secondary malignant neoplasm of bone, Malignant neoplasm of unspecified site of left female breast, Neoplasm related pain (acute) (chronic), Essential (primary) hypertension (when you have abnormally high blood pressure that's not the result of a medical condition. This form of high blood pressure is often due to obesity, family history and an unhealthy diet), Depression (feelings of severe despondency and dejection), unspecified, Anxiety (a nervous disorder characterized by a state of excessive uneasiness and apprehension, typically with compulsive behavior or panic attacks) disorder, unspecified. The start of care comprehensive assessment dated 12/27/21, failed to evidence patient stated goals and care preferences. 3. A review of the clinical record of patient #5, revealed a start of care date 9/8/19, that contained a plan of care for the certification period of 12/26/21 to 2/23/22, which evidenced diagnoses Encounter for fitting and adjustment of urinary device, encounter for attention to cystostomy (formation of an opening into the urinary bladder by surgical incision), mixed incontinence, Multiple Sclerosis (a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue), Chronic Kidney Disease Stage 3 (means you have an eGFR [estimated glomerular filtration rate] between 30 and 59. An eGFR between 30 and 59 means that there is some damage to your kidneys and they are not working as well as they should), Generalized anxiety (a nervous disorder characterized by a state of excessive uneasiness and apprehension) disorder, Dependence on		supervision of the Director of Nursing for the next 6 months to ensure 100% compliance. Every plan of care will have patient stated goals and patient preferences appropriately documented. Monthly review of the findings will be shared with the Administrator for the next six months for Administrator oversight. At the end of the 6 months, DON will be responsible of providing the findings and data collected. The goal is to achieve 100% compliance to correct this deficiency by the agency. Further appropriate action will be taken if any staff is not following the guidelines. After 6 months of review if the goal is not achieved the process will continue for another 3 months to achieve 100% compliance.	

wheelchair, and Personal history of urinary (tract) infections.

The re-certification comprehensive reassessment dated 12/26/21, failed to evidence patient stated goals and care preferences.

4. A review of the clinical record of patient #6, revealed a start of care date 12/17/21, that contained a plan of care for the certification period of 12/17/21 to 2/14/21 which evidenced diagnoses Diabetes Mellitus (A group of diseases that result in too much sugar in the blood, high blood glucose), Unilateral primary osteoarthritis (It occurs when the protective cartilage that cushions the ends of the bones wears down over time), left knee, Non-pressure chronic ulcer right foot (a damaged area on the foot that either does not heal or keeps returning), essential hypertension, atherosclerosis heart disease (when thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of the arteries close to your heart), Hyperlipidemia (your blood has too many lipids or fats, such as cholesterol and triglycerides) , unspecified, obesity, unspecified, and Body mass index (a weight-to-height ratio, calculated by dividing one's weight in kilograms by the square of one's height in meters and used as an indicator of obesity and underweight) [BMI] 37.0-37.9.

The start of care comprehensive assessment dated 12/17/21, failed to evidence patient stated goals and care preferences.

5. A review of the clinical record of patient #7, revealed a start of care date 11/9/21, that contained a plan of care for the certification period of 1/8/22 to 3/8/22, which evidenced diagnoses Pressure ulcer (injuries to skin and underlying tissue resulting from prolonged pressure on the skin) of right heel stage 4, Type 2 diabetes mellitus, acute osteomyelitis (the clinical term for a new infection in bone), right ankle and foot, Type 2 Diabetes Mellitus (an impairment in the way the body regulates and uses sugar (glucose) as a fuel) with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes) , Type 2 Diabetes with diabetic peripheral angiopathy (a blood vessel disease caused by high blood sugar levels without gangrene (a dangerous and potentially fatal condition that happens when the blood flow to a large area of tissue is cut off),

	Chronic Kidney Disease stage 5 (the kidneys are getting very close to failure or have completely failed), Dependence on renal dialysis (Dialysis does the work of your kidneys, removing waste products and excess fluid from the blood), Obstructive sleep apnea (occurs when the muscles that support the soft tissues in your throat, such as your tongue and soft palate, temporarily relax. When these muscles relax, your airway is narrowed or closed, and breathing is momentarily cut off), Obesity, Body mass index [BMI] 30.0-30.9, Long term use of insulin, and Long term use of aspirin. The start of care comprehensive assessment dated 11/9/21, failed to evidence patient stated goals and care preferences. 6. A review of the clinical record of patient # 8, revealed a start of care date 8/31/21,that contained a plan of care for the certification period of 1/5/22 to 3/5/22 which evidenced diagnoses Encounter for fitting and adjustment of urinary device, other hydronephrosis (swelling of one or both kidney) , Multiple sclerosis (a potentially disabling disease of the brain and spinal cord [central nervous system]), Neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), functional quadriplegia (paralysis of all four limbs), Trigeminal neuralgia (a condition characterized by pain coming from the trigeminal nerve, which starts near the top of the ear and splits in three, toward the eye, cheek and jaw), Generalized anxiety disorder (a nervous disorder characterized by a state of excessive uneasiness and apprehension), Hyperlipidemia (your blood has too many lipids [fats], such as cholesterol and triglycerides) , Major depressive disorder (a mood *disorder* that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning) , Gastro-esophageal reflux disease (occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach [esophagus]) without esophagitis, presence of neurostimulator (devices are implantable, programmable medical devices that deliver electrical stimulation to specific parts of the patient's brain, spinal cord or peripheral nervous system to help treat various conditions, including chronic pain, movement disorders, epilepsy and Parkinson's disease), dependence on supplemental oxygen, dependence on wheelchair, personal history of malignant neoplasm of cervix (cancer that occurs in the cells of the cervix), Colostomy (an opening in the			

large intestine, or the surgical procedure that creates one. The opening is formed by drawing the healthy end of the colon through an incision in the anterior abdominal wall and suturing it into place), personal history of nicotine, and a personal history of urinary tract infections.

The re-certification comprehensive reassessment dated 12/31/21, failed to evidence patient stated goals and care preferences.

7. A review of the clinical record of patient #11, revealed a start of care date 9/2/21, that contained a plan of care for the certification period of 12/31/21 to 2/28/22, which evidenced diagnoses Type 2 Diabetes Mellitus (an impairment in the way the body regulates and uses sugar[(glucose] as a fuel) with foot ulcer (an open sore or wound that occurs in approximately 15 percent of patients with diabetes, and is commonly located on the bottom of the foot), Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed, Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed, Type 2 diabetes with diabetic peripheral angiopathy (a blood vessel disease caused by high blood sugar levels) without gangrene (a dangerous and potentially fatal condition that happens when the blood flow to a large area of tissue is cut off), Venous insufficiency (chronic)(peripheral) (Improper functioning of the vein valves in the leg, causing swelling and skin changes), Essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition. This form of high blood pressure is often due to obesity, family history and an unhealthy diet), Unspecified atrial fibrillation (the heart's upper chambers (the atria) beat chaotically and irregularly out of sync with the lower chambers (the ventricles) of the heart), Restless legs syndrome (A condition characterized by a nearly irresistible urge to move the legs, typically in the evenings), Gout (a common and complex form of arthritis, that's characterized by sudden, severe attacks of pain, swelling, redness and tenderness in one or more joints, most often in the big toe), Long term use of oral hypoglycemic drugs, Long term use of aspirin, and Long term use of anticoagulants.

The re-certification comprehensive reassessment dated 12/30/21, failed to evidence patient stated goals and care preferences.

8. A review of the clinical record of patient #15, revealed a start of care date 11/1/21, that contained a plan of care for the certification period of 12/31/21 to 2/28/22, which evidenced diagnoses Pressure Ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) of sacral (lying near the sacrum the sacral region of the spinal cord) region, stage 4; Pressure ulcer of right heel, stage 3; Pressure ulcer of left heel, unstageable; Open wound, right lower leg; Hypertensive chronic kidney disease, stage 4 (your kidneys are moderately or severely damaged, the last stage before kidney failure) ; Myelodysplastic (a group of disorders caused by blood cells that are poorly formed or don't work properly) syndrome, and Personal history of malignant melanoma of skin (skin cancer).

The re-certification comprehensive reassessment dated 12/30/21, failed to evidence patient stated goals and care preferences.

9. A review of the clinical record of patient #16, revealed a start of care date 10/8/21, that contained a plan of care for the certification period of 12/7/21 to 2/7/22, which evidenced diagnoses Facture of 7th cervical vertebrae, Spondylosis with radiculopathy (causes pressure on the surrounding nerves there may be numbness, tingling or pain radiating into the chest, ribs, or abdominal areas), cervical region; Chronic pain syndrome, Rheumatoid arthritis (a form of arthritis that causes pain, swelling, stiffness and loss of function in your joints), and Restless legs syndrome (A condition characterized by a nearly irresistible urge to move the legs, typically in the evenings).

The re-certification comprehensive assessment dated 2/4/22, failed to evidence patient stated goals and care preferences.

10. A review of the clinical record for Patient #1, revealed a start of care date of 10/9/21, that contained a plan of care for the certification period of 12/8/21 - 2/5/22 with diagnoses that included, but were not limited to: Stage 4 Sacral

	loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as ligaments, tendons, muscle and or bone) Atrioventricular heart block, second degree (when the electrical signals that tell your heart to contract don't always pass between the top and bottom chambers of your heart like they should. This causes an abnormal heart beat (arrhythmia)). Hypertension (high blood pressure), Heart Failure (when the heart muscle doesn't pump blood as well as it should). The recertification comprehensive assessment dated 12/6/21, failed to evidence patient stated goals and care preferences. 11. A review of the clinical record for Patient #2, revealed a start of care date of 3/14/21, that contained a plan of care for the certification period of 1/8/22 - 3/8/22 with diagnoses which included, but were not limited to: Chronic venous status ulcers of right and left lower extremities (also known as nonhealing wounds, are open wounds occurring around the ankle or lower leg. They do not heal for weeks or months, and occasionally persist longer), venous insufficiency (when your veins have trouble sending blood from your limbs back to the heart. In this condition, blood doesn't flow back properly to the heart, causing blood to pool in the veins of one's legs), lymphedema (build-up of fluid in soft body tissues when the lymph system is damaged or blocked. The lymph system is a network of lymph vessels, tissues, and organs that carry lymph throughout the body. Lymphedema occurs when lymph is not able to flow through the body the way that it should), hypertension (high blood pressure), History of Covid infection (a highly contagious respiratory disease caused by the SARS-CoV-2 virus). The recertification comprehensive assessment dated 1/4/22, failed to evidence patient stated goals and care preferences. 12. A review of the clinical record for Patient #4, revealed a start of care date of 11/16/21, that contained a plan of care for the certification period of 1/15/22 - 3/15/22 with diagnoses which included, but were not limited to: Stage 4 right buttock pressure ulcer (full thickness skin and tissue loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as			

	ligaments, tendons, muscle and or bone), Multiple Sclerosis (a disease that can affect your brain and spinal cord, and can cause problems with vision, balance, muscle control), suprapubic catheter (a type of urinary catheter that is left in place. Rather than being inserted through your urethra, the catheter is inserted through a hole in the abdomen and then directly into the bladder, in order to empty the bladder of urine), colostomy (an operation that redirects the colon from its normal route, down toward the anus, to a new opening in the abdominal wall), contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right and left legs, dependence on wheelchair. The recertification comprehensive assessment dated 1/4/22, failed to evidence patient stated goals and care preferences. 13. A review of the clinical record for Patient #10, revealed a start of care date of 4/24/21, that contained a plan of care for the certification period of 12/19/21 - 2/17/22 with diagnoses which included, but were not limited to: Hemiplegia (paralysis of one side of the body) affecting left don-dominant side, suprapubic catheter (a type of urinary catheter that is left in place. Rather than being inserted through your urethra, the catheter is inserted through a hole in the abdomen and then directly into the bladder, in order to empty the bladder of urine). The recertification comprehensive assessment dated 12/16/22, failed to evidence patient stated goals and care preferences. 14. A review of the clinical record for Patient #12, revealed a start of care date of 1/6/22, that contained a plan of care for the certification period of 1/6/22 - 3/6/22 with diagnoses which included, but were not limited to: right total knee arthroplasty (a surgical procedure performed to relieve pain and restore function in severely diseased knee joints), asthma (a condition in which your airways narrow and swell and may produce extra mucus. This can make breathing difficult and trigger coughing, a whistling sound (wheezing) when you breathe out and shortness			

pressure).

The start of care comprehensive assessment dated 1/6/22, failed to evidence patient stated goals and care preferences.

15. A review of the clinical record for Patient #13, revealed a start of care date of 6/11/20, that contained a plan of care for the certification period of 12/3/21 - 1/31/22 with diagnoses that included, but were not limited to: Stage 4 Sacral Pressure Ulcer (full thickness skin and tissue loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as ligaments, tendons, muscle and or bone), Stage 4 Pressure Ulcer of left buttock, Stage 4 Pressure Ulcer of right buttock, quadriplegia, suprapubic catheter (is a type of urinary catheter that is left in place. Rather than being inserted through your urethra, the catheter is inserted through a hole in the abdomen and then directly into the bladder, in order to empty the bladder of urine), colostomy (an operation that redirects the colon from its normal route, down toward the anus, to a new opening in the abdominal wall), dependence on wheelchair.

The recertification comprehensive assessment dated 12/2/22, failed to evidence patient stated goals and care preferences.

16. In an interview on 2/7/22 at 4:02 PM, the administrator and nursing supervisor were notified of the concerns in relation to failure of comprehensive assessments to reflect patient stated goals and care preferences. An opportunity was provided to the agency to ask any questions or submit any additional information for consideration. Nothing further was presented for review.

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 the plan of care was created in conjunction with the primary care physician after an assessment, verbal start of care and recertification orders obtained from the physician for 12 (Patients 1, 2, 3, 4, 5, 6, 7, 8, 11, 13, 15, and 16) of 14 active records reviewed in a sample of 19. 1. A review of an undated agency s policy titled, Physician Communication Policy Number: C327", revealed, POLCIY The patient's clinical team from Home Health Care Solutions, LLC will establish and maintain communication with the physician throughout the certification period to ensure proper physician oversight of the Plan of Care and patient specific services. PROCEDURE 1. Agency personnel will contact the patient's physician: A. After the initial visit to verify any order, medications, and Plan of Care B. When there are changes in the patient's condition...D. When changes occur in the patient's expected response...2. All conferences or attempts to communicate with physician will be documented in the clinical record via a communication note or in the comment section of a clinical note. A. Documentation of the physician notification will include: 1. Date and time contacted...B. Documentation of attempted physician notification will include: 1. Date and time 2. Patient name 3. Name of physician attempting to notify 4. Reason for notification 5. Name of person taking message . A review of an undated agency's policy titled, "Recertification Policy Number: C329", revealed, "POLICY...Verbal orders for continuation of services beyond the original episode will meet measurable criteria...and will be approved by a clinical supervisor or the clinical manager. Verbal orders for recertification will be obtained from the patient's primary physician...PROCEDURE 1. All verbal orders for recertification will be initiated prior to the end of the current episode. 2. A verbal order will not be generated until there is a review of the patient's status and the criteria to qualify for recertification is met...3. The primary clinician will confer with physician...4. A physician	G0580	**G 0580-** Agency reviewed all findings in this element that was not met. Drugs, services, and treatments are administrated only as the ordered by a physician or allowed practitioner. Surveyor informed the agency that each clinical staff after their initial assessment are not obtaining verbal orders or returned physician authenticated plan of care. All clinicians were educated and provided specific information and documentation guidelines. After each initial assessment clinician will call the physician office to inform about their specific plan of care, visit frequency and duration to obtain verbal order before rendering care with future visits. Verbal orders should be documented after reaching out to the physician and should contain the name of the person contacted at physician's office with date and time. In case staff is unable to speak to a live person, they are to leave a detailed message on physician's secure voice mail, containing information regarding patient specific plan of care, visit frequency and duration. Clinicians will also leave their name and call back numbers. No care will be provided until call back is received and verbal order obtained and documented and sent to the physician for counter-signature. All clinical staff was educated and received written guidelines to obtain	2022-03-10

	Change order will be sent to physician reflecting his/her orders for recertification. 5. Any visits done by any discipline within an unapproved certification period will not be paid to the individual staff member making the visit..." A review of an undated agency's policy titled, "Physician Orders Policy Number: C315", revealed, "POLICY Physician orders will be obtained when indicated by patient need or a change in the patient's medical condition. All skilled services are provided under the direction of a physician. PROCEDURE...2. Physician telephone orders are documented on a physician verbal order...3. For tracking, a copy of the unsigned physician's verbal order is kept in the clinical record until..." 2. A review of the clinical record of patient #3, revealed a start of care date of 12/27/21, which contained a plan of care for the certification period of 12/27/21to 2/24/22, with orders for SN (skilled nursing): 2 times a week for 2 weeks, 1 time a week for 6 weeks, HHA (home health aide) 2 times a week for 3 weeks effective 1/4/22, PT (physical therapy), effective 12/29/21: 1 time a week for 1 week, 2 times a week for 4 weeks, 1 time a week for 3 weeks, and OT (occupational therapy), effective 12/29/21: 1 time a week for 1 week, 2 times a week for 2 weeks, 1 time a week for 3 weeks. A review of visit notes evidenced the HHA made care visits on 1/4/22, 1/7/22, and 1/10/22. Visit notes of PT evidenced visits on 1/5/22, 1/6/22, and 1/10/22. Visit notes of OT evidenced visits on 1/4/22, 1/7/22, and 1/10/22. A review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above care visits. 3. A review of the clinical record of patient #5, revealed a start of care date of 9/8/19, which contained a plan of care for the certification period of 12/26/21 to 2/23/22, with orders for SN 1 time a week. Review of visit notes evidenced a SN visit on 1/4/22. A review of the clinical record failed to evidence a verbal order, or a returned physician		verbal orders before each recertification, change in plan of care and after each assessment. All clinical staff was provided Agency policy titled ‘Physician orders” Policy number: C315 and “Recertification Policy” policy number C329 for review. Agency has created a Performance Improvement Process (PIP) to address this deficiency. The QA team, under the supervision of Director of Nursing (DON), will conduct 100% review of all Verbal Orders to ensure compliance achieved. Each month’s findings will be reviewed by the DON and Administrator for the oversight of this process. After 6 months, DON will share the findings with the Administrator to review the success of the PIP and 100% compliance of the guidelines. Appropriate action will be taken for any staff who is not following the guidelines. Goal is 100% compliance by the end of 6-month period starting 3/10/22. DON and Administrator will evaluate the results of the PIP and if 100% compliance is not achieved then PIP will continue for another 3 months to get to 100% compliance.	

authenticated plan of care, had been obtained prior to furnishing the above care visit.

4. A review of the clinical record of patient #6, revealed a start of care date of 12/17/21, which contained a plan of care for the certification period of 12/17/21 to 2/14/21, with orders for SN 1 wk 1 for SOC (start of care) only, PT 1 wk 1, 2 wk 3, 1 wk 3 effective 12/20/21. Review of visit notes evidenced SN visit note on 12/17/21 for SOC, PT visit notes on 12/20/21, 12/27/21, 12/29/21, 1/3/22, 1/5/22, 1/10/22, 1/13/22, 1/17/22, 1/21/22,1/24,22, and 1/27/22.

A review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above care visits.

5. A review of the clinical record of patient #8, revealed a start of care date of 8/31/21, which contained a plan of care for the certification period of 1/5/22 to 3/5/22, with orders for SN 1 wk 1, 2 wk 8, effective 1/2/22. Review of SN visit notes evidenced visits on 1/4/22, 1/7/22, and 1/11/22.

A review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above care visits.

6. A review of the clinical record of patient #7, revealed a start of care date of 11/9/21, which contained a plan of care for the certification period of 1/8/22 to 3/8/22, with orders for SN 1 wk 1, 3 wk 8, 1 wk 1. Review of SN visit notes evidenced visits on

1/8/22, 1/11/22, 1/15/22, 1/18/22, 1/20/22, 1/22/22, 1/25/22, 1/27/22, and PRN (as needed visit) 1/27/22.

A review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above care visits.

7. A review of the clinical record of patient #11, revealed a start of care date of 9/2/21, which

	contained a plan of care for the certification period of 12/31/21 to 2/28/22, with orders for SN 1 wk 1, 3 wk 8. Review of SN visit notes evidenced visits on 1/1/22, 1/6/22, and 1/9/22. A review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above care visits. 8. A review of the clinical record of patient #15, revealed a start of care date of 11/1/21, which contained a plan of care for the certification period of 12/31/21 to 2/28/22, with orders for SN 3 wk 8. Review of SN visit notes evidenced visits on 1/4/22, 1/8/22, 1/11/22, 1/15/22, 1/18/22, 1/22/22, 1/25/22, 1/27/22, and 1/29/22. A review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above care visits. 9. A review of the clinical record of patient #16, revealed a start of care date of 10/8/21, which contained a plan of care for the certification period of 12/7/21 to 2/7/22, with orders for PT 2 wk 4. Review of PT visit notes evidenced visits on 12/10/21, 12/14/21, 12/16/21, 1/6/22, 1/11/22, 1/14/22, 1/19/22, 1/21/22, 1/24/22, 1/28/22, and 2/2/22. A review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above care visits. 10. During a telephone interview on 2/2/22 at 2:17 PM with nurse F from entity E, stating they never get phone calls for physician orders from the agency regarding patient #16, stating the agency faxes orders to office E. 11. During a telephone interview on 2/2/22 at 3:20 PM with nurse D from entity C, stating they never get phone calls for physician orders from the agency regarding patient #11 and #15, they always fax orders.			

12. During a telephone interview on 2/2/22 at 2:17 PM with nurse H from entity G, stating the agency always fax orders, they never call us.

13. During a telephone interview on 2/3/22 at 2 PM, with employee O, RN stated once the assessment is completed, the plan of care is done, medication reconciliation is completed, will call the MD office but they don't usually return the call until 48 to 72 hours after, but we'll go ahead a provide services while waiting on the call ba

14. A review of the clinical record of patient #1, revealed a start of care date of 10/9/21, which contained a plan of care for the certification period of 12/8/21to 2/5/22, with orders for SN (skilled nursing) for wound care: 2 times a week for 1 week, 3 times a week for 8 weeks.

A review of visit notes evidenced the Skilled Nurse made care visits on 12/8/21, 12/10/21, 12/13/21, 12/15/21, 12/17/21, 12/20/21, 12/22/21, 12/24/22, 12/27/21 and 12/29/21.

A review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above (10) care visits.

15. A review of the clinical record of patient #2, revealed a start of care date of 3/14/21,

	for the certification period of 1/8/22 to 3/8/22, with orders for SN (skilled nursing) for wound care: 2 times a week for 8 weeks, 1 times a week for 1 week. A review of visit notes evidenced the Skilled Nurse made care visits on 1/10/22, 1/14/22, 1/17/22, 1/17/22, 1/21/22, and 1/24/22. A review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above (6) care visits. 16. A review of the clinical record of patient #4, revealed a start of care date of 10/9/21, which contained a plan of care for the certification period of 1/15/21to 3/15/22, with orders for SN (skilled nursing) for wound care: 3 times a week for 9 weeks. A review of visit notes evidenced the Skilled Nurse made care visits on 1/17/21, 1/19/22, 1/21/22, 1/24/22, 1/26/22, 1/28/22, 1/31/22, 2/2/22, and 2/5/22. A review of the clinical record			

	failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above (9) care visits. 17. A review of the clinical record of Patient #13, revealed a start of care date of 6/11/20, which contained a plan of care for the certification period of 12/3/21to 1/31/22, with orders for SN (skilled nursing) for wound care: 1 time a week for 1 week, 5 times a week for 8 weeks, 1 time a week for 1 week. A review of visit notes evidenced the Skilled Nurse made care visits on 12/4/21, 12/5/21, 12/7/21,12/8/21, 12/9/21, 12/11/22, 12/12/21, 12/15/21, 12/16/21, 12/18/21, 12/19/21, 12/21/21, 12/22/21, 12/23/21, 12/26/21, 12/28/21, 12/29/21, 12/30/21, 1/1/22, 1/2/22, 1/4/22, 1/5/22, 1/6/22, 1/8/22, 1/9/22, 1/11/22, 1/12/22, 1/13/22, 1/15/22, 1/16/22, and 1/18/22. A review of the clinical record failed to evidence a verbal order, or a returned physician authenticated plan of care, had been obtained prior to furnishing the above (21) care visits. 18. In an interview on 2/1/22 at			

	was queried as to the location of verbal orders in the clinical chart, which could not be located. The Clinical Manager indicated verbal orders should be located, "under Orders" or within the clinician's documentation. Further review of the clinical records failed to evidence documentation verbal orders had been obtained prior to furnishing services. 410 IAC 17-13-1(a)			
G0588	Reviewed, revised by physician every 60 days 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 plan of care was reviewed and revised by the physician who was responsible for the plan of care every 60 days, or as the patient's condition warrants for 10 (Patients 1, 2, 4, 10, 13, 5, 8, 11, 15, and 16) of 14 active records reviewed in a sample of 19. 7. A review of the clinical record of patient #5, revealed a recertification reassessment, dated 12/26/21 for the certification period of 12/26/21 to 2/23/21 with a start of care date 9/8/19; that evidenced diagnoses Encounter for fitting and adjustment of urinary device, encounter for attention to cystostomy (formation of an opening into the urinary bladder by surgical incision), mixed incontinence, Multiple Sclerosis (a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue), Chronic Kidney Disease Stage 3 (means you have an eGFR [estimated glomerular filtration rate] between 30 and 59. An eGFR between 30 and 59 means that there is some damage to your kidneys and they are not working as well as they should), Generalized anxiety (a nervous disorder characterized by a	G0588	**G 0588**- Agency reviewed all findings in this element that was not met. The plan was reviewed and revised by physician every 60 days. Agency educated all clinical staff regarding this deficiency and were provided Agency “Recertification Policy” Policy number C329. Staff was educated to call physician and obtain verbal order prior to each recertification and after recertification assessment with next cert period plan of care, frequency, duration, along with sharing completed 60-day summary which depicts all elements of care and goals status in the previous cert period. Staff demonstrated the understanding of this deficiency and the process to eliminate it. Agency has included this deficiency in the PIP created for G0580 and will monitor all documents to make sure the verbal orders were obtained prior	2022-03-10

	state of excessive uneasiness and apprehension) disorder, Dependence on wheelchair, and Personal history of urinary (tract) infections. The patient was to receive SN (skilled nursing) visits 1 time a week every 3 weeks to change suprapubic tube. The clinical record failed to evidence verbal orders for recertification prior to the end of the 12/25/21 episode, and failed to evidence the Primary Clinician conferred with the physician following the assessment to determine approval for recertification. 8. A review of the clinical record of patient #8, revealed a recertification reassessment dated 12/31/21 for the certification period of 1/5/22 to 3/5/22, with a start of care date 8/31/21,which evidenced diagnoses Encounter for fitting and adjustment of urinary device, other hydronephrosis (swelling of one or both kidney) , Multiple sclerosis (a potentially disabling disease of the brain and spinal cord [central nervous system]), Neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), functional quadriplegia (paralysis of all four limbs), Trigeminal neuralgia (a condition characterized by pain coming from the trigeminal nerve, which starts near the top of the ear and splits in three, toward the eye, cheek and jaw), Generalized anxiety disorder (a nervous disorder characterized by a state of excessive uneasiness and apprehension), Hyperlipidemia (your blood has too many lipids [fats], such as cholesterol and triglycerides) , Major depressive disorder (a mood *disorder* that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning) , Gastro-esophageal reflux disease (occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach [esophagus]) without esophagitis, presence of neurostimulator (devices are implantable, programmable medical devices that deliver electrical stimulation to specific parts of the patient's brain, spinal cord or peripheral nervous system to help treat various conditions, including chronic pain, movement disorders, epilepsy and Parkinson's disease), dependence on supplemental oxygen, dependence on wheelchair, personal history of malignant neoplasm of cervix (cancer that occurs in the cells of the cervix), Colostomy (an opening in the large intestine, or the surgical procedure that creates one. The opening is formed by drawing the healthy end of the colon through an incision in the anterior abdominal wall and suturing it into place), personal history of nicotine, and a		to each recertification. Each 60-day summary will have detailed information of care rendered, goal status and need of recertification. QA team will review 100% of all recertifications and 60-day summaries for the next 6 months under the supervision of the Director of Nursing. Monthly data and information will be shared with the Administrator to oversee the success of the PIP and provide appropriate education and changes to achieve 100% compliance by the end of 6 months. DON will be responsible to obtain all the data from QA and share with the Administrator within 6 months. Appropriate action will be taken for any individual staff who is lacking. Goal is to have 100% compliance by the end of 6-month period starting from 3/10/22. DON and Administrator will review the results and if 100% compliance is not achieved then process will continue for another 3 months to get the goal of 100% compliance.	

personal history of urinary tract infections. The patient was to receive SN visits 1 time a week, week 1; 2 times a week for 8 weeks to change foley catheter and colostomy care as needed.

The clinical record failed to evidence verbal orders for recertification prior to the end of the 1/4/21 episode, and failed to evidence the Primary Clinician conferred with the physician following the assessment to determine approval for recertification.

9. A review of the clinical record of patient #11, revealed a recertification reassessment dated 12/30/21 for the certification period 12/31/21 to 2/28/22, with a start of care date 9/2/21, which evidenced diagnoses Type 2 Diabetes Mellitus (an impairment in the way the body regulates and uses sugar[(glucose] as a fuel) with foot ulcer (an open sore or wound that occurs in approximately 15 percent of patients with diabetes, and is commonly located on the bottom of the foot), Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed, Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed, Type 2 diabetes with diabetic peripheral angiopathy (a blood vessel disease caused by high blood sugar levels) without gangrene (a dangerous and potentially fatal condition that happens when the blood flow to a large area of tissue is cut off), Venous insufficiency (chronic)(peripheral) (Improper functioning of the vein valves in the leg, causing swelling and skin changes), Essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition. This form of high blood pressure is often due to obesity, family history and an unhealthy diet), Unspecified atrial fibrillation (the heart's upper chambers [the atria] beat chaotically and irregularly, out of sync with the lower chambers [the ventricles] of the heart), Restless legs syndrome (A condition characterized by a nearly irresistible urge to move the legs, typically in the evenings), Gout (a common and complex form of arthritis, that's characterized by sudden, severe attacks of pain, swelling, redness and tenderness in one or more joints, most often in the big toe), Long term use of oral hypoglycemic drugs, Long term use of aspirin, and Long term use of anticoagulants. The patient was to receive SN 1 time a week, week 1; 3 times a week for 8 weeks for wound care.

The clinical record failed to evidence verbal

12/20/21 episode, and failed to evidence the Primary Clinician conferred with the physician following the assessment to determine approval for recertification.

10. A review of the clinical record of patient #15, revealed a recertification reassessment dated 12/30/21, for the certification period of 12/31/21 to 2/28/21 with a start of care date 11/1/21; which evidenced diagnoses Pressure Ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) of sacral (lying near the sacrum the sacral region of the spinal cord) region, stage 4; Pressure ulcer of right heel, stage 3; Pressure ulcer of left heel, unstageable; Open wound, right lower leg; Hypertensive chronic kidney disease, stage 4 (your kidneys are moderately or severely damaged, the last stage before kidney failure) ; Myelodysplastic (a group of disorders caused by blood cells that are poorly formed or don't work properly) syndrome, and Personal history of malignant melanoma of skin (skin cancer). The patient was to receive SN 3 times a week for 8 weeks for wound care.

The clinical record failed to evidence verbal orders for recertification prior to the end of the 12/30/21 episode, and failed to evidence the Primary Clinician conferred with the physician following the assessment to determine approval for recertification.

11. A review of the clinical record of patient #16, revealed a recertification reassessment dated 12/2/22, for the certification period 12/7/21 to 2/7/22 with a start of care date 10/8/21; which evidenced diagnoses Facture of 7th cervical vertebrae, Spondylosis with radiculopathy (causes pressure on the surrounding nerves there may be numbness, tingling or pain radiating into the chest, ribs, or abdominal areas), cervical region; Chronic pain syndrome, Rheumatoid arthritis (a form of arthritis that causes pain, swelling, stiffness and loss of function in your joints), and Restless legs syndrome (A condition characterized by a nearly irresistible urge to move the legs, typically in the evenings). The patient was to receive PT (physical therapy) 2 times a week.

The clinical record failed to evidence verbal orders for recertification prior to the end of the 12/6/21 episode, and failed to evidence the Physical Therapist or Primary Clinician

conferred with the physician following the assessment to determine approval for recertification.

12. In an interview on 2/1/22 at 4:42 PM, the Clinical Manager was queried as to the location of verbal orders to continue care in the clinical chart. The Clinical Manager indicated verbal orders should be located, "under Orders" or within the clinician's documentation. Further review failed to evidence physician review of the plan of care and failed to evidence physician authentication of the plan of care.

17-13-1(a)(2)

1. Review of policy titled, "Recertification, Policy Number: C329," revealed a section titled 'Policy' which stated, "The total Plan of Care will be reviewed at least every 60 days. Verbal orders for continuation of services beyond the original episode will meet measurable criteria by Home Health Care Solutions, LLC. and will be approved by a Clinical Supervisor or the Clinical Manager. Verbal orders for recertification will be obtained from patient's primary physician when the above criterion is met." A section titled 'Procedure' stated, "1. All verbal orders for recertification will be initiated prior to the end of the current episode. 2. A verbal order will not be generated until there is a review of the patient's status and and the criteria to qualify for recert is met. ... 3. The Primary Clinician will confer with physician following review to determine approval for recertification. 4. A physician change order will be sent to physician reflecting his/her orders for recertification."

2. A review of the clinical record for Patient #1, revealed a comprehensive recertification assessment dated 12/6/21, for the certification period of 12/8/21 - 2/5/22, with start of care date of 10/9/21 which evidenced diagnoses that included, but were not limited to: Stage 4 Sacral Pressure Ulcer (full thickness skin and tissue loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as ligaments, tendons, muscle and or bone) Atrioventricular heart block, second degree (when the electrical signals that tell your heart to contract don't always pass between the top and bottom chambers of your heart like they should. This causes an abnormal heart beat (arrhythmia)). Hypertension (high blood pressure), Heart Failure (when the heart muscle doesn't pump

blood as well as it should). Skilled nursing visit frequency for wound care was ordered as: 2 times per week for 1 week, then 3 times for 8 weeks.

The clinical record failed to evidence verbal orders for recertification prior to the start of the certification period and failed to evidence the Primary Clinician conferred with the physician following the recertification assessment dated 12/8/21, to determine approval for recertification.

3. A review of the clinical record for Patient #2, revealed a comprehensive recertification assessment dated 1/4/22 that contained a plan of care for the certification period of 1/8/22 - 3/8/22, and a start of care date of 3/14/21, included diagnoses which included, but were not limited to: Chronic venous status ulcers of right and left lower extremities (also known as nonhealing wounds, are open wounds occurring around the ankle or lower leg. They do not heal for weeks or months, and occasionally persist longer), venous insufficiency (when your veins have trouble sending blood from your limbs back to the heart. In this condition, blood doesn't flow back properly to the heart, causing blood to pool in the veins of one's legs), lymphedema (build-up of fluid in soft body tissues when the lymph system is damaged or blocked. The lymph system is a network of lymph vessels, tissues, and organs that carry lymph throughout the body. Lymphedema occurs when lymph is not able to flow through the body the way that it should), hypertension (high blood pressure), History of Covid infection (a highly contagious respiratory disease caused by the SARS-CoV-2 virus). Skilled nurse was providing wound care 2 times per week for 8 weeks, then 1 time per week for one week.

The clinical record failed to evidence verbal orders for recertification prior to the start of the certification period and failed to evidence the Primary Clinician conferred with the physician following the recertification assessment dated 1/4/22 to determine approval for recertification.

4. A review of the clinical record for Patient #4, revealed a comprehensive recertification assessment dated 1/14/22, that contained a plan of care for the 1/15/22 - 3/15/22 certification period, with diagnoses which included, but were

ulcer (full thickness skin and tissue loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as ligaments, tendons, muscle and or bone), Multiple Sclerosis (a disease that can affect your brain and spinal cord, and can cause problems with vision, balance, muscle control), suprapubic catheter (a type of urinary catheter that is left in place. Rather than being inserted through your urethra, the catheter is inserted through a hole in the abdomen and then directly into the bladder, in order to empty the bladder of urine), colostomy (an operation that redirects the colon from its normal route, down toward the anus, to a new opening in the abdominal wall), contractures of right and left legs, dependence on wheelchair. The comprehensive assessment indicated skilled nursing was providing wound care/wound vacuum changes to the sacral pressure ulcer 3 times per week for 8 weeks.

The clinical record failed to evidence verbal orders for recertification prior to the start of the certification period and failed to evidence the Primary Clinician conferred with the physician following the recertification assessment dated 1/14/22 to determine approval for recertification.

5. A review of the clinical record for Patient #10, revealed a recertification comprehensive assessment dated 12/16/21, that contained a plan of care for the certification period of 12/19/21 - 2/17/22 revealed a start of care date of 4/24/21, with diagnoses which included, but were not limited to: Hemiplegia (paralysis of one side of the body) affecting left non-dominant side, suprapubic catheter (a type of urinary catheter that is left in place. Rather than being inserted through your urethra, the catheter is inserted through a hole in the abdomen and then directly into the bladder, in order to empty the bladder of urine).

Frequency for skilled nurse visits, for management of catheter were ordered as, "1 time per week for 1 week, effective week of 12/19; 1/02; 1/16; 1/30; 2/13 x 5 visits."

The clinical record failed to evidence verbal

orders for recertification prior to the start of the certification period and failed to evidence the Primary Clinician conferred with the physician following the recertification assessment dated 12/16/21 to determine approval for recertification.

6. A review of the clinical record for Patient #13, revealed a recertification comprehensive assessment dated 12/2/21, that contained a plan of care for the certification period of 12/3/21 - 1/31/22 and revealed a start of care date of 6/11/20, with diagnoses that included, but were not limited to: Stage 4 Sacral Pressure Ulcer (full thickness skin and tissue loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as ligaments, tendons, muscle and or bone), Stage 4 Pressure Ulcer of left buttock, Stage 4 Pressure Ulcer of right buttock, quadriplegia, suprapubic catheter (is a type of urinary catheter that is left in place. Rather than being inserted through your urethra, the catheter is inserted through a hole in the abdomen and then directly into the bladder, in order to empty the bladder of urine), colostomy (an operation that redirects the colon from its normal route, down toward the anus, to a new opening in the abdominal wall), dependence on wheelchair. Skilled Nurse to provide wound care 1 time per week for 1 week, 5 times per week for 8 weeks, 1 time per week for 1 week.

The clinical record failed to evidence verbal orders for recertification prior to the start of the certification period and failed to evidence the Primary Clinician conferred with the physician following the recertification assessment dated 12/2/21 to determine approval for recertification.

G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review, observation, and interview, the agency failed to ensure the ordering physician was contacted for changes in the patient's condition and/or failed to notify the ordering physician for needs that suggested outcomes were not being met and that the patient's plan of care should be altered in 3 (Patients #1, 4, and 13) of 14 active records review. 1. Review of agency policy titled, "Clinical Records, Policy Number: A220," stated, "...minimum contents of the clinical record include: ...Q. wound assessments with measurement and drainage amount and skin condition around it... R. Statement of any changes in patient's condition. Review of agency policy titled, "Plan of Care, Policy Number: C312" stated, "Updated Plan of Care: The Plan of Care will be an ongoing and active document which may need to time updates based on patient needs, patient changes in condition, the need for additional services or discontinuation of current services. All changes will be made with the physician consent and will be signed by physician." A section titled 'Procedure' stated, "...5. The plan of care must be updated and revised as frequently as the patient's condition warrants due to the following: &B. Onset of new problem or need... 6. The plan of care is revised as frequently as deemed necessary by the Primary Clinician and/or the discipline staff based on on-going assessments of the patient and with the consent of the physician... 7. Clinicians will inform the the patient's physician of any changes which may indicate a need for change in the Plan of Care. Changes ordered by the physician must be written, dated and signed as a verbal order by the skilled discipline or supervisory staff." Review of agency policy titled, "Physician Orders, Policy Number: C315," stated Physician orders will be obtained when indicated by patient need or change in the patients medical condition. All skilled services are under direction of a physician."	G0590	**G 0590**- Agency reviewed all findings in this element, which was not met, that HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Agency educated all clinical staff members that on an ongoing basis, if patient is not improving or any changes causing delay or lack of improvement, then physician must be contacted to discuss current plan of care and seek changes to make improvements in patient health condition including all aspects of patient's health. In case of any degradation of wound, physician must be contacted to obtain verbal orders for any change in plan of care and treatments for the wound care. All attempts should be made to address these issues with the physician. In case physician is not willing to change orders, agency staff will document the attempt to reach out to the physician and share the information with the patient for patient education and further care and patient preference regarding the continuation of care. Agency again shared the policy titled "On-going Assessment" policy number C318 with all clinical staff members. Agency has created a QA team to monitor all wound	2022-03-10

	Review of agency policy titled, "On-going Assessment, Policy Number: C318," stated, "4. The patient's physician will be contacted whenever any of the following occur: & changes in the patient's condition...the patient's response or lack of response to care... 7. Verbal orders are generated and forwarded to physician." Review of agency policy titled, "Monitoring Response to Care, Policy Number: C320," stated, "3. The patient's physician will be contacted whenever any of the following occur: &changes in the patient's condition...changes that have occurred regarding diagnosis, treatments, medications, and limitations." Review of agency policy titled, "Communication in Care, Policy Number: C324" stated, "Timely and ongoing communication is the responsibility of each discipline member assigned to a case ... 4. Documentation of all communications will be included in the clinical record on an electronic message in the electronic medical record, communication note, case conference summary, and/or visit note ... 5. Documentation will include: the date and time of the communication, individuals involved with the communication, including professional title, information discussed, and the outcome of the communication." Review of agency policy titled, "Physician Communication, Policy Number: C327," stated, "The patient's clinical team from Home Health Care Solutions, LLC will establish and maintain communications with the physician throughout the certification period to ensure safe and appropriate care for the patient to ensure proper physician oversight of the Plan of Care and patient specific services... 1. Agency personnel will contact the patient's physician: & B. When there are changes is in the patient's condition...G. When any measurable outcomes are not being achieved... 2. All conferences or attempts to communicate with physician will be documented in the clinical record via a communication note or in the comment section of a clinical note. A. Documentation of the physician notification will include: 1. date and time contacted 2. Patient name 3. Name of physician or clinical staff notified 4. Reason for notification 5. Physician response 6. Action taken and/or orders obtained 7. Professional signature and title. B. Documentation of attempted physician		care patients 100% in the first 3 months starting 3/10/22 and 50% in the next 3 months under the supervision of the DON. Monthly data will be collected and shared with the Administrator for the oversight of the success of the education provided. Verbal orders element will be part of the PIP that has been established as in G0580 to achieve 100% compliance. DON will be responsible to collect the data each month and by the end of 6 months to share with the Administrator. Further appropriate action will be taken if any staff is not following the guidelines. Goal is to achieve 100% compliance. If the compliance is not achieved 100% then PIP will continue for another 3 moths to achieve the goal of 100% compliance.	

notification will include: 1. Date and time 2. Patient name 3. Name of Physician attempting to notify 4. Reason for notification 5. Name of person taking message."

2. A review of the clinical record for Patient #1, revealed a comprehensive assessment dated 12/8/21 with diagnoses that included, but were not limited to: Stage 4 Sacral Pressure Ulcer (full thickness skin and tissue loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as ligaments, tendons, muscle and or bone) Atrioventricular heart block, second degree (when the electrical signals that tell your heart to contract don't always pass between the top and bottom chambers of your heart like they should. This causes an abnormal heart beat (arrhythmia)). Hypertension (high blood pressure), Heart Failure (when the heart muscle doesn't pump blood as well as it should). Skilled nursing visit frequency for wound care was written as: 2 times per week for 1 week, then 3 times for 8 weeks.

A review of the clinical record on 1/28/22 evidenced a section of the OASIS (Outcome and Assessment Information Set, a patient specific, standardized assessment used in Medicare home health care to plan care, determine reimbursement, and measure quality) titled 'Integumentary Status', question, "Is patient using pressure relieving device(s)?" is marked "No". The next section, titled 'Comments', was left blank. Narrative from this same document failed to evidence any further explanation for reason for lack of a pressure-relieving device for a patient with a stage 4 sacral pressure ulcer. Assessment further revealed a wound measurement of: 4 centimeters wide x 2 centimeters long x 2 centimeters in depth. Goal for this Comprehensive Assessment stated, "wound will decrease in size by 50 % by 2/5/22."

In a subsequent comprehensive assessment, a recertification OASIS dated 2/4/22, wound measurement was 5 centimeters wide x 3 centimeters long x 2 centimeters deep. In a section titled integumentary Status, question, "Is patient using pressure relieving device(s)?" is marked "No". The next section, titled 'Comments', was left blank. Narrative of this same document failed to evidence any further explanation of lack of a pressure-relieving

ulcer, in light of the fact the wound measured larger than previous comprehensive assessment dated 12/6/21. Goal for this Comprehensive Assessment stated, "wound will decrease in size by 50% by 2/5/22, (which evidenced the identical date and time frame as the prior Comprehensive Assessment dated 12/6/21). The comprehensive assessment failed to evidence documentation regarding goal not being met and failed to update interventions to reflect this.

The comprehensive assessment failed to evidence documentation of reason for degradation of wound, failed to evidence physician had been verbally notified, and failed to evidence a change in wound care orders had been sought or attempts made to request changes be made to wound care orders.

3. Record review of patient #4 with a start of care of 11/16/22 with recertification period of 1/15/22 - 3/15/22 had diagnosis, including but not limited to Stage 4 Pressure Ulcer of the right buttock (full-thickness skin and tissue loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as ligaments, tendons, muscle and or bone), Multiple Sclerosis (a disease that can affect your brain and spinal cord, and can cause problems with vision, balance, muscle control), suprapubic catheter (a type of urinary catheter that is left in place. Rather than being inserted through your urethra, the catheter is inserted through a hole in the abdomen and then directly into the bladder, in order to empty the bladder of urine), colostomy (an operation that redirects the colon from its normal route, down toward the anus, to a new opening in the abdominal wall), contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of right and left legs, dependence on wheelchair. Patient was to receive home health aide visits, and skilled nursing visits for wound care.

Review of the clinical record on 1/31/22, evidenced undated and untitled photos of a left heel wound and of a right posterior leg wound were present in the clinical record.

The left heel wound was documented once in the in the clinical record on 1/7/22, in a Skilled Nursing visit note, in a section titled 'Coordination Plan' stated, "...Conferenced with: MD, Name: Dr. Knutson, Regarding: Regarding patient having discoloration from and possible breakdown on left heel stated, informed pressure relieving boots implemented to help with relief. No new order received." Document failed to evidence name of contact, job title of contact, and time contact was made with MD office regarding discovery of left heel wound.

Additionally, the clinical record failed to evidence communication with ordering physician regarding the discovery of right posterior lower leg wound, which was first mentioned in skilled nurse visit note dated 12/22/21 which stated, "Pt has new area on the left posterior leg {incorrect laterality}, no break in the skin, pressure noted from pt [sic patient] toe being up against the skin, protective border placed on left leg for protection. Pt laying in bed when SN arrived, reports having a new area of redness on the left posterior leg {incorrect laterality}, pt toenails were digging into the leg during the night, no break in the skin, explained applying padding to the area to protect from breakdown."
Document failed to evidence name of contact, job title of contact, and time contact was made with MD office regarding discovery of right leg wound.

On 1/31/22 at 3:18 PM, in a telephone interview with Nurse #L, RNCM for patient #4, when queried as to whether he/she had been made aware that patient had a wound to the right calf, stated, "No, [Nurse #J] did not make me aware." when queried as to whether Nurse #L was aware of wound to the left heel, she indicated she was unsure if she had been made aware of that wound. Nurse #L accessed their laptop during our call to view the photos as well, and indicated this left heel wound appeared to be "unstageable" in his/her opinion.

In an interview on 2/7/22 at 11:35 AM, Nurse # I with Dr. J's office, stated that they had not received any phone calls from the agency attempting to obtain verbal orders for Patient #4, neither any phone communication to inform physician of new finding of wound to Patient #4's right posterior leg. Nurse # I stated they had no

agency, "nothing in December, nothing in January."

In a subsequent return phone call on 2/8/22 at 3:14 PM, Nurse # I informed that she had no record of any calls placed to their office regarding Patient #4's new left heel wound. Nurse # I reiterated there were no phone calls or voice messages received from the Home Health agency and the first call on record was dated 2/1/22. When queried as to whether it was possible that a voicemail could have been missed, Nurse #I stated that voicemails are checked every hour and every call is documented. Nurse #I further stated he/she was able to see in to the records of Plastic Surgery and Infectious Disease office (who are also seeing Patient #4 for another wound), and can see there are no communications from the agency to either practice of the two new wounds.

The agency failed to ensure documentation evidenced verbal notification was made to physician after discovery of two new wounds (left heel and right posterior leg), and failed to evidence verbal orders were requested for wound care for both wound.

4. A review of clinical record for patient #13, revealed a comprehensive assessment dated 12/2/21, with diagnoses that included, but were not limited to: Stage 4 Sacral Pressure Ulcer (full thickness skin and tissue loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as ligaments, tendons, muscle and or bone), Stage 4 Pressure Ulcer of left buttock, Stage 4 Pressure Ulcer of right buttock, quadriplegia, suprapubic catheter (is a type of urinary catheter that is left in place. Rather than being inserted through your urethra, the catheter is inserted through a hole in the abdomen and then directly into the bladder, in order to empty the bladder of urine), colostomy (an operation that redirects the colon from its normal route, down toward the anus, to a new opening in the abdominal wall), dependence on

wheelchair. Skilled Nurse to provide wound care 1 time per week for 1 week, 5 times per week for 8 weeks, 1 time per week for 1 week.

In a telephone interview on 2/1/22 at 2:35 PM, Nurse #P with Dr. #Q of wound care center #R, indicated that there have been no new orders for wound care given by their center, nor record of this agency requesting new wound care orders since August 20, 2021. Stated Patient #13 was last seen by their office on 1/11/22, and there were plans for surgery to address the wounds, but informed that currently all surgeries are on hold, not related to Covid, but rather due to lack of staffing. The Comprehensive assessment failed to evidence documentation of this most recent physician visit and future plans for addressing the patient's wounds.

In a telephone interview on 2/7/22 at 2:42 PM, agency's wound care resource nurse, Nurse #M, stated part of her duties can involve reaching out to wound care centers to suggest changes to wound care if needed. When queried as the lack of documentation of clinicians contacting physician for change in wound care orders when a wound is not showing progress, Nurse #M states she has called the wound care center herself regarding Patient #13 and tried to get treatment changed, states in the case of Patient #13 the wound care center was not open to change. When asked where these communications or attempts would be documented, as there are none currently in the clinical record, Nurse #M answered that she knows the nurses talk with the wound care center but, "can't remember if they wrote a note." When queried as to whether KCI (a wound vacuum company) had been asked to consult on patient #13's case, Nurse #M stated, "I don't know". Additionally, she indicated she has just accepted a position at a hospital and will not be seeing agency's patients or 'co-treating' anymore.

The comprehensive assessment failed to evidence documentation of wound baseline, wound progress, clinician attempts to reach out to physician for verbal orders for a change in wound care, and upcoming plans and/or proposed interventions for the wound.

5. In an interview 1/31/22 at 4:26 PM, the

	Clinical Manager was queried as to how physician contact was documented when patients' condition had changed. The Clinical Manager indicated a phone call should be made to the physician, then a fax was sent to the physician. When queried as to where these communications would be documented, the Clinical Manager indicated the clinicians documented these communications in a nursing note, kmail (their internal email system), or the communication log in the clinical record. Further review of the above clinical records failed to evidence documentation the attending physicians had been notified of changes that may warrant an update to the plan of care. 410 IAC 17-13-1(a)(2)			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on record review, observation, and interview, the agency failed to ensure accepted standards of practice were followed, including the use of standard precautions, to prevent the transmission of infections and communicable diseases, during 3 (Patient's #2, 12, and 13) of 7 home visits. 1. Review of agency policy titled 'Wand Washing, Policy Number: IC 607', in section titled 'Hand Antisepsis' stated, "...3. Hands must be cared for by handwashing with soap and water or by hand antisepsis with alcohol based hands rubs (if hands not visibly soiled or when hand washing in the patient's home is not feasible):...After contact with a source of microorganisms (body fluids and substances, mucus membranes, non-intact skin, inanimate objects that are likely to be contaminated) &whenever gloves are contaminated, punctured or torn during use... after glove removal or glove changes."	G0682	**G 0682**- Agency reviewed all the findings in this element, which was not met, that the HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infection and communicable diseases. Agency was informed of the Nurse that failed to change the gloves between the two legs when rubbing lotion on each leg after completing the wound care with appropriate changes of gloves during each wound care. Nurse was educated about this finding and provided the guidelines. All nursing staff was provided the information and education in this regard during two meetings and all clinical staff was provided Agency “Infection Control policy” Number IC600 to ensure staff follow the appropriate guidelines for infection control. During home visit with surveyor, physical therapist forgot to place the	2022-03-10

	Review of agency policy titled 'Infection Control, Policy Number: IC 600', stated, " Infection prevention strategies in home care will focus on...wound care..." Review of agency policy titled 'Infection Control, Policy Number: IC 600', in a section titled 'Bag Technique Procedure' stated, "...In the home, identify a clean and safe area for the healthcare bag...Spread an impervious barrier on the surface before setting the bag down." 2. Review of a Centers for Disease Control document, "Standard Precautions," evidenced "IV. A. Hand Hygiene. IV. A. 1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces ... Perform hand hygiene: IV. A. 3. a. Before having direct contact with blood, body fluids or excretions, mucus membranes, non-intact skin, or wound dressings. IV. A. 3. b. After contact with blood, body fluids or excretions, mucus membranes, non-intact skin, or wound dressings... IV. A. 3. d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV. A. 3. e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV. A. 3. f. After removing gloves & IV. B. Personal Protective equipment (PPE) & IV. B. 2. Gloves. IV. B. 2. a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, non-intact skin, or potentially contaminated intact skin & could occur." 3. Review of an OSHA document, "Other Potentially Infectious Materials, 29 CFR 1910.1030(b) Other Potentially Infectious Materials" evidenced Other Potentially Infectious Materials means "(1) ... any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead)." 4. During a home visit on 1/28/22 for Patient #2		barrier pad between his therapy bag and the kitchen table, was also individually educated and trained. Proper bag technique and infection control education was shared with all nursing and therapy staff to adhere to the policy to minimize and prevent the transmission of infection. Agency Rehab Director has provided training for all therapy staff in this regard. Agency has created plan to continue doing random home visits for next 6 months with clinical staff to review infection control guidelines to make sure 100% adherence to the infection control and bag technique policy is accomplished. Each month, home visit findings will be shared with the DON and the Administrator. DON will supervise the process for home visits. Also, infection control will be part of each clinical staff annual evaluation and yearly training. Goal is to achieve 100% compliance at the end of 6-month period and results will be shared by the DON to the Administrator to meet the compliance and element with this policy. Further appropriate action will be taken if any staff is not following the guidelines. If goal of 100% is not achieved in 6 months, then process will continue for another 3 months to achieve 100% compliance.	

	limited to: Chronic venous status ulcers of right and left lower extremities (also known as nonhealing wounds, are open wounds occurring around the ankle or lower leg. They do not heal for weeks or months, and occasionally persist longer), venous insufficiency (when your veins have trouble sending blood from your limbs back to the heart. In this condition, blood doesn't flow back properly to the heart, causing blood to pool in the veins of one's legs), lymphedema (build-up of fluid in soft body tissues when the lymph system is damaged or blocked). Skilled nurse was providing wound care 2 times per week for 8 weeks, then 1 time per week for one week. Skilled Nurse #J was observed performing wound care to bilateral lower leg wounds. Each extremity had multiple scattered wounds (areas of non-intact skin). Nurse removed old dressing and cleansed all wound sites of both extremities. After cleansing wound beds, nurse removed gloves and performed hand hygiene and donned new gloves. With newly gloved hands, Nurse #J proceeded, in a lightly massaging motion, to rub her gloved hands over the entirety of the left lower extremity, over both intact and non-intact skin, set the left leg down on a pad already in place, then proceeded to lift right leg and rubbed in this same manner over the entirety of the right lower extremity, rubbing over all areas of intact and non-intact skin. Nurse #J returned to left lower extremity and repeated this sequence, rubbing the entirety of the lower left leg, then back to right leg for a second time. The nurse failed to remove gloves, perform hand hygiene, and don new gloves before attending to each leg. 5. During a home visit on 2/1/22 at 11:00 AM for Patient #12, with diagnoses which included, but were not limited to: right total knee arthroplasty (a surgical procedure performed to relieve pain and restore function in severely diseased knee joints), and receiving physical therapy 1 time per week for 1 week, 3 times per week for 2 weeks, and 2 times per week for 2 weeks, Physical Therapist #N was observed placing healthcare bag down on kitchen table without an impervious barrier in place. The physical therapist failed to practice proper bag technique by failing to ensure to use of an impervious barrier between healthcare bag and selected surface in a patient home.			

6. During a home visit on 2/1/22 for Patient #13, with diagnoses that included, but were not limited to: Stage 4 Sacral Pressure Ulcer (full thickness skin and tissue loss, a deep wound caused by prolonged pressure over a bony area of the body that can involve other structures such as ligaments, tendons, muscle and or bone), Stage 4 Pressure Ulcer of left buttock, Stage 4 Pressure Ulcer of right buttock, quadriplegia, suprapubic catheter (is a type of urinary catheter that is left in place. Rather than being inserted through your urethra, the catheter is inserted through a hole in the abdomen and then directly into the bladder, in order to empty the bladder of urine), colostomy (an operation that redirects the colon from its normal route, down toward the anus, to a new opening in the abdominal wall), dependence on wheelchair. Skilled Nurse was providing wound care 1 time per week for 1 week, 5 times per week for 8 weeks, and 1 time per week for 1 week,

Nurse #J was observed performing wound care to multiple Stage 4 wounds, nurse had donned new gloves just before completing wound care of large Stage 4 pressure ulcer to sacrum, left and right buttocks, hospital bed needed to be adjusted to complete wound care. Nurse #J touched hospital bed control panel with the back of gloved hand then returned to wounds and proceeded to palpate the intact skin superior to the periwound area, before returning to wound to complete final covering of large ABD pads and securing in place with tape.

The nurse failed to remove gloves after contact with the hospital bed control panel, failed to perform hand hygiene, and don new gloves before returning to the wound site to complete wound care.

7. In an interview 1/28/22 at 4:25 PM, with the Clinical Manager, wound care visit on that same date was discussed. The Clinical Manager had been present for the visit as well. Concerns related to break in infection control during wound care were reviewed. The Clinical Manager did not dispute findings, only nodded in agreement and when requested, had nothing further to add.

	410 IAC 17-12-1(m)			
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 be responsible for the day to day operation of the home health agency in regards to ensuring complete documentation on initial comprehensive assessments and re-assessments, ensuring patient care plans were collaborated by the staff with the physician every 60 days, failed to ensure documentation of coordination of care activities in the clinical record, failed to obtain verbal orders before furnishing services, failed to ensure services being provided met the patient's needs, and failed to ensure clinical records were complete and contained accurate information, for 1 of 1 home health agency. Findings include: 1. In regards to incomplete comprehensive assessments and recertification reassessments by Registered Nurses and/or qualified staff The agency failed to ensure the comprehensive assessments and recertification assessments were completely filled out, accurately reflected the patients current health status and past medical history, and failed to ensure assessments included patient's goals and care preferences. (See G 528) 2. In regards to lack of individualized care planning, coordination of services, and quality of care The agency failed to ensure the individualized plan of care included all pertinent diagnoses, all supplies and equipment, nutritional requirements, all accurate treatments, all safety measures to protect against injury, measurable outcomes and goals identified by the patient and clinicians along with patient care preferences; failed to ensure the plan of care was created in conjunction with the primary care physician after	G0948	**G 0948**- Agency reviewed the finding in this element for Administrator responsibility of all day-to-day operations that was not met as per surveyors' findings. This element was not shared during the exit meeting, but Agency understands the responsibility of the Administrator to make sure that all the elements that were found "Not Met "is the ultimate responsibility of the Administrator. Administrator has taken appropriate steps and formed PIPs and QA teams to eliminate the deficiencies on permanent basis. Also made sure that all staff has been educated of all the findings of the survey and educations has been provided to all the staff for all the improvement processes and PIPs in place. All tools have been created to identify any deficiencies not met. Proper teams and PIP process have been established as part of QAPI to make sure to achieve the compliance of all deficiencies identified as the result of this survey. Administrator will make sure to monitor day to day operations and continue to monitor all the changes to achieve the results and will make sure that agency will not have these deficiencies again in the future. All corrective actions have goals to meet 100% compliance	2022-03-10

	start of care and recertification orders from the physician, with the date and time when verbal orders were received; failed to ensure the documentation with dates and times; clinicians communicated with the prescribing physician, failed to ensure the ordering physician was contacted for changes in patient's condition and/or failed to notify the ordering physician for needs that suggested outcomes were not being met and that the patient's plan of care should be revised; and failed to ensure they coordinated and documented care delivery in the clinical record to meet the patient's needs. (See G 580 and G 588.) 3. In an interview on 2/7/22 at 4:02 PM, the administrator and nursing supervisor were notified of the above concerns. When asked for further information, explanation, or documentation, the administrator and nursing supervisor indicated having nothing further to provide. 410 IAC 17-12-1(c)(1)		target. Administrator has shared the corrective actions with the Board of Directors for their approval. Administrator will also provide all the information to the Agency Board of Directors for their approval of the results of the Corrective Actions taken as well at the end of 6-month period.	

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