STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HOME HEALTH CARE INC	9011 INDIANAPOLIS BOULEVARD, SUITE B, HIGHLAND, IN, 46322

(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
N0000	Initial Comments This was a State re-licensure survey for a home health agency, conducted by the Indiana Department of Health. Survey Dates: 6/27/2022, 6/28/2022, 6/29/2022, 6/30/2022, 7/1/2022, and 7/5/2022 Facility ID: 006647	N0000		2022-07-19
G0000	INITIAL COMMENTS This was a Federal Re-certification, and State re-licensure survey for a home health agency, conducted by the Indiana Department of Health. Survey Dates: 6/27/2022, 6/28/2022, 6/29/2022, 6/30/2022, 7/1/2022, and 7/5/2022. Facility ID: 006647 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Northwest Home Health Care, Inc. is precluded from providing its own home health aide	G0000	***During theemergency meeting of GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Agency being out of compliance with Conditions ofParticipation 42CFR 484.60 Care planning, coordination of services, and qualityof care.** **It wasagreed that Northwest**	2022-07-19

	period of two years from 7/5/2022 - 7/5/2024, due to being found out of compliance with Conditions of Participation 42CFR 484.60 Care planning, coordination of services, and quality of care. Quality Review Completed 07/14/2022		**Home Health Care, Inc. shall have a contract with Magdalena Carlay RN/BSNto Provide home health aide training and competency evaluation from July 20,2022 to July 5, 2024 to be in compliance with Conditions of Participation 42CFR 484.60 Care Planning, coordination of services, and quality of care.** **The Director ofNursing/ Administrator conducted an In-service on July 19, 2022 regarding NorthwestHome Health Care, Inc. is precluded from providing its own home health aidetraining and competency evaluation for a period of two years from 7/5/2022 -7/5/2024, due to being found out of compliance with Conditions of Participation42CFR 484.60 Care planning, coordination of services, and quality of care** **The Director ofNursing/ Administrator conducted an In-service on July 19, 2022 regarding the agreement that Northwest Home Health Care, Inc. shall have a contract with**	

			Magdalaena Carlay RN/BSNto Provide home health aide training and competency evaluation from July 20,2022 to July 5, 2024 to be in compliance with Conditions of Participation 42CFR 484.60 Care Planning, coordination of services, and quality of care. **The Director ofNursing/ Administrator will be responsible for implementing, maintaining andreinforcing these corrective actions to ensure that these deficiencies arecorrected and will not recur effective after the In-Service meeting to all thestaffs on July 19, 2022 .** **(see attachments)** **G0000 A1- A4: Business Associate Agreement** **G0000 B1 – B2: GB meeting** **G0000 B3 – B4: Inservice**	
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102.	E0000		2022-07-19

	Survey Dates: 6/27/2022, 6/28/2022, 6/29/2022, 6/30/2022, 7/1/2022, 7/5/2022 Facility ID: 006647			
E0006	Plan Based on All Hazards Risk Assessment 403.748(a)(1)-(2),482.15(a)(1)-(2),485.625(a)(1)-(§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented,	E0006	**E0006Plan Based on All Hazards Risk Assessment** *** During the emergency meeting on July 17, 2022 conducted by Governing body , the Director ofNursing/ Administrator discussed and reviewed regarding Northwest HomeHealth care, Inc. must develop and maintain an emergency preparedness plan thatmust be reviewed, and updated at least every 2 years.** **NorthwestHome Health care's emergency plan mustbe based on and include a documented, facility-based and community-based riskassessment, utilizing an all-hazards approach.** **TheAdministrator/ Director of Nursing havedeveloped an Emergency preparedness plan which is facility-based andcommunity-based risk assessment, utilizing an all-hazards approach.**	2022-07-19

	facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the agency failed to develop an emergency preparedness plan that was based on and included a documented facility-based and community-based risk assessment utilizing an all-hazards approach. The findings include: Record review on 6/29/2022, evidenced an		**TheAdministrator/ Director of Nursing haveinstructed all the Clinicians to instruct the patients and PCG on Emergencypreparedness plan which is facility-based and community-based risk assessment,utilizing an all-hazards approach** **The Administrator/ Director of Nursing have instructed all the Clinicians to providethe patient and PCG the community-based risk assessment, utilizing anall-hazards approach documents.** **Theadmitting clinician shall instruct the patient and PCG on Emergencypreparedness plan which is facility-based and community-based risk assessment,utilizing an all-hazards approach.** **Theadmitting clinician shall provide the patient and PCG the community-based riskassessment, utilizing an all-hazards approach documents. It will be underPatient Emergency Preparedness Plan.** **TheDirector of Nursing/ Administrator conducted an**	

	emergency preparedness binder which failed to include a documented all-hazards, facility-based and community-based risk assessment. During an interview on 6/29/2022, at 12:15 PM, when queried where the documentation was for the community and facility-based all-hazards risk assessment, administrator/clinical manager A indicated they would have to look to see if they had one. Upon survey exit, no further documentation was provided.		**In-service on July 19, 2022 regarding Emergency preparedness plan whichis facility-based and community-based risk assessment, utilizing an all-hazardsapproach .** **TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 .** **(see attachments)** **E0006 A1 – A59 : Patient EmergencyPreparedness Plan - Packet** **(Vulnerability risk forms)** **E0006 B1- B2: GBmeeting** **E0006 B3-B4: Inservice**	

E0031	Emergency Officials Contact Information 403.748(c)(2),482.15(c)(2),485.625(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:	E0031	**E0031Emergency Officials Contact Information** *** During the emergency meeting on July 17, 2022 conducted by Governing body , the Director ofNursing/ Administrator discussed and reviewed regarding Emergencypreparedness communication plan which includes contact information for federaland state local emergency preparedness staff.** **NorthwestHome Health care, Inc. must develop and maintain an emergency preparedness planwhich will include contact information for federal and state local emergencypreparedness staff.** **The Administrator/Director of Nursing have developed anEmergency preparedness communication plan whichincludes contact information for federal and state local emergency preparednessstaff.** **The Administrator/Director of Nursing shall ensure ensurethat all patients and PCG (if any) are made aware of the Emergencypreparedness communication plan which includes contact information**	2022-07-19

	(i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. Based on record review and interview, the agency failed to ensure the emergency preparedness communication plan included contact information for federal and state local emergency preparedness staff. The findings include: Record review on 6/29/2022, evidenced an emergency preparedness binder which failed to include contact information for state or federal emergency preparedness staff. During an interview on 6/29/2022, at 12:45 PM, when queried if the communication plan included contact information for state or federal emergency preparedness staff, administrator/clinical manager A indicated it did not, but she would add state and federal emergency preparedness contact information.		**for federaland state local emergency preparedness staff.** **Theclinician shall provide to all their designated patients and PCG the Emergencypreparedness communication plan which includes contact information for federaland state local emergency preparedness staff.** **Theadmitting clinician shall inform the patient and PCG of the Emergencypreparedness communication plan which includes contact information for federaland state local emergency preparedness staff.** **Theadmitting clinician shall provide to the patient and PCG the Emergencypreparedness communication plan which includes contact information for federaland state local emergency preparedness staff. It will be under Patient Emergency Preparedness Plan.** **The Administrator/Director of Nursing conducted anIn-service on July 19, 2022**	

			regardingEmergency preparedness communication plan which includes contact informationfor federal and state local emergency preparedness staff. **TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 .** **(see attachments)** **E0031 A1 – A59 : Patient Emergency Preparedness Plan – Packet** **(Important Emergency Official Hotlines and Contactinformation) .** **E0031B1 – B2: GB meeting** **E0031 B3 – B4: Inservice**	

G0374	Accuracy of encoded OASIS data 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on observation, record review, and interview, the agency failed to ensure OASIS data accurately reflected patient s status at time of assessment in 3 of 5 active clinical records reviewed. (#1, 4, 5) The findings include: 1. Record review evidenced an undated agency policy obtained 7/5/2022, titled Encoding and Reporting OASIS Data which stated, & Data will reflect patient status at time of assessment &. 2. Observation of a home visit for patient #1 was conducted on 6/28/2022, at 11:00 AM, to observe a routine home health aide visit. During the visit, the patient ambulated with a walker and standby assist to the bathroom for a shower. The patient was able to stand and change positions with minimal assistance and denied pain. Clinical record review for patient #1 was completed on 7/1/2022, for certification period 5/11/2022 7/9/2022. Record review evidenced an OASIS (outcome and assessment information set) Resumption of Care assessment dated 6/3/2022, which stated, & Height/Weight & [M1060] & Item could not be assessed & For example, patient cannot be weighed because of extreme pain, immobility,	G0374	**G0374Accuracy of encoded OASIS data** *** Duringthe emergency meeting on July 17, 2022 conductedby Governing body , Administrator/ Director of Nursing discussed and reviewed regarding Policy onEncoding and Reporting OASIS Data.** **Theadmitting clinician shall accurately encode and document the OASIS data thatreflects on the patient's status at the time of assessment.** **The admitting clinician shall obtainan order from the Physician to obtain the height and weight of the patient. Theadmitting clinician shall include the height and weight of the patient. The admittingclinician can put a mark on Item couldnot be assessed if the patient cannot be weighed because of extreme pain,immobility, or risk of pathological fractures**	2022-07-19

	or risk of pathological fractures &. 3. Clinical record review for patient #4 was completed on 7/1/2022, for certification period 6/6/2022 8/4/2022. Record review evidenced an OASIS Resumption of Care assessment dated 6/20/2022, which stated, & Height/Weight & [M1060] & Item could not be assessed & For example, patient cannot be weighed because of extreme pain, immobility, or risk of pathological fractures &. This document also indicated the patient was ambulatory with a walker, able to sit to stand independently, walked with supervision, and did not have extreme pain. 4. Clinical record review for patient #5 was completed on 7/1/2022, for certification period 6/7/2022 8/5/2022. Record review evidenced an OASIS start of care assessment dated 6/7/2022, which stated, & Height/Weight & [M1060] & Item could not be assessed & For example, patient cannot be weighed because of extreme pain, immobility, or risk of pathological fractures &. This document indicated the patient was a partial/moderate assist to a sit to stand and did not have extreme pain. During an interview on 7/1/2022 at 10:26 AM, when queried why the OASIS resumption of care assessments indicated the patients could not be weighed, administrator/clinical manager A stated, & the problem with this is & the computer system will not let us put them in &. Administrator/clinical manager A indicated the height and weight should be included in the OASIS assessments.		**putthe patient in high risk of fall or injury.** **It is thepolicy of NORTHWEST HOME HEALTH CARE, INC. to weigh the patient every 1-2 weeksdepending on the patient's condition and diagnosis.** **The Administrator/Director of Nursing conducted anIn-service on July 19, 2022 regardingPolicy on Encoding and Reporting OASIS Data; Policy on Weights.** **The Administrator/Director of Nursing will be responsiblefor implementing, maintaining and reinforcing these corrective actions toensure that these deficiencies are corrected and will not recur effective afterthe In-Service meeting to all the staffs on July 19, 2022** **(seeattachments)** **G0374 A1 : PolicyEncoding and Reporting OASIS Data** **G0374 B1 : Policy on Weights**	

			G0374 C1 – C2: **GBmeeting** **G0374 C3 – C4:** **Inservice** **An emergency meeting was held on July 27, 2022 conducted by Governing body , The Administrator/ Director of Nursing /Clinical manager discussed and reviewed the Agency's Plan of Correction on Accuracy on Encoded Oasis Data submitted that has been found unacceptable.** **On July 19, 2022 The Quality Assurance Team headed by The Administrator/ Director of Nursing /Clinical Manager with the Alternate Administrator/ Director of Nursing /Clinical Manager made sure that the clinician shall accurately encode and document the OASIS data that reflects on the patient's status at the time of assessment in all 100 % of all active clinical records which required an Oasis that was reviewed.** **On July 19, 2022 the Quality Assurance Team headed by**	

			The Administrator/ Director of Nursing /Clinical Manager with the Alternate Administrator/ Director of Nursing /Clinical Manager made sure that the admitting clinician shall obtain an order from the Physician to obtain the height and weight of the patient. The admitting clinician shall include the height and weight of the patient. The admitting clinician can put a mark on Item could not be assessed if the patient cannot be weighed because of extreme pain, immobility, or risk of pathological fractures or any other reasons that can put the patient in high risk of fall or injury in all 100 % of all active clinical records which required an Oasis that was reviewed. **(see Attachment)** **G0374 C2a GB meeting**	
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate	G0514	**G0514 RNperforms assessment** ***During theemergency meeting of GB on July 17,**	2022-07-19

	care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the agency failed to ensure an initial assessment visit was conducted within 48 hours of referral or on the physician ordered start of care date in 1 of 5 active records reviewed. (#1) The findings include: Record review evidenced an agency policy revised 7/16/2009, titled & Standards of Practice which stated, & Upon acceptance and admission of a patient, the admitting Registered Nurse/Therapist will assign the individual to the appropriately skilled professional & Service will be initiated within 48 hours after the assessment, unless documentation supports alternate plan based on patient needs and wishes and caregiver availability &. Clinical record review for patient #1 was completed on 7/1/2022, for certification period 1/11/2022 3/12/2022. Record review evidenced a referral document dated 1/3/2022, which indicated the agency accepted patient #1 for home health services. Record review evidenced the initial assessment visit was conducted on 1/11/2022, 8 days after referral. Record review failed to evidence the physician had ordered an initial assessment visit on 1/11/2022. During an interview on 7/1/2022 at 10:22 AM, when queried what the time frame was to complete initial assessment visits, administrator/clinical manager A stated, & Within 24 48 hours & if we can t see the patient & if they cancel & we have a paper document if it was a missed admission order & and we have a physician order that we can t		**2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy on Referral Process , Standards of Practice andEmphasized that Upon acceptance and admission of a patient, the admittingRegistered Nurse/Therapist will assign the individual to the appropriatelyskilled professional .The home health care services will be initiated within 48hours after the patient being referred to the agency, unless documentationsupports alternate plan based on patient needs and wishes and caregiveravailability.** **The Director of Nursing/ Administrator shall ensure thatthe initial Assessment visit must be held within 48 hours of referral, within48 hours of the patient's return home or in the Physician's ordered Start ofCare Date. In the event that patient was not seen within 48 hours. TheAdmitting Clinician will coordinate with the Clinical Manager / NurseSupervisor . The Clinical Manager / Nurse Supervisor will then coordinate withthe Primary**	

	#1 s initial assessment was delayed, administrator/clinical manager A stated, & the patient/family cancelled & I don t know why &. 410 IAC 17-14-1(a)(1)(A)		**Physician and will make a Missed Visit Report with the Reason ofthe Missed Visits and and will make an Order and will be signed by thePhysician that the patient was not seen within 48 hours. The ordered Start of Care will then beincluded in the Plan of care for Start of care or Resumption of Care order.** **The Director of Nursing/ Administrator conducted anIn-service on July 19, 2022 regardingReferral Process.** **The Director of Nursing/ Administrator will beresponsible for implementing, maintaining and reinforcing these correctiveactions to ensure that these deficiencies are corrected and will not recureffective after the In-Service meeting to all the staffs on July 19, 2022** **(See attachments) for** **G0514 A1 : Policy on Standards of Practice**	

			G0514 B1 – B4: Policy on ReferralProcess **G0514 C1 : MissedVisit Report Form** **G0514 D1 : Physician Order for Missed Visit** **G0514 E1 – E2: GBmeeting** **G0514 E3 – E4: Inservice**	
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure the comprehensive assessment accurately reflected the patients current health status in 2 of 5 active clinical records reviewed. (#1, 2) The findings include: 1. Record review on 7/5/2022, evidenced an undated agency policy obtained 7/5/2022, titled Comprehensive Patient Assessment which stated, & In addition to general health status/system assessment, Northwest Home Health Care Inc. comprehensive assessment tool will include: & Nutritional status is assessed & High risk indicators may include: & Weight loss of ten pounds in thirty days & Significant underweight or overweight status &.	G0528	**G0528 Health, psychosocial, functional, cognition** ***Duringthe emergency meeting of GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy on Comprehensive Patient Assessment.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will assessand document patient's Medications , All pertinent diagnosis, primary and OtherDiagnosis, Prognosis , Mental/Cognitive Status , Allergies , NutritionalRequirements , Functional Limitations ,**	2022-07-19

	2. Clinical record review for patient #1 was completed on 7/1/2022, for certification period 5/11/2022 7/9/2022. Record review evidenced a resumption of care/comprehensive re-assessment dated 6/3/2022, which failed to include a height and weight. Record review evidenced a recertification/comprehensive re-assessment dated 5/10/2022, which failed to include a height and weight. During an interview on 7/1/2022, at 10:50 AM, when queried why patient #1 s height and weight was not included in the comprehensive assessment, administrator/clinical manager A indicated there should have been a note indicating why the nurses could not obtain a weight. 3. Clinical record review for patient #2 was completed on 7/1/2022, for certification period 5/20/2022 7/18/2022. Record review evidenced a recertification/comprehensive re-assessment dated 5/17/2022, which failed to include a height and weight. During an interview on 7/1/2022, at 10:50 AM, administrator/clinical manager A indicated a height and weight should have been included in comprehensive assessments. 410 IAC 17-14-1(a)(1)(B)		**Activities Permitted/Restricted ,Safety measures, DME and Supplies , Advanced Directives , Caregiver Status ,Psychosocial Status, Emergency Preparedness , Orders For Discipline andTreatment , Goals , Rehabilitation Potential and Discharge Plan , HomeboundNarrative .** **Theadmitting clinician shall obtain an order from the Physician to obtain theheight and weight of the patient and record it in oasis and Plan of care. Thisis very essential to assess the Nutritional status of the patient. Weight loss of ten pounds in thirtydays and Significant underweight or overweight status are one of the High riskindicators .** **Patientswho are identified as being at moderate or high risk will be then referred tothe appropriate resource for follow-up and treatment as indicated.** **Theadmitting clinician can put a mark on Item could not be assessed if the patient cannot be weighed because**	

			or risk of pathological fractures or any otherreasons that can put the patient in high risk of fall or injury. **Theclinician will weigh the patient every 1-2 weeks depending on the patient'scondition and diagnosis. It is mandated that if there is a significant changeof weight, it shall be reported to RN Supervisor/ or MD.** **TheDirector of Nursing/ Administrator conducted an In-service on July 19, 2022 regarding Policy on Comprehensive PatientAssessment; Policy on Weights.**	

			TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 . **(See attachments) for** **G0528 A1- A3: Policy on Comprehensive PatientAssessment** **G0528 B1 : Policyon Weights** **G0528 C1 – C2: GB meeting** **G0528 C3 – C4: Inservice**	

			An emergency meeting of GB was held on July 27, 2022 , the Director of Nursing/ Administrator discussed and reviewed the Plan of Correction on Health, psychosocial, functional, cognition submitted that has been found unacceptable. **On July 19,2022 The Quality Assurance Team Headed by the Administrator/Director of Nursing/Clinical Manager with the Alternate Administrator/Director Of Nursing/Clinical Manager ensure that the Clinician will assess and document patient's Medications , All pertinent diagnosis, primary and Other Diagnosis, Prognosis , Mental/Cognitive Status , Allergies , Nutritional Requirements , Functional Limitations , Activities Permitted/Restricted , Safety measures, DME and Supplies , Advanced Directives , Caregiver Status , Psychosocial Status, Emergency Preparedness , Orders For Discipline and Treatment , Goals , Rehabilitation Potential and Discharge Plan , Homebound Narrative in all 100 % of all**	

			active Clinical records reviewed. **On July 19,2022 the Quality Assurance Team Headed by the Administrator/Director of Nursing/Clinical manager with the Alternate Administrator/Director Of Nursing/Clinical manager made sure that the admitting clinician shall obtain an order from the Physician to obtain the height and weight of the patient and record it in oasis and Plan of care. This is very essential to assess the Nutritional status of the patient. Weight loss of ten pounds in thirty days and Significant underweight or overweight status are one of the High risk indicators in all 100 % of all active Clinical records reviewed.** **On July 19,2022 the Quality Assurance Team Headed by the Administrator/Director of Nursing/Clinical manager with the Alternate Administrator/Director Of Nursing/Clinical manager that those who are identified as being at moderate or high risk will be then referred to the appropriate resource for**	

			follow-up and treatment as indicated in all 100 % of all active Clinical records reviewed. **On July 19,2022 the Quality Assurance Team Headed by the Administrator/Director of Nursing/Clinical manager with the Alternate Administrator/Director Of Nursing/Clinical manager made sure that the admitting clinician can put a mark on Item could not be assessed if the patient cannot be weighed because of extreme pain, immobility, or risk of pathological fractures or any other reasons that can put the patient in high risk of fall or injury in all 100 % of all active Clinical records reviewed.** **On July 19,2022 the Quality Assurance Team Headed by the Administrator/Director of Nursing/Clinical manager with the Alternate Administrator/Director Of Nursing/Clinical manager made sure that the clinician will weigh the patient every 1-2 weeks depending on the patient's condition and diagnosis. It is mandated that if there is a significant change**	

			of weight, it shall be reported to RN Supervisor/ or MD in all 100 % of all active Clinical records reviewed. **(see attachment)** **G0528 C2a GB meeting**	
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on record review and interview, the agency failed to include the patient s available support including their willingness and ability to provide care and availability and schedules in 1 of 5 active clinical records reviewed. (#5) The findings include: Record review evidenced an undated agency policy obtained 7/5/2022, titled Comprehensive Patient Assessment which stated, & In addition to general health status/system assessment & comprehensive assessment tool & will include: & Supportive assistance &. Clinical record review for patient #5 was completed on 7/1/2022, for certification period 6/7/2022 8/5/2022. Record review evidenced a start of care assessment/comprehensive assessment dated 6/7/2022, which stated, & Caregiver	G0538	**G0538Primary caregiver(s), if any** ***Duringthe emergency meeting of GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy on Comprehensive Patient Assessment.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will assessand document patient's Medications , All pertinent diagnosis, primary and OtherDiagnosis, Prognosis , Mental/Cognitive Status , Allergies , NutritionalRequirements , Functional Limitations , Activities Permitted/Restricted ,Safety measures, DME and Supplies ,**	2022-07-19

	help if needed &. This document failed to indicate names of family or their willingness, availability or schedule. During an interview on 7/1/2022, at 12:42 PM, when queried what information was expected to be included in the comprehensive assessment regarding supportive assistance, administrator/clinical manager A indicated the agency always asked the patient who would be available to help with specific tasks, and when they were available to assist. Administrator/clinical manager A indicated they would include it on all comprehensive assessments in the future.		**Advanced Directives , Caregiver Status ,Psychosocial Status, Emergency Preparedness , Orders For Discipline andTreatment , Goals , Rehabilitation Potential and Discharge Plan , HomeboundNarrative .** **TheDirector of Nursing/ Administrator shall ensure that the Clinician shalldocument the Supportive assistance of the patient which will include the namesof family/Caregiver/available support which includes their availability orschedule and ability/willingness to provide care and assume responsibility forhealthcare needs . This will be documented in the Oasis and Plan of Care underCaregiver status.** **TheDirector of Nursing/ Administrator conducted an In-service on July 19, 2022 regarding Policy on Comprehensive PatientAssessment which includes In addition to general health status/systemassessment,**	

			Inc. Comprehensive Patient assessmentwill include to document the Supportive assistance of the patient which willinclude the names of family/Caregiver/available support which includes theiravailability or schedule and ability/willingness to provide care and assumeresponsibility for healthcare needs . The Director of Nursing/ Administratorwill be responsible for implementing, maintaining and reinforcing thesecorrective actions to ensure that these deficiencies are corrected and will notrecur effective after the In-Service meeting to all the staffs on July 19, 2022. **(see attachments)** **G0538 A1 – A3: Policy on Comprehensive PatientAssessment** **G0538 B1 – B2: Policy on Patient Reassessment/Updateof Comprehensive Assessment**	

			G0538C1 – C2: **GB meeting** **G0538 C3 – C4: Inservice** **An emergency meeting of GB was held on July 17, 2022 , the Director of Nursing/ Administrator/Clinical manager discussed and reviewed the Agency's Plan of Correction on Primary caregiver(s), if any submitted that has been found to be unacceptable.** **On July 19, 2022, The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical manager and alternate Director of Nursing/ Administrator/Clinical manager ensured that the Clinician will assess and document patient's Medications , All pertinent diagnosis, primary and Other Diagnosis, Prognosis , Mental/Cognitive Status , Allergies , Nutritional Requirements , Functional Limitations , Activities Permitted/Restricted , Safety measures, DME and Supplies , Advanced Directives , Caregiver Status , Psychosocial Status,**	

			Emergency Preparedness , Orders For Discipline and Treatment , Goals , Rehabilitation Potential and Discharge Plan , Homebound Narrative in all 100 % of all active clinical records reviewed. **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical manager and alternate Director of Nursing/ Administrator/Clinical manager ensured that the Clinician shall document the Supportive assistance of the patient which will include the names of family/Caregiver/available support which includes their availability or schedule and ability/willingness to provide care and assume responsibility for healthcare needs . This will be documented in the Oasis and Plan of Care under Caregiver status in all 100 % of all active clinical records reviewed.** **(see attachment)**	

			G0538 C2a GB meeting	
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on observation, record review, and interview, the agency failed to update the comprehensive assessment due to a major decline in patient s health status in 1 of 5 active clinical records reviewed. (#3) The findings include: Record review evidenced an undated agency policy obtained 7/5/2022, titled Patient Reassessment/Update of Comprehensive Assessment which stated, & The comprehensive assessment will be updated and revised as often as the patient s condition warrants due to major decline or improvement in health status &. Observation of a home visit for patient #3 was conducted on 6/29/2022, at 5:00 PM, to observe a routine skilled nurse visit. The patient was observed to be bedbound, severely obese, alert, oriented, wearing 3 liters of oxygen per nasal cannula, and in a hospital bed. The patient had a nebulizer machine in her lap. Registered nurse B removed dressings	G0544	**G0544Update of the comprehensive assessment** ***Duringthe emergency meeting of GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy on Policy on Patient Reassessment/Update ofComprehensive Assessment.** **The Director ofNursing/ Administrator shall ensure that the Comprehensive Assessment will beupdated and revised as often as the patient's condition warrants due to majordecline or improvement in health status by the Clinician.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician shall ensureperform a comprehensive assessment in response to decline in patient status,including foul smelling wound with copious drainage, respiratory distress, orsevere pain.**	2022-07-19

	6/27/2022. The abdominal wound dressing was 100% soaked in drainage. Registered nurse B indicated the patient received skilled nursing for dressing changes once per week, and the dressings were to be changed daily, which were completed by person B. Patient was observed to have an abdominal wound, which had a copious amount of foul smelling, brown drainage, with macerated skin surrounding; and a large, bright red, very painful wound in the inner forearm extending to the inner, upper arm. During wound care, patient #3 was observed grimacing and yelling out in pain. After prompting from surveyor, registered nurse B laid the patient flat in bed and turned her on her side to assess the skin on her buttocks, which was pink, purple, and scarred. After laying flat and rolling, the patient was repositioned in bed sitting up. At this time, the patient appeared to be short of breath, breathing rapidly, anxious, and was unable to complete a sentence without taking breaths. Patient #3 requested her albuterol (a medicine that opens the airways) nebulizer treatment. Registered nurse B looked, but the patient did not have any more albuterol. Person B (family member) indicated the albuterol had not been delivered by the pharmacy, and they had run out of albuterol the previous day. Patient #3 used a rescue albuterol inhaler instead, and after about 15 minutes, appeared to be in no respiratory distress, and was resting comfortably. Registered nurse B called the pharmacy, which was closed, and indicated they would call again the next day. Clinical record review for patient #3 was completed on 7/5/2022, for certification period 6/21/2022 8/19/2022. Record review failed to evidence the agency had performed a comprehensive assessment in response to decline in patient status, including foul smelling wound with copious drainage, respiratory distress, or severe pain. Clinical record review evidenced a communication note dated 6/29/2022, which stated, & Patient is short of breath every time head of bed is not elevated and when constantly talking. Patient s wounds has a little		**TheDirector of Nursing/ Administrator shall ensure that Any revised Plan of caremust be communicated to the patient, patient representative , caregiver, allPhysicians issuing orders must reflect current information from the patient'supdated progress toward the measurable outcomes and goals identified byNorthwest Home Health Care, Inc and the patient in the plan of care. TheDirector of Nursing/ Administrator shall ensure that the Clinician will assessand document patient's Medications , All pertinent diagnosis, primary and OtherDiagnosis, Prognosis , Mental/Cognitive Status , Allergies , NutritionalRequirements , Functional Limitations , Activities Permitted/Restricted ,Safety measures, DME and Supplies , Advanced Directives , Caregiver Status , PsychosocialStatus, Emergency Preparedness , Orders For Discipline and Treatment , Goals ,Rehabilitation Potential and Discharge Plan , Homebound Narrative . TheDirector of**	

	bit of foul odor. This is a chronic problem. Coordinated with [physician C] and stated we cannot just keep on giving antibiotics all the time. [Physician C] will see the patient today. SN [skilled nurse] to monitor and check patient s wounds again next week and [physician C] will decide if she needs to be in hospital &. During an interview on 7/1/2022, at 11:39 AM, when queried when the agency would complete an updated comprehensive assessment, administrator/clinical manager A stated, & if there s a sudden change in patient s condition or if patient went to the hospital, and every certification &. When queried why another comprehensive assessment was not completed, administrator/clinical manager A indicated the doctor had been made aware and indicated the nurse should recheck the patient the next week. When queried if the doctor saw the patient, administrator/clinical manager A indicated the doctor did not see the patient but was planning on visiting the next week. 410 IAC 17-14-1(a)(1)(B)		**Nursing/ Administrator shall ensure that the Clinician shall Revisethe Plan of Care to update the resumption of care comprehensive assessmentfindings .** **TheDirector of Nursing/ Administrator conducted an In-service on July 19, 2022 regarding Policy on PatientReassessment/Update of Comprehensive Assessment.** **TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 .** **(see attachments)** **G0544A1 – A2: Policy on Patient Reassessment/Update of ComprehensiveAssessment** **G0544 B1 : ComprehensiveAssessment tool for wounds** **G0544 C1 – C2: GB**	

			meeting **G0544 C3 – C4: Inservice** **An emergency meeting of GB was held on July 27, 2022 , the Director of Nursing/ Administrator /Clinical manager discussed and reviewed the Agency's Plan of Correction on Update of the Comprehensive assessment submitted that has been found unacceptable** **On July 19, 2022 The Quality Assurance team headed by the Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Comprehensive Assessment will be updated and revised as often as the patient's condition warrants due to major decline or improvement in health status by the Clinician in all 100 % of all active clinical records reviewed.** **On July 19, 2022 The Quality Assurance team headed by Director of Nursing/**	

			Administrator with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician shall ensure perform a comprehensive assessment in response to decline in patient status, including foul smelling wound with copious drainage, respiratory distress, or severe pain in all 100 % of all active clinical records reviewed. **On July 19, 2022 The Quality Assurance team headed by Director of Nursing/ Administrator with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that Any revised Plan of care must be communicated to the patient, patient representative , caregiver, all Physicians issuing orders must reflect current information from the patient's updated progress toward the measurable outcomes and goals identified by Northwest Home Health Care, Inc and the patient in the plan of care. The Director of Nursing/ Administrator shall ensure that the Clinician will assess and document patient's Medications , All**	

			pertinent diagnosis, primary and Other Diagnosis, Prognosis , Mental/Cognitive Status , Allergies , Nutritional Requirements , Functional Limitations , Activities Permitted/Restricted , Safety measures, DME and Supplies , Advanced Directives , Caregiver Status , Psychosocial Status, Emergency Preparedness , Orders For Discipline and Treatment , Goals , Rehabilitation Potential and Discharge Plan , Homebound Narrative . The Director of Nursing/ Administrator shall ensure that the Clinician shall Revise the Plan of Care to update the resumption of care comprehensive assessment findings in all 100 % of all active clinical records reviewed. **(see attachment)** **G0544 C2a GB meeting**	
G0564	Discharge or Transfer Summary Content	G0564	**G0564Discharge or Transfer Summary Content**	2022-07-19

	484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the agency failed to send all necessary medical information pertaining to the patient s current course of illness and treatment to the health care practitioner in 1 of 2 discharge records reviewed. (#7) The findings include: Record review evidenced an undated agency policy obtained 7/5/2022, titled Discharge Summary which stated, & The discharge summary will include & diagnosis &. Clinical record review for patient #7 was completed on 7/5/2022, for certification period 4/8/2022 6/6/2022. Record review evidenced a discharge summary dated 6/2/2022, which failed to include the following diagnoses which were included, and addressed with interventions, on the plan of care: hypertension (high blood pressure), rheumatoid arthritis (a type of auto-immune arthritis), irritable bowel syndrome, hyperlipidemia (high cholesterol), and hypothyroidism (low thyroid levels). During an interview on 7/5/2022, at 10:48 AM, when queried what information should be included on the discharge summary, administrator/clinical manager A indicated the discharge summary have included the diagnoses from the plan of care.		***During the emergency meeting of GB on July 17, 2022 the Director of Nursing/ Administrator discussed and reviewed the Policy on Discharge or Transfer Summary.** **The Director of Nursing/ Administrator shall ensure that the Patient's Discharge or Transfer Summary shall have all necessary medical information pertaining to the patient's current course of illness and treatment to the health care practitioner which includes pertinent diagnosis of the patient which were included and addressed with interventions documented in the plan of care.** **The Director of Nursing/ Administrator conducted an In-service on July 18,2022 regarding Policy on Discharge or Transfer Summary.** **The Director of Nursing/ Administrator will be responsible for implementing, maintaining and reinforcing these corrective actions to ensure that these deficiencies are corrected and will not recur effective after the**	

			In-Service meeting to all the staffs on July 19, 2022 . **(see attachments)** **G0564 A1 – A4:** **Policy on Discharge or Transfer Summary** **G0564 B1 – B2:** **GB meeting** **G0564 B3 – B4:** **Inservice** **An emergency meeting of GB was held on July 27, 2022, the Director of Nursing/ Administrator /Clinical Manager discussed and reviewed the Plan of Correction on Discharge or Transfer Summary Content submitted that was found to be unacceptable** **On July 19, 2022 the Quality assurance Team headed by TheDirector of Nursing/ Administrator/Clinical manager with the Alternate Director of Nursing/ Administrator/Clinical manager ensured that the Patient's Discharge orTransfer Summary shall have all necessary medical information pertaining to**	

			thepatient's current course of illness and treatment to the health carepractitioner which includes pertinent diagnosis of the patient which wereincluded and addressed with interventions documented in the plan of care. This deficiency will be monitored using the Northwest Home Health Care Discharge and Transfer QA tool. (see Attachment) **(see attachments)** G0564 C2a GB meeting G0564 C2ab Transfer/DC QA tool	
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services	G0570	**G570 Careplanning, coordination, quality of care** ***Duringthe emergency meeting of PAG and GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy Care plans, Coordination of Patient services, Standards of Practice ,Referral Process ,**	2022-07-19

	necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review and interview, the home health agency failed to: ensure patients were accepted for care based on the expectation the home health agency was able to meet their needs (see tag G0570); ensure each patient received home health services written in their plan of care and the plan of care was individualized (see tag G0572); ensure the plan of care contained all medications and treatments, diagnoses, medical equipment and nutritional requirements (see tag G0574); ensure all orders were recorded in the plan of care (see tag G0576); ensure services and treatments were administered only as ordered by a physician (see tag G0580); ensure the home health agency staff promptly alerted the primary care physician to changes in the patient s condition (see tag G0590); and coordinate care delivery to meet the patient s needs and/or involve the patient in the coordination of care activities (see tag G0608). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care. A standard citation was also evidenced at this level as follows: Based on observation, record review, and interview, the agency failed to accept patients based on the expectation that the agency		**Intervention policy.** **TheDirector of Nursing/ Administrator shall ensure that a complete Plan of Carewill be formulated which include: All pertinent diagnosis(es), The patient'sMental status, psychosocial, and cognitive status, Type of services, supplies,equipment required , The frequency, and duration of all visits to made ,Prognosis , Rehabilitation potential, Functional limitations , Activities permitted , Specific dietary ornutritional requirements or restrictions , All Medications, treatments, andprocedures , Safety measures to protectagainst injury. The Director of Nursing/ Administrator shall ensure that acomplete Plan of Care is individualized.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician shall recordall patient care orders, including verbal orders in the Plan of care ; ensurepatients were accepted for care based**	

	could meet the patient s medical, nursing, and rehabilitative needs in the patient s place of residence in 3 of 7 clinical records reviewed. (#1, 3, 6) The findings include: 1. Record review evidenced an agency policy revised 7/16/2009, titled Standards of Practice which stated, & If Northwest Home Health Care, Inc. cannot fulfill the required health care need, a referral will be made to other appropriate community resources and referral source will be notified &. 2. Clinical record review for patient #1 was completed on 7/1/2022, for certification period 5/11/2022 7/9/2022. Record review evidenced a hospital referral dated 6/1/2022, which stated, & Based on the clinical findings of this encounter, the following services are medically necessary: & skilled nursing & speech language pathology & Based on clinical findings of this encounter, this patient has a need for these skilled services because: & has a functional swallowing disorder &. Clinical record review evidenced a plan of care for certification period 5/11/2022 7/9/2022, dated 6/3/2022, which indicated the patient was to receive skilled nursing once a week for six weeks and home health aide twice a week for 5 weeks. Review failed to evidence speech language pathology orders. During an interview on 6/28/2022, at 11:00 AM, when queried if patient #1 received speech therapy services, person A (patient #1 s family member) indicated the patient had not received speech therapy services. Person A indicated patient #1 had been on thickened liquids after discharge from the hospital, and when they ran out of thickener, the home health nurse observed the patient drink a cup of thin liquids. Person A indicated the home health nurse said patient #1 was fine and did not have any issues swallowing.		**on the expectation the home health agencywas able to meet their needs ; ensure each patient received home healthservices written in their plan of care and the plan of care was individualized;ensure the plan of care contained all medications and treatments, diagnoses,medical equipment and nutritional requirements; ensure all orders were recordedin the plan of care ; ensure services and treatments were administered only asordered by a physician ; ensure the home health agency staff promptly alertedthe primary care physician to changes in the patient's condition ; andcoordinate care delivery to meet the patient's needs and/or involve the patientin the coordination of care activities.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will providea quality health care in a safe environment. The individualized plan of care mustalso specify the patient and caregiver education and training. Services must**	

	During an interview on 7/1/2022, at 10:37 AM, when queried why patient #1 did not receive speech language pathology services as ordered on the referral, administrator/clinical manager A stated, & the hospital is aware that we don t have a speech therapist & we tell them we can t take the patient if they need speech &. 3. Observation of a home visit for patient #3 was conducted on 6/29/2022, at 5:00 PM, to observe a routine skilled nurse visit. The patient was observed to be bedbound, severely obese, alert, oriented, wearing 3 liters of oxygen per nasal cannula, and in a hospital bed. The patient had a nebulizer machine in her lap. Registered nurse B removed dressings to abdomen and left arm, which were dated 6/27/2022. The abdominal wound dressing was 100% soaked in drainage. Registered nurse B indicated the patient received skilled nursing for dressing changes once per week, and the dressings were to be changed daily, which were completed by person B. Patient was observed to have an abdominal wound, which had a copious amount of foul smelling, brown drainage, with macerated skin surrounding; and a large, bright red, very painful wound in the inner forearm extending to the inner, upper arm. Registered nurse B asked patient #3 if patient had a wound clinic appointment yet, and patient #3 indicated she had not. During dressing change to left arm, patient #3 was observed grimacing and yelling in pain. Registered nurse B asked patient when she last took pain medication, and patient indicated the previous day, no further pain assessment was observed. After prompting from surveyor, registered nurse B laid the patient flat in bed and turned her on her side to assess the skin on her buttocks, which was pink, purple, and scarred. After laying flat and rolling, the patient was repositioned in bed sitting up. At this time, the patient appeared to be short of breath, breathing rapidly, anxious, and was unable to complete a sentence without taking breaths. Patient #3 requested her albuterol (a medicine that opens the airways) nebulizer treatment. Registered nurse B looked, but the patient did not have any		**befurnished in accordance with accepted standards of practice.** **The Director ofNursing/ Administrator shall ensure that the Clinician shall ensure to verifythe services that the patient needs. It will be documented in the Verificationof Diagnosis and Services Provided form. If Northwest Home Health Care, Inc.cannot fulfill the required health care need, a referral will be made to otherappropriate community resources and referral source will be notified.** **The Director ofNursing/ Administrator shall ensure that the Clinician shall ensure to verifythe treatment that the patient needs. Upon referral if the Physician orderedSpeech Therapy services for Swallow test for the patient . The Director ofNursing/ Administrator shall ensure that the discharge planners, physicians,social workers, and the community will be**	

	more albuterol. Person B (family member) indicated the albuterol had not been delivered by the pharmacy, and they had run out of albuterol the previous day. Patient #3 used a rescue albuterol inhaler instead, and after about 15 minutes, appeared to be in no respiratory distress, and was resting comfortably. Registered nurse B called the pharmacy, which was closed, and indicated they would call again the next day. Registered nurse B failed to assess the patient s vital signs during or after the respiratory distress. The surveyor requested the nurse check the patient s vitals before exiting the home visit, and the oxygen saturation was 96%. Clinical record review for patient #3 was completed on 7/1/2022, for certification period 4/22/2022 6/20/2022 and 6/21/2022 8/19/2022. Record review evidenced a referral/discharge summary dated 4/20/2022, which stated, & Recommendations for placement given skilled need for dressing changes but spoke with both her nephew and her daughter which did not want placement and will have 24-hour care including nurse 3 times a week for dressing changes as well as a home health care doctor &. This document indicated the wound dressing to abdomen was to be changed every 12 hours and as needed for 50% drainage, and the left arm dressing was to be changed daily and as needed. Record review evidenced a comprehensive assessment/start of care document dated 4/22/2022, for certification period 4/22/2022 6/20/2022, which indicated patient received skilled nursing visits 1 time per week for 1 week, 2 times per week for 2 weeks, and 1 time per week for 6 weeks. This document indicated the abdominal wound measured 1.2 cm (centimeters) x 1.0 cm x 0.4 cm. Record review evidenced a comprehensive re-assessment/recertification dated 6/16/2022, for certification period 6/21/2022 8/19/2022, which indicated the abdominal wound measured 1.3 cm x 1.2 cm x 0.5 cm. Record review evidenced a plan of care for certification period 6/21/2022 8/19/2022, which indicated the patient was to receive skilled nursing visits 1 time per week for 9 weeks. This document indicated the abdominal		**notified that we are unable toprovide services/ treatment and admit the patient . In the event that thepatient is active with our agency and the Physician ordered Speech Therapyservices for Swallow test . The Director of Nursing/ Administrator shall ensureto obtain an order from the Physician to refer the patient to Out patientSpeech therapy for Swallow test or refer the patient to another home healthagency if the patient needs further Speech therapy services.** **The Nurse Supervisor ornurse determines if the Agency can provide service. If service can** **be provided, the nurseaccepts referral information and completes the Intake Referral Form.** **If the call is not froma physician, the physician is contacted to confirm service needs and to**	

	every 2 days and as needed. Record review failed to evidence the home health agency provided 3 skilled nurse visits per week as ordered on discharge from the hospital. Clinical record review evidenced a communication note dated 1/21/2021, which indicated the home health agency had arranged transportation to wound clinic. Record review failed to evidence any current communication notes regarding transportation to wound clinic. During an interview on 7/1/2022, at 11:28 AM, when queried why patient #3 did not receive 3 skilled nurse visits per week as indicated on the referral order, administrator/clinical manager A indicated it was because the nurses taught the patient s family member to do the dressing changes instead. When queried why the abdominal wound was larger on the recertification than on the start of care assessment, administrator/clinical manager A stated, & every visit if there was any change in condition, we always coordinate with the physician & we coordinated with the physician regarding wound status & and it s documented &. Administrator/clinical manager A indicated the abdominal wound size always fluctuated, and because patient #3 was not a surgical candidate due to co-morbidities, the wound would never heal. At 11:41 AM, when queried if patient #3 ever went to the wound clinic, administrator/clinical manager A stated, & she previously went to wound clinic & I called all the ambulance services, and there s no medical necessity for an ambulance unless she s going to the hospital & her primary doctor goes to her house and looks at her wounds too & because her wounds won t ever heal the wound clinic said it s not necessary &. At 11:51 AM, when queried what interventions were completed regarding the patient not having albuterol nebulizer, administrator/clinical manager A stated, & after [registered nurse B] left, we coordinated with the doctor & We called in the morning and at night & I called [person B] to make sure the patient was fine & When she talks she gets shortness of breath & I spoke with the doctor, and he said no he didn t make		**obtain verbal orders asnecessary. If service cannot be provided, the caller is given the names** **of other agencies thatcan provide required services.** **The Director ofNursing/ Administrator shall ensure that all patients admitted to NORTHWESTHOME HEALTH CARE, INC. will receive a comprehensive assessment that includesidentification of pain and its impact on function as well as the treatment andefficacy of treatment. Pain will be treated as a, "vital sign" andNORTHWEST HOME HEALTH CARE, INC. will strive to ensure that pain is measuredand treated.** **The Director ofNursing/ Administrator shall ensure that the Clinician shall provide skilledassessment, teaching/training and reinforcement of teaching to properly assess,manage and mitigate pain .**	

	a visit, but will visit next week &. Administrator/clinical manager A indicated the pharmacy delivered patient #3 s albuterol nebulizer on 6/30/2022. When queried how the agency was meeting patient needs if the patient did not receive wound care as initially ordered, wound was not healing, patient could not get transport to wound clinic, patient did not have nebulizer medication available, the nurse did not adequately assess the patient, and the patient experienced respiratory distress, administrator/clinical manager A stated, & our goal for her is no more further deterioration & no hospitalization & and prevention of further pressure ulcer development &. Administrator/clinical manager A indicated the nurse should always recheck vitals if a change in patient status was observed. 4. Clinical record review for patient #6 was completed on 7/5/2022, for certification period 11/23/2021 1/21/2022. Record review evidenced a start of care assessment dated 11/23/2021, which stated, & patient agreeable to home healthcare services to include SN [skilled nurse], PT [physical therapy], HHA [home health aide] &. Record review evidenced a plan of care dated 11/23/2021, for certification period 11/23/2021 1/21/2022, which failed to evidence any orders for home health aide services. Record review evidenced a physician order dated 12/20/2021, which stated, & Request for home health aide to start & frequency 2x5 [twice per week for 5 weeks] &. Review indicated the agency failed to order home health aide services for 28 days after identifying patient s need. During an interview on 7/5/2022, at 10:11 AM, when queried why the patient did not receive home health aide services when the need was identified, administrator/clinical manager A indicated the agency should have made an order for whatever discipline was ordered on start of care. 410 IAC 17-13-1(a)		**The Director of Nursing/ Administratorshall ensure that the Clinician will further assess the patient's pain byasking patient on Frequency ofPain Interfering with patient's activity or movement, current pain intensity,description of pain,**Current Pain Management Effectiveness . **TheDirector of Nursing/ Administrator shall ensure that the Clinician will adequately assess the patient's vital signs during or after therespiratory distress. Patients are reassessed when significant changes occur intheir condition. Reassessments are conducted every visit based on physicianorders, patient conditions, and/or professional staff judgment.** **The Director ofNursing/ Administrator shall ensure that all disciplines of NORTHWEST HOME HEALTH CARE, INC.shall report and document any significant findings found in the patient'scondition by the**	

			clinician. Any findings that fall out of the parameters shallbe rechecked by the designated discipline and shall be reported. The disciplineshould notify and promptly alerted the Supervisor/Clinical Manager and thePhysician for proper follow-up, monitoring and immediate action needed for thepatient's overall health status. Any orders received by the Supervisor/ClinicalManager from the Physician shall be documented in the patient's progress record. **TheDirector of Nursing/ Administrator shall ensure that every visit , theClinician shall assess patient's integumentary status, identify any signs andsymptoms of impaired skin integrity, report significant changes to physicianpromptly.** **TheDirector of Nursing/ Administrator shall ensure that clinician will follow Thefrequency, and duration of all visits to be made that is in the Plan of care.**	

			TheDirector of Nursing/ Administrator shall ensure that the Clinician shall ensurethe coordination and supervision of services to assigned patients for theongoing evaluation of the patient's needs ; the Clinician shall ensure thatpatients will receive all services outlined in the plan of care. **TheDirector of Nursing/ Administrator shall ensure that the Clinician shallperform a comprehensive assessment in response to decline in patient status,including wound status, increased in wound measurements, respiratory distress,or severe pain.** **TheDirector of Nursing/ Administrator shall ensure that clinician will havecurrent communication notes regarding transportation to wound clinic. Theclinician will make an effort to coordinate again with the ambulance forpatient's transportation or refer patient to social worker for transportationand other community resources.**	

			TheDirector of Nursing/ Administrator shall ensure that the Clinician shall ensureto verify the services that the patient needs. It will be documented in theVerification of Diagnosis and Services Provided form; ; the Clinician shallensure that patients will receive all services outlined in the plan of care. **TheDirector of Nursing/ Administrator conducted an In-service on July 19, 2022 regarding Care plans, Coordination of Patient services, Standards of Practice ,Referral Process , Intervention policy .** **TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 .**	

			(see attachments) **G0570 A1 – A2: Policy on Care plans** **G0570 B1 – B2: Policy on Coordination of Patient services** **G0570 C1 : Policy on Standards of Practice** **G0570 D1 – D4: Policy on Referral Process** **G0570 E1 : Policy on Intervention policy** **G0570 F1 – F2: GB meeting** **G0570 F3 – F4: Inservice**	
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is	G0572	**G0572Plan of care** ***Duringthe emergency meeting conducted by GB on July 17, 2022, the Director of**	2022-07-19

	established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review, and interview, the agency failed to ensure the patients received the services written in an individualized plan of care in 3 of 5 active clinical records reviewed. (#1, 2, 3) The findings include: 1. Record review evidenced an undated agency policy obtained 7/5/2022, titled Coordination of Patient Services which stated, & The following are essential components of professional coordination and supervision of services to assigned patients for the ongoing evaluation of the patient s needs & Appropriate and timely completion of physician orders &. 2. Record review evidenced an undated agency policy obtained 7/5/2022, titled Patient Rights which stated, & The Patient Rights includes but is not limited to, the patient s right to: & Receive all services outlined in the plan of care &. 3. Clinical record review for patient #1 was completed on 7/1/2022. Record review evidenced a plan of care for certification period 5/11/2022 7/9/2022, dated 6/3/2022. This document stated, & Therapy services required for increased functional disability programs & Patient requires skilled intervention of physical therapy for exercises to increase strength and endurance, implementation of safety measures and evaluation for assistive devices due to impaired function or declining functional ability as demonstrated by increased weakness &. Record review failed to evidence patient		**discussed and reviewed the Policy on Coordination of PatientServices, Patient Rights, Policy on Pain Assessment/Management andRevised Policy on Clinical records and Policy on Plan of care.** **TheDirector of Nursing/ Administrator shall ensure that the formulated complete individualizedPlan of Care shall include: All pertinent diagnosis(es), The patient's Mentalstatus, psychosocial, and cognitive status, Type of services, supplies,equipment required , The frequency, and duration of all visits to made ,Prognosis , Rehabilitation potential, Functional limitations , Activities permitted , Specific dietary ornutritional requirements or restrictions , All Medications, treatments, andprocedures , Safety measures to protectagainst injury.** **The Director of Nursing/Administrator shall ensure that the Clinician shall ensure the coordination andsupervision of services to assigned patients for the ongoing evaluation of**	

	received physical therapy services as ordered on the plan of care. During an interview on 7/1/2022, at 10:43 AM, when queried what services the patients should receive, administrator/clinical manager A indicated the patients should receive all the services ordered on the plan of care, as ordered by a physician. When queried why patient #1 did not receive therapy services as ordered on the plan of care, administrator/clinical manager A indicated they had previously provided therapy to patient #1. 4. Clinical record review for patient #2 was completed on 7/1/2022. Record review evidenced a plan of care for certification period 5/20/2022 7/18/2022, dated 6/3/2022. This document indicated the patient was to receive skilled nursing care once per week for 9 weeks. Record review evidence the patient failed to receive a skilled nurse visit on 5/21/2022 and 6/7/2022, as ordered on the plan of care. Record review evidenced a missed visit note dated 5/21/2022, which stated, & Reason: Patient/family cancelled & will reschedule visit: next week &. Review evidenced a missed visit note dated 6/7/2022, which stated, & Reason: Patient/family cancelled & will reschedule visit: next week &. Record review failed to evidence the physician ordered visits to be rescheduled for the following week. During an interview on 7/1/2022, at 11:02 AM, when queried how the agency handled missed visits, administrator/clinical manager A stated, & for rescheduling a missed visit & when the nurse calls the patient and patient wants to reschedule, we make a schedule & If the patient doesn t want to reschedule we create a missed visit &. Administrator/clinical manager A indicated the physician would be notified of a missed visit, but an order was not required to reschedule for the next week. When queried why patient #2 cancelled his nursing visits, administrator/clinical manager A stated, & I will start giving reasons why & sometimes they		**thepatient's needs ; the Clinician shall ensure that patients will receive allservices outlined in the plan of care.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician willdocument any additional information regarding reason patient cancelled/refusedin the Missed visit notes . Verbal/telephone orders shall be obtained from thepatient's physician that patient had a missed visit on that particular weekand the visit needs to be rescheduled the following week.** **The Directorof Nursing/ Administrator shall ensure that upon admission and every visits ,theClinician shall do a complete comprehensive assessment.** **The Directorof Nursing/ Administrator shall ensure that the Clinician shall assesscardiovascular status, identify any signs and symptoms of impairedcardiovascular function ; Cardiovascularassessment**	

	don t give me reasons & but I will add documentation now & I don t know why he cancelled &. 5. Observation of a home visit for patient #3 was conducted on 6/29/2022, at 5:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was observed to be alert, oriented, severely obese, wearing 3 liters of oxygen per nasal cannula, and bedbound. Registered nurse B asked patient #3 how her pain is, but failed to ask patient for any descriptors, location, or rating, and failed to instruct patient in measures to mitigate her pain. Registered nurse B asked patient #3 when she last took pain medication, and the patient indicated the previous day. The patient was observed to have a small abdominal wound with a copious amount of brown, foul smelling drainage, and macerated surrounding skin. Patient had a large wound to left interior forearm and left interior upper arm, in the crease of the elbow, with a bright red wound bed, and clear/bloody drainage. When registered nurse B attempted to remove the old dressing from the left arm wounds, patient #3 was observed grimacing, and yelling/crying out in pain at the slightest touch to the wound. During the visit, registered nurse B failed to perform a complete physical assessment to include assessment of pedal pulses, peripheral edema, and a pain assessment. Registered nurse B failed to complete a full skin assessment, including skin on buttocks, sacrum, and ischium, failed to apply Vitamin A and D ointment to buttocks, sacrum, and ischium, and failed to assess skin on back or heels. At 5:50 PM, registered nurse B began cleaning up the wound care supplies and packing to leave the home visit. At this time, surveyor requested registered nurse B to assess the patient s skin on bottom. Registered nurse B rolled patient on her side, and surveyor observed the skin to buttocks, which was scarred, pink, and purple. Clinical record review for patient #3 was completed on 7/1/2022. Record review evidenced a plan of care dated 6/27/2022, for certification period 6/21/2022 8/19/2022. This		**shall include assessment ,evaluate location, extent and severity ofedema. The Director of Nursing/Administrator shall ensure that the Clinician shall report significant changesto physician promptly when edema (swelling) is noted.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician shall assesspatient's integumentary status, identify any signs and symptoms of impairedskin integrity, report significant changes to physician promptly.** **The Director ofNursing/ Administrator shall ensure that all patients admitted to NORTHWESTHOME HEALTH CARE, INC. will receive a comprehensive assessment that includesidentification of pain and its impact on function as well as the treatment andefficacy of treatment. Pain will be treated as a, "vital sign" andNORTHWEST HOME HEALTH CARE, INC. will strive to ensure that pain is measuredand treated.**	

	following orders for skilled nursing: notify physician of pain level greater than 5, monitor and mitigate pain, perform complete physical assessment each visit, notify physician of any potential problems that impede completion of patient recovery and desired goals, assess integumentary status, cleanse wound on sacrum (bone at base of spine) to ischium (bottom pelvic bones) with normal saline, pat dry, apply Vitamin A and D ointment daily, and cleanse wound on left and right buttocks with normal saline, pat dry, apply Vitamin A and D ointment daily. Record review failed to evidence physician was notified of extreme level of pain to left arm during dressing changes. During an interview on 7/1/2022, at 11:37 AM, when queried what nurse should do to mitigate pain as ordered on the plan of care, administrator/clinical manager A indicated the nurse should call the patient before going to the visit for wound care and instruct patient to take pain medication to mitigate pain. Administrator/clinical manager A indicated the physician should be notified if the pain is greater than a 5. At 11:55 AM, when queried what a complete assessment should include, administrator/clinical manager A stated, & we do a head-to-toe assessment, I always ask so I can get the supplies & Full body assessment, check for pressure ulcers, open wounds, and check with the doctor & If there are wounds, we use the wound worksheet, the type of wound, size, type of wound, dressing type &. Administrator/clinical manager A indicated a complete assessment should have included checking pulses, heart rate, blood pressure, and edema. Administrator/clinical manager A stated, & Usually we always do a full assessment and a full skin assessment. 410 IAC 17-13-1(a)		**The Director ofNursing/ Administrator shall ensure that the Clinician shall provide skilledassessment, teaching/training and reinforcement of teaching to properly assess,manage and mitigate pain.** **The Director of Nursing/Administrator shall ensure that the Clinician will assess the patient’s Frequency of Pain Interfering with patient'sactivity or movement, current pain intensity, description.** **The Director of Nursing/ Administratorshall ensure that the Clinician will further assess the patient’s pain byasking patient on Frequency ofPain Interfering with patient's activity or movement, current pain intensity,description of pain,**Current Pain Management Effectiveness **.** **TheDirector of Nursing/**	

			that the Clinician shall reportto the attending physician and agency supervisor the patient's level of pain (greater than 5/10 in a pain scale) as soon as possible after observing thechange. **TheDirector of Nursing/ Administrator shall ensure that Patient's pain will beassessed every visit and all Disciplines will use an appropriate Nonverbal PainAssessment Method for patients unable to communicate to evaluate the pain andwill coordinate with Clinical Manager/Supervisor and Physician if pain isbeyond the parameter . The Nonverbal Pain Assessment Method is alreadyincorporated in the Start of Care Oasis, Resumption of care Oasis,Recertification Oasis, Follow up , Discharge oasis. The Director of Nursingshall ensure that nurses will be given a Nonverbal Pain Assessment Form to useto assess and document patient's pain for unable to communicate every visit.The**	

			Director of Nursing shall ensure that disciplines will document zero (0)or no pain not (X) if patient is not complaining of any pain. **TheDirector of Nursing/Administrator shall ensure that the nurse/therapist willuse a standardized NORTHWEST HOME HEALTH CARE, INC. accepted pain assessmenttool that evaluates the location, duration, severity (rating scale),alleviating factors, exacerbating factors, current treatment (medication andnon-medication) and response to treatment.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician shall assesspatient's integumentary status, identify any signs and symptoms of impairedskin integrity and report to the Physician.** **TheDirector of Nursing shall ensure that for patients who have wounds , Nursesshall follow Plan of care for wound dressing : SN perform and instructpatient/caregiver to perform wound care which**	

			includesdressing/management/frequency of dressing change. **An In-service conductedon July 19, 2022 regarding Policy onPlan of care, Coordination of Patient Services, Pain Assessment/Management ,Policy on Clinical Record .** **TheDirector of Nursing/Administrator conducted an In-service on July 19, 2022 regarding Policy on Clinical Records andproper documentation on Wound care.** **The Directorof Nursing/ Administrator will be responsible for implementing, maintaining andreinforcing these corrective actions to ensure that these deficiencies arecorrected and will not recur effective after the In-Service meeting to all thestaffs on July 19, 2022 .** **(See attachments) for :** **G0572 A1 – A3: Policy on Plan of care** **G0572 B1 – B2: Policy on Coordination of**	

			PatientServices **G0572 C1 – C2: Policy on Pain Assessment/Management** **G0572 D1 – D2: Wong Baker FACES Pain Rating Scale** **G0572 E1 – E3: Policy on Clinical Record** **G0572F1 – F2: GB meeting** **G0572 F3 – F4: Inservice** **G0572 Plan of care** **An the emergency meeting conducted by GB was held on July 27, 2022, the Director of Nursing/ Administrator/Clinical Manager discussed and reviewed the Agency's Plan of Correction on Plan of care that has been found out unacceptable** **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/**	

			Administrator/Clinical Manager ensured that the formulated complete individualized Plan of Care shall include: All pertinent diagnosis(es), The patient's Mental status, psychosocial, and cognitive status, Type of services, supplies, equipment required , The frequency, and duration of all visits to made , Prognosis , Rehabilitation potential , Functional limitations , Activities permitted , Specific dietary or nutritional requirements or restrictions , All Medications, treatments, and procedures , Safety measures to protect against injury in all 100 % of all active clinical records reviewed. **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured the coordination and supervision of services to assigned patients for the ongoing evaluation of the patient's needs ; the Clinician shall**	

			receive all services outlined in the plan of care in all 100 % of all active clinical records reviewed. **On July 19,2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician will document any additional information regarding reason patient cancelled/refused in the Missed visit notes . Verbal/telephone orders shall be obtained from the patient's physician that patient had a missed visit on that particular week and the visit needs to be rescheduled the following week in all 100 % of all active clinical records reviewed.** **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that upon admission and every visits**	

			,the Clinician shall do a complete comprehensive assessment in all 100 % of all active clinical records reviewed. **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician shall assess cardiovascular status, identify any signs and symptoms of impaired cardiovascular function ; Cardiovascular assessment shall include assessment ,evaluate location, extent and severity of edema. The Director of Nursing/ Administrator shall ensure that the Clinician shall report significant changes to physician promptly when edema (swelling) is noted in all 100 % of all active clinical records reviewed.** **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/**	

			Administrator/Clinical Manager ensured that the Clinician shall assess patient's integumentary status, identify any signs and symptoms of impaired skin integrity, report significant changes to physician promptly in all 100 % of all active clinical records reviewed. **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that all patients admitted to NORTHWEST HOME HEALTH CARE, INC. will receive a comprehensive assessment that includes identification of pain and its impact on function as well as the treatment and efficacy of treatment. Pain will be treated as a, "vital sign" and NORTHWEST HOME HEALTH CARE, INC. will strive to ensure that pain is measured and treated in all 100 % of all active clinical records reviewed.** **On July 19, 2022 The Quality**	

			Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician shall provide skilled assessment, teaching/training and reinforcement of teaching to properly assess, manage and mitigate pain in all 100 % of all active clinical records reviewed. **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician will assess the patient's Frequency of Pain Interfering with patient's activity or movement, current pain intensity, description in all 100 % of all active clinical records reviewed.** **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/**	

			Administrator/Clinical Manager ensured that the Clinician will further assess the patient's pain by asking patient on Frequency of Pain Interfering with patient's activity or movement, current pain intensity, description of pain,Current Pain Management Effectiveness **in all 100 % of all active clinical records reviewed.** **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician shall report to the attending physician and agency supervisor the patient's level of pain (greater than 5/10 in a pain scale) as soon as possible after observing the change in all 100 % of all active clinical records reviewed.** **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/**	

			Administrator/Clinical Manager ensured that Patient's pain will be assessed every visit and all Disciplines will use an appropriate Nonverbal Pain Assessment Method for patients unable to communicate to evaluate the pain and will coordinate with Clinical Manager/Supervisor and Physician if pain is beyond the parameter . The Nonverbal Pain Assessment Method is already incorporated in the Start of Care Oasis, Resumption of care Oasis, Recertification Oasis, Follow up , Discharge oasis. The Director of Nursing shall ensure that nurses will be given a Nonverbal Pain Assessment Form to use to assess and document patient's pain for unable to communicate every visit. The Director of Nursing shall ensure that disciplines will document zero (0) or no pain not (X) if patient is not complaining of any pain in all 100 % of all active clinical records reviewed. **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/**	

			Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the nurse/therapist will use a standardized NORTHWEST HOME HEALTH CARE, INC. accepted pain assessment tool that evaluates the location, duration, severity (rating scale), alleviating factors, exacerbating factors, current treatment (medication and non-medication) and response to treatment in all 100 % of all active clinical records reviewed. **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician shall assess patient's integumentary status, identify any signs and symptoms of impaired skin integrity and report to the Physician in all 100 % of all active clinical records reviewed.** **On July 19, 2022 The Quality Assurance Team headed by The Director of Nursing/**	

			Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that for patients who have wounds , Nurses shall follow Plan of care for wound dressing : SN perform and instruct patient/caregiver to perform wound care which includes dressing/management/frequency of dressing change in all 100 % of all active clinical records reviewed. **(See attachment)** **G0572 C2a GB meeting**	
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made;	G0574	**G0574Plan of care must include the following** ***Duringthe emergency meeting of GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy on Plan of care.** **The Director of Nursing/ Administrator shall ensure that acomplete Plan of Care formulated to include: All pertinent**	2022-07-19

	(v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review and interview, the agency failed to ensure the plan of care included nutritional requirements, type of supplies or equipment required, all medications and treatments, and/or all pertinent diagnoses in 4 of 5 active clinical records reviewed. (#1, 2, 3, 4) The findings include: 1. Record review evidenced an undated agency policy obtained 7/5/2022, titled Plan of Care which stated, & The plan of care shall be completed in full to include: & All pertinent diagnosis & Type of services, supplies, equipment required & The frequency, and duration of all visits to be made & Specific dietary or nutritional requirements or restrictions & All medications, treatments, and procedures & All patient care orders, including verbal orders, must be recorded in the plan of care &.		**diagnosis(es), Thepatient's Mental status, psychosocial, and cognitive status, Type of services,supplies, equipment required , The frequency, and duration of all visits tomade , Prognosis , Rehabilitationpotential , Functional limitations , Activities permitted , Specific dietary ornutritional requirements or restrictions , All Medications, treatments, andprocedures , Safety measures to protectagainst injury.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will have acomprehensive assessment which will include a review of patient's nutritional requirements. This will bedocumented in the Oasis and Plan of care.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will have acomprehensive assessment which will include a review of patient's all pertinentdiagnoses. . This will be documented in the Oasis and Plan of care. The Directorof Nursing/ Administrator shall ensure that the Clinician shall ensure toverify the patient's pertinent diagnosis. It will be documented in the Verification of Diagnosis , Services Provided form andPlan of Care.** **TheDirector of Nursing/ Administrator shall ensure**	

	2. Clinical record review for patient #1 was completed on 7/1/2022, for certification period 5/11/2022 7/9/2022. Record review evidenced a hospital referral order dated 6/1/2022, which indicated the patient had a swallowing disorder, required home health speech therapy services, and was on a thickened liquid diet. Review of a plan of care for certification period 5/11/2022 7/9/2022, dated 6/3/2022, failed to include nutritional requirements of thickened liquids. During an interview on 6/28/2022, at 11:00 AM, person A (patient #1 s family member) indicated patient #1 was on thickened liquids following hospital discharge on 6/1/2022. During an interview on 7/1/2022, at 10:40 AM, when queried what nutritional requirements patient #1 should have included on their plan of care, administrator/clinical manager A indicated the plan of care should include the thickened liquid requirements. 3. Observation of a home visit for patient #2 was conducted on 6/29/2022, at 2:30 PM to observe a routine physical therapy visit. During the visit, the patient was observed to have a commode in use. Clinical record review for patient #2 was completed on 7/1/2022. Record review evidenced a plan of care for certification period 5/20/2022 7/18/2022 which failed to include a commode under durable medical equipment and supplies. During an interview on 7/1/2022, at 11:10 AM, when queried what equipment should be included on the plan of care, administrator/clinical manager A stated, & whatever the patient is using & I even include what patient is not using & It s included on the plan of care &.		**that the Clinician will have acomprehensive assessment which will include a review the (DME) type of suppliesor equipment required. It will be documented in the OASIS and Patient's Plan ofcare under Durable Medical Equipment. Upon admission the clinician will assessand document the Durable Medical Equipment the patient is using; in the eventthat the clinician assess that the patient will need an equipment Duringadmission and every clinician visit; the clinician will have a Verbal ortelephone order from the Physician.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will have acomprehensive assessment which will include a review of all medications thepatient is taking. This assessment will identify potential adverse effects anddrug reactions, including ineffective therapy, significant side effects,significant drug interactions, duplicate drug therapy , medication discrepancyand non-compliance with therapy.**	

	4. Observation of a home visit for patient #3 was conducted on 6/29/2022, at 5:00 PM, to observe a routine skilled nurse visit. The patient stated during the visit that she got dizzy when repositioning. Clinical record review for patient #3 was completed on 7/1/2022, for certification periods 4/22/2022 6/20/2022 and 6/21/2022 8/19/2022. Record review evidenced a referral order dated 4/20/2022, which evidenced the following diagnoses, which were not included on the patient s plan of care: deep vein thrombosis (blood clot in vein), GI bleed (bleeding in stomach), and hypotension (low blood pressure). During an interview on 7/1/2022, at 11:26 AM, when queried which diagnoses should be included on the plan of care, administrator/clinical manager A stated, & whatever has the biggest impact on the patient & her biggest/most severe problems &. 5. Clinical record review for patient #4 was completed on 7/1/2022, for certification period 6/6/2022 8/14/2022. Record review evidenced a discharge summary/referral order dated 6/17/2022, which indicated the patient was discharged on the following medications not included in the plan of care: ciprofloxacin (antibiotic) and hydrocodone-acetaminophen (pain medication). Clinical record review evidenced a comprehensive re-assessment/resumption of care assessment completed on 6/20/2022, which stated, & Also noted the day after he was released he had ER visit due to gout [disease causing joint pain] flare up and has also started prednisone [medication for inflammation] &. Record review failed to evidence diagnosis of gout on plan of care. During an interview on 7/1/2022, at 12:21 PM,		**The Director ofNursing/ Administrator shall ensure that the Clinician will review thismedication list with the physician, and confirm those medications that are tobe continued or discontinued. The doses will be confirmed with the physicianand changes will be noted in the Medication profile record and on the Plan ofCare.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will have aVerbal or telephone Medication orders written down and read back forverification to minimize errors and misinterpretation of written or verbal medicationorders .** **TheDirector of Nursing/ Administrator shall ensure that the Clinician willreconcile all medications taken by the client prior to admission to home carewith those ordered at the time of admission, before and after inpatient admissionstays, and at the time of discharge.** **TheDirector of Nursing/ Administrator conducted an**	

	when queried why patient #4 s plan of care did not include all medications, administrator/clinical manager A indicated every recertification or resumption of care the agency updates the patient s medication list, typically by reviewing the discharge medication list, and updating as necessary. At 12:30 PM, when queried if the diagnosis of gout should be on this patient s plan of care, administrator/clinical manager A stated, & we expect the pertinent diagnoses to be listed if it doesn t affect the patient then sometimes won t be on there &. 410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C) 410 IAC 17-13-1(a)(1)(D)(ii, viii, ix)		**In-service on July 19, 2022 regarding Plan of care.** **TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 .** **(see attachments)** **G0574 A1 – A3: Policy on Plan of Care** **G0574 B1 : Verification/Confirmationof Diagnosis(es) and Disciplines Provided form.** **G0574 C1 – C2: GB meeting** **G0574 C3 – C4: Inservice** **An emergency meeting of GB was held on July 27, 2022, the Director of Nursing/ Administrator/Clinical manager discussed and**	

			reviewed the Plan of Correction on Plan of care must include the following submitted that has been found unacceptable. On July 19, 2022 the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager and the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that a complete Plan of Care formulated to include: All pertinent diagnosis(es), The patient's Mental status, psychosocial, and cognitive status, Type of services, supplies, equipment required , The frequency, and duration of all visits to made , Prognosis , Rehabilitation potential , Functional limitations , Activities permitted , Specific dietary or nutritional requirements or restrictions , All Medications, treatments, and procedures , Safety measures to protect against injury in all 100 % of all clinical records reviewed. On July 19, 2022 the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager and the Alternate Director of Nursing/ Administrator/Clinical Manager ensured **that the Clinician will have a comprehensive assessment which will include a review of**	

			requirements. This will be documented in the Oasis and Plan of care in all 100 % of all clinical records reviewed. On July 19, 2022 the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager and the Alternate Director of Nursing/ Administrator/Clinical Manager ensured **that the Clinician will have a comprehensive assessment which will include a review of patient's all pertinent diagnoses. . This will be documented in the Oasis and Plan of care. The Director of Nursing/ Administrator shall ensure that the Clinician shall ensure to verify the patient's pertinent diagnosis. It will be documented in the Verification of Diagnosis , Services Provided form and Plan of Care** in all 100 % of all clinical records reviewed. On July 19, 2022 the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager and the Alternate Director of Nursing/ Administrator/Clinical Manager ensured **that the Clinician will have a comprehensive assessment which will include a review the (DME) type of supplies or equipment required. It will be documented in the OASIS and Patient's Plan of care under Durable Medical Equipment. Upon admission the clinician will assess and document the**	

			Durable Medical Equipment the patient is using; in the event that the clinician assess that the patient will need an equipment During admission and every clinician visit; the clinician will have a Verbal or telephone order from the Physician in all 100 % of all clinical records reviewed. On July 19, 2022 the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager and the Alternate Director of Nursing/ Administrator/Clinical Manager ensured **that the Clinician will have a comprehensive assessment which will include a review of all medications the patient is taking. This assessment will identify potential adverse effects and drug reactions, including ineffective therapy, significant side effects, significant drug interactions, duplicate drug therapy , medication discrepancy and non-compliance with therapy** in all 100 % of all clinical records reviewed. On July 19, 2022 the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager and the Alternate Director of Nursing/ Administrator/Clinical Manager ensured **that the Clinician will review this medication list with the physician, and confirm those**	

			continued or discontinued. The doses will be confirmed with the physician and changes will be noted in the Medication profile record and on the Plan of Care in all 100 % of all clinical records reviewed. On July 19, 2022 the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager and the Alternate Director of Nursing/ Administrator/Clinical Manager ensured **that the Clinician will have a Verbal or telephone Medication orders written down and read back for verification to minimize errors and misinterpretation of written or verbal medication orders** in all 100 % of all clinical records reviewed. On July 19, 2022 the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager and the Alternate Director of Nursing/ Administrator/Clinical Manager ensured **that the Clinician will reconcile all medications taken by the client prior to admission to home care with those ordered at the time of admission, before and after inpatient admission stays, and at the time of discharge** in all 100 % of all clinical records reviewed. **(see attachment)**	

			G0574 C2a GB meeting	
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. Based on record review and interview, the agency failed to ensure all patient care orders were recorded on the plan of care in 1 of 3 home visits conducted. (#3) The findings include: Record review evidenced an undated agency policy obtained 7/5/2022, titled Plan of Care which stated, & All patient care orders, including verbal orders, must be recorded in the plan of care &. Clinical record review for patient #3 was completed on 7/5/2022, for certification periods 4/22/2022 6/20/2022 and 6/21/2022 8/19/2022. Record review evidenced a referral order dated 4/20/2022, which included the following wound care treatment orders, which were not included on the plan of care: Cavilon (barrier ointment for skin protection) to skin surrounding abdominal wound and to buttocks, sacrum (bone at base of spine), and ischium (bones forming the base of the pelvis), Venelex (skin cream for wound treatment) to heels, feet, elbows, and posterior ears, and Micotin (antifungal powder) powder and Kaltostat (absorbent wound dressing) to breast and groin skin folds.	G0576	**G0576 Allorders recorded in plan of care** ***Duringthe emergency meeting of GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy on Plan of Care.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will reviewthe wound care treatment orders from the referral orders, coordinate with thePhysician, verify and obtain an order.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician shall ensureall patient wound care treatment orders are recorded in the plan of care.Verbal/telephone orders shall be obtained from the patient's physician forchanges of wound care treatment**	2022-07-19

	During an interview on 7/1/2022, at 11:26 AM, when queried why Cavilon, Micotin, Venelex and Kaltostat were not included on the plan of care, administrator/clinical manager A stated, & let me check & the particular day we admitted her there was no open areas or redness, but we always coordinate with the doctor if it needs to be ordered &.		**orders from the referral and will be documentedin the Plan of care.** **TheDirector of Nursing/Administrator conducted an In-service on July 19, 2022 regarding Policy on Plan of Care and Woundcare.** **TheDirector of Nursing/ Administrator will be responsible for implementing, maintainingand reinforcing these corrective actions to ensure that these deficiencies arecorrected and will not recur effective after the In-Service meeting to all thestaffs on July 19, 2022 .** **(Seeattachments) for :** **G0576A1 – A3: Policy on Plan of Care.** **G0576 B1 – B2: GB meeting** **G0576 B3 – B4: Inservice** **G0576 All orders recorded in plan of care** **An emergency meeting of GB**	

			the Director of Nursing/ Administrator /Clinical Manager discussed and reviewed the Plan of Correction on All orders recorded in plan of care submitted that has been found unacceptable. **On July 19, 2022 the Quality Assurance Team headed by the Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician will review the wound care treatment orders from the referral orders, coordinate with the Physician, verify and obtain an order on all 100 % of all active clinical records reviewed.** **On July 19, 2022 the Quality Assurance Team headed by the Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician shall ensure all patient wound care treatment orders are recorded in the**	

			Verbal/telephone orders shall be obtained from the patient's physician for changes of wound care treatment orders from the referral and will be documented in the Plan of care on all 100 % of all active clinical records reviewed. **(See attachment)** **G0576 C2a GB meeting**	
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the agency failed to ensure services and treatments were administered only as ordered by a physician in 2 of 5 active clinical records reviewed. (#1, 4) The findings include: 1. Record review evidenced an undated agency policy obtained 7/5/2022, titled Plan of Care which stated, & Home care services are furnished under the supervision and direction of the patient s physician &. 2. Clinical record review for patient #1 was completed on 7/1/2022, for certification period 5/11/2022 7/9/2022. Record review	G0580	**G0580Only as ordered by a physician** ***Duringthe emergency meeting of GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy on Plan of Care.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician shall recordall patient care orders, including verbal orders in the Plan of care.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician shall ensure to verify the treatmentthat the patient needs. Upon referral if the**	2022-07-19

	evidenced a hospital referral order dated 6/1/2022, which indicated the patient had a swallowing disorder, required home health speech therapy services, and was on a thickened liquid diet. Review of a plan of care for certification period 5/11/2022 7/9/2022, dated 6/3/2022, failed to evidence any orders for a swallow evaluation by the home health nurse. During an interview on 6/28/2022, at 11:00 AM, person A (patient #1 s family member) indicated patient #1 was on thickened liquids following hospital discharge on 6/1/2022. Person A indicated when patient #1 ran out of thickener for fluids, a nurse from the home health agency observed the patient drink thin liquids and the nurse said the patient was fine and didn t have any problems swallowing. Person A indicated patient drank thin liquids and a regular diet after nurse evaluation. During an interview on 7/1/2022, at 10:40 AM, when queried what treatments the nurses should be providing to patients, administrator/clinical manager A indicated they should be performing the orders ordered by the physician and included on the plan of care. 3. Clinical record review for patient #4 was completed on 7/1/2022, for certification period 6/6/2022 8/4/2022. Record review evidenced a resumption of care assessment dated 6/20/2022, which stated, & pt [patient] is due to have foley [catheter inserted into the urethra to drain urine] removed today and was done so with no complications &. Record review evidenced a plan of care for certification period 6/6/2022 8/4/2022, which failed to include an order for the skilled nurse to remove the foley catheter. During an interview on 7/1/2022, at 12:34 PM, when queried why the nurse removed the foley if there was no order, administrator/clinical manager A stated, & the plan of care has not been sent yet, but we will		**Physician ordered Speech Therapyservices for Swallow test for the patient . The Director of Nursing/Administrator shall ensure that the discharge planners, physicians, socialworkers, and the community will be notified that we are unable to provideservices/ treatment and admit the patient . In the event that the patient isactive with our agency and the Physician ordered Speech Therapy services forSwallow test . The Director of Nursing/ Administrator shall ensure to obtain anorder from the Physician to refer the patient to Out patient Speech therapy forSwallow test or refer the patient to another home health agency if the patientneeds further Speech therapy services.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician shallensure to document treatment orders are recorded in the plan ofcare. Verbal/telephone orders shall be obtained from the patient's physician when**	

	send it and always make orders for interventions &. 410 IAC 17-13-1(a)		**to remove patient's Foley catheter andwill be documented in the communication note and Plan of care.** **TheDirector of Nursing/ Administrator conducted an In-service on July 19, 2022 regarding Plan of Care** **TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 .** **(see attachments)** **G0580 A1 – A3: Policy on Plan of Care** **G0580 B1 – B2: GB meeting** **G0580 B3 – B4: Inservice**	

			G0580 Only as ordered by a physician **An emergency meeting of GB was held on July 27, 2022 the Director of Nursing/ Administrator/Clinical Manager discussed and reviewed the Plan of Correction Only as ordered by a physician submitted which was found un acceptable.** **On July 19, 2022, The Quality Assurance Team headed by the The Director of Nursing/ Administrator /Clinical Manager with the Alternate Director of Nursing/ Administrator /Clinical Manager ensured that the Clinician shall record all patient care orders, including verbal orders in the Plan of care in all 100 % active Clinical records reviewed.** **On July 19, 2022, The Quality Assurance Team headed by the The Director of Nursing/ Administrator /Clinical Manager with the Alternate Director of Nursing/ Administrator /Clinical Manager ensured that the Clinician shall ensure to verify the treatment that the patient needs. Upon referral if the Physician ordered Speech Therapy services for Swallow test for the patient . The Director of**	

			Nursing/ Administrator shall ensure that the discharge planners, physicians, social workers, and the community will be notified that we are unable to provide services/ treatment and admit the patient . In the event that the patient is active with our agency and the Physician ordered Speech Therapy services for Swallow test . The Director of Nursing/ Administrator shall ensure to obtain an order from the Physician to refer the patient to Out patient Speech therapy for Swallow test or refer the patient to another home health agency if the patient needs further Speech therapy services in all 100 % active Clinical records reviewed. **On July 19, 2022, The Quality Assurance Team headed by the The Director of Nursing/ Administrator /Clinical Manager with the Alternate Director of Nursing/ Administrator /Clinical Manager ensured that the Clinician shall ensure to document treatment orders are recorded in the plan of care. Verbal/telephone orders shall be obtained from the**	

			patient's physician when to remove patient's Foley catheter and will be documented in the communication note and Plan of care e in all 100 % active Clinical records reviewed. **(see attachment)** **G0580 C2a GB meeting**	
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 observation, record review, and interview, the agency failed to promptly alert the physician to any changes in patients condition or needs which suggested outcomes were not being achieved, or the plan of care needed to be altered in 2 of 3 home visits conducted. (#1, 3) The findings include: 1. Record review evidenced an undated agency policy obtained 7/5/2022, titled Plan of Care which stated, & Professional staff shall promptly alert the physician to any changes	G0590	**G0590Promptly alert relevant physician of changes** ***During the emergencymeeting of GB on July 17, 2022 theDirector of Nursing/ Administrator discussed and reviewed the Policy on Plan ofcare ,Policy on Patientreassessment/update of comprehensive assessment and Policy on Pain assessment/management .** **The Director ofNursing/ Administrator shall ensure that the Clinician shall promptly alert thephysician**	2022-07-19

	&. 2. Observation of a home visit for patient #1 was conducted on 6/28/2022, at 11:00 AM, to observe a routine home health aide visit. During the visit, the patient was observed to have 3+ pitting edema (swelling that when pressed, leaves an indentation of 5 6 mm that takes up to 30 seconds to rebound) to bilateral feet and ankles. During the visit, the patient was observed to have a purple/brown, scabbed area to top of third toe. Clinical record review for patient #1 was completed on 7/1/2022. Record review evidenced two comprehensive re-assessments dated 5/10/2022, and 6/3/2022, for certification period 5/11/2022 7/9/2022. These documents indicated patient did not have any edema (swelling) to lower legs or feet and indicated patient s skin was intact at time of assessment. Review evidenced a skilled nurse visit note dated 5/17/2022, which indicated the patient had non-pitting edema to bilateral lower extremities. Review failed to evidence the physician was notified of new edema on 5/17/2022, or 6/28/2022, visit. Record review failed to evidence the physician was notified of scabbed area to top of right third toe during 6/28/2022, home visit. During an interview on 7/1/2022, at 10:54 AM, when queried if the physician was notified of new edema, administrator/clinical manager A stated, & They always coordinate with the doctor & maybe it s on and off again for his edema & and we would document that the edema is on and off &. At 10:55 AM, when queried what the agency considers a wound, administrator/clinical manager A stated, & Any disruption in the skin is considered a wound &. When queried about scabbed area to third toe observed during home visit and if the physician was notified, administrator/clinical manager A stated, & we always coordinate with the physician & maybe it s new & but I ll check & any new change in the skin we document and coordinate with the physician &.		**to any changes that suggest a need to alter the Plan of Care, Policyon Patient reassessment/update of comprehensive assessment , Policy on Pain assessment/management.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician shall reportto the attending physician and agency supervisor the Significant changes inclient condition will be as soon as possible after observing the change.** **The Director of Nursing/ Administrator shall ensure that theClinician shall assess cardiovascular status, identify any signs and symptomsof impaired cardiovascular function ; Cardiovascularassessment shall include assessment ,evaluate location, extent and severity of edema. The Director of Nursing/ Administrator shallensure that the Clinician shall report significant changes to physicianpromptly when edema (swelling) is noted.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician shall assesspatient's integumentary status, identify any signs and symptoms of impairedskin integrity, report significant changes to physician promptly.** **The Director of Nursing/ Administrator shall ensurethat all patients admitted to NORTHWEST HOME HEALTH CARE, INC. will receive acomprehensive**	

	3. Observation of a home visit for patient #3 was conducted on 6/29/2022, at 5:00 PM, to observe a routine skilled nurse visit. During the visit, the nurse performed wound care to a left arm wound. Patient was observed grimacing and yelling out in pain with any slight touch to wound. Registered nurse B asked patient when she last took pain medication, and patient indicated the day before. Clinical record review for patient #3 was completed on 7/5/2022. Record review evidenced a plan of care for certification period 6/21/2022 8/19/2022, which stated, & Patient s activity level will improve due to effective pain control by/within 8/19/2022 & Patient will attain optimal effectiveness of pain management regimen & Patient/Caregiver will demonstrate ability to manage pain medication regimen &. Record review evidenced a communication note dated 6/29/2022, which failed to evidence the physician was notified of patient s severe pain and need for plan of care to be altered to meet patient s needs. During an interview on 7/1/2022, at 11:37 AM, when queried if the physician was notified of patient s high level of pain, and need for plan of care to be altered, administrator/clinical manager A stated, & the doctor was aware, and we always instruct the family members to give pain medications to the patient before the visits & I will ask the nurse if she needs stronger medication for pain and to get an order from the doctor &. 410 IAC 17-13-1(a)(2)		**assessment that includes identification of pain and its impact onfunction as well as the treatment and efficacy of treatment. Pain will betreated as a, "vital sign" and NORTHWEST HOME HEALTHCARE, INC. will strive to ensure that pain is measured and treated. The Director of Nursing/ Administrator shall ensurethat the Clinician shall provide skilled assessment, teaching/training andreinforcement of teaching to properly assess, manage and mitigate pain. The Director of Nursing/ Administrator shall ensurethat the Clinician will assess the patient’s Frequencyof Pain Interfering with patient's activity or movement, current painintensity, description. The Director of Nursing/Administrator shall ensure that the Clinician shall report to the attendingphysician and**	

			patient's level of pain (greater than 5/10in a pain scale) as soon as possible after observing the change. **TheDirector of Nursing/ Administrator shall ensure that the coordination with thePhysician has been documented in the Communication notes.** **The Director ofNursing/ Administrator conducted an In-service on July 19, 2022 regarding Policy on Plan of care , Policy onPatient reassessment/update of comprehensive assessment , Policy on painassessment/management .** **TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 .**	

			(see attachments) **G0590 A1 – A3: Policy on Plan of care** **G0590 B1 – B2: Policy on Patient Reassessment/Updateof comprehensive assessment** **G0590 C1 – C2: Policy on pain assessment/management** **G0590 D1 – D2: GB meeting** **G0590 D3 – D4: Inservice** **An emergency meeting of GB was held on July 27, 2022 the Director of Nursing/ Administrator discussed and reviewed the plan of Correction on Promptly alert relevant physician of changes submitted that has been found out unacceptable.** **On July 19, 2022, the Quality Assurance team headed by the The Director of**	

			Nursing/Administrator/Clinical Manager with the Alternate Director of Nursing/Administrator/Clinical Manager ensured that the Clinician shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care, Policy on Patient reassessment/update of comprehensive assessment , Policy on Pain assessment/management in all 100 % active Clinical records reviewed. **On July 19, 2022, the Quality Assurance team headed by the The Director of Nursing/Administrator/Clinical Manager with the Alternate Director of Nursing/Administrator/Clinical Manager ensured that the Clinician shall report to the attending physician and agency supervisor the Significant changes in client condition will be as soon as possible after observing the change in all 100 % active Clinical records reviewed.** **On July 19, 2022, the Quality Assurance team headed by the The Director of Nursing/Administrator/Clinical Manager with the Alternate Director of Nursing/Administrator/Clinical Manager**	

			cardiovascular status, identify any signs and symptoms of impaired cardiovascular function ; Cardiovascular assessment shall include assessment ,evaluate location, extent and severity of edema. The Director of Nursing/ Administrator shall ensure that the Clinician shall report significant changes to physician promptly when edema (swelling) is noted **in all 100 % active Clinical records reviewed.** **On July 19, 2022, the Quality Assurance team headed by the The Director of Nursing/Administrator/Clinical Manager with the Alternate Director of Nursing/Administrator/Clinical Manager ensured** that the Clinician shall assess patient's integumentary status, identify any signs and symptoms of impaired skin integrity, report significant changes to physician promptly **in all 100 % active Clinical records reviewed.** **On July 19, 2022, the Quality Assurance team headed by the The Director of Nursing/Administrator/Clinical Manager with the Alternate Director of Nursing/Administrator/Clinical Manager ensured that all patients admitted to NORTHWEST HOME HEALTH CARE, INC. will receive a comprehensive assessment that includes identification of pain and its impact on function as well as the treatment and efficacy of treatment. Pain will be treated as a, "vital sign" and**	

			CARE, INC. will strive to ensure that pain is measured and treated in all 100 % active Clinical records reviewed. **On July 19, 2022, the Quality Assurance team headed by the The Director of Nursing/Administrator/Clinical Manager with the Alternate Director of Nursing/Administrator/Clinical Manager ensured that the Clinician shall provide skilled assessment, teaching/training and reinforcement of teaching to properly assess, manage and mitigate pain in all 100 % active Clinical records reviewed.** **On July 19, 2022, the Quality Assurance team headed by the The Director of Nursing/Administrator/Clinical Manager with the Alternate Director of Nursing/Administrator/Clinical Manager ensured that the Clinician will assess the patient's Frequency of Pain Interfering with patient's activity or movement, current pain intensity, description in all 100 % active Clinical records reviewed.**	

			On July 19, 2022, the Quality Assurance team headed by the The Director of Nursing/Administrator/Clinical Manager with the Alternate Director of Nursing/Administrator/Clinical Manager ensured that the Clinician shall report to the attending physician and agency supervisor the patient's level of pain (greater than 5/10 in a pain scale) as soon as possible after observing the change in all 100 % active Clinical records reviewed. **On July 19, 2022, the Quality Assurance team headed by the The Director of Nursing/Administrator/Clinical Manager with the Alternate Director of Nursing/Administrator/Clinical Manager ensured that the coordination with the Physician has been documented in the Communication notes in all 100 % active Clinical records reviewed.** **(see attachment)**	

			G0590 C2a GB meeting	
G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the agency failed to coordinate care delivery to meet the patient s needs and/or involve the patient in the coordination of care activities in 1 of 5 active clinical records reviewed. (#5) The findings include: Record review evidenced an undated agency policy obtained 7/5/2022, titled Coordination of Patient Services which stated, & The following are essential components of professional coordination and supervision of services to assigned patients for the ongoing evaluation of the patient s needs: & Maintaining efficient communications with patient, family, physician and all care providers to ensure prompt transmission of significant information that may require immediate action or decision-making & Coordinating with patient, family and caregivers and all involved	G0608	**G0608Coordinate care delivery** ***During the emergencymeeting of GB on July 17, 2022 theDirector of Nursing/ Administrator discussed and reviewed the Policy onCoordination of Patient Services.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician shallcoordinate the services or treatment received by the patients other than homehealth agency for the ongoing evaluation of the patient's needs and will**	2022-07-19

	services to unify and maximize their contributions to ensure patient safety, comfort and benefits of services &. Clinical record review for patient #5 was completed on 7/1/2022. Record review evidenced a plan of care for certification period 6/7/2022 8/5/2022, which indicated the patient was to receive skilled nursing services 2 times per week for 1 week and 1 time per week for 8 weeks for wound care to right 4th toe and left heel, and home health aide services 1 time per week for 9 weeks. This document indicated the patient went to dialysis and also a wound clinic for wound care treatment to his left heel. The plan of care failed to indicate which days patient went to wound clinic or dialysis, and failed to indicate location or specific contact information for dialysis clinic or wound clinic. Record review evidenced a physical therapy plan of care for certification period 6/7/2022 8/5/2022, which indicated the patient was to receive physical therapy services 2 times per week for 3 weeks, and 1 time per week for 3 weeks. Record review indicated the patient only received 1 physical therapy visit the week of 6/12/2022, and failed to receive any home health aide, skilled nurse, or physical therapy visits for week of 6/19/2022 and 6/26/2022. Record review evidenced missed visit notes for dates 6/16/2022, 6/21/2022, 6/23/2022 and 6/28/2022, which all stated, & Patient/family cancelled &. These notes failed to include any additional information regarding reason patient cancelled. Record review failed to evidence any coordination or documentation from the wound clinic or dialysis clinic. During an interview on 7/1/2022, at 12:30 PM, administrator/clinical manager A indicated patient #5 went to wound clinic on Thursdays or Fridays. When queried which days patient went to dialysis, administrator/clinical manager A stated, & I think, if I m not mistaken Monday, Wednesday, and Friday & I ll double check with the nurse &. At 12:40 PM, when queried how the agency coordinated care for patients who have multiple disciplines and other services, administrator/clinical manager		**bedocumented in the Coordination of Care form .** **TheDirector of Nursing/ Administrator shall ensure that patients receivingtreatments other than home health agency like Dialysis or wound clinic , personal care agency and anytreatment facility; the Clinician willindicate the location or specific contact information for dialysis clinic orwound clinic , personal care agency and any treatment facility ; the Clinicianwill indicate the indicate which days patient went to wound clinic or dialysisand any treatment facility; the Clinician shall Maintain an efficientcommunications with patient, family, physician and all care providers to ensureprompt transmission of significant information that may require immediateaction or decision-making. It will be documented in the Patient's Oasis , CareCoordination notes and will be documented in the Plan of care.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will**	

	with him & say this is the day the nurse will go & tell the other disciplines to not go that day, to spread out & in case he always cancels, we coordinate with the doctor for the meantime to d/c [discontinue] the therapy & He cooperates when therapy is there &. At 12:47 PM, when queried how the agency coordinated care with the wound clinic, administrator/clinical manager A stated, & we coordinate as needed and at least every 30 days & We always give them our information if they want to coordinate with us & we always get papers from the wound clinic, and I m going to ask now & I think we don t have them yet & but the nurse called wound clinic &. When queried which wound clinic patient went to, administrator/clinical manager A indicated she didn t know which one exactly. 410 IAC 17-14-1(a)(1)(F) 410 IAC 17-14-1(c)(6)		**documentany additional information regarding reason patient cancelled/refused in theMissed visit notes .** **TheDirector of Nursing/ Administrator conducted an In-service on July 19, 2022 regarding Policy on Coordination of PatientServices .** **TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 .** **(see attachments)** **G0608A1 – A2: Policy on Coordination of PatientServices** **G0608 B1 – B2: Coordination of Care forms** **G0608 C1 : MissedVisit Form** **G0608 D1 :**	

			Physicianorder Missed visit **G0608 E1 – E2: GB meeting** **G0608 E3 – E4: Inservice** **G0608 Coordinate care delivery** **An emergency meeting of GB held on July 27, 2022 the Director of Nursing/ Administrator /Clinical Manager discussed and reviewed the Plan of correction on Coordinate care Delivery submitted that has found unacceptable.** **On July 19, 2022, the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician shall coordinate the services or treatment received by the patients other than home health agency for the**	

			ongoing evaluation of the patient's needs and will be documented in the Coordination of Care form in all 100 % of all active clinical records reviewed. **On July 19, 2022, the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that patients receiving treatments other than home health agency like Dialysis or wound clinic , personal care agency and any treatment facility; the Clinician will indicate the location or specific contact information for dialysis clinic or wound clinic , personal care agency and any treatment facility ; the Clinician will indicate the indicate which days patient went to wound clinic or dialysis and any treatment facility; the Clinician shall Maintain an efficient communications with patient, family, physician and all care providers to ensure prompt transmission of significant information that may require**	

			immediate action or decision-making. It will be documented in the Patient's Oasis , Care Coordination notes and will be documented in the Plan of care in all 100 % of all active clinical records reviewed. **On July 19, 2022, the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician will document any additional information regarding reason patient cancelled/refused in the Missed visit notes in all 100 % of all active clinical records reviewed.** **(see attachment)** G0608 C2a GB meeting	
G0616	Patient medication schedule/instructions 484.60(e)(2)	G0616	**G0616Patient medication schedule/instructions** ***Duringthe emergency**	2022-07-19

	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. Based on observation, record review, and interview, the agency failed to ensure patients received written medication schedule/instructions which included all of the medication names, dosages, and frequency in 3 of 3 home visits conducted. (#1, 2, 3) The findings include: 1. Record review evidenced an undated agency policy obtained 7/5/2022, titled Plan of Care which stated, & Northwest Home Health Inc. Shall provide the patient and caregiver with a copy of written instructions outlining: & Patient medication schedule/instructions, including medication name, dosage and frequency and which medications will be administered by the NHHC, INC. Personnel and personnel acting on behalf of the agency &. 2. Observation of a home visit for patient #1 was conducted on 6/28/2022, at 11:00 AM, to observe a routine home health aide visit. During the visit, a home health binder was reviewed which contained a medication list. This medication list failed to include the following medications which were ordered on the plan of care: ferrous sulfate (iron), Triflora Arthritis Gel (gel for arthritis pain), probiotic (for digestive health), Imodium (for diarrhea), and acetaminophen (for pain). During an interview on 7/1/2022, at 10:53 AM, when queried why the written medication schedule in patient s home did not include all medications ordered, administrator/clinical manager A stated, & I will enforce with my nurses &. At 10:20 AM, when queried how the agency provides written instructions for medications to patients, administrator/clinical manager A stated, & The nurse fills out a medication list in the patient s chart & they		**meeting of GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy on Plan of care and Policy on Medicationreconciliation.** **The Director of Nursing/ Administrator shall ensure that the Clinicianwill review the medications with the patient/PCG and will provide a copy of the list all medications which will includethe schedule/instructions (name, dosage , frequency) in the home healthPatient's chart binder which were ordered in the plan of care as verified withthe Physician.** **TheDirector of Nursing/ Administrator conducted an In-service on July 19, 2022 regarding Policy on Plan of care and Policy onMedication reconciliation.** **TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 .** **(see attachments)** **G0616 A1 - A3:**	

	look at all the bottles & if there are new medications, we update their medication profile &. 3. Observation of a home visit for patient #2 was conducted on 6/29/2022, at 2:30 PM, to observe a routine physical therapy visit. During the visit, a home health binder was reviewed, which contained a medication list. The medication list failed to include Flonase (for stuffy nose), which was included on the patient s plan of care. 4. Observation of a home visit for patient #3 was conducted on 6/29/2022, at 5:00 PM, to observe a routine skilled nurse visit. During the visit, a home health binder was reviewed, which contained a medication list. The medication list failed to include Protonix (medication for stomach acid), which was on the patient s plan of care medication list. During an interview on 7/1/2022, at 11:20 AM, when queried which medications were included on patients written medication instructions, administrator/clinical manager A indicated all medications should have been included.		**Policyon Plan of care** **G0616 B1 - B2: MedicationReconciliation Profile (patients; binder forms)** **G0616 C1 - C2: Policyon Medication reconciliation** **G0616 D1 – D2 : GB meeting** **G0616 D3 - D: Inservice** **An emergency meeting of GB was held on July 27, 2022 the Director of Nursing/ Administrator/Clinical Manager discussed and reviewed the Plan of Correction on Patient medication schedule/instructions submitted that has been found unacceptable.** On July 19,2022 the Quality Assurance team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician will review the medications with the patient/PCG and will provide a copy of the list all medications which will include the schedule/instructions (name,	

			dosage , frequency) in the home health Patient's chart binder which were ordered in the plan of care as verified with the Physician in all 100 % of all active Clinical Records reviewed. The Satisfaction survey will be used as a tool to monitor this deficiency. (see Attachment) **(see attachments)** **G0616 C2a GB meeting** **G0616 C2abc Satisfaction Survey**	
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation, record review, and interview, the agency failed to provide a copy of a written plan of care in 1 of 3 home visits conducted. (#1) The findings include: Record review evidenced an undated agency policy obtained 7/5/2022, titled Plan of Care	G0618	**G0618 Treatmentsand therapy services** ***Duringthe emergency meeting of GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy on Plan of Care and Patients rights andresponsibilities .** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will providethe patient/PCG a**	2022-07-19

	Inc. shall provide the patient and caregiver with a copy of written instructions outlining: & Any treatments to be administered by NHHC, INC. personnel acting on behalf of NHHC, INC. including therapy services &. Observation of a home visit for patient #1 was conducted on 6/28/2022, at 11:00 AM, to observe a routine home health aide visit. During the visit, a home health binder was reviewed. This binder failed to evidence a current plan of care or written instructions regarding treatments to be administered by home health personnel. During an interview on 7/1/2022 at 10:17 AM, when queried what written information the agency provided to patients regarding treatments to be administered, administrator/clinical manager A indicated the agency provided patients with a written plan of care document. When queried why patient #1 did not have a written plan of care document, administrator/clinical manager A indicated they did not know, all patients should receive one.		**current and updated plan of care or written instructionsregarding treatments to be administered by home health personnel.** **TheDirector of Nursing/ Administrator conducted an In-service on July 19, 2022 regardingPolicy on Plan of Care and Patients rights and responsibilities.** **The Directorof Nursing/ Administrator will be responsible for implementing, maintaining andreinforcing these corrective actions to ensure that these deficiencies arecorrected and will not recur effective after the In-Service meeting to all thestaffs on July 19, 2022 .** **(see attachments)** **G0618 A1 -A3 : Policyon Plan of Care** **G0618 B1 -B4 : Patients rights and responsibilities** **G0618 C1 – C2**	

			GB meeting **G0618 C3 -C4 :** **Inservice** **G0618 Treatments and therapy services** **An emergency meeting of GB was held on July 27, 2022, the Director of Nursing/ Administrator discussed and reviewed the Plan of Correction on Treatments and therapy services submitted that has been found unacceptable.** **On July 19, 2022 the Quality Assurance team headed by the The Director of Nursing/ Administrator /Clinical Manager with the Alternate Director of Nursing/ Administrator /Clinical Manager ensured that the Clinician will provide the patient/PCG a current and updated plan of care or written instructions regarding treatments to be administered by home health personnel in all 100 % of all active Clinical records reviewed. The patient**	

			to monitor the deficiency. (see attachment) **(see attachments)** **G0618 C2a GB meeting** **G0618 C2abc Satisfaction Survey**	
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the agency failed to accurately prepare clinical notes in 1 of 5 active clinical records reviewed. (#1) The findings include: Record review evidenced an undated agency policy obtained 7/5/2022, titled Skilled Nursing Services which stated, & The registered nurse & prepare clinical notes &. Record review evidenced an agency policy	G0716	**G0716Preparing clinical notes** ***Duringthe emergency meeting of GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy on Skilled Nursing and Policy on ClinicalRecords.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will prepareclinical notes accurately. All entries recorded in the record must be legibleand accurate. In the**	2022-07-19

	revised 7/16/2009, titled Clinical Records which stated, & All entries recorded in the record must be legible and accurate &. Clinical record review for patient #1 was completed on 7/1/2022. Record review evidenced a plan of care for certification period 5/11/2022 7/9/2022, which indicated the patient received skilled nursing and home health aide services. Record review evidenced a transfer summary dated 5/24/2022, which indicated the patient received skilled nursing, home health aide, and physical therapy services. Clinical record review on 7/1/2022, evidenced a skilled nurse visit dated 5/17/2022, which stated, & Patient requires skilled intervention of physical therapy to teach and train patient/caregiver on exercises to increase strength and endurance, implementation of safety measures and use of assistive devices due to impaired function or declining functional ability to perform ADL s/IADL s [activities of daily living/instrumental activities of daily living] safely &. During an interview on 7/1/2022, at 10:24 AM, when queried why patient #1 s transfer summary indicated they received physical therapy services when they were not, administrator/clinical manager A indicated they had included physical therapy services on the transfer summary because the patient had previously received therapy services. Administrator/clinical manager A indicated the patient was not receiving physical therapy during the certification period pertinent to the transfer summary. At 10:43 AM, when queried why the skilled nurse visit note indicated patient needed therapy services, which were not provided, administrator/clinical manager A stated, & I think it was just carried over from the previous notes & I will check &. 410 IAC 17-14-1(a)(1)(E)		**event that an clinician wishes to correct data, it shallbe done as an amendment, without change to the original entry. It shall beidentified as an additional document appended to the original clinical record.** **TheDirector of Nursing/ Administrator conducted an In-service on July 19, 2022 regarding Policy on Skilled Nursing and Policyon Clinical Records.** **TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 .** **(see attachments)** **G0716 A1 -A2 :** **Policyon Skilled Nursing** **G0716 B1 – B3:**	

			Policy on Clinical Records **G0716 C1 – C2:** **GB meeting** **G0716 C3 – C4:** **Inservice** **G0716 Preparing clinical notes** **An emergency meeting of GB was held on July 27, 2022, the Director of Nursing/ Administrator discussed and reviewed the Plan of Correction on Preparing clinical Notes submitted that has been found unacceptable.** **On July 19, 2022, the Quality Assurance team headed by The Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician will prepare clinical notes accurately. All entries recorded in the record must be legible and accurate. In the event that a clinician wishes to correct data, it shall be done as an amendment, without change to the original entry. It shall be identified as an additional**	

			original clinical record in all 100 % active Clinical Records reviewed. This deficiency was monitored by making sure that all clinical notes will not be marked as completed unless approved by the Quality assurance Team. **(see attachment)** **G0716 C2a GB meeting**	
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and interview, the home health agency failed to ensure communication with all physicians involved in the plan of care as related to the current plan of care in 1 of 5 active clinical records reviewed. (#4) The findings include: Record review evidenced an undated agency policy obtained 7/5/2022, titled Medical Supervision which stated, & Northwest Home	G0718	**G0718Communication with physicians** ***Duringthe emergency meeting of GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy on Medical Supervision ,Policy onComprehensive patient assessment , Medication orders, MedicationReconciliation.** **TheDirector of Nursing/ Administrator shall ensure**	2022-07-19

	Health Care, Inc. Responsibilities include: & Periodic updates on patient condition/progress & Confidential and accurate communication about patients & Prompt reporting of a change in patient condition &. Clinical record review for patient #4 was completed on 7/1/2022, for certification period 6/6/2022 8/4/2022. Record review evidenced a referral/discharge summary dated 6/17/2022, which included the following medications not included on the patient s plan of care or medication list: ciprofloxacin (antibiotic) and hydrocodone-acetaminophen (pain medication). This document indicated patient was to stop taking Bactrim (antibiotic), which was included in plan of care. Record review failed to evidence any communication with physician regarding medication list discrepancy on discharge orders and plan of care. During an interview on 7/1/2022, at 12:29 PM, when queried if the physician was notified, administrator/clinical manager A stated, & yes they should be, but I ll see if it s documented &. 410 IAC 17-14-1(a)(1)(G)		**acommunication with all physicians involved in the plan of care as related tothe current plan of care.** **The Director of Nursing/ Administrator shall ensure that theClinician shallhave a prompt reporting of a change in patient condition ; shall have confidentialand accurate communication about patients ; shall have periodic updates onpatient condition/progress.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will have acomprehensive assessment which will include a review of all medications the patientis taking. This assessment will identify potential adverse effects and drug reactions,including ineffective therapy, significant side effects, significant drug interactions,duplicate drug therapy , medication discrepancy and non-compliance withtherapy.** **The Director ofNursing/ Administrator shall ensure that the Clinician will review thismedication list with the physician, verify and confirm**	

			be continued or discontinued. The doses will **be confirmed with thephysician and changes will be noted in the Medication Profile record in theoffice chart and patient's home binder chart and in the Plan of Care.** **TheDirector of Nursing/ Administrator shall ensure that the Clinician will have aVerbal or telephone Medication orders written down and read back forverification to minimize errors and misinterpretation of written or verbalmedication orders .** **TheDirector of Nursing/ Administrator shall ensure that the Clinician willreconcile all medications taken by the client prior to admission to home carewith those ordered at the time of admission, before and after inpatientadmission stays, and at the time of discharge.** **TheDirector of Nursing/ Administrator conducted an In-service on July 19, 2022 regarding Policy on Medical Supervision ,Policy on**	

			Comprehensive patient assessment, Policy on medication orders andPolicy on medication reconciliation. **TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 .** **(see attachments)** **G0718 A1 – A2:** **Policyon Medical Supervision** **G0718 B1 – B3: Policy on Comprehensive patient assessment** **G0718 C1 – C2:** **Policy on medication orders** **G0718 D1 – D2: Policy on medication reconciliation** **G0718 E1 – E2:** **GBmeeting** **G0718 E3 – E4:** **Inservice**	

An emergency meeting of GB was held on July 27, 2022 the Director of Nursing/ Administrator /Clinical Manager discussed and reviewed the Plan of Correction on Communication with physicians submitted that has been found unacceptable

On July 19,2022, the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician will have a communication with all physicians involved in the plan of care as related to the current plan of care in all 100 % of all active Clinical Records reviewed. This deficiency was monitored by making sure that any communication note will not be marked as completed unless approved by the Quality assurance team

On July 19, 2022, the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the

			Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician **shall have a prompt reporting of a change in patient condition ; shall have confidential and accurate communication about patients ; shall have periodic updates on patient condition/progress in all 100 % of all active Clinical Records reviewed. This deficiency was monitored by making sure that any communication note will not be marked as completed unless approved by the Quality Assurance team.** On July 19, 2022, the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured **that the Clinician will have a comprehensive assessment which will include a review of all medications the patient is taking. This assessment will identify potential adverse effects and drug reactions, including ineffective therapy, significant side effects, significant drug interactions, duplicate drug therapy , medication discrepancy and non-compliance with therapy in all 100 % of all active Clinical Records reviewed.**	

			This deficiency was monitored by making sure that any communication note or medication order will not be marked as completed/to be send to MD unless approved by the Quality Assurance team. **On July 19, 2022, the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured that the Clinician will review this medication list with the physician, verify and confirm those medications that are to be continued or discontinued. The doses will be confirmed with the physician and changes will be noted in the Medication Profile record in the office chart and patient's home binder chart and in the Plan of Care in all 100 % of all active Clinical Records reviewed. This deficiency was monitored by making sure that any communication note or medication order will not be marked as completed/to be send to MD unless approved by the Quality Assurance team.** **On July 19, 2022, the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the**	

			Administrator/Clinical Manager ensured **that the Clinician will have a Verbal or telephone Medication orders written down and read back for verification to minimize errors and misinterpretation of written or verbal medication orders in all 100 % of all active Clinical Records reviewed. This deficiency was monitored by making sure that any communication note or medication order will not be marked as completed/to be send to MD unless approved by the Quality Assurance team.** On July 19, 2022, the Quality Assurance Team headed by The Director of Nursing/ Administrator/Clinical Manager with the Alternate Director of Nursing/ Administrator/Clinical Manager ensured **that the Clinician will reconcile all medications taken by the client prior to admission to home care with those ordered at the time of admission, before and after inpatient admission stays, and at the time of discharge in all 100 % of all active Clinical Records reviewed. This deficiency was monitored by making sure that any communication note or**	

			marked as completed/to be send to MD unless approved by the Quality Assurance team. **(see attachment)** **G0718 C2a GB meeting**	
G0808	Onsite supervisory visit every 14 days 484.80(h)(1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit. Based on record review and interview, the home health agency failed to ensure a registered nurse made supervisory visits at least every 14 days in 1 of 5 active clinical records reviewed. (#2) The findings include: Record review evidenced an agency policy revised 7/16/2009, titled Supervision of Staff which stated, & When patients are receiving skilled nursing services in addition to personal	G0808	**G0808Onsite supervisory visit every 14 days** ***Duringthe emergency meeting of GB on July 17, 2022 the Director of Nursing/ Administratordiscussed and reviewed the Policy on Supervision of Staff /Home health aidesupervision .** **TheDirector of Nursing/ Administrator shall ensure that patients who are receiving home health aide services in addition topersonal care, the registered nurse or other appropriate skilled professionalwho is giving care to the patient willmake an onsite supervisory visit to the patient's residence at least every twoweeks either when**	2022-07-19

	supervisory visit to the patient s residence at least every two weeks either when the aide is present to observe and assist, or when the aide is absent, to assess the relationship and determine whether the goals are being met &. Clinical record review for patient #2 was completed on 7/1/2022, for certification period 5/20/2022 7/18/2022. Record review evidenced a plan of care dated 6/2/2022, for certification period 5/20/2022 7/18/2022 which indicated the patient was receiving home health aide services twice per week, skilled nursing services once per week, and physical therapy services once per week. Record review failed to evidence any supervisory visits were conducted during the certification period. During an interview on 7/1/2022, at 11:00 AM, when queried how often supervisory visits were completed, administrator/clinical manager A stated, & every week & the rule is 2 weeks & but we do every week for best practice &. When queried why patient #2 had no supervisory visits completed, administrator/clinical manager A stated, & we always have them & it s really weird why they aren t in there &.		**the aide is present to observe and assist, or when the aideis absent, to assess the relationship and determine whether the goals are beingmet /Home health aide follows Care plan.** **TheDirector of Nursing/ Administrator conducted an In-service on July 19, 2022 regardingSupervision of Staff/ Home health aide supervision** **TheDirector of Nursing/ Administrator will be responsible for implementing,maintaining and reinforcing these corrective actions to ensure that thesedeficiencies are corrected and will not recur effective after the In-Servicemeeting to all the staffs on July 19, 2022 .** **(see attachments)** **G0808 A1 -A2 :** **Policyon Supervision of Staff/Home health aide supervision**	

G0808 B1 – B2:
GBmeeting

G0808 B3 – B4:
Inservice

G0808 Onsite supervisory visit every 14 days

An emergency meeting of GB was held on July 17, 2022 the Director of Nursing/ Administrator/Clinical Manager discussed and reviewed the Plan of Correction on Onsite Supervisory visit every 14 days submitted that was found unacceptable.

On July 19, 2022 the Quality Assurance Team headed by the The Director of Nursing/ Administrator /Clinical Manager with the Alternate Director of Nursing/ Administrator /Clinical Manager ensured that patients who are receiving home health aide services in addition to personal care, the registered nurse or other appropriate skilled professional who is giving

			care to the patient will make an onsite supervisory visit to the patient's residence at least every two weeks either when the aide is present to observe and assist, or when the aide is absent, to assess the relationship and determine whether the goals are being met /Home health aide follows Care plan in all 100 % of all active Clinical Records reviewed. This deficiency was monitored using the Home Health Aide Quality Assurance tool (see attachment) **(see attachments)** G0808 C2a GB meeting **G0808 C2abcd HHA QA Tool**	

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