STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	300041604	A. BUILDING B. WING	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFIRST REHAB LLC	7225 NOVAS LANDING, SELLERSBURG, IN, 47172

(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
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 for a Home Health Provider. Survey Dates: 4/18/22-4/21/2022 Census: 598 unduplicated At this Emergency Preparedness survey, Carefirst Rehab LLC was found to be found to be in compliance with Conditions of Participation 42 CFR 484.102 Emergency Preparedness requirements for Medicare Participating Providers. QR Completed 5/5/2022 A4	E0000		2022-05-18
N0000	Initial Comments	N0000		2022-05-18

	This visit was for a Federal and State Re-licensure survey of a home health provider. Survey Dates: 4/18-21/2022 Census: 598 unduplicated			
G0000	This visit was for a Federal Recertification and State Re-licensure Survey of a Home Health provider. Survey Dates: 4/18/22, 4/19/22, 4/20/22, and 4/21/22 Census: 598 unduplicated Extended Survey Announced 4/20/22 at 3:00 pm These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings.	G0000		2022-05-18
G0422	Written notice within 4 business days 484.50(a)(4) Provide written notice of the patient's rights and responsibilities under this rule and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section to a patient-selected representative within 4 business days of the initial evaluation visit. 1. The complete clinical record	G0422	· 1. All staff was in-serviced on May 9, 2022 thatincluded review of the agency policy Transfer and Discharge Summary that thebeneficiary will be instructed on and provided a copy of the writtennotification of transfer and discharge policies at the	2022-05-18

	for patient #1 was reviewed on 4-18-2022. The record failed to evidence written notification of transfer and discharge policies. 2. The complete clinical record for patient #2 was reviewed on 4-18-2022. The record failed to evidence written notification of transfer and discharge policies. 3. The complete clinical record for patient #3 was reviewed on 4-20-2022. The record failed to evidence written notification of transfer and discharge policies. 4. The complete clinical record for patient #4 was reviewed on 4-18-2022. The record failed to evidence written notification of transfer and discharge policies. 5. The complete clinical record for patient #5 was reviewed on 4-20-2022. The record failed to evidence written notification of transfer and discharge policies. 6. The complete clinical record for patient #6 was reviewed on 4-20-2022. The record failed to evidence written notification of transfer and discharge policies. 7. The complete clinical record for patient #7 was reviewed on		time of the home healthadmission. · The Home Health admission packets now have theagency policy for notification of transfer and discharge. All active patientshave been provided with the agency's policies for notification of transfer anddischarge. · 2. The clinical manager or designee will audit 20%of patient records as part of the monthly record reviews for 3 months for 100%compliance that the beneficiary was instructed and provided a copy of thewritten notification of transfer and discharge. Then 10% of charts will bereviewed quarterly for (1) one year for 100% compliance to ensure regulatorycompliance as part of the quality assurance plan to prevent reoccurrence. · 3.The clinical manager will be responsible for thecorrective action plan. · 4. The corrective action will be effective immediately.Completion date will be on May 18, 2022.	

	4-19-2022. The record failed to evidence written notification of transfer and discharge policies. 8. The complete clinical record for patient #8 was reviewed on 4-20-2022. The record failed to evidence written notification of transfer and discharge policies. 9. The complete clinical record for patient #9 was reviewed on 4-19-2022. The record failed to evidence written notification of transfer and discharge policies. 10. The complete clinical record for patient #10 was reviewed on 4-21-2022. The record failed to evidence written notification of transfer and discharge policies. 11. The complete clinical record for patient #11 was reviewed on 4-18-2022. The record failed to evidence written notification of transfer and discharge policies. 12. The complete clinical record for patient #12 was reviewed on 4-20-2022. The record failed to evidence written notification of transfer and discharge policies. 13. The complete clinical record for patient #13 was reviewed on 4-20-2022. The record failed to			

	evidence written notification of transfer and discharge policies. 14. The complete clinical record for patient #14 was reviewed on 4-21-2022. The record failed to evidence written notification of transfer and discharge policies. 15. During interview with Clinical Manager C and Business Office Manager L on 4/21/2022 at 1220 they stated there is the Advanced Beneficiary Notice (ABN) explanation in the patient admission book and thought this covered the discharge notice requirement.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer	N0488	· 1. All staff was in-serviced on May 9, 2022 to theagency policy *"Transfer/Discharge"* that “At the visit beforethe discharge (at least 15 days prior to discharge) the patient/client will berequired to sign a “Notice of Medicare Provider Non-coverage”. The patient willbe given instructions on Right to appeal the decision to discharge. · The Clinical Manager counseled all dischargingclinicians are required to sign document on Notice of Medicare providernon-coverage. The	2022-05-18

	reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. 1. An undated policy titled "Discharge/Transfer Policy" was provided by the Clinical Manager on 04/20/2022 at 12:30 p.m. The policy indicated but was not limited to; "1. At around two weeks before the discharge the patient client will be required to sign the Notice of Medicare Non-Coverage ... At the visit before the discharge (at least 15 days prior to discharge) the patient/client will be required to sign a "notice of Medicare provider non-coverage" ... 7. Patient/family will be informed of the discharge at least 5 days prior to discharge and will participate in the discharge		document will have instructions on right to appeal discharge. · 2. The Clinical Manager of designee will audit 20%of all patient discharge records monthly for 3 months for 100% compliance withall discharged patients having a signed Notice of Medicare Non-Coveragedocument. Then 10% of discharged charts will be reviewed quarterly for the next12 months for 100% compliance to ensure regulatory compliance as part of thequality assurance plan to prevent reoccurrence. · 3. The clinical manager will be responsible for thecorrective action plan. · 4.The corrective action will be effective immediately.Completion date will be on May 18, 2022.	

	planning process". 2. The complete clinical record for patient #1 was reviewed on 4-18-2022. The record failed to evidence a 15 calendar day notice given to patient prior to discharge. 3. The complete clinical record for patient #9 was reviewed on 4-19-2022. The record failed to evidence a 15 calendar day notice given to patient prior to discharge. 4. The complete clinical record for patient #10 was reviewed on 4-21-2022. The record failed to evidence a 15 calendar day notice given to patient prior to discharge. 5. The complete clinical record for patient #11 was reviewed on 4-18-2022. The record failed to evidence a 15 calendar day notice given to patient prior to discharge. 6. During interview with the Administrator, Clinical Manager and Business Office Manager on 4/21/2022 at 12:30 pm the administrator stated how would they know two weeks in advanced if a patient needs to be discharged and they were unaware of the regulation of the 15 day notice.			
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. 1. An undated policy titled "Medication Administration" and "Medication Profile" was provided by the Clinical Manager on 4/20/2022 at 12:30 p.m. The policy indicated but was not	G0536	· 1. All staff was in-serviced on May 9, 2022 to theagency policy “Medication Administration” and “Medication Profile” on thatincluded all patients medication profiles will be updated at least every 60days and whenever there is a change in the medication. · The clinical manager	2022-05-18

	medication monitoring to determine their action, indication, special precautions, patient's response to therapy, side effects, allergies, and other contraindications, and to ensure appropriateness and continuity of care and include the following information necessary for creating an accurate medication history and a complete medication profile and to identify potential complications from the therapy being provided & The medication list is collectively maintained in the clinical record. The plan of care will demonstrate the patient/client's current medication regimen, and additions and/or modifications will be identified in clinical notes, progress notes, summary reports, or communication notes & medication profiles must be updated at least every 60 days and whenever there is a change in the medication regime." 2. The complete clinical record for patient #1 for the certification period of 3/17/2022 through 5/15/2022 was reviewed on 4-18-2022. The record failed to evidence a signed and updated medication profile. 3. The complete clinical record for patient #2 for the certification period of 3/10/22 through 05/08/2022 was reviewed on 4-18-2022. The record failed to evidence a signed and updated medication profile. 4. The complete clinical record for patient #3 for the certification period of 2/14/2022 through 4/14/2022 was reviewed on 4-20-2022. The record failed to evidence a signed and updated medication profile. 5. The complete clinical record for patient #4 for the certification period of 2/04/2022 through 4/04/2022 was reviewed on 4-18-2022. The record failed to evidence a signed and updated medication profile. 6. The complete clinical record for patient #6 for the certification period of 1/28/2022 through 3/28/2022 was reviewed on 4-20-2022. The record failed to evidence a signed and updated medication profile. The record revealed a document titled "Physician's Order Report" received from		completed medicationprofile review for all active patients and an updated medication profile wasreviewed and updated for all active patients including, the medication profilefor patients #1 through #14 reviewed at the time of the home health survey thatare still active. An updated medication list was placed in the patient’s homefolder. · 2. The clinical manage or designee will review 20%of all patient records monthly for 3 months for 100% compliance of medicationprofiles updated with medication changes and at least every 60 days within thepatient records including a signed medication profile that will be placed inthe patient’s home folder. Then 10% of charts will be reviewed quarterly for (1)one year for 100% compliance to ensure regulatory compliance as part of thequality assurance plan to prevent reoccurrence. · 3.The clinical manager will be responsible for thecorrective action plan. · 4. The corrective action will be effective immediately.Completion date will be on May 18, 2022.	

patient #6 included an order for Mary's Magic Butt Cream to be applied twice daily to the peri area. The medication profile in the clinical record indicated an order for Mary's Magic Butt Cream to be taken orally twice a day.

Observation during the 4/20/2022 home visit revealed patient #6's current medication profile was inconsistent with the medications in the home. The medication profile indicated patient #6 took Omeprazole (medication used to treat heartburn) Oral (by mouth) Capsule Delayed-Release 20mg (milligrams) daily. Patient #6 stated they do not take Omeprazole for heartburn. The patient stated they take Papaya Enzymes and Chlorella Micro-Algae for heartburn, neither of the two medications are listed on the medication profile.

The patient's medication profile included Cough DM Children's Oral Liquid Extended-Release 30mg/5mL as an ongoing medication. The patient stated they only took the medication for a short period when sick.

The medication profile in the home included an order for Alendronate Sodium Oral Tablet 70mg taken once a week, the patient stated they are not on that medication.

The patient medication profile included an order for Magnesium Oxide 400 mg taken daily but the patient did not have the medication at the home.

The patient stated they are also taking Bilberry and Blackseed oil as needed neither of which are included on the medication profile.

7. The complete clinical record for patient #5 for the certification period of 4/13/2022 through 6/11/2022 was reviewed on 4-20-2022. The record failed to evidence a signed and updated medication profile.

Observation during the

visit revealed Patient #5's current medication profile for the certification period 3/29/2022 to 5/27/2022 was inconsistent with the medications in the home. The medication profile indicated the following:

Amlodipine Besylate (a medication to treat high blood pressure) 5 mg (milligrams) oral tablet daily. Patient #5 and spouse indicated this medication had been discontinued.

Aspirin (a medication to relieve pain, fever, or inflammation) adult low dose delayed release 81 mg daily (1 tablet). Patient #5 and spouse indicated the correct dose to be 2 tablets daily.

Carbidopa-Levodopa (a medication to treat Parkinson s Disease) oral tablet disintegrating 25-100 mg, 1 tablet 4 times per day orally and Carbidopa-Levodopa ER (extended release) oral tablet 50-200 mg, 1 tablet at bedtime orally. Patient #5 and spouse indicated the correct dose to be Carbidopa-Levodopa ER oral tablet 25-200 mg, take 2 tablets (6 a.m., 10 a.m., 2 p.m., 6 p.m., and 10 p.m.) daily.

Sennosides-Docusate Sodium (a medication used to treat constipation) oral tablet 8.6-50 mg, 1 tablet twice per day. Patient #5 and spouse indicated this medication is only taken as needed.

Medications missing from medication profile per Patient #5 and spouse included: Furosemide (a medication used to treat fluid build-up) 20 mg tablet, 2 tablets daily (breakfast and 2 p.m.), Keflex (an antibiotic) 500 mg twice per day for 10 days then discontinue and start Keflex 250 mg daily routinely, and Vitamin D3 (supplement) 50 mcg (micrograms), one tablet daily.

8. The complete clinical record for patient #7 for the certification period of 4/20/2022 through 6/18/2022 was reviewed on 4-19-2022. The record failed to evidence a signed and updated medication profile.

9. The complete clinical record for patient #8 for the certification period of 1/21/2022 through 3/21/2022 was reviewed on 4-20-2022. The record failed to evidence a signed and updated medication profile.

10. The complete clinical record for patient #9 for the certification period of 2/09/2022 through 4/09/2022 was reviewed on 4-19-2022. The record failed to evidence a signed and updated medication profile.

The medication profile for patient #9 revealed an allergy to codeine (opiate used to treat

	pain) and an ongoing medication order for acetaminophen/codeine (combination medication used to treat pain) oral tablet consisting of 300 mg of acetaminophen and 30 mg of codeine prescribed to be taken once a day. The record failed to include documentation of communication with the physician related to the patient currently taking a medication listed as an allergy or the described reaction of the allergy to the medication. 11. The complete clinical record for patient #10 for the certification period of 2/01/2022 through 4/01/2022 was reviewed on 4-21-2022. The record failed to evidence a signed and updated medication profile. 12. The complete clinical record for patient #11 for the certification period of 3/17/2022 through 5/15/2022 was reviewed on 4-18-2022. The record failed to evidence a signed and updated medication profile. 13. The complete clinical record for patient #12 for the certification period of 3/18/2022 through 5/16/2022 was reviewed on 4-20-2022. The record failed to evidence a signed and updated medication profile. 14. The complete clinical record for patient #13 for the certification period of 2/16/2022 through 4/26/2022 was reviewed on 4-20-2022. The record failed to evidence a signed and updated medication profile. 15. The complete clinical record for patient #14 for the certification period of 2/16/2022 through 4/16/2022 was reviewed on 4-21-2022. The record failed to evidence a signed and updated medication profile.			
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	G0536	· 1. All staff was in-serviced on May 9, 2022 to theagency policy “Medication Administration” and “Medication Profile” on thatincluded all patients medication profiles will	2022-05-18

	therapy. 17. Observation during the home visit with patient #7 on 4/19/2022 revealed the current medication profile was inconsistent with the medications in the home. The medication profile indicated patient #7 took docusate sodium (medication used to treat constipation) Oral (by mouth) tablet 50 mg (milligrams)-8.6 mg daily, Levemir FlexPen subcutaneous solution (medication used to treat diabetes) subcutaneous (under the skin) SQ injection 100 units/ml- 25 units SQ at bedtime, Novolog FlexPen subcutaneous solution (medication used to treat diabetes) subcutaneous (under the skin) SQ injection 100 units/ml- 10 units SQ before meals, nyamyc external powder (medication used to treat fungal skin infection) Topical (on the skin) powder 100000 units/gram apply to affected site twice a day, Nystatin external (medication used to treat fungal skin infection) Topical (on the skin) cream 100000 units/gram apply to affected site twice a day, Oxycodone HCL ER oral tablet 12 hour (used to treat pain) 10 mg take 1 tab as needed twice a day as needed, flomax (used to treat urinary retention) 0.4 mg cap oral take twice daily, and triamterene HCTZ (used to treat high blood pressure) oral (by mouth) capsule 25mg-37.5 mg take once daily. Patient #7 stated they do not take any of the medications listed on the medication profile other than the insulin and the one for my blood pressure . During interview RN E stated she		be updated at least every 60days and whenever there is a change in the medication. · The clinical manager completed medicationprofile review for all active patients and an updated medication profile wasreviewed and updated for all active patients including, the medication profilefor patients #1 through #14 reviewed at the time of the home health survey thatare still active. An updated medication list was placed in the patient's homefolder. · 2. The clinical manage or designee will review 20%of all patient records monthly for 3 months for 100% compliance of medicationprofiles updated with medication changes and at least every 60 days within thepatient records including a signed medication profile that will be placed inthe patient's home folder. Then 10% of charts will be reviewed quarterly for (1)one year for 100% compliance to ensure regulatory compliance as part of thequality assurance plan to prevent reoccurrence. · 3.The clinical manager will be responsible for thecorrective action plan. · 4. The corrective action will be effective immediately.Completion date will be on May 18, 2022.	

	asks the patient #7 every visit if they have any medication changes and what those changes are. She stated patient #7 has denied changes to medication up to this point. 18. Observation during the home visit with patient #8 on 4/19/2022 revealed the current medication profile was inconsistent with the medications in the home. The medication profile indicated patient #7 took duloxetine (medication used to treat depression) Oral (by mouth) capsule 40 mg (milligrams) twice daily. Medication in the home reveals duloxetine 60 mg capsules. Patient #8 had the following medications in the home and were not listed on the medication profile Dulcolax (used to treat constipation) 5 mg daily as needed, Iron with Vitamin C (used to treat a vitamin or mineral deficiency) 65 mg daily, and hydrocodone-APAP (used to treat pain) 5mg-325 mg every eight hours as needed. Patient stated they take the medications that are in the home at this time. Patient stated ondansetron (used to treat nausea) 4 mg tab daily has been discontinued. During interview PT F they stated the patient is asked at every visit if they have any medication changes and medication bottles are reviewed at recertification visits. 410 IAC 17-14-1(a)(1)(B)			
G0576	All orders recorded in plan of care 484.60(a)(3)	G0576	. 1. All staff was in-serviced on May 9, 2022 to	2022-05-18

	All patient care orders, including verbal orders, must be recorded in the plan of care. 4. Observation during the 4/20/2022 home visit revealed patient #6's current medication profile included in the home record was inconsistent with the medications in the home. Bilberry, Blackseed Oil, Papaya Enzymes, and Chlorella Micro-Algae were all observed in the home during the visit. Patient #6 stated they are currently taking Bilberry and Blackseed Oil daily and Papaya Enzymes and Chlorella Micro Algae as needed for heartburn. The patient stated the agency has written down they take omeprazole for heartburn but that is a medication they no longer take. A document titled "Plan of Care" for the certification period of 4/13/2022 through 6/11/2022 located in the home record for patient #6 failed to evidence orders for Bilberry, Blackseed Oil, Papaya Enzymes, and Chlorella Micro-Algae. A document titled "Medication Profile" for patient #6 located in the home record failed to evidence orders for Bilberry, Blackseed Oil, Papaya Enzymes, and Chlorella Micro-Algae. During an interview on 4/20/2022 at 1:10 p.m., the Speech-Language Pathologist (SLP) stated the patient does take a lot of supplements and nursing is following the patient. The SLP confirmed with the patient all medication changes.		theagency policy "Physicians Plan of Treatment" that included physicianorders are established and documented for the health care services the agencyprovides. All changes for the patient plan of treatment including medicationchanges will be updated in the patient plan of care and placed in the homefolder. · The clinical manager reviewed the plan of carefor the patients #6, #7, and #8 and an updated plan of care was placed in thepatient's home folder on May 10, 2022. The clinical manager reviewed 100% ofall active patient plan of cares and all updated plan of cares were placed inthe patient's home folder. · 2. The clinical manager or designee will audit 20%of all patient records with the monthly chart reviews for 100% compliance withplan of care updates as the patient condition or plan of treatment changesincluding the medication profile for 3 months. Then 10% of charts will bereviewed quarterly for (1) one year for 100% compliance to ensure regulatorycompliance as part of the quality assurance plan to prevent reoccurrence. · 3. The clinical manager will be responsible for thecorrective action plan.	

			· 4. The corrective action will be effective immediately.Completion date will be on May 18, 2022.	
G0576	All orders recorded in plan of care 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. 1. An undated policy titled "Physicians Plan of Treatment" was provided by the Clinical Manager on 4/20/2022 at 12:30 pm. The policy indicated but was not limited to "... physician orders are established and documented for the health care services the Agency provides to those patients/clients ... " 2. During the home visit with patient #8 on 4/19/2022 review of the home folder revealed the current medication profile was inconsistent with the medications in the home. The medication profile indicated patient #7 took duloxetine (medication used to treat depression) Oral (by mouth) capsule 40 mg (milligrams) twice daily. Medication in the home reveals duloxetine 60 mg capsules. Patient #8 had the following medications in the home and were not listed on the medication profile Dulcolax (used to treat constipation) 5 mg daily as needed, Iron with Vitamin C (used to treat a vitamin or mineral deficiency) 65 mg daily, and hydrocodone-APAP (used to treat pain) 5mg-325 mg every eight hours as needed. Patient stated they take the medications that are in the home at this time. Patient stated ondansetron (used to treat	G0576	· 1. All staff was in-serviced on May 9, 2022 to theagency policy "Physicians Plan of Treatment" that included physicianorders are established and documented for the health care services the agencyprovides. All changes for the patient plan of treatment including medicationchanges will be updated in the patient plan of care and placed in the homefolder. · The clinical manager reviewed the plan of carefor the patients #6, #7, and #8 and an updated plan of care was placed in thepatient’s home folder on May 10, 2022. The clinical manager reviewed 100% ofall active patient plan of cares and all updated plan of cares were placed inthe patient’s home folder. · 2. The clinical manager or designee will audit 20%of all patient records with the monthly chart reviews for 100% compliance withplan of care updates as the patient condition or plan of treatment changesincluding the medication profile for 3 months. Then 10% of charts will bereviewed quarterly for (1) one	2022-05-18

	discontinued. During interview PT F they stated the patient is asked at every visit if they have any medication changes and medication bottles are reviewed at recertification visits. 3. During the home visit with patient #7 on 4/19/2022 view of the home folder revealed the current medication profile was inconsistent with the medications in the home. The medication profile indicated patient #7 took docusate sodium (medication used to treat constipation) Oral (by mouth) tablet 50 mg (milligrams)-8.6 mg daily, Levemir FlexPen subcutaneous solution (medication used to treat diabetes) subcutaneous (under the skin) SQ injection 100 units/ml- 25 units SQ at bedtime, Novolog FlexPen subcutaneous solution (medication used to treat diabetes) subcutaneous (under the skin) SQ injection 100 units/ml- 10 units SQ before meals, nyamyc external powder (medication used to treat fungal skin infection) Topical (on the skin) powder 100000 units/gram apply to affected site twice a day, Nystatin external (medication used to treat fungal skin infection) Topical (on the skin) cream 100000 units/gram apply to affected site twice a day, Oxycodone HCL ER oral tablet 12 hour (used to treat pain) 10 mg take 1 tab as needed twice a day as needed, flomax (used to treat urinary retention) 0.4 mg cap oral take twice daily, and triamterene HCTZ (used to treat high blood pressure) oral (by mouth) capsule 25mg-37.5 mg take once daily.		year for 100% compliance to ensure regulatorycompliance as part of the quality assurance plan to prevent reoccurrence. · 3. The clinical manager will be responsible for thecorrective action plan. · 4. The corrective action will be effective immediately.Completion date will be on May 18, 2022.	

	Patient #7 stated they the only medication they take is the insulin and the one for my blood pressure . During interview RN E stated she asks the patient #7 every visit if they have any medication changes and what those changes are. She stated patient #7 has denied changes to medication up to this point.			
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. 1. An undated policy titled "Physician's Plan of Treatment" was provided by the Clinical Manager on 04/18/2022 at 3:45 p.m. The policy indicated but was not limited to; "The physician's plan of treatment shall be reviewed by the attending physician in consultation with the Agency's professional personnel at such interval as the severity of the patient/client's illness inquires & more frequently when & there is a significant change in condition." 2. The complete clinical record for patient #4 with a start of care (SOC) of 2/04/2022 was reviewed on 04/18/2022. The record evidenced the following: A SOC OASIS document dated 2/4/2022 indicated, but was not limited to; "Urinary Incontinence or catheter & no incontinence or catheter & renal/genitourinary status & within normal limits." A document titled "Patient Communication Log" dated 2/14/2022 signed by the Clinical Manager stated "SN {skilled nurse] reports no	G0590	· 1. All staff was in-serviced on May 9, 2022 to theagency policy "Physicians Plan of Treatment" that included theclinician will promptly notify the physician to any changes in the patient’scondition or needs that suggest that outcomes are not being achieved and/orthat the patient plan of care should be altered. *"Thephysician's plan of treatment shall be reviewed by the attending physician inconsultation with the Agency's professional personnel at such interval as theseverity of the patient/client's illness inquires … more frequently when …there is a significant change in condition."* The clinical staff was specifically educated onpromptly alerting the physician of changes in the patient’s condition withhistory of urinary tract infections. · The clinical manager counseled the clinician(s)who	2022-05-18

	other week." A document titled "Skilled Visit Note" dated 2/15/2022 signed by RN B indicated but was not limited to; "Genitourinary & Incontinence & urine color & yellow-green & urine odor & foul odor & checked patient groin area and looks red and irritated." RN LM failed to notify the physician of patient #4's yellow-green foul odor and new-onset incontinence. A document titled "Skilled Visit Note" dated 3/04/2022 signed by RN B indicated patient #4 had a pain level of 5 in the groin area and penis described as a burning sensation. The patient exhibited incontinence, yellow-green urine with a foul odor, and a Foley catheter (a flexible tube that a clinician passes through the urethra and into the bladder to drain urine) now present. RN LM documented "the patient has redness on the going [sic] area, testis [sic] are swollen and irritated & positive for difficulty urinating, dysuria (painful urination), and testicular pain, fatigue, and low-grade temperature. At PE (physical exam) the patient has mild suprapubic discomfort with palpation & urology was contacted and recommended sending the patient to ER (emergency room) & the patient was seen in the ER, prescribed ceftriaxone 2g IV (intravenously). Discharged with a prescription for cefdinir 300 twice daily." Eighteen (18) days elapsed from RN B identifying abnormal genitourinary findings to reporting the abnormal findings to the physician resulting in an adverse outcome, an emergency room admission, for the patient. 3. The complete clinical record for patient #9 with a start of care (SOC) of 2/09/2022 was reviewed on 04/18/2022. The record evidenced the following: A document titled "Home Health Plan of Care & Certification" for the certification period 2/09/2022 through 4/09/2022 was signed by the patient's physician on 1/21/2022 and the Clinical Manager on 2/14/2022. The document indicated patient #9 had an extensive history of urinary tract infections. A document titled "Skilled Nursing Visit Note"		documented signs and symptoms of a urinary tract infection for patient #4and #9 and the documentation did not support that the physician was notified withreview of the agency policy for notifying the physician on May 9,2022. · 2. The clinical manager or designee will audit 20%of patient records with the monthly chart reviews for 100% compliance that thephysician is notified promptly with all changes in the patient conditions andneed to alter the plan of care for 3 months. Then 10% of charts will bereviewed quarterly for (1) one year for 100% compliance to ensure regulatorycompliance as part of the quality assurance plan to prevent reoccurrence. · 3. The clinical manager will be responsible for thecorrective action plan. · 4. The corrective action will be effective immediately.Completion date will be on May 18, 2022.	

	for dates 2/12/2022, 2/23/2022, 3/02/2022, 3/09/2022, 3/16/2022, 3/22/2022, and 3/30/2022 signed by RN B all indicated but were not limited to; "Genitourinary & urgency & dysuria & retention & Pt (patient) voiding well &SN (skilled nurse) conts (continues) to educate patient on & s/s (signs/symptoms) of UTI & pt voiced no concerns at this time" A document titled "Skilled Nursing Visit Note" dated 3/30/2022 signed by RN B indicated a goal of "patient will be UTI free within 6wks (6 weeks) & goal status: progressing." A discharge OASIS document dated 4/07/2022 indicated, but was not limited to; "Elimination Status & has this patient been treated for a Urinary Tract Infection in the past 14 days & no" RN B failed to notify patient #9's physician of patient #9's symptoms of a UTI for all 7 visits completed by the RN. 4. During an interview on 4/20/2022 at 10:15 a.m., the Clinical Manager stated they could not find any other notes as to why the MD (medical doctor) was not notified of patient #4's dark foul urine and stated patient #9's notes were clearly copied and pasted but they did find a few notable differences unrelated to urinary status and patient #9 was on antibiotics prophylactically for urinary tract infections. IAC 410 17-13-1(a)(2)			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. 4. The home care folder for Patient #6 was reviewed during the home visit on 4-19-2022 and revealed a document titled "Medication Profile (Patient Version)" for the certification period 04/013/2022 through 06/11/2022. The	G0616	. 1.All staff was in-serviced on May 9, 2022 to theagency policy *"policy that includes the regulatory language forproviding the medication list in plain language for the patient to understand"*that included the home health agency will provide the patient medication schedule/instructions,including	2022-05-18

	medication instructions included the following terminology "OD [Every Day] & BID [Twice a Day], PRN [As Needed], and PO [By Mouth]. The Medication Profile failed to use plain language. 5. The home care folder for Patient #5 was reviewed during the home visit on 4-20-2022 and revealed a document titled "Medication Profile (Patient Version)" for the certification period 04/13/2022 through 06/11/2022. The medication instructions included the following terminology "OD [Every Day] & BID [Twice a Day], PRN [As Needed], QHS [every night at bedtime], QID [4 times a day], TID [3 times a day] and PO [By Mouth]. The Medication Profile failed to use plain language. 6. During the exit conference on 4/21/2022 at 12:45 p.m. the administrator, alternate administrator, and clinical manager acknowledged the medication profiles were not in plain language.		medication name, dosage, and frequency in plain language the patientcan understand. · The clinical manager reviewed the medicationlist for patient's #4, #5, #6, #7, and #8 and provided an updated medicationlist in language the patient can understand. The clinical manager reviewed 100%of all active patient medication lists and any medication list that neededupdated in plain language for the patient to understand were placed in thepatient's home folder. · 2. The clinical manager or designee will audit 20%of patient records with the monthly chart reviews for 100% compliance with medicationlist provided to the patient to be provided in plain language that the patientcan understand for 3 months. Then 10% of charts will be reviewed quarterly for(1) one year for 100% compliance to ensure regulatory compliance as part of thequality assurance plan to prevent reoccurrence. · 3.The clinical manager will be responsible for thecorrective action plan. · 4.The corrective action will be effective immediately.Completion date will be on May 18, 2022.	

G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. 1. The home folder for Patient #4 was reviewed during the home visit on 4-19-2022. The folder failed to evidence medication instructions written in plain language. The folder evidenced the following: A document titled "Care Plan (Patient Version)" for the certification period 04/05/2022 through 06/03/2022 revealed medication instructions including "amlodipine besylate ... QD - PO ... Docusate sodium ...BID ... Milk of Magnesia ... Q24H PRN ... ropinirole ... QHS". 2. The home folder for Patient #8 was reviewed during the home visit on 4-19-2022. The folder failed to evidence medication instructions written in plain language. The folder evidenced the following: A document titled "Care Plan (Patient Version)" for the certification period 1/21/2022 through 03/21/2022 revealed medication instructions	G0616	· 1.All staff was in-serviced on May 9, 2022 to theagency policy *"policy that includes the regulatory language forproviding the medication list in plain language for the patient to understand"*that included the home health agency will provide the patient medication schedule/instructions,including medication name, dosage, and frequency in plain language the patientcan understand. · The clinical manager reviewed the medicationlist for patient's #4, #5, #6, #7, and #8 and provided an updated medicationlist in language the patient can understand. The clinical manager reviewed 100%of all active patient medication lists and any medication list that neededupdated in plain language for the patient to understand were placed in thepatient's home folder. · 2. The clinical manager or designee will audit 20%of patient records with the monthly chart reviews for 100% compliance with medicationlist provided to the patient to be provided in plain language that the patientcan understand for 3 months. Then 10% of charts will be reviewed quarterly for(1) one year for 100% compliance to ensure regulatory compliance	2022-05-18

	including "ondansetron ... TID ... Nystatin...QID" 3. The home folder for Patient #7 was reviewed during the home visit on 4-19-2022. The folder failed to evidence medication instructions written in plain language. The folder evidenced the following: A document titled "Care Plan (Patient Version)" for the certification period 02/19/2022 through 04/19/2022 revealed medication instructions including "amlodipine besylate ... QD - PO ... Levemir FlexPen ... SQ"		plan to prevent reoccurrence. · 3.The clinical manager will be responsible for thecorrective action plan. · 4.The corrective action will be effective immediately.Completion date will be on May 18, 2022.	
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; A policy titled "Clinical Record Contents" was provided by the Clinical Manager on 4/18/2022 at 3:45 p.m. The document indicated but was not limited to; "Progress Notes & each caregiver is responsible for recording the care delivered." The complete clinical record for patient #9 with a start of care (SOC) of 2/09/2022 was reviewed on 04/18/2022. The record evidenced the following: A document titled "Skilled Nursing Visit Note" for dates 2/12/2022, 2/23/2022, 3/02/2022, 3/09/2022, 3/16/2022, 3/22/2022, and 3/30/2022 signed by RN B all indicated but were not limited to; "Genitourinary & urgency & dysuria & retention & Pt (patient) voiding well &SN (skilled nurse) conts (continues) to	G0716	· 1.All staff was in-serviced on May 9, 2022 to theagency policy *"Clinical Record Contents"* that included eachcaregiver is responsible for recording the care delivered. Each discipline willensure all clinical notes are accurate and depict an accurate assessment of thepatient. · 2. The clinical manager or designee will audit 20%of patient records with the monthly chart reviews for 100% compliance with allprogress notes documenting an accurate and complete assessment of the patient'scondition and response to treatment at the	2022-05-18

	UTI & pt voiced no concerns at this time." The clinical summary for the certification period of 12/29/2021 through 2/26/2022 indicated but was not limited to; "Admission summary pt (#9) is alert and able to make needs known, pt states she is forgetful at times. Pt complains of pain in her lower back daily. Pt has health hx (history) GERD, HTN (hypertension), Depression, Degenerative Disc, PVD (peripheral vascular disease), Osteroparitis. Pt lives in a 2-story home with her husband who is the primary CG (caregiver) for spouse. Spouse has CG 3xs to assist them with daily needs. VS (vital signs) wnl (within normal limits) per pt baseline. Skin warm and dry to touch. No open areas noted. Abd soft and tender BS+ (bowel sounds positive) x 4 quads. Pt had BM (bowel movement) today. The clinical summary for the certification period of 2/9/2022 through 4/09/2022 indicated but was not limited to; "Admission summary pt (#9) is alert and able to make needs known, pt states she is forgetful at times. Pt complains of pain in her lower back daily. Pt has health hx (history) GERD, HTN (hypertension), Depression, Degenerative Disc, PVD (peripheral vascular disease), Osteroparitis. Pt lives in a 2-story home with her husband who is the primary CG (caregiver) for spouse. Spouse has CG 3xs to assist them with daily needs. VS (vital signs) wnl (within normal limits) per pt baseline. Resp (respirations) even and unlabored no soa (shortness of air) noted. Skin warm and dry to touch. No open areas noted. Abd soft and tender BS+ (bowel sounds positive) x 4 quads. Pt had BM (bowel movement) today. During an interview on 4/20/2022 at 10:15 a.m., the Clinical Manager stated patient #9's notes were clearly copied and pasted but they did find a few small differences. The clinical Manager acknowledged "patient voiding well" and painful urination, urgency, and retention were contradictive statements all listed on every visit note. 410 IAC 17-14-1(a)(1)(E)		time of the visit for 3 months. Then10% of charts will be reviewed quarterly for (1) year for 100% compliance to ensureregulatory compliance as part of the quality assurance plan to preventreoccurrence. · 3.The clinical manager will be responsible for thecorrective action plan. · 4. The corrective action will be effective immediately.Completion date will be on May 18, 2022.	
G1014	Interventions and patient response	G1014	· 1.All staff was in-serviced	2022-05-18

	484.110(a)(2) All interventions, including medication administration, treatments, and services, and responses to those interventions; 1. An undated policy titled "Physician's Plan of Treatment" was provided by the Clinical Manager on 04/18/2022 at 3:45 p.m. The policy indicated but was not limited to; "The physician's plan of treatment shall be reviewed by the attending physician in consultation with the Agency's professional personnel at such interval as the severity of the patient/client's illness inquires & more frequently when & there is a significant change in condition." 2. The complete clinical record for patient #4 with a start of care (SOC) of 2/04/2022 was reviewed on 04/18/2022. The record failed to include interventions and/or results of those interventions for abnormal findings for patient #4 on visit date 2/14/2022. The record evidenced the following: A SOC OASIS document dated 2/4/2022 indicated, but was not limited to; "Urinary Incontinence or catheter & no incontinence or catheter & renal/genitourinary status & within normal limits." A document titled "Patient Communication Log" dated 2/14/2022 signed by the Clinical Manager stated "SN {skilled nurse] reports no concerns. SN plans to see the patient every other week." A document titled "Skilled Visit Note" dated 2/15/2022 signed by RN B indicated but was not limited to; "Genitourinary & Incontinence & urine color & yellow-green & urine odor & foul odor & checked patient groin area and looks red and irritated." RN LM failed to notify the physician of patient #4's yellow-green foul odor and new-onset incontinence. During an interview on 4/20/2022 at 10:15 a.m., the Clinical Manager stated they could not find any other notes as to why the MD (medical		on May 9, 2022 to theagency policy *"Physician Plan of Treatment"* that included *“the physician's plan of treatment shall be reviewed by theattending physician in consultation with the Agency's professional personnel atsuch interval as the severity of the patient/client's illness inquires … morefrequently when … there is a significant change in condition.”* Theagency policy was reinforced, and all clinicians were instructed that thepatient visit documentation must include all interventions, including medicationadministration, treatments, and services and responses to those interventions. Additionally,all abnormal findings during assessments will result in prompt notification tothe physician and communication documented within the clinical record. · The clinical manager counseled the employee(s) documentationfindings during the survey that lacked documentation to support the patientvisit note included a full assessment with the patients response to treatmentand where the physician was not notified promptly for changes in the patientcondition. · 2. The clinical manager or designee will audit 20%of	

	doctor) was not notified of patient #4's dark foul urine and stated patient #9's notes were clearly copied and pasted but they did find a few notable differences unrelated to urinary status." 3. The complete clinical record for patient #9 with a start of care (SOC) of 2/09/2022 was reviewed on 04/18/2022. The record failed to include interventions and/or results of those interventions for abnormal findings for patient #9 for 7 home visits reviewed. The record evidenced the following: A document titled "Home Health Plan of Care & Certification" for the certification period 2/09/2022 through 4/09/2022 was signed by the patient's physician on 1/21/2022 and the Clinical Manager on 2/14/2022. The document indicated patient #9 had an extensive history of urinary tract infections. A document titled "Skilled Nursing Visit Note" for dates 2/12/2022, 2/23/2022, 3/02/2022, 3/09/2022, 3/16/2022, 3/22/2022, and 3/30/2022 signed by RN B all indicated but were not limited to; "Genitourinary & urgency & dysuria & retention & Pt (patient) voiding well &SN (skilled nurse) conts (continues) to educate patient on & s/s (signs/symptoms) of UTI & pt voiced no concerns at this time" A document titled "Skilled Nursing Visit Note" dated 3/30/2022 signed by RN B indicated a goal of "patient will be UTI free within 6wks (6 weeks) & goal status: progressing." A discharge OASIS document dated 4/07/2022 indicated, but was not limited to; "Elimination Status & has this patient been treated for a Urinary Tract Infection in the past 14 days & no"		patient records with the monthly chart reviews for 100% compliance for allinterventions, including medication administration, treatments, and servicesand responses to those interventions and for documentation that the physicianwas notified with any change in the patient's condition or assessment findingsoutside the physician parameters for 3 months. Then 10% of charts will bereviewed quarterly for (1) one year for 100% compliance to ensure regulatorycompliance as part of the quality assurance plan to prevent reoccurrence. · 3.The clinical manager will be responsible for thecorrective action plan. · 4.The corrective action will be effective immediately.Completion date will be on May 18, 2022.	
G1014	Interventions and patient response	G1014	· 1.All staff was in-serviced on May 9, 2022 to theagency	2022-05-18

	484.110(a)(2) All interventions, including medication administration, treatments, and services, and responses to those interventions; 4. The complete clinical record for patient #7 with a SOC 12/21/2021 was reviewed on 4/19/2021. The record failed to reveal documentation of wound measurements obtained by the agency throughout the admission. During interview with the Clinical Manager they stated there was a conversation regarding patient #7 and his wound measurements. It was decided not to measure this wound due to its size and irregularity. Documentation was not evidenced in the medical record of the decision to not measure the wound and why.		policy *"Physician Plan of Treatment"* that included *"the physician's plan of treatment shall be reviewed by theattending physician in consultation with the Agency's professional personnel atsuch interval as the severity of the patient/client's illness inquires … morefrequently when … there is a significant change in condition."* Theagency policy was reinforced, and all clinicians were instructed that thepatient visit documentation must include all interventions, including medicationadministration, treatments, and services and responses to those interventions. Additionally,all abnormal findings during assessments will result in prompt notification tothe physician and communication documented within the clinical record. · The clinical manager counseled the employee(s) documentationfindings during the survey that lacked documentation to support the patientvisit note included a full assessment with the patients response to treatmentand where the physician was not notified promptly for changes in the patientcondition. · 2. The clinical manager or designee will audit 20%of patient records with the monthly	

			chart reviews for 100% compliance for allinterventions, including medication administration, treatments, and servicesand responses to those interventions and for documentation that the physicianwas notified with any change in the patient's condition or assessment findingsoutside the physician parameters for 3 months. Then 10% of charts will bereviewed quarterly for (1) one year for 100% compliance to ensure regulatorycompliance as part of the quality assurance plan to prevent reoccurrence. · 3.The clinical manager will be responsible for thecorrective action plan. · 4.The corrective action will be effective immediately.Completion date will be on May 18, 2022.	

G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. 1. An undated policy titled "Discharge/Transfer" policy was provided by the clinical manager on 4/20/2022 at 12:30 p.m. The document indicated but was not limited to; "Prior to discharging the patient/client, the attending physician shall be notified. A written discharge summary, which shall be prepared within 30 days of discharge, will be sent to the physician with a copy maintained in the clinical record. The discharge summary will include: a. The reason for discharge. B. The patient/client's physical and psychosocial status at the time of the discharge c. A summary of the care and services provided d. Patient/client progress toward desired goals e. Instructions and referrals provided to the patient/client." 2. The complete clinical record for patient #1 for the certification period of 3/17/2022 through 5/15/2022 was reviewed on 4-18-2022. The record failed to evidence a complete written discharge summary. The record evidenced the following: A 3/17/2022 dated OASIS assessment signed by RN B that indicated patient # 1 did not have a power of attorney. A document titled "Patient Communication	G1022	· 1. All staff was in-serviced on May 9, 2022 to theagency policy *"Discharge/Transfer"* that included Prior todischarging the patient/client, the attending physician shall be notified. Awritten discharge summary, which shall be prepared within 30 days of discharge,will be sent to the physician with a copy maintained in the clinical record.The discharge summary will include: o A. The reason for discharge. o B. The patient/client's physical andpsychosocial status at the time of the discharge o C. A summary of the care and services provided o D. Patient/client progress toward desired goals o E. Instructions and referrals provided to thepatient/client. · 2.The clinical manager or designee will audit 100%of patient records with the monthly chart reviews for 100% compliance with documentedevidence in the patient record to support a complete discharge summary wasprovided to the primary care practitioner who will be responsible for providingcare and services to the patient after home health discharge within 5 businessdays of the patient	2022-05-18

	RN B that indicated but was not limited to; "Called and spoke with patient son & about seeing patient for resumption of care & PT (patient is no longer living with son & he is living with a different son & states (patient #1) doesn't want additional HH (home health) services." 3. During an interview on 4/20/2022 at 12:30 p.m. the Clinical Manager stated a discharge order was sent due to the patient's son stating he didn't want services but it was just an order to discharge from the agency. 4. The complete clinical record for patient #9 for the certification period of 2/09/2022 through 4/09/2022 was reviewed on 4-19-2022. The record failed to evidence a complete written discharge summary. The record evidenced the following: A document titled "Discharge Order" dated 04/07/2022 indicated "To discharge from Carefirst Rehab for home health care services due to therapy goals met & Goals To meet patient's medical needs. Patient Informed: Yes."		discharge or within 2 business days of the patient transferfor 3 months. Then 10% of charts will be reviewed quarterly for the next 12 monthsfor 100% compliance to ensure regulatory compliance as part of the qualityassurance plan to prevent reoccurrence. · 3. The clinical manager will be responsible for thecorrective action plan. · 4.The corrective action will be effective immediately.Completion date will be on May 18, 2022.	
G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. 5. The complete clinical record	G1022	· 1. All staff was in-serviced on May 9, 2022 to theagency policy *"Discharge/Transfer"* that included Prior todischarging the patient/client, the attending physician shall be notified. Awritten discharge summary, which shall be prepared within 30 days of discharge,will be sent to the physician with a copy maintained in the clinical record.The discharge summary will include: o A. The reason for discharge.	2022-05-18

for patient #2 for the certification period of 12/03/2021 through 1/31/2022 was reviewed on 4-18-2022. The record failed to evidence a complete written discharge summary. The record evidenced the following:

A document titled "Discharge Order" dated 12/30/2021 at 10:00 am indicated "To discharge from Carefirst Rehab for home health care services due to therapy goals met & Goals To meet patient's medical needs. Patient Informed: Yes."

6. The complete clinical record for patient #10 for the certification period of 12/31/2021 through 2/28/2022 was reviewed on 4/21/22. The record failed to evidence a complete written discharge summary. The record evidenced the following:

Document titled "OASIS Assessment Details" dated 2/24/2022 and contained a discharge summary that stated "Pt has partially met his goals and is being dc'd from HHS to OP services for continuation of therapy...".

7. The complete clinical record for patient #11 for the

o B. The patient/client's physical andpsychosocial status at the time of the discharge

o C. A summary of the care and services provided

o D. Patient/client progress toward desired goals

o E. Instructions and referrals provided to thepatient/client.

· 2.The clinical manager or designee will audit 100%of patient records with the monthly chart reviews for 100% compliance with documentedevidence in the patient record to support a complete discharge summary wasprovided to the primary care practitioner who will be responsible for providingcare and services to the patient after home health discharge within 5 businessdays of the patient discharge or within 2 business days of the patient transferfor 3 months. Then 10% of charts will be reviewed quarterly for the next 12 monthsfor 100% compliance to ensure regulatory compliance as part of the qualityassurance plan to prevent reoccurrence.

· 3. The clinical manager will be responsible for thecorrective action plan.

· 4.The corrective action will be effective immediately.Completion date

	certification period of 2/01/2021 through 4/01/2022 was reviewed on 4/18/22. The record failed to evidence a complete written discharge summary. During interview on 4/20/2022 Clinical Manager stated there was not a discharge summary for patient 11. 410 IAC 17-15-1(a)(6)		will be on May 18, 2022.	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE