STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K034	A. BUILDING B. WING	02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPOINTE HEALTHCARE	8515 BLUFFTON RD, FORT WAYNE, IN, 46809

(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 a federal recertification and state re-licensure of a home health provider with 1 complaint. The survey was announced as partially extended on 2/25/2022 at 9:21 a.m. Complaint Number 29472: Unsubstantiated: Lack of sufficient evidence. These deficiencies reflect State Findings cited in accordance with 410 IAC 17. QA: 3/21/2022	G0000		2022-02-28
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review, interview, and policy review, the agency failed to ensure a drug interaction review	G0536	**1. How are you going to correct thedeficiency? If already corrected, include the following steps and state date ofcorrection.** Patient #7 A Drug Interaction Report was completed with theinclusion of clonidine on 02/28/2022. Adding clonidine to	2022-02-28

	completed included all medications listed on the plan of care, for 1 of 5 active records reviewed (#7). Findings include: Review of an agency policy dated 03/06/20, titled Client Comprehensive Assessment (C-145) included, but not limited to, & will accurately reflect and include & review of all medications the client is currently using in order to identify & adverse effects and drug reactions & ineffective drug therapy & significant side effects & significant drug interactions & duplicate drug therapy &. A record review for Patient #7 was completed on 02/24/22, start of care date 11/25/20, and included a document titled Home Health Certification and Plan of Care , for certification period 01/19/22-03/19/22, with a primary diagnosis of feeding difficulties (difficulty swallowing), and, but not limited to, monoallelic mutation of CACNA1 (condition that causes movement disorder). This plan of care included the daily medications of Clonidine [used for movement disorder]. The most recent medication interaction review, was dated01/18/2022 and failed to evidence a drug interaction for clonidine. During an interview on 02/24/22 at 3:30 PM, Employee C, clinical supervisor, indicated there should be a drug regimen review for clonidine.		the medication liston the report did not identify any additional interactions or duplications oftherapy. An updated interaction report was faxed to the PCP. **2. How are you going to prevent the deficiencyfrom recurring in the future, even if already corrected?** Phase 1 of preventionis to audit 100% of the drug interaction reports to ensure all prescribedmedications are included for 100% of clients by 03/27/2022 In the event thatdiscrepancies were found an updated drug interaction report was faxed tothe primary care physician as coordination of care. Phase 2 consists of25% of all charts to be audited each quarter to ensure ongoing compliance. 100%of charts to be audited a minimum of once each calendar year. **3. Who is going to be responsible for numbers1 and 2 above: i.e., director, supervisor, etc.?** 1.) ClinicalCare Managers 2.) Administrator,Clinical Supervisor and Clinical Care Manager	

			4. By what date are you going to have thedeficiency corrected? The identified deficiency in patient #7s chart was corrected on02/28/2022.	
G0578	Conformance with physician orders 484.60(b) Standard: Conformance with physician or allowed practitioner orders. Based on policy review, record review, and interview the agency failed to ensure all physician orders were executed in 1 of 5 active records reviewed (Patient #2). Findings include: 1. Review of an agency job description dated 01/18, titled Registered Nurse included, but not limited to, & develops and/ or follows an individualized Plan of Care & that incorporates the individual client s specific needs &. Review of an agency policy dated 03/06/20, titled Client Plan of Care (C-580) stated, "C. The individualized Plan of Care must specify the care and services necessary to meet the client specific needs as identified in the comprehensive assessment, including identification of the responsible disciple."	G0578	**1. How are you going to correct thedeficiency? If already corrected, include the following steps and state date ofcorrection.** On 02/28/22 An order was sent to the Primary Care Provider clarifyingthat scheduled trach changes are to be performed by mom per her request unlessmom is unavailable, or in the event of an emergency, in which case the nurse willperform the trach change. Educated CCMs and nursing staff to ensure all physician orderedtreatments contained in the Plan of Care that parents request to perform haveorders stating that the treatment will be performed by parents/caregiversunless the parent is unavailable or in the event of an emergency, in which casethe nurse will perform the specified treatment.	2022-02-28

	2. Record review for Patient #2 was completed on 02/23/22, start of care date 10/17/18, included a document titled Home Health Certification and Plan of Care, for certification period 01/04/2022 to 03/04/2022, with primary diagnosis of Cerebral Palsy (damage that occurs to the immature, developing brain that affects movement and muscle tone or posture) and diagnosis of tracheostomy (a surgical opening made through the neck into the windpipe) with physician orders that included skilled nursing visits 6 to 16 hours per day, 4 to 7 days per week, throughout the certification period, and orders for the skilled nurse to change the patient's "trach" [tracheostomy] "every 1-2 weeks. Review of skilled nurse visit notes, titled Nursing Flow Sheet for the dates 01/04/22 to 02/02/22 and 02/04/22 to 02/13/22 [There was no skilled nurse visit on 02/03/2022.] failed to evidence the tracheostomy change was completed by the skilled nurse from 01/04/2022 through 02/13/2022. During an interview on 02/24/22 at 3:00 PM, Employee C, clinical supervisor, indicated the patient s mother changed the trach on Mondays.		**2. How are you going to prevent the deficiencyfrom recurring in the future, even if already corrected?** Phase 1: By 03/27/22 a minimum of 1 flow sheet per staff member for 100%of staff have been audited against the patient's Plan of Care to ensurecompliance with physician ordered treatment. If it was discovered that anordered treatment was being performed by a parent/caregiver (per their request)clarification orders were sent to the PCP stating that the parent is to performphysician ordered plan of treatment, nurse to perform at parent's request,during their absence or in an emergent situation. Phase 2: Following the complete flow sheet/Plan of Care audit, quarterlyaudits of flow sheet/Plan of Care will occur on an ongoing basis to ensurecontinued compliance and accuracy. A minimum of 25% of charts/flow sheets areaudited each quarter ensuring that each staff member is audited a minimum ofyearly. **3. Who is going to be responsible for numbers1 and 2 above: i.e., director, supervisor, etc.?**	

			1.) ClinicalCare Manager 2.) ClinicalCare Manager, Clinical Supervisor and Administrator **4. By what date are you going to have thedeficiency corrected?** The deficiency in patient #2's physician ordered treatment was clarifiedand corrected on 02/28/2022	
G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on policy review, record review, and interview, the skilled nurse failed to ensure the comprehensive assessment included a complete cardiopulmonary assessment in 1 of 5 active records reviewed (Patient #2). Findings include: 1. The agency policy with a revision date of 4/14/2020, retroactive date of 3/06/20, titled Client Comprehensive Assessment (C-145) stated, C. Comprehensive assessment will accurately reflect and include & current health & status. The agency policy with revision date	G0706	**1. How are you going to correct thedeficiency? If already corrected, include the following steps and state date ofcorrection.** Phase 1: Employee C who is Clinical Supervisor and a Clinical Care Mangerwas provided education and training related to the following policies ClientComprehensive Assessment (C – 145) and Client Plan of Care (C – 580) on 02/28/2022please find the uploaded copy of the training sign off sheet Phase 2: 100% of comprehensive assessments were audited by 03/27/2022	2022-02-28

	4/14/2020 and retroactive date of 3/06/2020 titled, Client Plan of Care (C-580)" stated, "The plan of care is based on a comprehensive assessment." 2. Record review on 02/23/22 for patient #2, start of care10/17/18, included document titled Home Health Certification and Plan of Care for certification period 01/04/22 to 03/04/22, with diagnoses but not limited to, Chronic Obstructive Pulmonary Disease (inflammatory lung disease that causes obstructed airflow from the lungs), tracheostomy (surgical opening made through the neck into the windpipe), and Ventilator Dependence (requires a device to mechanically pump oxygen into the body). The record evidenced an agency document titled Comprehensive Assessment dated 01/03/22 which failed to evidence a complete cardiopulmonary assessment of heart sounds, edema, and pulses. During an interview on 02/24/22 at 3:00 PM, when queried as to the lack of a cardiopulmonary assessment, Employee C, the clinical supervisor, indicated the information would be documented in the physician summary in the plan of care.		**2. How are you going to prevent the deficiencyfrom recurring in the future, even if already corrected?** Audits on comprehensive assessments will be performed with all chartaudits quarterly to ensure all areas of the assessment are met, complete andlegible. Each quarter 25% of patientcharts will be audited with 100% of charts being audited yearly. Re-educationwill be provided as needed if discrepancies are noted. **3. Who is going to be responsible for numbers1 and 2 above: i.e., director, supervisor, etc.?** 1.) Administrator 2.) Administrator,Clinical Supervisor and Clinical Care Manager **4. By what date are you going to have thedeficiency corrected?** Re-education completed with Employee C (who is the Clinical Supervisorand Clinical Care Manager) on 02/28/2022	
G1012	Required items in clinical record	G1012	**1. How are you going to correct thedeficiency? If**	2022-02-28

484.110(a)(1)

The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders;

Based on policy review, record review and interview, the agency failed to follow their policy and ensure all visit notes were received by the agency office within 7 days for 2 of 5 active records reviewed (Patients #1 and 7).

Findings include:

Review of a policy titled Clinical Records & Medical Record Retention (C 450)," with a revision date of 11/13/2018, revealed documentation of services must & be incorporated/ filed in the clinical record within fourteen (14) days.

A record review was completed on 2/23/2022 for Patient #3, start of care 2/8/2020, for the certification period 12/31/2021 2/28/2022. Review of the record revealed notes missing from the record for nursing services provided on 2/4/2022 and 2/6/2022. The note dated 2/4/2022 was received in the office on 2/14/2022, and the note dated 2/6/2022, was received in the office 2/9/2022. The notes were provided upon request on 2/23/2022.

During an interview on 2/21/2022 at 9:20 p.m., Employee A, Administrator, indicated clinical notes should be incorporated into the chart within 14 days of the service.

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Review of an agency policy titled

already corrected, include the following steps and state date ofcorrection.

Provide individualized education to Employees who were identified asnoncompliant with policy (C – 450) Clinical Records & Medical RecordRetention by failing to submit documentation within 7 days of providing care on02/28/22

2. How are you going to prevent the deficiencyfrom recurring in the future, even if already corrected?

Phase 1: 100% of Nursing Flow Sheets and Home Health Aide Visit Noteswill be tracked by the Staffing Coordinator and Administrative Assistant toensure compliance is maintained. 02/28/22 and Ongoing

Phase 2: 100% of staff will complete training related to Clinical Records& Medical Record Retention (C – 450) by 04/15/22

3. Who is going to be responsible for numbers1 and 2 above: i.e., director, supervisor, etc.?

1.) ClinicalSupervisor and Clinical Care Manager

	Retention (C 450)," with a revision date of 11/13/2018, indicated & required documentation for each service must be & returned to the office within seven (7) [sic] of when services where [sic] provided and incorporated/ filed in the clinical record within fourteen (14) days &. A record review was completed on 02/23/22 for Patient #1, start of care 08/05/21, for the certification period 02/01/22 04/01/22. Review of the record revealed nursing flow sheet notes missing from the record for services provided on 02/11/22, 02/15/22, 02/16/22, 02/17/22 and 02/18/22. The notes were provided upon request on 02/25/22. The notes for 02/16/22 and 02/17/22 were date stamped as received in the office on 02/23/22. Employee C, clinical supervisor indicated the notes for 02/11/22, 02/15/22 and 02/18/22 were received in the office on 02/25/22. The record failed to evidence the nursing flow sheet notes were returned to the office within 7 days of when services were provided and incorporated in the clinical record within 14 days. During an interview on 02/24/22 at 3:20 PM, Employee C, clinical supervisor, indicated would provide the missing records on 02/25/22. A record review was completed on 2/24/2022 for Patient #7, start of care		2.) ClinicalSupervisor and Clinical Care Manager / Staffing Coordinator and AdministrativeAssistant **4. By what date are you going to have thedeficiency corrected?** 02/28/2022 and ongoing	

	01/19/22 03/19/22. Review of the record revealed home health aide notes missing from the record for services provided on 02/10/22, 02/11/22 and 02/18/22. The notes were provided upon request on 02/25/22. The notes were date stamped as received in the office on 02/24/22. The record failed to evidence the home health aide visit notes were returned to the office within 7 days of when services were provided and incorporated in the clinical record within 14 days. During an interview on 02/24/22 at 3:30 PM, Employee C, clinical supervisor, indicated would provide the missing records on 02/25/22.			

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