

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 200156590A	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2022
NAME OF PROVIDER OR SUPPLIER PEDIATRIC INFANT & FAMILY PERSONAL CARE SPECIAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1512 BURR ST, GARY, IN, 46406	
(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 visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: 7/20/2022, 7/21/2022, 7/22/2022, 7/25/2022, 7/26/2022, 7/27/2022, 7/28/2022, and 7/29/2022 Census: 15 Quality Review Completed on 8/16/22 by SFF	N0000		2022-08-22
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Relicensure survey in conjunction with a complaint. Survey Dates: 7/20/2022, 7/21/2022, 7/22/2022, 7/25/2022, 7/26/2022, 7/27/2022, 7/28/2022, and 7/29/2022	G0000		2022-08-22

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

	Complaint #: 61618 - Substantiated. Federal and State Deficiencies were cited. Census: 15 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Quality Review Completed on 8/16/22 by SFF			
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 . Survey Dates: 7/20/2022, 7/21/2022, 7/22/2022, 7/25/2022, 7/26/2022, 7/27/2022, 7/28/2022, and 7/29/2022 Census: 15 At this Emergency Preparedness survey, Pediatric Infant and Family Home Care Specialist, Inc, was found to have been in compliance with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, including staffing and the implementation of staffing during a pandemic at 42 CFR 484.102 Quality Review Completed on 8/16/22 by SFF	E0000		2022-08-22
G0572	Plan of care 484.60(a)(1)	G0572	G 572 Date of completion 8/22/2022	2022-08-22

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 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 record review and interview, the agency failed to ensure each patient received the services and treatments ordered in the plan of care for 2 of 2 clinical records reviewed where a tracheostomy (an incision in the neck to open a direct airway) was present. (#1, #4)

The findings include:

G572

*. Clinical record review on 7/26/2022 for patient #1, start of care 5/21/2022, certification period 5/21/2022 to 7/19/2022, primary diagnosis of Dependence on respirator, evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 6/7/2022. The plan of care had a subsection titled, Safety Measures: , which stated, Anticoagulant precautions & O2 [oxygen] Precautions & Seizure precautions

Clinical record review evidenced a group of agency documents titled SKILLED NURSING VISIT NOTE . Review of each of the nurses notes from 5/21/2022 to 7/8/2022 failed to evidence Anticoagulant precautions, Oxygen precautions, and Seizure Precautions.

During an interview on 7/27/2022 at 11:01 AM, the administrator indicated safety should be addressed at each visit and should be documented in the nurses notes.

The plan of care had a subsection titled, Orders for Discipline and Treatments & , which stated, & SN [skilled nurse] to assess / monitor client s ability to tolerate feeding;

G 572

Date of completion 08/22/2022

The administrator Has held an in-services on 8/14/2022, for all nurses instructing them of the importance of following the plan care. The assistance administrator will direct the staff to be specify in their notes that they have read the plan of care per certification period.

The Administrator will read 100 percent of each note turned in by the skilled nurse to ensure the nurse is reading and adhering to the plan of care. The Administrator has modified and then trained the skilled nurse on how to complete the nurse note, to include an assessment page so the nurse will have to document that the task was completed, address what and how it was conducted, i.e., feeding, trach care, vent setting and all vital services of the patient's care.

During the in services the Administrator admonished all staff that they had to adhere to the frequency and duration of plan a care. The Nurses will have to call into the office if their shifts ends early.

greater than 100 cc [cubic centimeters] &. Review of each of the nurses' notes from 5/21/2022 to 7/8/2022 failed to evidence an assessment of feeding residue.

During an interview on 7/27/2022 at 11:01 AM, the administrator indicated if the nurse checked for feeding residue, it should be documented in the nurse's notes.

410 IAC 17-13-1(a)

1. Record review of an agency policy titled Skilled Professional Services dated 12/12/2019, stated Purpose: Skilled professionals who provide services to PIF patients under direction or under arrangement participate in the coordination of care & Procedure: & B. Responsibilities of skilled professionals. Skilled professional service providers are required to assume the following responsibilities: & 3. Providing services that are ordered by the physician as indicated in the plan of care ... 5. Preparing clinical notes &.

2. Record review of an undated policy titled Missed Visits Reports retrieved on 7/29/2022, stated Policy: In our efforts to remain in compliance with the physician's order and to ensure that clients remain safe in their present environment, we must notify the physician of the client's non-compliance & Purpose: To ensure that the physician's orders are being followed at the frequency in which he/she has stated in the physician's order and the client is safe in homebound &.

3. Clinical record review on 7/29/22, for patient #4, start of care 9/13/2021, primary diagnosis of anoxic [greatly deficient of oxygen] brain damage, evidenced a document titled Home Health Care and Plan of Care for certification period 5/11/2022 - 7/9/2022, and signed by the physician on 5/29/22. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated & SN/LPN [licensed practical nurse] 5 -7 days weekly (8-12hrs [hours] per visit) to assess vital signs and all body systems & SN to assess/perform/instruct on chest

Every Plan of care will be monitor and approved by the administrator 100% of all nurses' notes will be reviewed monthly to ensure the skilled nurses are retaining what they have learned

The Administrator is responsible for monitoring these corrective actions to ensure the plan of correction in place is being adhered to and this deficiency will not occur again.

	Vest: & Frequency BID [twice daily] (on hold) &. Review of agency documents titled Skilled Nursing Visit Note for the certification period 5/11/2022 7/9/2022 failed to evidence the minimum of 8 hours for SN services per visit was met on 5/20/2022, 6/17/2022, 6/24/2022, and 7/1/2022. Review failed to evidence the minimum of 5 days per week was met for SN services for week 3 (5/23/2022 5/29/2022), and week 9 (7/4/2022 7/9/2022). Record review failed to evidence missed visit documentations. Record review failed to evidence the frequencies and durations of visit were followed as ordered on the plan of care. Review of agency documents titled Skilled Nursing Visit Note which were signed by LPN 2, evidenced the cough vest/chest physiotherapy were provided to the patient on the following dates: 6/16/2022, 6/20/2022, 6/21/2022, 6/23/2022, 6/29/2022, 6/28/2022, 6/30/2022, 7/2/2022, 7/4/2022, 7/5/2022, and 7/7/2022. Review failed to evidence orders for chest physiotherapy/cough vest were followed as ordered in the plan of care.			
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; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations;	G0574	G 574 Date of completion 08-22-2022 The Administrator has educated the RN as to how to properly complete the assessment forms. The assessment forms will be completed in it's entirety, and will be thoroughly audited to ensure that all areas are addressed. Which will include the treatments, assessment and frequency of the wound care, and medication use, route,	2022-08-22

(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 record review and interview, the agency failed to ensure the plan of care was individualized and included complete medication orders and orders for discipline and treatment for 6 of 7 clinical records reviewed. (#1, #2, #4, #5, #6, #7).

The findings include:

*. Clinical record review on 7/26/2022 for patient #1, start of care 5/21/2022, certification period 5/21/2022 to 7/19/2022, primary diagnosis of Dependence on respirator, evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 6/7/2022. The plan of care evidenced a subsection titled, Orders for Discipline and Treatments &. , which stated, & SN [skilled nurse] to assess / perform / instruct on wound care, SN observing aseptic technique to: Cleanse sacral wound with normal saline, pat dry, pack with Opticell [a gelling fiber wound dressing], apply foam dressing &. Review of the plan of care failed to evidence frequency of wound care.

During an interview on 7/27/2022 at 10:32 AM, the administrator indicated all wound orders should include frequency of the wound care.

The plan of care evidenced a subsection titled,

dosage, location, amount, and the duration. Any supplemental order that that are given after the plan of care has been completed will be titled addendum to the Plan of care.

The Plan of care will cease to mention when the patient is non responsive, that the patient and/or caregiver will verbalize that they understand. The plan of care will be individualized to mention that Patient/caregiver will verbalized that they understand only when it is applicable.

The Administrator has in-services the Register Nurses to ensure all aspect of the Plan of Care is complete and individualized. The Administrator will review all plans of care to ensure that all information, i.e, treatments, medications according to the standard.

The Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is correct and will not re-occur.

Plans , which stated, The Client / Caregiver will verbalize understanding of disease processes to include Respiratory failure, seizure disorder and chronic sacral wound. The Client / Caregiver will verbalize understanding on Ketogenic diet a [high-fat, adequate-protein, low-carbohydrate diet] as evidenced by compliance with the diet plan within cert [certification] period & SN discussed emergency preparedness plan with Client / Caregiver &. The plan of care evidenced a subsection titled, Mental Status , which indicated the patient was non-verbal. The plan of care failed to evidence goals individualized to the patient.

During an interview on 7/27/2022 at 10:57 AM, the administrator indicated patient #1 was non-verbal and patient goals were not individualized to the patient.

The plan of care had a subsection titled, Medications &. , which stated, & DIAZEPAM [a medication used to treat anxiety, muscle spasms, and seizures] & EVERY 12 HRS PRN [as needed] & EPINEPHRINE [a medication used to treat allergic reactions, to restore cardiac rhythm, and to control mucosal congestion, glaucoma, and asthma] 0.15 MG [milligrams] / 0.3 CC [cubic centimeters] PRN & GUAIFENESIN [a medication used to relieve congestion] & EVERY 4 HRS PRN & IPRATROPIUM / ALBUTEROL [a medication used to treat chronic obstructive pulmonary disease] 0.5 -2.5 (3CC) EVERY 4 HOURS AS NEEDED & LORAZEPAM [a medication used to treat anxiety or seizures] & EVERY 4 HRS AS NEEDED & MYCOLOG II [a medication used to treat fungal infections] APPLY TOPICALLY 3 X DLY & ZOFRAN [a medication used to treat nausea] EVERY 8 HRS PRN & ACETAMINOPHEN 500 MG PP [per feeding tube] EVERY 6 HRS PRN &. Review of the plan of care failed to evidence the route for Epinephrine and Ipratropium / Albuterol. Review of the plan of care failed to evidence the indication for usage of Diazepam, Epinephrine, Ipratropium / Albuterol, Lorazepam, Zofran and Acetaminophen. Review of the plan of care failed to evidence where, on the body, Mycolog was used.

During an interview on 7/27/2022 at 10:48 AM, the administrator indicated all medication

orders should include the route, frequency and dose of the medication. The administrator indicated all PRN medications should include an indication for their usage, and all topical medications should include where, on the body, they were used.

410 IAC 17-13-1(a)(1)(D)(ix-x)

1. Record review of an agency policy titled Plan of Care CMS #485 and Physician Orders revised in 2006, stated Policy & Skilled nursing and other home health services will be in accordance with a Plan of Care based on the patient's diagnosis and assessment of immediate and long range needs and resources & Procedure & 1. The Plan of Care is established in consultation with the physician, Agency staff, the patient and members of the patient's family. The Plan of Care includes: & Types of services and equipment required & Frequency of visits and duration & Medications and treatments & 6. Care and services provided will be provided according to physician orders. Orders are current and updated &.

2. Clinical record review on 7/27/22, for patient #2, start of care 8/3/2019, diagnoses include but not limited to paraplegia and pressure wound, evidenced a document titled Home Health Care and Plan of Care for certification period 5/19/2022 7/17/2022, and signed by the physician on 6/9/2022. This document had an area subtitled 10. Medications: Dose/Frequency/Route & which stated Cellerate Gel [topical gel infused with collagen to treat various wounds and burns] Apply topical to wound 1-3 x [times] weekly & Another area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) stated SN to visit 1-3w9 [1 to 3 times per week for 9 weeks] &

Review of this document evidenced a range for use of cellerate gel and SN visits. Review failed to evidence indications for use of cellerate gel and when a SN visit should occur 1, 2, or 3 times per week. Review failed to evidence an amount or location for cellerate gel use. Review failed to evidence the frequency and duration of SN visits were individualized to the patient. Review failed to evidence cellerate gel

Review failed to evidence all required components of the plan of care.

3. Clinical record review on 7/29/22, for patient #4, start of care 9/13/2021, primary diagnosis of anoxic [greatly deficient of oxygen] brain damage, evidenced a document titled Home Health Care and Plan of Care for certification period 5/11/2022 7/9/2022, and signed by the physician on 5/29/22. This document had an area subtitled 10. Medications: Dose/Frequency/Route which stated & Albuterol Sulfate [bronchodilator; relaxes the muscles around the airways to breathe easier] & every 4 hrs PRN & Nystatin [antifungal medication] & Apply topically 2 x dly [times daily] & Hydrocortisone [steroid medication] 2 x dly apply topically & Mupirocin [antibiotic cream] 3 x dly apply topically & Clindamycin [antibiotic] 2 x dly apply topically &. Review failed to evidence indications for use of PRN medications. Review failed to evidence the medication form of Nystatin, Hydrocortisone, and Clindamycin. Review failed to evidence instructions on where to apply topical medications. Review failed to evidence the plan of care was individualized to the patients care needs.

4. Clinical record review on 7/29/22, for patient #5, start of care 6/9/2021, primary diagnosis of pressure ulcer to sacral region, evidenced a document titled Home Health Care and Plan of Care for certification period 6/4/2022 8/2/2022, and signed by the physician on 6/30/2022. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated SN to visit 1-3w9 [1 to 3 times per week, for 9 weeks] to assess vital signs and all body systems & SN to assess/perform/instruct on wound care. SN observing aseptic technique to: Cleanse sacral wound with a normal saline, pat dry, apply Endoform [wound care dressing] to wound bed and secure with tape &.

Review failed to evidence instructions for when a SN would visit 1, 2, or 3 times per week. Review failed to evidence the frequency in which wound care would be provided. Review failed to evidence the plan of care contained instructions individualized to the patient s needs.

During an interview on 7/29/2022, at 10:32 AM, administrator 1 indicated the range of visits per week was meant to accommodate for the patient's frequent doctor appointments or missed visits.

5. Clinical record review on 7/29/22, for patient #6, start of care 10/1/2021, primary diagnosis of a pressure ulcer to the sacral [area of the body located between the lower back and tailbone] region, evidenced a document titled, Home Health Care and Plan of Care for certification period 11/30/2021 1/28/2022, and signed by the physician on 12/16/2021. This document had an area subtitled 10. Medications: Dose/Frequency/Duration which stated & Percocet [pain medication] & 2 x dly PRN [2 times daily as needed] & Zofran [anti-nausea medication] & every 8 hrs PRN [8 hours as needed] & Tylenol [mild pain and fever reducer] every 4 hrs PRN & Another area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) stated SN to visit 1 3 times weekly to assess vital signs and all body systems & SN to perform wound care 1 3 times weekly & SN to assess/perform/instruct on picc [peripherally inserted central catheter] dressing change weekly and PRN using sterile technique & SN to assess/perform/instruct to change tubing and daily PRN &.

Review of this document failed to evidence the duration for services to continue. Review failed to evidence instructions for when a SN would visit 1, 2, or 3 times per week. Review failed to evidence when wound care would be provided 1, 2, or 3 times per week. Review failed to evidence indications to change picc line dressing more frequently than weekly. Review failed to evidence indications when to change tubing more frequently than daily. Review failed to evidence PRN indications for all medications. Record review failed to evidence the plan of care was individualized to the patient's specific needs.

6. Clinical record review on 7/29/22, for patient #7, start of care 4/1/2022, primary diagnoses of an open wound to the thorax region [area of the body between the neck and the abdomen], evidenced a document titled Home Health Care and Plan of Care for certification

	period 4/1/2022 5/30/2022, and signed by the physician on 4/19/2022. This document had an area subtitled 10. Medications: Dose/Frequency/Route which stated Albuterol 90 MCG [microgram] 1 puff inhaler 4 x dly [4 times daily] PRN & Nyostatin creme [sic] Apply topically dly PRN & another area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) stated &SN to visit 1 - 3 times weekly to assess vital signs and all body systems &. Review of this document failed to evidence the duration for services to continue. Review failed to evidence instructions for when a SN would visit 1, 2, or 3 times per week. Review failed to evidence indications for use of Albuterol. Review failed to evidence indications for use of Nystatin cream, and location to apply. Review failed to evidence the plan of care was individualized to the patient and their needs. During an interview on 7/29/2022, at 10:48 AM, administrator 1 indicated the frequency and duration of SN visit was not specified on the plan of care.			
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 home health agency failed to ensure medications and treatments were carried out according to the physician orders for 4 of 7 clinical records reviewed. (#2, #4, #6, #7) The findings include: 1. Record review of a policy retrieved on 7/29/2022, titled Medication Orders revised in 2006, stated Policy & The Agency will minimize errors and misinterpretation of written or verbal medication orders & Purpose & To assess that medication orders are written clearly and transcribed accurately & Procedure	G0580	G580 Date of completion: 08/22/2022 The administrator in-services August 14, 2022 all skilled nurse, the nurses instructed to follow the plan of care that is send to the home every 60 days., and if there were any changes in the plan of care we would communicate during the team meetings monthly, to minimize error the plan of care and/or supplement orders will be compared with the skilled nurse note to ensure the nurses are following the order of the physician orders. The physician'	2022-08-22

& 1. Physician orders must contain dosage, route and frequency & 4. Indication for use must be included in PRN [as needed] medication orders or if medication is ordered for a condition not usually treated with that medication & 7. Specific medication orders include: PRN orders must specify dose, route, frequency and indication for use &.

2. Clinical record review on 7/27/22, for patient #2, start of care 8/3/2019, diagnoses include but not limited to paraplegia and pressure wound, evidenced a document titled Physician's Order Form dated 6/16/2022, stated SN [skilled nurse] Observing Aseptic Technique to: Sacral [section of the spine between the lower back and tail bone] & Cleanse wound well with Normal Saline, pat dry, apply protective barrier ointment to protect surrounding skin, apply Endoform [wound care dressing to assist with healing and tissue growth] to wound bed, cover with dry gauze and secure with tape. Do not remove dressing or get wet until next visit &. Review of this physician's order failed to evidence the frequency which the wound care should be performed.

During an interview on 7/27/2022, at 10:48 AM, administrator 1 indicated the frequency was not documented on the order.

Record review of an agency document titled Physician's Order Form dated 7/1/2022, stated SN to apply Iodosorb [ointment used to cleanse the wound, absorb fluids, and can speed up healing process] to sacral wound &. Review of this physician's order failed to evidence the frequency which the Iodosorb should be applied. Review failed to evidence the procedure to clean and dress the sacral wound in conjunction with the Iodosorb. Review failed to evidence wound care was provided per the doctor's order.

3. Clinical record review on 7/29/22, for patient #4, start of care 9/13/2021, primary diagnosis of anoxic [greatly deficient of oxygen] brain

orders are now more descriptive and individualized for the patient. When there is an order in the middle of a recertification period, the skilled nurse will be notified of changes and document that this was a change in the care of the patient.

During the admission recertification, or resumption of care, the Registered Nurses have been instructed to specific the treatment, and medication, each pic list and medication sheet will be review before the note is entered in to the record.

The Administrator will make monthly communication to the skilled nurse to ensure that the nurse has adopted the change (if any) and that the orders are being carried out. 100 percent of the skilled nurse note will be reviewed for compliance.

The administrator will be responsible for monitoring 100 percent of the skilled nurse notes to show compliance to this corrective action to ensure that deficiency is corrected and will not occur again

Physician Telephone Orders dated 6/28/2022, which stated Apply Bacitracin topically to effected [sic] area PRN [as needed] &. Review of this document failed to evidence indication for when to apply the medication. Review failed to evidence where on the body to apply the medication. Record review failed to evidence the treatment was provided as ordered by the physician.

4. Clinical record review on 7/29/22, for patient #6, start of care 10/1/2021, primary diagnosis of a pressure ulcer to the sacral [area of the body located between the lower back and tailbone] region, evidenced a document from entity 1 titled Visit Discharge Instructions Details dated 12/29/2021. This document had orders for a sacral wound, right ischial [region of the hip bone] wound, and left ischial that ordered wound care to be provided 3 times a week.

Record review evidenced a document titled, Home Health Care and Plan of Care for certification period 11/30/2021 1/28/2022, and signed by the physician on 12/16/2021. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated & SN to perform wound care 1 3 times weekly &. Record review failed to evidence wound care was provided as ordered by the physician.

5. Clinical record review on 7/29/22, for patient #7, start of care 4/1/2022, diagnoses include but not limited to an open wound on the thorax region [area of the body between the neck and abdomen], obesity, and type 2 diabetes, evidenced a document titled Physician Telephone Orders dated 4/7/22, stated SN to apply nyostatin [sic; Nystatin antifungal medication that can come in various forms including but not limited to a powder, topical cream, and oral solution] to affected area PRN [as needed] &. Review of the telephone order failed to evidence the frequency and indications for use of the medication. Review failed to evidence the form (powder/cream/solution/etc.) of the

	medication and amount to use. Review failed to evidence where the affected area was located. Review failed to evidence all treatments were provided as ordered by the physician. During an interview on 7/29/2022, at 10:43 AM, administrator 1 indicated the telephone order did not have complete documentation and should have been more specific. 410 IAC 17-13-1(a)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to promptly alert the physician to changes in the patient's condition in 2 of 2 patients with a tracheostomy (an opening created in the neck to help someone breathe). (#1, #4) The findings include: *. Clinical record review on 7/26/2022 for patient #1, start of care 5/21/2022, certification period 5/21/2022 to 7/19/2022, primary diagnosis of Dependence on respirator, evidenced a group of agency documents titled, SKILLED NURSING VISIT NOTES . A nurse s note dated 6/1/2022, shift 7:00 AM to 3:00 PM, indicated the patient s blood pressure was 74/50. Review of the nurse s note failed to evidence physician notification of the low blood pressure. During an interview on 7/27/2022 at 11:11 AM,	G0590	G590 Date of completion 08-22-2022 During the in-service, August 14, 2022 the administrator gave each nurse a hand-out explaining when the skilled nurse was to call administrator for guidance, who will then give them further instructions. Each nurse was admonished that vital outside of the perimeter of the plan of care or any significant changes in the patient condition they must make the proper notifications. During the instruction the nurse were given example as when notification should be made, and all stated that they understood the importance of assessment, notification, and calling 911	2022-08-22

the administrator indicated if the patient's blood pressure was 74/50, the nurse should notify the physician, and document that communication in the nurse's visit note.

Clinical record review evidenced a nurse's note dated 5/31/2022, shift 7:00 PM to 7:00 AM, which stated, & Returned home from hospital tonight in bad condition & pt [patient] is lethargic & bilateral rhonchi [a sound heard with a stethoscope when listening to lungs that are congested] with bilateral wheezing [a whistling sound made by breathing when an airway is partially blocked] noted. Vital sign [sic] not in normal range T [temperature] 101.3. R [respirations] 35. P [pulse] 125. B/P [blood pressure] 160/94. PRN [as needed] meds given, Tylenol for fever, neb tx. [nebulizer treatment] for rhonchi. Ativan for B/P et [and] HR [heart rate] & Continue to monitor &. Review of the nurse's note failed to evidence physician notification of the patient's change in condition.

During an interview on 7/27/2022 at 11:11 AM, when informed of the findings, the administrator indicated she was not aware of the situation, and the nurse should have contacted the physician, or contacted her and she would have contacted the physician.

Clinical record review evidenced a nurse's note dated 7/6/2022, shift 8:00 PM to 11:00 PM, which indicated the patient had a temperature of 100.4, rhonchi to bilateral lung fields, and a productive cough with yellow mucus. Review of the nurse's note failed to evidence physician notification of the patient's change in condition.

During an interview on 7/27/2022 at 11:11 AM, when informed of the findings, the administrator indicated the nurse should have contacted the physician, or contacted her and she would have contacted the physician.

410 IAC 17-13-1(a)(2)

1. Record review of an agency policy titled Significant Change In Condition dated 2/1/2019, stated Policy: Each patient will have appropriate reassessments performed and documented for significant changes in condition (SCIC) & Procedure: & if a patient experiences a significant change in condition

The skilled nurse note has been modified to ensure that the nurse will conduct a complete assessment every shift, and must notify the administrator of changes in the patient condition. The Administrator/ Asst. Clinical will review 100 percent of each clinical note to ensure compliance

The Administrator is responsible for monitoring these corrective actions to ensure the plan of correction in place is being adhered to and this deficiency will not occur again

that was not envisioned in the original plan of care, the agency must notify the physician, to received [sic] direction on how to adjust the plan of care to ensure that the client is receiving the care that is required to address there [sic] care and/ or the disease process & An addendum to the plan of care will be created for the physician signature, the Patient and or the patient s representative will be notified of the change and the new course to treatment &.

2. Clinical record review on 7/29/22, for patient #4, start of care 9/13/2021, primary diagnosis of anoxic [greatly deficient of oxygen] brain damage, evidenced a document titled Home Health Care and Plan of Care for certification period 5/11/2022 7/9/2022, and signed by the physician on 5/29/22. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated & [SN] to assess vital signs and all body systems knowledge of disease processes and its associated care and treatment, medication regimen knowledge, and signs/symptoms of complications necessitating medical attention & SN to assess/perform/instruct on pulse oximetry [a noninvasive way to monitor oxygen saturation in the blood] PRN [as needed] per symptomology & SN to assess/monitor cardiovascular status and notify MD of & pulse rate > [greater than] 100 [beats per minute] and < [less than] 60 [beats per minute] &.

Record review of agency documents titled Skilled Nursing Visit Note signed by LPN 2, evidenced a pulse rate greater than 100 beats per minute on the following dates: 5/10/2022, 5/16/2022, 5/17/2022, 5/23/2022, 5/24/2022, 5/26/2022, 5/31/2022, 6/2/2022, 6/7/2022, 6/9/2022, 6/13/2022, 6/14/2022, 6/20/2022, 6/21/2022, 6/27/2022, 6/28/2022, 6/30/2022, 7/4/2022, and 7/5/2022. Record review failed to evidence reassessment of the pulse rate. Review failed to evidence physician notification for the abnormally elevated pulse rates.

Record review of agency documents titled Skilled Nursing Visit Note evidenced the patient s respiration rate was 24 breaths per

	period of 5/11/2022 7/9/2022, performed by LPN 2. Review failed to evidence physician notification for the abnormal respiration rate. Record review of agency documents titled Skilled Nursing Visit Note signed by LPN 2, evidenced a pulse oximetry level less than 90% on the following dates: 6/16/2022, 6/20/2022, 6/30/2022, 7/2/2022, and 7/4/2022. Record review failed to evidence low blood oxygen saturation levels were reported to the physician.			
N0608	Clinical Records 410 IAC 17-15-1(a)(1-6) Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the	N0608	N 608 Date of completion 8-22-2022 The Governing Board along with the Administrator will re-evaluate the discharge policy and the administrator has in-service the RN on the discharge policy. The intake/ and discharge staff will ensure that the proper documentation is given to the staff, and the Administrator will ensure that the document are completed in a timely manner If it is an immediate discharge the physician will be notified immediately. A copy of the discharge order and summary will be monitored for completeness before being filed away The Administrator will be responsible for monitoring each	2022-08-22

discharge summary was maintained for all discharged patients in 2 of 2 closed clinical records. (#6, #7)

The findings include:

1. Record review of an undated agency policy titled Transfer and Discharge Policy retrieved on 7/29/2022, stated Policy & PIF [Pediatric Infant and Family] Home Care Home Health arranges for a safe and appropriate transfer/discharge to other care entities when the needs of the patient exceeds their capabilities or if goals were met. Discharge starts on each admission & Procedure & PIF Home Care may only transfer or discharge the patient if: & 2. The patient or payer will no longer pay for the services provided by the HHA [home health agency] & 4. The patient refuses services, or elects to be transferred or discharged &.

2. Clinical record review on 7/29/22, for patient #6, start of care 10/1/2021, primary diagnosis of a pressure ulcer to the sacral [area of the body located between the lower back and tailbone] region, evidenced a document titled Physician s Order Form dated 1/7/2022, which stated Per family request, patient is going to different agency. Therefore, all services are terminated and client is discharged from agency. MD [Doctor of Medicine] notified via fax/phone &. Record review failed to evidence a discharge summary was created for this patient. Record review failed to evidence a discharge summary was sent to the physician. Record review failed to evidence a discharge summary was sent to the patient s new home health agency.

During an interview on 7/29/2022, at 10:52 AM, administrator 2 indicated there was not a transfer/discharge summary for this patient.

3. Clinical record review on 7/29/22, for patient #7, start of care 4/1/2022, diagnoses include but not limited to open wound in the thorax [area of the body between the neck and abdomen] region, obesity, and type 2 diabetes, evidenced an agency document titled

dischargepacket before assigning this to an Rn to ensure that that this agency is followingthe discharge procedure, so this deficiency is corrected and will not recur

	Agency has been notified that patient has chosen another agency for personal care needs. Therefore all home health services are terminated and patient is discharged from agency. MD notified via fax/phone &. Record review failed to evidence a discharge summary was created for this patient. Record review failed to evidence a discharge summary was sent to the physician. Record review failed to evidence a discharge summary was sent to the patient's new home health agency. During an interview on 7/29/2022, at 10:43 AM, when queried if a discharge summary was sent out, administrator 2 indicated the patient received a month of free services after billing documents were requested. Administrator 2 indicated when the billing documents were brought up to the patient again, the patient decided to go to a different agency, as stated on the physician's order.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the home health agency failed to ensure the skilled nurse (SN) prepared clinical notes to document on all pertinent tasks as identified in the plan of care and policy for 6 of 7 clinical records reviewed. (#1, #2, #4, #5, #6, #7) The findings include: *. Clinical record review on 7/26/2022 for patient #1, start of care 5/21/2022, certification period 5/21/2022 to 7/19/2022, evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE. The plan of care had a subsection titled, Other Pertinent Diagnosis, which stated, & Pressure ulcer of sacral region [area above the	G0716	G 716 Date of completion 08-22-22 The Administrator On August 14, 2022, has instituted a modified Skilled Nurse note where the nurses will be required to make an assessment of the patient. A description of the patient individual care will be listed on the note and the nurse must document, the assessment what was done, how it was completed, the care given, descriptions, what was observed during the treatment, the outcome, was there any instruction conducted. All wounds will be measured on	2022-08-22

tailbone] , stage 4 [a very deep bedsore, reaching into muscle and bone and causing extensive damage]". The plan of care had a subsection titled, "Orders for Discipline and Treatments....", which stated, " ... SN [skilled nurse] to assess / perform / instruct on wound care...."

Clinical record review evidenced a group of agency documents titled SKILLED NURSING VISIT NOTE . Review of each of the nurses notes from 5/21/2022 to 7/8/2022 failed to evidence assessment and measurement of the wound.

During an interview on 7/25/2022 at 2:24 PM, the administrator indicated wound care was performed by the nurse three times per week. The administrator indicated the nurse should assess the wound each time wound care was performed and document the assessment in the nurses notes. The administrator indicated the nurse should measure the wound once per week and document the measurements in the nurses notes.

Review of the plan of care evidenced a primary diagnosis of Dependence on respirator (ventilator). The plan of care had a subsection titled, Orders for Discipline and Treatments & . , which stated, & SN [skilled nurse] to perform vent [ventilator] care & Vent settings: Peep [positive end-expiratory pressure] 5 Type A/C [assist/control] Rate 12 TV [tidal volume] 450 PC [pressure-controlled ventilation] 18 IST [inspiratory strength training] 1.0 PS [pressure support ventilation] 15 Sensitivity 2 High Pressure 60 Low Pressure 2 FiO2 [percentage of oxygen] 30% & SN to assess / perform / instruct on trach [tracheostomy][an opening created in the neck to help someone breathe] care &.

Clinical record review evidenced a group of agency documents titled SKILLED NURSING VISIT NOTE . Review of each of the nurses notes from 5/21/2022 to 7/8/2022 failed to evidence ventilator settings. Review of each of the notes failed to evidence assessment of the tracheostomy.

Monday. Any other individualized

100 percent of the Clinical records will be reviewed by the administrator for frequency and duration, and all other pertinent information to ensure that all Clinical records are in compliance with the plan of care, the regulation governing this Home Care Agency, and the COP's

The clinical Director will monitor the plan of correction and be responsible to ensure this plan of action is being carried out and to prevent and further deficiency in this area will not reoccur.

During an interview on 7/27/2022 at 11:15 AM, the administrator indicated the nurse should document ventilator settings and assessment of the tracheostomy each shift.

Clinical record review evidenced a skilled nursing visit note dated 6/8/2022, shift 7:00 AM to 11:00 AM, signed by LPN (licensed practical nurse) 2, which stated, & 11 a [AM] Triple lumen catheter out. To ER per ambulance. Tolerated well.

Clinical record review evidenced a skilled nursing note dated 6/8/2022, shift 11:00 AM to 5:00 PM, signed by LPN 2, which stated, 11 a Received per ER cart & 12:30 Medication given per PEG tube [feeding tube inserted through the abdomen into the stomach] & 2:30 XXXL Results from enema, Coccyx wound cleansed and packed with saline moistened gauze and covered with padded dressing. Tolerated well &.

On 7/27/2022 at 11:16 AM, when informed of the findings, the administrator reviewed the nurse's notes and stated, I don t understand . The administrator indicated the nurse would not go to the emergency room with the patient, or perform duties like give an enema and change a dressing on a patient in the emergency room. The administrator indicated the nurse's notes did not clearly explain the current patient status or what happened to the patient on 6/8/2022.

410 IAC 17-14-1(a)(1)(E, B)

1. Record review of an agency policy titled Skilled Nursing Policy dated 12/1/2018, stated Policy & Pediatric Infant & Family Home Health Care Specialist, Inc., Furnishes skilled nursing services by or under the supervision of a registered nurse and in accordance with the plan of care & Purpose & Each patient receives nursing care as ordered on the plan of care &.

2. Record review of a policy retrieved on 7/29/2022, titled Patient Education revised in 2006, stated Policy & Agency staff will provide initial and ongoing education to meet each individual patient s needs & Procedure & 2. Based on patient s condition, physician ordered care and assessed needs, patient/family will receive education, as appropriate, about: Plan of care &

Medications, including safe and effective use & 3. The patient education provided will be: & Documented &.

3. Record review of an agency policy titled Clinical Note Policy dated 1/31/2019, stated Policy & A notation of a contact with a patient that is written, timed, and dated, and which describes signs and symptoms, treatment, drugs administered, and the patient's reaction or response, and any changes in physical or emotional condition during a given period of time & Purpose & Detailed documentation and observation of the patient's medical condition at the time of the assessment & Procedure & All clinical documentation is timed, dated, signed with the appropriate professional designation, and includes all of the information requested & All teaching, assessment, treatments, and findings are documented & Additional forms are used when there is a change in care etc. Care Summary, Physician Orders, Case Conference, And OASIS [Outcomes and Assessment Information Set] Elements (Transfer To Inpatient Facility/Death At Home) &.

*. Clinical record review on 7/27/22, for patient #2, start of care 8/3/2019, diagnoses include but not limited to paraplegia and pressure wound, evidenced a document titled Home Health Care and Plan of Care for certification period 5/19/2022 7/17/2022, and signed by the physician on 6/9/2022. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated & SN [skilled nurse] to assess/perform/instruct on wound care & SN to instruct client on signs/symptoms of infection to include chills, fever, increase in drainage or the presence of odor & SN to implement an [sic] instruct on standard precautions/infection control & SN to assess/perform/instruct on interventions to prevent pressure ulcers & SN to assess/perform/instruct on techniques to prevent falls & SN to instruct on intervention to aide with wound healing &.

Record review evidenced agency documents titled SN Note Integumentary Training which failed to evidence wound care, assessments and teaching/instructions were documented as

ordered on the plan of care, to including but not limited to wound care, signs/symptoms of infection, standard precautions, and fall prevention for the following dates: 5/20/2022, 5/27/2022, 6/1/2022, 6/3/2022, 6/10/2022, 6/13/2022, 6/17/2022, 6/20/2022, 6/24/2022, 6/27/2022, 7/8/2022, 7/11/2022, 7/13/2022, and 7/15/2022. Review failed to evidence the SN documented the teaching and instructions as ordered by the physician on the plan of care.

Record review of agency documents titled SN Note Integumentary Training failed to evidence wound assessments were performed per agency policy for the following dates: 5/27/2022, 6/1/2022, 6/3/2022, 6/10/2022, 6/17/2022, 6/20/2022, 6/24/2022, 6/27/2022, 7/8/2022, 7/11/2022, 7/13/2022, and 7/15/2022. Record review failed to evidence the SN documented wound care and assessments to include treatment performed, descriptions of odor, color, and/or drainage, and weekly measurements of the patient's wound as stated in the agency's policy.

*. Clinical record review on 7/29/22, for patient #4, start of care 9/13/2021, primary diagnosis of anoxic [greatly deficient of oxygen] brain damage, evidenced a document titled Skilled Nursing Visit Note signed by LPN 1, on 5/13/2022. This document stated Time In: 9A [AM] Out: 6P [PM] &.

Record review evidenced an agency document titled Skilled Nursing Visit Note signed by LPN 2, on 5/13/2022. This document stated Time In: 3P Out: 9P &.

Review of these documents evidenced the patient received care from LPN 1 and LPN 2 on 5/13/2022, at the same time, from 3:00 PM to 6:00 PM.

During an interview on 7/29/2022, at 10:39 AM, administrator 1 indicated there would not have been 2 skilled nurses in the patient's home at the same time. Review failed to evidence a skilled nurse prepared clinical notes appropriately.

*. Clinical record review on 7/29/22, for patient #5, start of care 6/9/2021, primary diagnosis of pressure ulcer to sacral region, evidenced a document titled Home Health Care and Plan of

Care for certification period 6/4/2022 8/2/2022, and signed by the physician on 6/30/2022. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated SN to assess/perform/instruct on wound care & SN to assess/perform/instruct on interventions to prevent pressure ulcers & SN to assess/monitor/instruct for signs/symptoms of fluid overload to include shortness of breath, increase of abdominal girth, edema to lower extremities & SN to implement and instruct on medication regimen &.

Review of agency documents titled SN Integumentary Training signed by LPN 4, evidenced wound care was performed on 6/10/2022, 6/17/2022, 6/24/2022, 7/1/2022, 7/8/2022, and 7/15/2022. Record review failed to evidence the SN provided wound care per agency policy to include weekly measurements. Review failed to evidence the SN provided teaching including but not limited to edema, shortness of breath, and medication regimens for the certification period as instructed on the plan of care. Review evidenced the narrative notes to have the same information, including typos, description, and wound care teaching. Review failed to evidence the SN documented instructions provided as they were ordered in the plan of care.

*. Clinical record review on 7/29/22, for patient #6, start of care 10/1/2021, primary diagnosis of a pressure ulcer to the sacral [area of the body located between the lower back and tailbone] region, evidenced a document titled, Home Health Care and Plan of Care for certification period 11/30/2021 1/28/2022, and signed by the physician on 12/16/2021. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated & SN to perform wound care 1 3 times weekly, SN using aseptic technique to cleanse wound well with normal saline, apply skin prep to surrounding area, apply wound VAC @ 200mmgh to left/right Ilium [area of the body that forms the hip bones] an Aquacel [foam dressing] to sacrum, apply dry gauze and secure with tape &.

Record review of agency documents titled SN

Note Integumentary Training from 12/3/2021 12/29/2021, evidenced a section subtitled Analysis of Findings/Interv.[interventions]/Instruc. [instructions] where the SN documented treatments and education/instructions provided. Review failed to evidence wound care assessments were documented in the SN visit notes to include weekly measurements per agency policy.

*. Clinical record review on 7/29/22, for patient #7, start of care 4/1/2022, diagnoses include but not limited to open wound in the thorax [area of the body between the neck and abdomen] region, obesity, and type 2 diabetes, evidenced a document titled Home Health Certification and Plan of Care for certification period 4/1/2022 5/30/2022, and signed by the physician on 4/19/2022. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated SN to implement and instruct on standard precautions/infection control & SN to oversee management of disease processes to include CHF [congestive heart failure] and diabetes & SN to assess/perform/instruct on wound care 1 3 times weekly. SN observing aseptic technique to cleanse wound on back well with normal saline, apply protective barrier to surrounding area, apply aquacel [foam dressing], cover with dry gauze and secure with tape. SN to apply triple antibiotic creme [sic] to wound under belly fold & SN to assess/instruct on interventions to prevent pressure ulcers & SN to assess/perform/instruct on O2 [oxygen] Administration at 4L/Min [liters per minute] & SN to assess/instruct on diabetic care to include diet, activity, stress, foot care, skin care &.

Record review of agency documents titled SN Note Integumentary Training from 4/4/2022 5/6/2022, evidenced a section subtitled Analysis of Findings/Interv.[interventions]/Instruc. [instructions] where the SN documented treatments and education/instructions provided. Record review of the SN visit notes evidenced the failed to evidence wound care

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

measurements, per the agency's policy. Review of these documents failed to evidence all pertinent diagnoses and treatments were documented including but not limited to CHF and continuous oxygen usage. Review failed to evidence specific integumentary teaching was provided including but not limited to wound care prevention, signs and symptoms of infection, and foot care as instructed in the plan of care.			
---	--	--	--

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
---	-------	-----------