Amended POC accepted on 10n-19-2022
Deborah Franco, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200231350A	A. BUILDING B. WING	09/16/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 Agency. Survey Date: 9/12/22, 9/13/22, 9/14/22, 9/15/22, and 9/16/22 Census: 430 At this Emergency Preparedness survey, Preferred Home Care continued to be out of compliance at 42 CFR 484.102 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies.	E0000	PREFERRED HOME CARE, INC is submitting the following Plan of Correction in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction is not intended as an admission, does not constitute an admission by and should not be construed as an admission by PREFERRED HOME CARE, INC that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to patients of the Agency. PREFERRED HOME CARE, INC desires this Plan of Correction to be considered our Allegation of Compliance." PREFERRED HOME CARE, INC has retained the services of a nurse consultant.	2022-10-21

	QR by Area 3 on 9-30-2022		The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
G0000	INITIAL COMMENTS This visit was for a Federal Post Condition revisit and a follow-up to a State Relicensure survey of a Medicare Home Health Agency following the original Recertification and State Relicensure survey conducted on 6/9/2022. Survey Dates: 9/12/22, 9/13/22, 9/14/22, 9/15/22, and 9/16/22 Census: 430 During this survey, 2 Condition level deficiencies were corrected; 1 new Condition level deficiency was cited: 4 standard level deficiencies were corrected; 1 standard level deficiency was recited and 2	G0000	PREFERRED HOME CARE, INC is submitting the following Plan of Correction in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction is not intended as an admission, does not constitute an admission by and should not be construed as an admission by PREFERRED HOME CARE, INC that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to patients of the Agency. PREFERRED HOME CARE, INC desires this Plan of Correction to be considered our	2022-10-21

	new standard level deficiencies were cited. Preferred Home Health Care, Inc. continues to be out of compliance with the requirements of the Condition of Participation 42 CFR 484.50, Patient Rights. Based on the Condition-level deficiencies during the 6/9/2022 survey, your Home Health Agency was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 6/9/2022. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency continues to be precluded from operating or being the site of a home health aide training, skills competency, and/or competency evaluation program for a period of two years beginning 6/9/2022 and continuing through 6/8/2024. The deficiencies cited in this survey are reflected in findings cited pursuant to 410 IAC 17. See the survey report for findings.		Allegation of Compliance." PREFERRED HOME CARE, INC has retained the services of a nurse consultant. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

	QR by Area 3 on 9-28-2022			
E0001	Establishment of the Emergency Program (EP) 403.748,482.15,485.625 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and	E0001	1.Describe what the agency did to correct the deficient practice for each client cited in the deficiency. Agency failed to ensure the comprehensive emergency preparedness program met all requirements to meet the health, safety, and security needs of their staff and patient population for 1 of 1 agency (E0001). After the previous survey in June 2022, a comprehensive EP Plan had been added to Summit's internal site and office EP binder. Two EP documents were also created and dispersed to clinicians to add to current patients' SOC packets and to the SOC packets for future patients. There was not 100% follow through by clinicians so	2022-10-21

	The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: Based on record review and interview, the agency failed to ensure the comprehensive emergency preparedness program met all requirements to meet the health, safety, and security needs of their staff and patient population for 1 of 1 agency (E0001) and failed to ensure patients had written and individualized Emergency Preparedness plans included as part of their comprehensive assessments for 10 of 10 clinical records reviewed (E0017). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition, /Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies /at /42 CFR 484.102. Findings include: 9. During a home visit on 9/13/22 with Pt #2, when queried about their admission folder, Pt #2 stated they threw it away. During a phone interview on		patients continued to be missing EP forms in the SOC folder and therefore, were not accessible to the patient. Ongoing, Agency will be printing and giving paper SOC folders to all current patients and future patients. The folders will contain the appropriate EP information for each patient. Clinicians will fill out the EP forms at SOC and inform patients that the forms will be kept in the SOC folder. A picture of the EP form will be uploaded to the patient's EMR. 2. Describe how the agency reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. Compliance Officer, in conjunction with Clinical Director, Administrator, and Rehab coordinator, have reviewed the contents of the	

	9/15/22 at 10:55 AM, when queried about the QR code, Pt #2 indicated that they know nothing about it, and asked what it was for. When this writer explained it was a way to access a patient handbook, Pt #2 stated no one had explained it to her. When queried if Pt #2 provided an email so that the agency could email documents to them, they stated no. 10. During a home visit with on 9/14/22 at 2:30 PM Pt #3, when queried about the QR code indicated they didn't know anything about it, and their smartphone was smarter than them, but that their family member might know something about it. During a phone interview on 9/14/22 at 3:20 PM with Pt #3's family member I indicated the patient's rights and advance directives should be in their folder. Family member I stated they had not been present for the admission. When queried about the possibility of receiving documents via email, they indicated there were none. When queried about the QR code in Pt #3 folder, family member I indicated they hadn't		SOC packet to ensure the necessary EP documents are present. New SOC packets with appropriate EP documents will be printed and assembled beginning the week of 10-9-22. Clinicians will be informed via email that paper SOC packets will be issued to all current and future patients beginning week of 10-16-22. Clinicians will be mandated to obtain the new packets from the office and disperse to all current and future patients that week. Clinicians will also be trained via email the appropriate information to cover with the patient at SOC and which documents need to be completed in the SOC packet. To ensure compliance, a clinician checklist will be added to the SOC folder and clinicians/patients will sign the form indicating all requirements have been completed. Clinicians will sign off in Paycom that this training is understood. 3. Describe the steps or	

	been told about the code. 11. During a phone interview on 9/14/22 at 1:15 PM with Pt #7, when queried about the QR code, they indicated they had no idea what a QR code is. Pt #7 indicated the only documents in their folder were their Plan of Care, Admission Service agreement, and Safety measures. When queried about the possibility of the agency emailing the required documents, Pt #7 indicated they hadn't asked for their email address. 12. During an interview on 9/14/22 at 2:45 PM with ST #1, they indicated they use DocuSign for the admission packet and further indicated they hadn't utilized the QR code in the admission folder. 13. During a phone interview on 9/15/22 at 8:31 AM with RN #5, when queried about the admission process, RN #5 indicated the patient handbook is on DocuSign and the patient will look as they are going through it. RN #5 indicated patients have the option to have documents either mailed or emailed to them. When		has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. New SOC packets with appropriate EP documents will be printed and assembled beginning the week of 10-9-22. Clinicians will be informed via email that paper SOC packets will be issued to all current and future patients beginning the week of 10-16-22. Clinicians will be mandated to obtain the new packets from the office and disperse to all current and future patients that week.	

	queried about the QR code in the admission packet, they indicated the QR code was mandated by the State and Federal Regulations so if the patient has any issues, the patient can utilize the code, as all the information is in the code. 14. During a phone interview on 9/14/22 at 11:52 AM with RN #6, when queried about the QR code, they indicated didn't know about it and if they didn't know about it, the patients they provide service to, don't know about it. 15. During an interview on 9/15/22 at 1:30 PM with the administrator, when queried about the QR Code in the admission packets, she indicated all employees have been educated on the use of the QR code, with an explanation in the document on how to contact the agency if patients want the paper documents. 1. Review of an undated agency document titled 'Summit Home Care and Hospice Emergency Preparedness Plan' stated,		Clinicians will also be trained via email the appropriate information to cover with the patient at SOC and which documents need to be completed in the SOC packet. To ensure compliance, a clinician checklist will be added to the SOC folder and clinicians/patients will sign the form indicating all requirements have been completed. Clinicians will sign off in Paycom that this training is understood. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place to ensure 100% compliance and who will be responsible for monitoring. Randomized calls will be made by Rehab Coordinator and Administrator to patients beginning the week of 10-23-22 to ensure each patient has a SOC folder, the folder has all necessary information, and that the assigned SOC clinician has covered the items on the checklist. Rehab Coordinator and Administrator will be	

	"Planning...Administration 1. Each office will keep and maintain a current list of...vendors, emergency services, hospitals and other appropriate community resources." /On page 5 stated, "...Patient and Care Planning 1. Upon SOC/admission, the admitting nurse will assign each patient a priority/disaster risk/triage code, dictating that patient's emergency rating. The admitting nurse will obtain a list of contact numbers and discuss emergency planning options with both the patient and family. /This information is documented on admission in Well Sky and on paper kept in the patient's home as a reference to. The admitting nurse works with the patient, preparing a list of items that will be available for use in an emergency situation, this is patient specific. a. Any patients requiring special equipment such as power for life support will be registered with the local utility companies and with local emergency offices. /This admitting Summit nurse will educate both patients and families on managing an emergency situation. b. a list of medical vendors who supply patient supplies will be noted in the chart in Well Sky and in the patient's home." / Review of an agency document dated April 2015 titled 'EMERGENCY MANAGEMENT PLAN Policy No. 6-037.1' stated, "PURPOSE To establish a plan which allows for the continuation of services in the event of a disaster affecting the organization or the community." Page 5 (Policy No. 6-037.5) stated, "Patient Preparedness - Detailed written instructions will be given to patients and/or family members to ensure an appropriate and timely response in the event of an emergent event that may		responsible for ongoing compliance. The training provided to current clinicians regarding the SOC packets will be memorialized and added to new employee training to ensure 100% future compliance. Administrator/designee will audit all current patient charts to ensure there is documentation clinician has covered all items on the checklist and checklist has been uploaded to the patient chart. Once 100% compliance is achieved, 10% will be audited quarterly to ensure compliance is maintained. 5. By what date are you going to have the deficiency corrected? Week of 10-9-22 New SOC packets will be printed and assembled Week of 10-16-22 Clinicians will	

	cause interruptions of service. Information provided may include: 1. Emergency contact telephone numbers 2. Names of contact persons 3. Local resources for civil preparedness 4. Evacuation routes 5. Availability of local shelters and other community resources 6. Maintenance of backup medical equipment when indicated 7. Methods to obtain needed medications, supplies and equipment 8. Necessity of having a plan for obtaining food/water, caring for pets and obtain important documents."		current and future patients Week of 10-23-22 Rehab Coordinator and Administrator to call randomized patients to ensure compliance of this deficiency will be completed by 10-28-22.	

	Review of an untitled agency document located in the agency's Admission folder, stated "Access a copy of our electronic start of care packet & Emergency preparedness documents for you and your family." A QR code is present, with instructions to '"SCAN TO VIEW" printed below. To the right of the code, "Scan using your mobile phone or electronic device via your camera. Select the link that generates to be directed to the documents via the Summit Home Care Website." "If you would prefer a hard copy please contact our office: 1-800-858-5474". 2. A review of the clinical records for patients 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10 failed to evidence completed, individualized Emergency Preparedness Plans were in place. 3. In an interview on 9/14/22 at 11:49 AM, RN 1 informed that since the last survey they have received a lot of training including Emergency Planning. When queried about the way the patient receives this information, RN 1 indicated her understanding was that 7-10 days after the admission visit, a copy of all the consents signed, DocuSign'ed items, and 15-20 other pages of information are			

	mailed to the patient's home. When queried about the use of the QR code found in the admission packet, RN 1 indicated he/she had never scanned this for themself and probably ought to. 4. In an interview on 9/13/22 at 12:00 PM with Patient 5, when queried about receiving an emergency plan from the agency, the patient was unable to produce one. When queried as to whether the patient had ever used the QR in the Admission folder, Patient 5 indicated he/she had not used it, and stated, "I'm not a 'QR' person". 5. In an interview on 9/14/22 at 1:00 PM the spouse of Patient 4 is queried as to whether they have an Emergency Plan from the agency. The spouse indicated that he/she did not think so. The admission folder was reviewed and contained 3 sheets, one of which contained a QR code. The spouse was asked if he knew about the QR code, they replied saying, "I wouldn't know what to do with it." The spouse was asked if he/she could access the			

	using his/her smartphone. The spouse stated "I think mine is a smartphone", joking further that they felt the phone might be smarter than him/her. LPN 2 attempted to talk the spouse through using the phone to read the QR code, the attempt was unsuccessful. The LPN then asked if she could try it for the spouse, and found the phone was not equipped to read the QR code. The LPN indicated she would contact the office to request a plan of care be sent to the patient. The spouse was unable to produce an Emergency plan for the patient. 6. In an return phone call on 9/14/22 at 8:05 PM, Person E, a family member of Patient 8, stated they were not in possession of a copy of Patient Rights or an Emergency Preparedness plan from the agency. He/she stated they had a folder with a document in hand titled "home health plan of care" but indicated there was nothing else from the agency. When queried if they were aware of a QR, he/she stated that it was on one of the sheets in the folder and stated, "never used it, what's that for?"			

	7. In an interview on 9/15/22 at 1:05 PM, the former Administrator indicated the process of getting the Emergency Preparedness information to the patients had recently changed and now there were two pages that should be in a patient's home folder, and submitted these to surveyors for review, these pages were to be provided to all patients by visiting clinicians who were to check each folder during visits and ensure that patients had the two new forms in place as of 7/14/22, the Administrator-in-training concurred. 8. In an interview on 9/16/22 at 12:27 PM, agency RN 4 indicated that during an admission he/she will go through the elements of the admission on her electronic device with the patient, including an evacuation check-off list but stated, "we send all DocuSign [documents], it gets mailed to them." RN 4 then indicated someone else in the office is tasked with mailing out copies out to the patient. When queried regarding the use of the QR code that is in the			

	haven't really used it, to be honest. At least not with my admits."			
G0406	Patient rights 484.50 Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. Based on record review and interview, the agency failed to inform the patients and or patient representatives of the patient rights in a manner that was understood in 6 of 10 clinical records reviewed. (Patients 2, 3, 4, 5, 7, and 8.) Findings include: 1. A review of an agency's policy dated April 2015, titled, 'ADMISSION CRITERIA AND PROCESS Policy No 2-003.1' revealed, "PURPOSE To establish standards and a process by which a patient can be evaluated and accepted for admission. POLICY...Once a	G0406	1.Describe what the agency did to correct the deficient practice for each client cited in the deficiency. Agency failed to inform the patients and or patient representatives of the patient rights in a manner that was understood in 6 of 10 clinical records reviewed. (G0406) Agency will be printing and giving paper SOC folders to all current patients and future patients. The folders will contain a Patient Handbook, which will list Patient Rights. Clinicians will be trained to cover Patient Rights at the time of SOC. Patients will sign a form at the time of SOC indicating they agree that all information has been covered and understood. 2. Describe how the agency	2022-10-21

	the organization is responsible for providing care and services within it financial and service capabilities, mission and applicable law and regulations. Admission Criteria...3. The education and training of organization personnel will be recorded according to organization policy..." A review of an agency's policy dated April 2015, titled 'PATIENT BILL OF RIGHTS Policy No. 2-002.1' revealed, "PURPOSE To encourage awareness of patient rights and provide guidelines to assist patients in making decisions regarding care and for active participation in care planning. POLICY Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights as described. A patient may designate someone to act as his/her representative. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by the organization. To Assist with fully understanding patient rights, all policies will be available to the organization		reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. Compliance Officer, in conjunction with Clinical Director, Administrator, and Rehab coordinator, have reviewed the contents of the SOC packet to ensure the necessary documents are present in the Patient Handbook. New SOC packets with appropriate documents will be printed and assembled beginning the week of 10-9-22. Clinicians will be informed via email that paper SOC packets will be issued to all current and future patients beginning week of 10-16-22. Clinicians will be mandated to obtain the new packets from the office and disperse to all current and future patients that week. Clinicians will also be trained via	

	personnel, patients, and his/her representatives...PROCEDURE 1. The Patient Bill of Rights statement defines the right of the patient to:...K. Receive Advance Directives information prior to or at the time of the first home visit...P. Receive in writing, prior to the start of care, the telephone numbers for the State Home Health Hotline and the ACHC Hotline...(Patient will be given ACHC address as well.). S. Patient privacy rights related to the collection of the Outcome and Assessment Information Set (OASIS)..." A review of an agency's policy dated April 2015 titled, 'PATIENT PRIVACY RIGHTS Policy No. 2-014.1' revealed, "PURPOSE To encourage awareness of patient privacy rights and Summit Orthopaedic Home Care's legal duties with respect to these rights...POLICY To assist with fulling understanding patient privacy rights and responsibilities, all policies will be available to the organization personnel, patients...PROCEDURE 1. The patient will be provided with information about his/her privacy rights in the		information to cover with the patient at SOC and which documents need to be covered and completed in the SOC packet. To ensure compliance, a clinician checklist will be added to the SOC folder and clinicians/patients will sign the form indicating all requirements have been completed. Clinicians will sign off in Paycom that this training is understood. 3. Describe the steps or systemic changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.	

	Practices, which will be given to the patient during the admission visit..." A review of an agency's policy dated April 2015 titled, 'Facilitating Communication Policy No. 2-040.1', revealed, "PURPOSE To assure that patients...with speech, vision, or hearing impairments, as well as those who have a limited command of the English language, have access to appropriate interpretive assistance and other aids at no cost to patient(s) being served...POLICY...PROCEDURE 1. The inital assessment will determine the patient's communication ability..." 2. A review of clinical record #2 evidenced a document titled, 'ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES' , indicating Pt #2 signed they have received a copy of the Notice of Privacy Practices, Communication Preferences Regarding PHI, During a home visit on 9/13/22 with Pt #2, when queried of their admission folder, Pt #2 stated they threw it away.		New SOC packets with appropriate EP documents will be printed and assembled beginning the week of 10-9-22. Clinicians will be informed via email that paper SOC packets will be issued to all current and future patients beginning the week of 10-16-22. Clinicians will be mandated to obtain the new packets from the office and disperse to all current and future patients that week. Clinicians will also be trained via email the appropriate information to cover with the patient at SOC and which documents need to be completed in the SOC packet. To ensure compliance, a clinician checklist will be added to the SOC folder and clinicians/patients will sign the form indicating all requirements have been completed. Clinicians will sign off in Paycom that this training is understood. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality	

	3. During a home visit with Pt #3, when reviewing their admission folder, Pt. #3 stated all the information is in it. Upon reviewing the contents, there were signed by Pt #3: Home Health Admission Service Agreement, indicating the patient had received verbal and written information on the following: Advance Directives, Patient' Rights, Agency's Complaint/Grievance process, and the Indiana State Department of Health Toll Free Complaint Hotline number (1-800-227-6334) CMS statement of Patient Privacy Rights and Privacy Act Statement, Acknowledgment a receipt of the Agency's Notice of Privacy Practices, Acknowledgement and receipt of the Agency's Disclosure of Information Policy, Infection Control and Universal Precautions. and a Plan of Care, Another document in the admission folder was a document with "Summit Home Care" letterhead indicated a "START OF CARE DATE:" was blank, it further indicated, "Access a copy of our electronic Start of Care packet & Emergency preparedness documents for you and your		into place to ensure 100% compliance and who will be responsible for monitoring. Randomized calls will be made by Therapy Director and Adminstrator to patients beginning the week of 10-23-22 to ensure each patient has a SOC folder, the folder has all necessary information, and that the assigned SOC clinician has covered the items on the checklist. Rehab Coordinator and Administrator will be responsible for ongoing compliance. The training provided to current clinicians regarding the SOC packets will be added to new employee training to ensure 100% future compliance. Administrator/designee will audit all current patient charts to ensure there is documentation clinician has covered all items on the checklist and checklist has been uploaded to the patient chart. Once 100% compliance is achieved, 10% will be audited quarterly to ensure compliance	

	family." The document had a QR code on it, beside the code it stated, "Scan using your mobile phone or electronic device via your camera. Select the link that generates to be directed to the documents via the Summit Home Care Website. If you would prefer a hard copy, please contact our office 1-800-858-5474." When queried about the QR code, Pt #3 indicated they didn't know anything about it, and their smartphone was smarter than them. 4. During a phone interview with Pt #2 on 9/15/22 at 10:55 AM, when queried about the QR code, Pt #2 indicated that they know nothing about it, and asked what it was for. When this writer explained it was a way to access a patient handbook, Pt #2 stated no one had explained it to her. When queried if Pt #2 provided an email so that the agency could email documents to them, they stated no. 5. During a phone interview on 9/14/22 at 3:20 PM with Pt #3's family member I indicated the patient's rights and advance directives should be in their		is maintained. 5. By what date are you going to have the deficiency corrected? Week of 10-9-22 New SOC packets will be printed and assembled Week of 10-16-22 Clinicians will disperse new SOC folders to current and future patients Week of 10-23-22 Rehab Coordinator and Administrator to call randomized patients to ensure compliance Compliance of this deficiency will be completed by 10-28-22.	

	folder. Family member I stated they had not been present for the admission. When queried about the possibility of receiving documents via email, they indicated there were none. When queried about the QR code in Pt #3 folder, family member I indicated they hadn't been told about the code. 6. During a phone interview on 9/14/22 at 1:15 PM with Pt #7, when queried about the QR code, they indicated they had no idea what a QR code is. Pt #7 indicated the only documents in their folder were their Plan of Care, Admission Service agreement, and Safety measures. When queried about the possibility of the agency emailing the required documents, Pt #7 indicated they hadn't asked for their email address. 7. During an interview on 9/14/22 at 2:45 PM with ST #1, they indicated they use DocuSign for the admission packet and further indicated they hadn't utilized the QR code in the admission folder. 8. During a phone interview on 9/15/22 at 8:31 AM with RN #5,			

	when queried about the admission process, RN #5 indicated the patient handbook is on DocuSign and the patient will look as they are going through it during the admission. RN #5 indicated patients have the option to have documents either mailed or emailed to them. When queried about the QR code in the admission packet, RN #5 indicated the QR code was mandated by the State and Federal Regulations so if the patient has any issues, the patient can utilize the code, as all the information is in the code. 9. During a phone interview on 9/14/22 at 11:52 AM with RN #6, when queried about the admission process RN #6 indicated patients sign all consents in Docusign, and those documents are mailed to each patient. When this writer queried RN #6 of the QR code, RN #6 stated they didn't know about it and if they didn't know about it, the patients they see don't know about it. 10. During an interview on 9/15/22 at 1:30 PM with the administrator, when queried			

admission packets, she indicated all employees have been educated on the admission process and the use of the QR code, with clear instruction in the document on how to contact the agency if patients want the paper documents.

11. In an interview on 9/14/22 at 11:49 AM with RN 1, when queried about the way the patient receives patient rights (and other information), RN 1 indicated her understanding was that 7-10 days after the admission visit, a copy of all the consents signed, DocuSign'ed items, and 15-20 other pages of information are mailed to the patient's home. When queried about the use of the QR code found in the admission packet, RN 1 indicated he/she had never scanned this for themselves and probably ought to.

12. In an interview on 9/13/22 at 12:00 PM with Patient 5, when queried about receiving information on patient rights (among other information) from the agency, the patient was unable to produce any

	whether the patient had ever used the QR in the Admission folder, Patient 5 indicated he/she had not used it, and stated, "I'm not a 'QR' person". 13. In an interview on 9/14/22 at 1:00 PM the spouse of Patient 4 is queried as to whether they have additional documents, (aside from the 3 pages found within the admit folder: an untitled page with QR code, a summary page of Summit services, and a blank calendar) from the agency. The spouse indicated that he/she did not think so. The admission folder was reviewed and contained 3 sheets, one of which contained a QR code. The spouse was asked if he knew about the QR code, replied saying, "I wouldn't know what to do with it." The spouse was asked if he/she could access the information from the QR code by using his/her smartphone. Spouse stated, "I think mine is a smartphone", joking that he/she felt the phone might be smarter than him/her. LPN 2 attempted to talk the spouse through using the phone to read the QR code, the attempt was unsuccessful. The LPN then asked if she could try it for the			

spouse, and found the phone was not equipped to read the QR code. The LPN indicated she would contact the office to request a plan of care be sent to the patient. The folder failed to evidence a copy of Patient's rights.

14. In an return phone call on 9/14/22 at 8:05 PM, Person E, a family member of Patient 8, stated they were not in possession of a copy of Patient Rights or an Emergency Preparedness plan from the agency. He/she stated they had a folder with a document in hand titled "home health plan of care" but indicated there was nothing else from the agency. When queried if they were aware of a QR code, he/she stated that it was on one of the sheets in the folder and stated, "never used it, what's that for?"

15. In an interview on 9/16/22 at 12:27 PM, agency RN 4 indicated that during an admission he/she will go through the admission packet on her electronic device with the patient including an evacuation check-off list, but stated, "we send all DocuSign

	them." When queried as to how the patient receives their copy of this, RN 4 indicated someone else in the office is tasked with mailing out copies out to the patient. When queried regarding the use of the QR code that is in the admission folder, RN 4 stated, "I haven't really used it, to be honest. At least not with my admits."			
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 inform the ordering provider of a change in condition in 1 (Patient 4) of 4 home visits observed. Findings include: 1. Review of an agency policy dated April 2015 titled 'Monitoring Patient's Response/Reporting to	G0590	1.Describe what the agency did to correct the deficient practice for each client cited in the deficiency. Agency failed to inform the ordering provider of a change in condition in 1 of 4 home visits observed. (G0590) The clinician in question was provided with education and corrective action. Staff meeting/inservice was held for all disciplines/clinicians to provide education to all that patients are to contact the treating clinician/case manager and the office with any change in medical condition and that the office number is located in	2022-10-21

	Physician Policy No. 4-012.1,' stated, "PURPOSE To provide guidelines for monitoring the patient's response to care, and for reporting to the patient's physician. POLICY Clinicians will monitor, document, and report the patient's response to care and treatment provided on each home visit .... Clinicians will establish and maintain ongoing communication with with the physician to ensure safe and appropriate care for the patient. PROCEDURE ... 3. The patient's physician will be contacted the same day when any of the following occur: A. Significant changes in the patient's condition. B. Significant changes in the patient's psychosocial status ... F. When there is any problem implementing the plan of care ... 4. All conferences or attempts to communicate with physician will be documented in the clinical record. A. Documentation of the physician notification will include: 1. Date and time contacted 2. Patient name 3. Name of Physician or his/her representative 4. Reason for notification 5. Physician's response 6. Action or orders obtained 7. Professional's signature and title. B Documentation of attempted		the SOC folder. In addition, the necessity of alerting relevant/ of record physicians of condition changes, concerns, decline, and/or improvements in overall status and changes to plan of care was reviewed. MD is to be notified at time of visit or as soon as possible. If LPN is made aware of a change in patient condition they are to notify RN case managers at time of visit or as soon as possible. For a period of 30 days the Administrator or designee will ride along once weekly with a randomly selected patient from the cited clinician’s caseload and observe clinicians for compliance. All Clinicians will sign attestation in Paycom that this training is understood and that patients will be informed that they are to notify the clinician/case manager and the office with any change in medical condition and that this information is included in the patient handbook for future reference.	

	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." 2. Review of the clinical record for Patient #4 contained a plan of care with a start of care date of 2/10/22 for the recertification period of 8/9/2022 - 10/7/2022 and had diagnoses that included, but were not limited to, Pressure Ulcer of the sacral region stage 2 (a sore caused by unrelieved pressure that breaks down the skin and extends to the layer beneath it, in this case the area is located between the lower back and the tailbone), unspecified dementia without behavioral disturbance (impaired ability to remember or think, or make decisions that interfere with the ability to perform everyday activities), essential hypertension (abnormally high blood pressure that is not the result of a medical condition, often due to obesity, family history and an unhealthy diet), type 2 diabetes (a chronic condition that affects the way the body processes blood sugar, the body either doesn't produce enough insulin		2. Describe how the agency reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. HHA reviewed the current roster of patients with randomized selection, reviewed each client with the LPN cited in the survey, and reinforced education provided in the immediate correction plan. HHA immediately developed and implemented corrective action and education. DIrector of nursing provided staff in-services for all disciplines/clinicians on 09/20/2022 and 09/22/2022 to educate / review, Emails were also sent to all clinical staff to review the information that was provided during the in-services. Clinicians will sign attestation in Paycom that this training is understood and patients are informed that they are to notify the office and the clinician/case	

	or resists insulin), and gastrointestinal hemorrhage (a symptom of a disorder in your digestive tract, the blood often apears in stool or vomit but isn't always visible, the level of bleeding can range from mild to severe and can be life threatening). Skilled nursing services were ordered: 1 time per week for 10 weeks, for wound care. Review of the clinical record contained an untimed agency document dated 9/14/22, titled 'Patient Communication,' created by LPN 2 which stated, "Called pcp related pt [sic patient] having elevated bps [blood pressures], increased anxiety, progressing dementia, and regarding different wound care orders again. Left message for the nurse to cal this nurse back awaiting call". The document failed to contain a contact time and contact name. 3. During a home visit for Patient 4 on 9/14/22 at 1:00 PM, Licensed Practical Nurse (LPN) 2 completed ordered wound care. An elevated blood pressure reading of 155/75 was noted by LPN 2 as being high for the		manager with any change in medical condition and that this information is included in the patient handbook for future reference. 3. Describe the steps or systemic changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Agency will continue to reinforce education as needed that is provided in the immediate correction plan. HHA immediately developed and implemented corrective action and education. DIrector of nursing will continue to provide staff in-services/meetings for all disciplines for ongoing compliance. Clinicians will sign attestation in Paycom that this training is understood and patients are informed that they are to notify the office and the clinician/case manager with any change in medical condition and that this information is	

	patient's spouse. The visit was completed and the LPN and surveyor had exited the home, the spouse followed outside shortly thereafter, walked toward LPN 2 and the surveyor, and stated he wanted to ask a question out of earshot of the patient so as not to exacerbate the patient's dementia. The spouse informed the LPN that the patient was now complaining of a headache and additionally stated the patient had a "microbleed." The spouse asked LPN 2 if he/she should contact the doctor, and the LPN confirmed that the spouse should contact the doctor. The LPN suggested that the headache could be due to dehydration. The LPN asked no further follow-up questions (exactly what microbleed are you referencing) of Patient #4's spouse, did not return to assess Patient #4, and did not make any phone calls at that time. 4. On 9/14/22 at 2:39 PM, following the home visit for Patient 4,shared these concerns with the Administrator-in-training and former Administrstor by phone to inform of the spouse's report of new headache and the		included in the patient handbook for future reference. Meetings/Inservices will be performed quarterly at minimum. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place to ensure 100% compliance and who will be responsible for monitoring. Agency will continue to review the current roster of patients with randomized selection, review each client with the LPN cited in the survey, and reinforce education as needed that is provided in the immediate correction plan. HHA immediately developed and implemented corrective action and education. For a period of 30 days the Administrator or designee will ride along once weekly with a randomly selected patient from cited clinician’s caseload and observe clinician for compliance. DIrector of	

	mention of a microbleed, and that spouse asked if he/she should get in touch with the physician about it and that LPN 2 indicated to the spouse that yes, the spouse should, and the LPN left the home. The Administrator-in-training indicated that there would be follow-up on the matter. 5. In an interview on 9/15/22 at 4:05 PM, person H for Dr. F, when queried as to whether any calls from the agency had been received recently about Patient #4's complaint of a headache and elevated blood pressure, stated the only calls on record from the agency were received on 9/13/22, which was a request from the agency nurse for a change in Patient #4's wound care orders, there were no entries for the date of 9/14/22, but stated there was a call made today, 9/15/22, at 11:54 AM regarding an elevated blood pressure from yesterday's visit (9/14/22). Person H then connected the call to Dr. F's Nurse G. In an interview on 9/15/22 at 4:18 PM, Nurse G for Dr. F, verified there were no calls on 9/14/22 to report Patient #4's		nursing will continue to provide staff in-services/meetings for ongoing compliance. Meetings/Inservices will be performed quarterly at minimum. Clinicians will sign attestation in Paycom that this training is understood and patients are informed that they are to notify the office and clinician/case manager with any change in medical condition and that this information is included in the patient handbook for future reference. Director of Nursing/designee will audit all visit notes submitted by cited LPN weekly, to ensure that if there is documentation of a change in patient condition, there is documentation MD has been notified . Also, if the LPN was made aware of change during their visit there should also be documentation that the RN Case Manager was notified of the change. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. In addition, randomized calls will be made by Therapy	

	elevated blood pressure or headache, Nurses G did state there was an entry dated today, 9/15/22 at 11:54 AM from agency LPN 2 who reported an elevated blood pressure of 159/74 from yesterday's visit, but there was no mention of a headache. In an interview on 9/15/22 at 4:41 PM with agency RN 3, who performed the most recent Supervisory visit for Patient 4 and LPN 2 on 9/7/22, stated was not contacted about the 9/14/22 visit regarding an elevated blood pressure reading nor report by Patient 4 of a headache. Also indicated, Had received no phone call, nor 'Tiger Text' from LPN 2. RN 3 indicated he/she believed RN 4 was actually the case manager for this patient. In an email received on 9/16/22 at 8:03 AM, the Administrator-in-training was unable to provide any documentation of communication in the form of 'Tiger Texts' from LPN 2 to any other staff RN or case manager, regarding the findings from Patient 4's home visit on 9/14/22. "As of now there are		patients beginning the week of 10-23-22 to ensure each patient has a SOC folder, the folder has all necessary information, and that the assigned SOC clinician has instructed the patient to call the office and notify the clinician/case manager of any change in medical condition. Administrator/designee will audit all current patient charts to ensure there is documentation clinician has covered all items on the SOC checklist, including contents of the Patient Handbook, and that the checklist has been uploaded to the patient chart. Once 100% compliance is achieved, 10% will be audited quarterly to ensure compliance is maintained. Rehab Coordinator and Administrator will be responsible for ongoing compliance.	

	not any. The LPN may very well still be gathering information, etc. [LPN 2] has 48 hours to submit, and in extenuating circumstances, it may take more time." In an interview on 9/16/22 at 12:27 PM, agency RN 4, case manager for Patient 4, was unaware of the elevated blood pressure reading from 9/14/22 and was unaware the spouse reported the patient's complaint of a headache nor that the spouse had made mention of a "microbleed." When queried as to the usual practice as to what happens when an LPN has a finding of concern during a visit. RN 4 indicated that if it is important or urgent the LPN will call or Tiger Text the RN. RN 4 stated did not have a 'Tiger Text' to this effect from LPN 2. RN 4 indicated he/she would have expected a 'Tiger Text' from LPN 2 on this matter. RN 4 checked his/her email while on the call and did not find an email from LPN 2 regarding Patient 4. RN 4 informed that new 'communication notes' in the electronic medical record, are the 'first thing' to pop up on their documentation device, checked the device while on the		5. By what date are you going to have the deficiency corrected? 10/21/2022 Ride alongs to begin week of 10/23/2022	

	call, and found a communication note dated 9/14/22. RN 4 indicated had not seen this note yet, and read through it. When queried as to whether a headache was mentioned in the note, RN 4 indicated the headache was mentioned. In an interview on 9/16/22 at 10:49 AM with the former Administrator, when informed of the MD for Patient 4 not being notified the same day nor receiving all pertinent information (ie. headache), the former Administrator indicated that in a case like this there would be disciplinary action taken. In an interview on 9/16/22 at 11:56 AM with the current Administrator-in-Training, when informed of the MD not being notified the same day and all pertinent information not being relayed on Patient 4, stated this was "disappointing" and indicated corrective action and re-education would take place. LPN 2 was unavailable for interview, as it was reported by the administration that he/she had been involved in a motor			

	vehicle accident on the morning of 9/16/22. 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 observation, record review, and interview the agency failed to ensure staff implemented infection prevention measures, including hand hygiene while providing patient care in 3 (Home health aide #1, licensed practice nurse #2, and speech therapist #1) of 4 home visits observations. 1. A review of an agency's policy dated April 2015 titled, "Bag Technique Policy No. 6-013.1" revealed, "PURPOSE To describe the procedure for maintaining a clean nursing bag/computer bag and preventing cross-contamination. POLICY As part of the infection/exposure plan...personnel will consistently implement principles to maximize efficient use of the	G0682	1.Describe what the agency did to correct the deficient practice for each client cited in the deficiency. Agency failed to ensure staff implemented infection prevention measures, including hand hygiene while providing patient care in 3 of 4 home visits observations. (G0682) HHA immediately developed and implemented corrective action and education. DIrector of nursing provided Staff in-services that were performed on 09/20/2022 and 09/22/2022 to educate / review hand hygiene/infection control. Mandatory inservice for all disciplines conducted reviewed proper bag technique/infection control conducted week of 10/03/2022 and 10/10/2022 with 100% participation required by all disciplines. Handwashing, bag technique and when to change gloves were part of the training with	2022-10-21

	patient's care supply bag and when used in caring for patients. PROCEDURE...Bag Technique 1. The bag will be placed on a clean surface (i.e., a surface that can be easily disinfected) in the car and in the home...5. When the visit is completed, reusable equipment will be cleaned using alcohol, soap and water, or appropriate solution, hands will be washed, and equipment and supplies will be returned to the bad. 6. Hands will be decontaminated prior to returning clean equipment to bag..." Review of an agency document dated April 2015, titled 'HAND HYGIENE Policy No. 6-006.1' stated, "PURPOSE...To prevent cross-contamination and home care-acquired infections...POLICY...Personnel providing care in the home care setting will regularly wash their hands, per the most recently published CDC regulations and guidelines in healthcare settings...PROCEDURE...3. hand decontamination using an alcohol-based hand rub should be performed: A. Before having direct contact with patients...C. After contact with the patient's intact skin (when taking the		return demonstration by 100% clinicians. Emails were also sent to all clinical staff to review the information that was provided during the in-services. Meetings/Inservices will be performed quarterly at minimum. Attestation signatures are required via PayCom system to track compliance regarding this training and return demonstration. 2. Describe how the agency reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. HHA reviewed the current roster of patients of the cited clinicians, reviewed each client with identified staff, and reinforced education provided in the immediate correction plan of the clinicians cited in the survey. HHA immediately developed and implemented	

	pulse, blood pressure, or lifting a patient)...E. When moving from a contaminated body site to a clean body site during patient care. F. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient...At any time, personnel may choose to wash their hands with soap and running water in addition to using an alcohol-based hand rub..." 2. During a home visit with HHA #1 on 9/13/22 at 10:00 AM at Pt's #2, HHA #1 washed their hands, dried them with toilet paper, and donned gloves. HHA #1 assisted Pt #2 into the bathroom, to sit on the toilet lid, and Pt #2 began to undress. HHA #1 assisted as needed. When Pt #2 was ready to pull the briefs off, Pt #2 stood and HHA #1 assisted in pulling the brief down, Pt #2 sat back on the toilet, and HHA #1 removed the brief from Pt #2 ankles, threw it in the trash, and tied the trash shut. HHA #1 assisted Pt #2 into the shower and assisted as the patient requested. HHA #1 took towels off the shelf, placed 1 over the toilet lid, and when ready, assisted Pt #2 from the shower		DIrector of nursing provided staff in-services for all disciplines/clinicians that were performed on 09/20/2022 and 09/22/2022 to educate / review with 100% return demonstration. Emails were also sent to all clinical staff to review the information that was provided during the in-services. Meetings/Inservices will be performed quarterly at minimum. Attestation signatures are/will be required via PayCom system to track compliance regarding this training and return demonstration. 3. Describe the steps or systemic changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. HHA immediately developed and implemented corrective action and education. DIrector	

	to the toilet, Pt #2 sat on the toilet lid, and HHA #1 began to dry the patient. HHA #1 then assisted the patient with dressing their upper body, then assisted the patient to their bedroom, where Pt #2 sat on their bed, HHA #1 retrieved powder and applied it to the top of Pt #2 feet, and applied socks to both feet. HHA #1 doffed their gloves and assisted Pt #2 to the stairs, where Pt #2 was able to sit on the stair lift and go downstairs. Once downstairs, HHA #1 went into the bathroom to perform hand hygiene, turned the water off with a bare hand, took toilet paper to dry hands, then turned the light off with bare hands. 3. During a home visit with ST #1 on 9/14/22 at 1:30 PM at Pt #3's, ST #1 performed hand hygiene, reached into their bag, created a barrier on the kitchen counter, pulled out alcohol pads and gloves, donned the gloves, took out blood pressure cuff from the bag, and placed the blood pressure bag on the kitchen table and placed their bag on the chair. ST #1 took the patient's vital signs, cleaned all equipment, and immediately placed all the items on the		of nursing will continue to provide staff in-services/meetings for all disciplines for ongoing compliance at least quarterly. DIrector of nursing provided staff in-services for all disciplines/clinicians that were performed on 09/20/2022 and 09/22/2022 to educate / review with 100% return demonstration. Emails were also sent to all clinical staff to review the information that was provided during the in-services. Attestation signatures are required via PayCom system to track compliance regarding this training and return demonstration. The training provided to current clinicians regarding infection control is also provided to new employees to ensure 100% future compliance. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put	

	barrier, doffed their gloves, and performed hand hygiene. ST #1 began clearing the kitchen table off, took their blood pressure cuff bag, and put it on the kitchen counter. ST #1 performed hand hygiene, reached into their bag and brought out 2 small tins, and placed them on the table, which contained cards for the patient to practice word pronunciation, then hung their bag on the back of the chair. Once completed, ST #1 placed the cards back into the tins and placed them into their bag. ST #1 placed the blood pressure cuff into the blood pressure bag and gathered all the equipment and placed the items in their bag. 4. On 9/15/22 at 2:05, when the administrator was informed of the home visit that occured on 9/13/22 , she stated, that the HHA should have performed hand hygiene and changed gloves more often. 5. On 9/15/22 at 2:10 PM, the former administrator was informed of the home visit that occured on 9/14/22 with ST #1. He stated ST #1 should have hung their bag from the chair.		into place to ensure 100% compliance and who will be responsible for monitoring. All 4 cited clinicians will have weekly ride-along visits by the administrator or designee for 4 weeks or until 100% compliance is achieved with each of these clinicians. Ongoing, 3 random clinicians per month will have unannounced ride-along visits to ensure proper infection control for a period of 12 months or until 100% compliance is achieved 3 months consecutively. Ongoing, the DIrector of nursing will continue to provide staff in-services/meetings for ongoing compliance. Attestation signatures are/will be required via PayCom system to track compliance. The Administrator will be responsible for ongoing compliance. 5. By what date are you going to have the deficiency corrected?	

	6. During a home visit on 9/14/22 at 1:00 PM, LPN 2 completed wound care for Patient 4. The home was moderately cluttered, and care was completed in the patient's living room which was carpeted. A paper plate with a small pile of wet food sat on the carpet. The carpeting was visibly discolored and spotted in many areas with what appeared to be 'pet accidents'. The spouse informed that he/she had recently attempted to clean the carpet himself. The spouse indicated he/she had put their dog 'away' for the visit. LPN 2 completed taking the patient's vital signs, then proceeded to place each item used for the visit: scissors, blood pressure cuff, pulse oximeter, on a chux pad that had been placed on the carpeted floor at the beginning of the visit. The LPN then, with freshly sanitized hands, reached into a bag and pulled out several small flat packets of alcohol wipes and a few larger flat packets of		10/21/2022 Ride alongs to begin week of 10/23/2022	

	sanitizing wipes directly on the carpet, next to the chux pad. As they were needed, the LPN would pick up a packet from the carpeted floor, tear the packet open by holding it in one hand while tearing the top across the packet with the other hand, thereby touching the back of the packet (which had had contact with the carpet). The LPN then pulled out the alcohol wipe/sanitizing wipe, unfolded it to expose more surface area of the wipe, and worked their away around the item being cleaned by holding the item in one position and wiping it down, then turning the item to wipe a new section, and repeating this process until all surfaces were wiped down. The LPN did so using the right hand which had contact with the back of the packets which had contact with the carpeting, thereby simultaneously sanitizing and contaminating the item being 'sanitized'. The LPN's scissors were wiped down in this fashion and were then returned to the LPN's bag. The automatic blood pressure cuff was wiped down in this fashion and then returned to an already open hard white plastic case, whose bottom half was sitting			

	on the chux, and the hinged top half was sitting on the carpet. The LPN raised the top portion of the case over the blood pressure cuff, now tucked inside, to close it shut, then proceeded to pick up a small alcohol packet sitting on the carpet next to the chux pad, tore it open, pulled out the wipe inside, unfolded it, and cleaned the outside of the case, turning it around while wiping several times in an attempt to cover all outside surfaces of the case, then returned the item to the bag. The LPN sanitized his/her electronic device in this fashion and then tossed the device onto the couch next to the seated patient. The LPN then sanitized the pulse oximeter in this fashion and returned the item to his/her bag. 7. In an interview on 9/15/22 at 2:09 PM the Administrator in training indicated that she and the new compliance officer would work together to create specific infection control policies to address sanitizing and what is to be utilized by the clinicians. 410 IAC 17-12-1(m)			

G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on observation, record review, and interview the agency failed to ensure clinical notes and/or communication notes were documented contemporaneously with a patient's change in condition, was accurate, and failed to ensure the veracity of date and time of contact made with a physician in regard to a patient, in 1 (Patient 4) of 10 clinical records reviewed. Findings include: 1. During a home visit for Patient 4 on 9/14/22 at 1:00 PM, Licensed Practical Nurse (LPN) 2 completed scheduled wound care. An elevated blood pressure reading of 155/75 was noted as being high for the	G1024	1.Describe what the agency did to correct the deficient practice for each client cited in the deficiency. Agency failed to ensure clinical notes and/or communication notes were documented contemporaneously with a patient's change in condition, was accurate, and failed to ensure the veracity of date and time of contact made with a physician in regard to a patient, in 1 of 10 clinical records reviewed. (G1024) The clinician in question was provided with education and corrective action. All disciplines meeting/inservice was held to provide education to all the necessity of alerting relevant/ of record physician of condition changes, concerns, decline, and/or improvements in overall status and changes to plan of care, proper documentation/recording/notification procedures to facilitate patient/client care. MD is to be notified at time of visit or as soon as possible. If LPN is made aware of change in patient condition they are to notify RN	2022-10-16

	patient and was shared with the patient's spouse. The visit was completed and the LPN and this surveyor had exited the home, the spouse followed outside shortly thereafter, walked toward the LPN and surveyor, and stated he wanted to ask a question out of earshot of the patient so as not to exacerbate the patient's dementia, The spouse proceeded to inform the LPN that the patient was now complaining of a headache and additionally stated the patient had a "microbleed". The spouse asked LPN 2 if he/she should contact the doctor, and the LPN confirmed that the spouse should indeed contact the doctor. The LPN suggested that the headache could be due to dehydration. The LPN asked no further follow-up questions such as what "microbleed" was being referenced, did not return into the home to conduct further assessment (hydration, type, duration, location and severity of the headache,) and was not observed to make any phone calls prior to departure. 2. Review of the clinical record for Patient #4 contained a plan of care with a start of care date		case manager at time of visit or as soon as possible. 2. Describe how the agency reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. HHA reviewed the current roster of patients with randomized selection, reviewed each client with LPN, and reinforced education provided in the immediate correction plan. HHA immediately developed and implemented corrective action and education. DIrector of nursing provided staff in-services were performed on 09/20/2022 and 09/22/2022 to educate / review. Emails were also sent to all clinical staff to review the information that was provided during the in-services. 3. Describe the steps or	

	period of 8/9/2022 - 10/7/2022 and had diagnoses that included, but were not limited to, Pressure Ulcer of the sacral region stage 2 (a sore caused by unrelieved pressure that breaks down the skin and extends to the layer beneath it, in this case the area is located between the lower back and the tailbone), unspecified dementia without behavioral disturbance (impaired ability to remember or think, or make decisions that interfere with the ability to perform everyday activities), essential hypertension (abnormally high blood pressure that is not the result of a medical condition, often due to obesity, family history and an unhealthy diet), type 2 diabetes (a chronic condition that affects the way the body processes blood sugar, the body either doesn't produce enough insulin or resists insulin), and gastrointestinal hemorrhage (a symptom of a disorder in your digestive tract, the blood often apears in stool or vomit but isn't always visible, the level of bleeding can range from mild to severe and can be life threatening). Skilled nursing services were ordered: 1 time per week for 10 weeks, for		systemic changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. HHA will continue to review the current roster of patients with randomized selection, review each client with clinician cited in the survey, and reinforce education as needed that is provided in the immediate correction plan. HHA immediately developed and implemented corrective action and education. DIrector of nursing will continue to provide staff in-services/meetings for all disciplines for ongoing compliance. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place to ensure 100% compliance and who will be responsible for monitoring. HHA will continue to review the current roster of patients with randomized selection, review	

	wound care. Review of the clinical record contained an untimed, agency document dated 9/14/22, created by LPN 2 titled 'Patient Communication' which stated, "Called pcp [Primary Care Physician] pt having elevated bps, increased anxiety, progressing dementia, and regarding different wound care orders again. Left message for the nurse to cal this nurse back awaiting call." The document failed to contain a contact time and the contact's name. 3. In an interview on 9/15/22 at 4:05 PM, person H for Dr. F, when queried as to whether any calls from the agency had been received recently, stated the only calls on record from the agency were received on 9/13/22, which was a request from the agency nurse for a change in wound care orders, there were no entries for the date of 9/14/22, but stated there was a call made today, 9/15/22, at 11:54 AM regarding an elevated blood pressure from yesterday's visit (9/14/22). Person H then connected the call to Dr. F's Nurse G.		each client with clinician cited in the survey, and reinforce education as needed that is provided in the immediate correction plan. HHA immediately developed and implemented corrective action and education. DIrector of nursing will continue to provide staff in-services/meetings for all disciplines for ongoing compliance. Attestation signatures are/will be required via PayCom system to track compliance. Director of Nursing/designee will audit all visit notes submitted weekly to ensure that if there is documentation of a change in patient condition, there is documentation that the MD has been notified . Also, if LPN was made aware of change during their visit there should also be documentation that the RN Case Manager was notified of the change. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. The Administrator/Director of Nursing will be responsible for monitoring these corrective	

	In an interview on 9/15/22 at 4:18 PM, Nurse G for Dr. F, verified there were no calls on 9/14/22 to report elevated blood pressure or headache, Nurses G stated there was an entry dated today, 9/15/22 at 11:54 AM from the agency LPN 2 who reported an elevated blood pressure of 159/74 from yesterday's visit, but there was no mention of a headache. In an interview on 9/15/22 at 4:41 PM with agency RN 3, who performed the most recent Supervisory visit for Patient 4 and LPN 2 on 9/7/22, stated was not contacted about the 9/14/22 visit regarding an elevated blood pressure reading nor reported headache for Patient 4. Also indicated, received no phone call, nor 'Tiger Text' from LPN 2. RN 3 informed surveyor that he/she believed RN 4 was actually the case manager for Patient 4. In an interview on 9/16/22 at 12:27 PM, agency RN 4, case manager for Patient #4, was unaware of the elevated blood pressure reading from 9/14/22 and was unaware the spouse reported the patient's complaint		deficiency is corrected and will not recur. 5. By what date are you going to have the deficiency corrected? 10/16/2022	

spouse had made mention of a "microbleed." When queried as to the usual practice as to what happens when an LPN has a new finding or report of new symptom during a visit. RN 4 indicated that if it is important or urgent the LPN will call or Tiger Text the RN. RN 4 stated did not have a 'Tiger Text' to this effect from LPN 2. RN 4 indicated he/she would have expected a 'Tiger Text' from LPN 2 on this matter. RN 4 checked his/her email while on the call and did not find an email from LPN 2 regarding Patient 4. RN 4 indicated that new communication notes are the 'first thing' to pop up on their documentation device, checked the device while on the call, and found a communication note dated 9/14/22. Indicated had not seen this note yet, and read through it. When queried as to whether a headache was mentioned in the note, RN 4 indicated the headache was mentioned.

In an interview on 9/16/22 at 9:45 AM the former Administrator is asked about the date and time the visit note and communication note for

9/14/22 from LPN 2 for Patient 4 were created and was asked to provide documentation of same. At 9:59 AM the former Administrator submitted a sticky note which indicated the visit note for 9/14/22 was 'signed' by LPN 2 on 9/15/22 at 4:40 PM, and the communication note was 'signed' 9/15/22 at 12:28 PM. When asked to submit information regarding the creation or initiation date and time of the notes, he could not provide this and explained it was due to electronic clinical record system limitations.

In an interview on 9/16/22 at 10:27 AM the former Administrator was queried as to whether clinicians had the ability to back-date documentation, he indicated he would check.

In an interview on 9/16/22 at 10:49 AM, the former administrator indicated the clinicians do not have the ability to backdate documentation.

In an interview on 9/16/22 at 10:49 AM with the former Administrator, when informed

being notified timely nor relaying all pertinent information, he indicated that in a case like this there would be disciplinary action taken.

In an interview on 9/16/22 at 11:56 AM with the current Administrator-in-Training, when informed of the MD not being notified timely and pertinent information not being relayed (ie. headache) regarding Patient 4, stated this was "disappointing" and indicated corrective action and re-education would take place.

In an interview on 9/16/22 at 1:15 PM, shared with the agency that Dr. F's office was unable to corroborate what LPN 2 documented in the clinical record for Patient 4, Administrator in training indicated this was a "disappointment" and that she would be addressing the situation. The Administrator-in-training also indicated that she would be contacting the physician herself. Additionally, she indicated concern that, "if this is happening, it needs to stop."

The LPN in question was unable

	to be interviewed, as the administration reported that he/she had been involved in a motor vehicle accident on the morning of 9/16/22. 410 IAC 17-15-1(a)(7)			

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