STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARETENDERS	8777 PURDUE RD, SUITE 100, INDIANAPOLIS, IN, 46268

(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 Deemed Home Health Provider. Survey Dates: 08-08, 08-09, 08-10 and 08-11-2022. Census: 38 QR by Area 3 on 8-24-2022	N0000	POC approved on 9-16-2022 Deborah Franco, RN	2022-09-01

N0462	Home health agency administration/management 410 IAC 17-12-1(h) Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on record review, interview, and observation, the agency failed to ensure all employees had physical examinations 180 prior to their first patient contact in 1 of 3 direct care staff records reviewed (Licensed Practical Nurse (LPN) #1.) Findings Include: 1. Review of an agency policy with a revised date of 07-01-22, titled "Staff Screening, New Hire and Annual," indicated "Purpose: To establish a process to ensure appropriate staff screening prior to hire ... Employee who will have direct patient contact will have a physical exam by a physician or nurse practitioner no more than 180 days before date employee has direct patient contact ...." 2. LPN #1's personnel record was reviewed on 08-10-22, and evidenced a start date of 07-18-22 and a first patient contact date of	N0462	LPN was sent to get Physical Immediately on 8/11/22. BusinessManager and Executive Director audited all Employee Health Records forPhysicals within 180 days of 1st patient contact to 100% compliance,for rest of employees at agency. Executive Director held 1:1 Education with Business Manager with reviewof Staff Screening, New Hire & Annual Policy #6.002 on 8/11/22 Upon new hire there will bea 2-tier check system to ensure compliance, the Business Manager and/or TrainedDesignee, and the Executive Director. Responsible Person: Executive Director Date of Completion: 8/12/22 ExecutiveDirector and/or Trained Designee will audit upon hire and at 90-day evaluationto ensure 100% compliance with this measure. This willremain a permanent	2022-08-12

	07-19-22. LPN #1's filed failed to evidence any record of a physical examination prior to employment with the home health agency. A review of an agency document dated 08-11-2022, titled "Worker Schedule Report," indicated LPN #1 had completed skilled nursing visits with 42 patients from 07-19-22 to 08-08-22. 2. During a home visit on 08-10-22 at 11:10 AM, at Patient #2's residence, observed skilled care provided by LPN #1 to Patient #2. During an interview on 08-11-22 at 8:35 AM, the Business Office Manager stated, "The LPN came from Texas. Our sister office in Texas does not require employees to get physicals. LPN #1 was pulled from the schedule and going to get a physical first thing this AM." 3. During an interview on 08-11-22 at 2:50 PM, the administrator confirmed physicals are required for all direct care staff.		process for 100% of all New Hires.	
N0470	Home health agency administration/management 410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review, and interview, the agency failed to ensure direct care employees (LPN 1 and OT 1) implemented agency policy to	N0470	LPN1 and OT1were given immediate 1:1 education and corrections made following their patientobservation visits, with understanding verbalized. Then follow up In-home visits performed toensure compliance and understanding with education given with 100% compliance. In homevisits done with all staff to ensure compliance with proper Hand Hygiene,Infection Control, Standard Precautions	2022-08-12

follow infection control guidelines in 2 of 3 home visits (Patients #2 and 4.)

Findings Include:

1. A review of an agency policy with the revised date of 05-01-19, titled "Hand Hygiene," indicated "Purpose: To help prevent the spread of microorganisms and infection by cross-contamination and to provide practice guidelines... Staff performs hand hygiene by handwashing with soap and water or using an alcohol-based hand sanitizer: a. before direct contact with patients... e. after contact with inanimate objects(including medical equipment but excluding the point of care device which is cleaned at the beginning and end of the patient visit) near the patient. F. before and after removal of personal protective equipment (PPE). G. after the visit after contact with a patient's intact skin, (e.g., when taking vital signs and lifting the patient) ...."

2. A review of an agency policy with the revised date of 12-01-2. Titled "Standard Precautions" indicated "...To prevent the spread of disease and infection ... Hand Hygiene...Perform hand hygiene immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms ...."

3. A review of an agency policy with the revised date of 11-01-21, titled "Infection Control Plan," indicated "Purpose: To enhance the safety and quality of patient care provided by staff...Prevent the transmission of infection through proper sanitation of medical equipment, devices, and supplies ...."

4. During a home visit on 8-10-22 at 11:05 AM, for Patient #2, LPN #1 was observed to enter the kitchen area and place their nursing bag on the kitchen counter, reached in their bag

and Bag Technique.

Review ofHand Hygiene Policy # 8.004, Infection Control Policy 8.001, and StandardPrecautions Policy #8.005, with all staff at in-service 8/18/22.

2 In-HomeObservation Visits per week to ensure continued compliance and understanding.

Responsible Person: Executive Director

Date of Completion: 8/12/22

ED and/or trained designee will perform 2 in-home visits per week to ensure continued compliance with this element of performance per policy for 3 months and until 100% compliant for 2 consecutive months, and then to be monitored quarterly with home observation visits and reported to QAPI Team.

blue barriers and put the bag on the barrier. LPN #1 was then observed to take out their blood pressure cuff, stethoscope, thermometer, oxygen saturation monitor, and tablet and placed them on the barrier from the bag without performing hand hygiene or cleaning the tablet prior to use. The LPN placed the stethoscope around their neck. The LPN performed hand hygiene, obtained the stethoscope from around their neck, and auscultated Patient #2's lung sounds without cleaning the stethoscope. LPN #1 had Patient #2 sign the tablet without cleaning the tablet prior and did not offer hand hygiene to Patient #2 after they touched the table screen. The LPN was then observed to gather supplies, reach into their bag without performing hand hygiene, and clean their tablet. The above practice failed to follow infection control guidelines and the agency's policies.

During an interview on 8-10-22 at 12:40 PM, the Administrator stated, "I was so embarrassed during that visit." The Administrator confirmed LPN #1 did not perform hand hygiene, don gloves, and was in and out of her bag without performing hand hygiene.

5. During a home visit on 08-11-22 at 1:10 PM, for Patient #4, OT #1 was observed to enter Patient #4's apartment to the patient's living area, reached into their bag and obtain blue barriers, and placed their bag on one of the barriers without performing hand hygiene. The OT then was observed to get in their bag and place their blood pressure cuff, thermometer, and alcohol gel on the other barrier. The OT did not clean the tablet after they removed it from the bag, placed it on the barrier, and did not perform hand hygiene before returning to their bag for gloves. OT #4 went to the patient's bedroom, performed hand hygiene, donned clean gloves, and assisted Patient #4 in transferring from the bed to the wheelchair. The OT performed hand range of motion exercises on Patient #4. The OT wore gloves while sitting in the patient's walker and, off and on, would hold the handles of the walker during Patient #4's word memory exercises. Patient #4 received a high five from the OT

	after completing a correct memory word with a gloved hand. The OT was observed cleaning their equipment and placing it back in the bag without removing gloves or performing hand hygiene. The OT picked up the tablet wearing the same gloves and requested Patient #4 to sign the visit note with their finger using initials. Patient #4 used their finger and signed the tablet without being offered hand hygiene afterward. The above practices failed to follow infection control guidelines and the agency's policies. During an interview on 08-11-22 at 2:50 PM, the Administrator confirmed during the home visit they observed the OT getting in and out of their bag without performing hand hygiene and failure to implement infection prevention measures with the gloves and tablet.			
N0486	Q A and performance improvement 410 IAC 17-12-2(h) Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review and interview, the agency failed to ensure all services were coordinated with other health service providers that provided care to their patients in 4 active patients who received services from other health care providers (Patients #1, 3, 4, and 5) and 1 of 2 discharged clinical records reviewed (Patient #6.) Findings Include: 1. A review of an agency policy with a revised	N0486	Patient CareManager called and documented in EMR Coordination of Care with all facilitiesfor the active patients cited in this deficiency. Patient #1 Hasbeen discharged. Unable to correct deficiency. Patient #3Has been discharged. Unable to correct deficiency. Patient #4 Coordinationof Care with Assisted Living Facility for Patient. Patient #5Coordinated Care with Dialysis Center, and Wound Care Center and Nephrologist. Patient #6 Has beenDischarged.	2022-09-01

	date of 08-01-19, titled "Coordination of Care, From Admit through Discharge," indicated "Purpose: To establish processes and criteria so that the coordination of patient care will be optimal from admit through discharge. Policy: The agency provides care and services within an integrated continuum of care system. This is accomplished by: Identifying patient needs through assessment and communication with other health care providers ... Coordinating patient care among various disciplines to ensure services are continuous and coordinated from admission to discharge...5. Coordination of care among disciplines: Significant changes in the patient's condition (i.e., New worsening symptoms, new or changed orders, or vital signs not within physician ordered parameters) ... 6. Coordination of services with other organizations and community: When the patient receives services from other organizations and/or individual's care is coordinated to ensure that patient's needs are met efficiently ...7. Coordination of care with patient and caregiver: Written information obtained from the plan of care will be provided to the patient and caregiver outlining: a. Visit schedule including frequency of visits by agency staff...c. Treatments to be administered by staff ... including therapy services...." 2. A review of the clinical record for Patient #1, the start of care date of 07-22-22, contained a plan of care for the initial certification period of 07-22-22 to 09-19-22. The initial plan of care and the clinical record failed to evidence any documentation of coordination of care with Entity D, a dialysis facility, or Entity V, a mental health outpatient clinic, from whom Patient #1 received health care services.		Unable to correct deficiency Education wasdone with each clinician in with these patients to review the Coordination ofCare, from Admit through Discharge Policy# 2.1.017 on 8/10/22 and 8/11/22 andagain with all staff on 8/18/22. Review of theCoordination of Care, from Admit through Discharge Policy# 2.1.017, with allstaff at in-service 8/18/22. ExecutiveDirector and/or Trained Designee will continue to audit all new Plans of Care,for Coordination of Care Compliance. Responsible Person: Executive Director Date of Completion: 9/1/22 ExecutiveDirector and/or Trained Designee will perform 4 Chart Audits Per week to ensurecontinued compliance with this element of performanceper policy for 3 months and until 100% compliant for 2 consecutive months, andthen to be reviewed with Quality chart audits.	

A review of agency documents titled "Client Coordination Note Report," dated 07-22-22 through 08-09-22, failed to evidence any documentation of coordination of care with Entity D, to include Patient #1's dietary and fluid restrictions as a dialysis patient, the type and location, care and maintenance of Patient #1's dialysis access site, medications received at the dialysis center, etc.

The clinical record contained a "Referral Request" document dated 07-18-22, from Entity Q, a mobile primary care practitioner group. The date of service was 07-08-22, and indicated "...The patient also presented with chronic renal failure. It is described as stable. The symptom is ongoing. The symptom is alleviated by hemodialysis...The patient goes to dialysis Tuesday, Thursday, and Saturday. He Goes to [sic] Entity D for HD (hemodialysis) ... Patient began with [sic] Entity V... increased sertraline (a drug used to treat depression, obsessive-compulsive disorder, post-traumatic stress disorder, social anxiety disorder, and panic disorder to 125 mg (milligrams) ...."

A review of facility documents received on 08-10-22, provided to the surveyor from Entity D, titled "Medication List" and "Imported Provider Note Basic," indicated Patient #1 was seen at Entity D by the patient's nephrologist, Person U. The documents further revealed Patient#1 went to Entity D every Tuesday, Thursday, and Saturday for treatment. Patient #1 had a CVC (Central Venous Catheter) used for access during treatments. Patient #1 has a left AVF (Arteriovenous Fistula) that was not used due to the need for the fistula to mature.

During a phone interview on 08-10-22 at 2:10 PM, Person E, the Director of Entity D, confirmed Patient #1 was receiving treatment at their facility. Person E confirmed they would send the medication list and the last nephrologist visit note from Person U, the patient's nephrologist.

During a phone interview on 08-10-22 at 2:28

PM, Patient #1's spouse, Person F, confirmed Patient #1 received treatment at Entity D. Person F indicated Patient #1 was sent to the hospital during treatment yesterday due to a low heart rate and difficulty breathing. Person F verified they do not use Patient #1's fistula due to not having matured; they must use the right chest central venous catheter access line.

3. A review of the clinical record for Patient #3, the start of care date of 07-12-22, contained a plan of care for the initial certification period of 07-12-22 to 09-09-22. The initial plan of care and the clinical record failed to evidence any documentation of coordination of care with Entity I, a dialysis facility.

A review of agency documents titled "Client Coordination Note Report," dated 07-12-22 through 08-09-22, failed to evidence any documentation of coordination of care with Entity I.

A review of documents received from Entity 3, the patient's physician medical group, on 08-09-22, titled "Office Visit Note," indicated Patient #3 had a care team. The care team listed included: the patient nephrologist, Person L, Entity I, the dialysis center where the patient received treatment, and Person M, the patient's infectious disease physician.

During an interview on 08-09-22 at 1:03 PM, Patient #3 confirmed they received dialysis treatment at Entity I, to include Patient #3's dietary and fluid restrictions as a dialysis patient, the type and location, care, and maintenance of Patient #3's dialysis access site, medications received at the dialysis center, etc.

During an interview on 08-11-22, at 3:35 PM, Person H, the director of Entity I, confirmed Patient #3 received treatment at their facility.

	4. A review of the clinical record for Patient #4, the start of care of 07-26-22, contained a plan of care for the initial certification period of 07-26-22 to 09-23-22. The initial plan of care and the clinical record failed to evidence any documentation of coordination of care with Entity X, the Assisted Living Facility (ALF) where Patient #4 resided. A review of agency documents titled "Client Coordination Note Report," dated 07-25-22 through 08-09-22 failed to evidence any documentation of coordination of care with Entity X, to include documentation of any updates to the treatment plan, progress toward goals, modalities, paint assessment, etc. from the OT at Patient #4's ALF. During a home visit to Patient #4's residence on 08-11-22 at 1:00 PM, observed a nurse's station with facility staff across the residence of Patient #4. The Occupational Therapist (OT) was observed completing a therapy session with Patient #4. When queried about coordinating care with Entity X, the OT at the ALF indicated they informed the home health agency of any changes in the patient after the Administrator prompted the OT by stating, "Do you report off on the visit or changes?" 5. A review of the clinical record for Patient #5, the start of care date of 08-01-22, contained a plan of care for the initial certification period of 08-01-22 to 09-29-22. The initial plan of care and the clinical record failed to evidence any documentation of coordination of care with Entity D, a dialysis facility, or Entity P, a wound care center. A review of the referral documents from Entity Z, dated 07-28-22, indicated Patient #5 received services from Entity P one time a week for wound care. The documents further evidenced Patient #5 received services from Entity D for hemodialysis via their left upper arm AV (Arteriovenous) fistula on Mondays, Wednesdays, and Fridays.			

	A review of agency documents titled "Client Coordination Note Report" dated 08-01-22 through 08-10-22 failed to evidence any documentation of coordination of care with Entity D or Entity P. During the entrance conference on 08-08-2022 at 9:00 AM, the Administrator indicated the coordination of care with other health care providers would be documented at the bottom of their notes or in the coordination of care notes. 6. A review of the clinical record for Patient #6, with a discharge date of 05-17-22, evidenced an agency document titled "Client Coordination Note Report," with a late entry date of 05-19-22. The note indicated, "...Discharge Summary: Patient is being discharged from skilled therapy services due to no nursing staff available for catheter care...." The clinical record of Patient #6 failed to evidence documentation of coordination of care with Entity G, the home health agency to which Patient #6 to was transferred. During an interview on 08-10-22 at 1:50 PM, when requested the coordination of care documentation from the Alternate Administrator/Alternate Clinical Manager, indicated there was no documentation of coordination of care with Entity G, the home care agency that Patient #6 transferred to. The Alternate Administrator /Alternate Clinical Manager indicated Former Employee Y took Patient #6 with them to their new employment at the home care agency, Entity G.			

	7. During an interview on 08-09-22 at 3:15 PM, when queried about all the healthcare providers being identified on the patient's plan of care and the requirement of agency policy for documentation of coordination of care, the Administrator stated, "I know it is an issue. We are working on this. I just recently discussed this in our meeting."			
N0504	Patient Rights 410 IAC 17-12-3(b)(2)(D)(i) Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. Based on observation, record review, and interview, the agency failed to implement its policy to ensure the patients were informed of the disciplines and frequency of care to be furnished in 3 of 5 active clinical records reviewed. (Patients #2, 3, and 4) Findings Include: 1. The agency admission packet was received from the administrator on 08-08-22. A review of an agency admission folder contained a	N0504	Corrections madeimmediately following visits with patients/family in home folders. 1:1education completed with clinicians completing SOC for these patients,following the patient observation visits, with understanding verbalized. Then follow up In-home visits performed to ensure compliance and understandingwith education given, with 100% compliance regarding consents, and calendarswith visits, types and frequencies in home. Patient #2 ExecutiveDirector sat in home after visit with family and patient and reviewed SOCpacket, Consent and calendar and completed with patient and family prior toleaving. Patient #3 Cliniciantook patient instructions to the home that includes, ordered disciplines andfrequencies.	2022-08-18

	Responsibilities." The document had a section titled "The Patient has the following rights:" that indicated "... The care furnished, based on the comprehensive assessment; the disciplines that will furnish care; the frequency of visits: ...." 2. A review of an agency policy with a revision date of 08-01-19, titled "Coordination of Care, From Admit through Discharge," indicated "Purpose: To establish processes and criteria so that the coordination of patient care will be optimal from admit through discharge. Policy: The agency provides care and services within an integrated continuum of care system. This is accomplished by: Identifying patient needs through assessment and communication with other health care providers ... Coordinating patient care among various disciplines to ensure services are continuous and coordinated from admission to discharge...7. Coordination of care with patient and caregiver: Written information obtained from the plan of care will be provided to the patient and caregiver outlining: a. Visit schedule including frequency of visits by agency staff...c. Treatments to be administered by staff ... including therapy services...." 3. A review of the clinical record of Patient #2, with a start care date of 07-25-22, and an initial certification period of 07-25-22 to 09-22-22, evidenced an agency document titled "Home Health Certification and Plan of Care" dated 07-22-22 and electronically signed by Physical Therapist #3 and the Alternate Administrator/Alternate Clinical Manager. The document had a section subtitled "Frequency/Duration of Visits" that indicated Physical Therapist (PT) 2 times a week for 2 weeks, 1 time a week for 4 weeks, 1 every 2 weeks for 2 weeks, and Occupational Therapist (OT) 1 time a week for 1 week. A review of Patient #2's home health agency folder contained a blank consent, blank calendars, and blank admission agreement. The Administrator verified the clinician did not complete the agency folder. The		Patient #4 OT reviewedand completed calendar and instructions with patient prior to leaving. Printed patientinstruction report, which includes, disciplines and frequency for 100% of allactive patient census and delivered to patients. Review of PatientRights and Responsibilities Policy #1.001, and Coordination of Care, from Admitthrough Discharge Policy #2.1.017, with all staff at in-service 8/18/22. 2 In-Home Observation Visits per week to ensure continued compliance andunderstanding. Responsible Person: Executive Director Date of Completion: 8/18/22 ED and/or traineddesignee will perform 2 in-home visits per week to ensure continued compliancewith this element of performance per policy for 3 months and until 100%compliant for 2 consecutive months, and then to be monitored quarterly withhome observation visits and reported to QAPI Team.	

	Administrator reviewed the agency packet with Patient #2 and Person C's family member. The agency failed to provide Patient #2 notice in advance of the disciplines that would furnish care and the frequency of those visits for each discipline. During a home visit at Patient #2's residence on 08-10-22 at 11:00 AM, Patient #2 and their family member Person C voiced concerns to the administrator regarding not knowing what staff was coming to see Patient #2 and when. Person #2 further indicated their frustration regarding the numerous phone calls from two different therapists and wanting to either come while Patient #2 was downstairs eating or late in the evening. 4. A review of the clinical record of Patient #3, with a start care date of 07-12-22, and an initial certification period of 07-12-22 to 09-09-22, evidenced an agency document titled "Home Health Certification and Plan of Care," dated 07-12-22, and electronically signed by the Alternate Administrator/Alternate Clinical Manager. The document had a section subtitled "Frequency/Duration of Visits" that indicated Skilled Nursing for 1 time a week for 8 weeks, PT for 1 time a week for 1 week, and OT for 1 time a week for 1 week. A review of Patient #3's home health agency folder failed to evidence documentation of the disciplines that would furnish care and the frequency of those disciplines. During a home visit at Patient #3's residence on 08-11-22 at 10:35 AM, Patient #3 indicated the clinicians called right before they came for a visit. 5. A review of the clinical record of Patient #4, with a start care date of 07-26-22, and an initial certification period of 07-26-22 to			

	titled "Home Health Certification and Plan of Care" dated 07-25-22 and electronically signed by Physical Therapist #2 and the Alternate Administrator/Alternate Clinical Manager. The document had a section subtitled "Frequency/Duration of Visits" that indicated PT for 1 time a week for 4 weeks, 2 times a week for 2 weeks, and OT for 1 time a week for 1 week, 2 times a week for 3 weeks, and 1 time a week for 2 weeks. During a home visit at Patient #4's residence on 08-11-22 at 1:00 PM, a review of an agency folder failed to evidence documentation of the disciplines that would furnish care and the frequency of care visits. During an interview on 08-10-22 at 12:40 PM, the Administrator confirmed the patients should have been informed of disciplines coming and the frequency of care visits.			
N0524	Patient Care 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis.	N0524	Reviewed POCfor each active patient cited, orders received and POC corrected for all activepatients cited. Patient #1 Hasbeen discharged. Unable to correct deficiency. Patient #3Has been discharged. Unable to correct deficiency. Patient #5 POCcorrected with MD's, Diabetes Supplies, Diet and fluid restriction, blood sugarparameters. Review of 100%all active patient Plans of Care done to ensure compliance. New	2022-08-18

(v) Rehabilitation potential.

(vi) Functional limitations.

(vii) Activities permitted.

(viii) Nutritional requirements.

(ix) Medications and treatments.

(x) Any safety measures to protect against injury.

(xi) Instructions for timely discharge or referral.

(xii) Therapy modalities specifying length of treatment.

(xiii) Any other appropriate items.

Based on record review and interview, the agency failed to ensure all medical supplies were listed on the plan of care; all physicians' ordering were listed on the plan of care, all allergies were listed on the plan of care, and failed to ensure all nutritional requirements were listed on the plan of care for 3 of 5 active clinical records reviewed. (Patients #1, 3, and 5)

Findings Include:

1. A review of the clinical record for Patient #1, with a start of care date of 07-22-22, with a certification period of 07-22-22 to 09-19-22, evidenced an agency document titled "Home Health Certification and Plan of Care" dated 07-29-22 and signed by the physician. The plan of care evidenced diagnoses which included but were not limited to; hypertensive heart & chronic kidney disease with heart failure and with stage 5 chronic kidney/ESRD, heart failure unspecified, type 2 diabetes

created for any patient affected.

ExecutiveDirector held a mandatory meeting for all staff on 8/18/22.

Review of Planof Care Policy #2.1.007, with all staff at in-service.

Responsible Person: Executive Director

Date of Completion: 8/18/22

Executive Director and/or Trained Designee will perform 4 Chart AuditsPer week to ensure continued compliance with this element of performance perpolicy for 3 months and until 100% compliant for 2 consecutive months, and thento be reviewed with Quality chart audits.

	end-stage renal disease, chronic respiratory failure with hypoxia, long term use of insulin, dependence on renal dialysis, anxiety disorder, other chronic pain, pain in the right ankle and joints of right foot, and pain in left ankle and joints of the left foot. The section titled "Orders of Disciplines and Treatments" indicated, "... When vital signs are obtained, licensed professional to report vital signs falling outside the following established parameters temp (temperature)<95>100 pulse <50>100 resp (respirations) <6>24 systolic bp (blood pressure) <90>160 diastolic bp <60>90 pain <0>6 O2sat (oxygen saturation) <90>100," but failed to give parameters to report blood sugar above or below defined parameters. The plan of care contained a section titled "Nutritional Requirements: Renal Diet" but failed to list fluid restriction and type of renal diet. The plan of care failed to evidence the use of diabetic supplies in the section titled "DME and Supplies." The plan of care contained the section titled "Allergies," which indicated Patient #1 had allergies to clindamycin and egg whites and failed to list Patient #1's allergy to Ativan. The plan of care failed to list all the healthcare providers providing orders for Patient #1, including Person T, with Entity S, who provided wound care treatments and orders, and Person W, with Entity V, that was providing mental health support and medication changes, and Person 27, with Entity D, which provided renal treatment orders and monitoring. A review of a document titled "Provider Note," received on 08-10-22, and provided by Person E, the director of Entity D, indicated the visit date of 08-09-22. The document indicated the patient's phosphorus was uncontrolled; potassium was slightly elevated, CVC (central venous catheter) was working without issues, AVF (Arteriovenous Fistula) was maturing, and [Patient #1] recently saw vascular and was coordinating updates. The document further evidenced Patient #1 had an allergy to Ativan. The document evidenced the name of Person # 27 as the healthcare provider.			

A review of a document dated 08-03-22, titled "Physician Orders," from Entity S, indicated "Wound Care Orders."

During an interview on 08-10-22 at 2:10 PM, Person F, a family member of Patient #1, confirmed Patient #1 was receiving dialysis at Entity D, and Entity S saw Patient #1 for treatment to a wound that was not healing.

2. A review of the clinical record for Patient #3, with a start of care date of 07-12-22, with a certification period of 07-12-22 to 09-09-22, evidenced an agency document titled "Home Health Certification and Plan of Care," dated 07-25-22 and signed by the provider. The plan of care evidenced diagnoses which included but were not limited to; encounter for surgical aftercare following surgery on the circulatory system, hypertensive heart & chronic kidney disease with heart failure and with stage 5 chronic kidney/ESRD, acute diastolic congestive heart failure, type 2 diabetes mellitus, end-stage renal disease, long term use of insulin, dependence on renal dialysis, and personal history of COVID-19. The section titled "Orders of Disciplines and Treatments." The plan of care failed to evidence parameters for blood sugar to be reported if above or below defined parameters. The plan of care contained a section titled "Nutritional Requirements: Diabetic Diet, No Concentrated Sweets" but failed to list their 2-liter fluid restriction and specific diet. The plan of care failed to evidence the use of diabetic supplies in the section titled "DME and Supplies." The plan of care contained a section titled "Allergies" and indicated Patient #3 had a penicillin allergy and failed to list Patient #3's allergies to amoxicillin and cefazolin. The plan of care failed to list all the healthcare providers providing orders for Patient #3, including Person L, with Entity I, who provide renal treatment orders and monitoring.

A document titled "Provider Note" was received from Entity N, the provider's medical

	document indicated Patient #3 had allergies to amoxicillin, cefazolin, and penicillin. The note contained a section titled "Patient's Care Team" that evidenced that Patient #3 received treatment at Entity I, the provider overseeing their renal treatment orders and monitoring was Person L. The document further indicated Person M was managing the patient's infection. During an interview on 08-09-22 at 1:03 PM, Patient #3 confirmed they had a fluid restriction of 2 liters per 24-hour period. The patient further confirmed they received treatment at Entity I three times a week. During a home visit at Patient #3's residence on 08-11-22 at 10:35 AM, observed Physical Therapist #2 complete their patient assessment. The physical therapist reviewed Patient #3's diet after Patient #3 indicated that their blood sugar was 153 that morning. Patient #3 further confirmed that they check their blood sugar twice a day and give their own insulin. 3. A review of the clinical record for Patient 5, with a start of care date of 08-01-22, with a certification period of 08-01-22 to 09-29-22, evidenced an agency document titled "Home Health Certification and Plan of Care," dated 08-01-22, and electronically signed by the Alternate Administrator/ Alternate Clinical Manager. The plan of care evidenced diagnoses which included but were not limited to; encounter for change or removal of nonsurgical wound dressing, type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene, non-pressure chronic ulcer other parts right foot, non-pressure ulcer of right heel, other complication of amputation stump, chronic diastolic congestive heart failure, chronic respiratory failure with hypoxia, end-stage renal disease, long-term use of insulin, and dependence on renal dialysis. The section titled "Orders of Disciplines and Treatments" indicated, "... When vital signs are obtained, licensed professional to report vital signs falling outside the following established			

parameters temp <97>100.5 pulse <60>190 resp <12>22 systolic bp <80>150 diastolic bp <60>90 pain <0>6 O2sat <90>100." The plan of care failed to evidence parameters to report blood sugar if above or below defined parameters. The plan of care contained a section titled "Nutritional Requirements: Diabetic Diet, No Concentrated Sweets" and failed to list fluid and specific diet restrictions. The plan of care failed to evidence the use of diabetic supplies in the section titled "DME and Supplies." The plan of care failed to list all the healthcare providers who provided orders for Patient #5 including Person 28, with Entity 30, which provided vascular surgical treatments and orders and monitoring, Entity P, which provided wound care treatment, orders, and monitoring, and Entity 29, which provided renal treatment, orders, and monitoring.

A review of the clinical record of Patient #5 contained the agency's referral documents from Entity 31, dated 07-28-22. The referral documents evidenced notes titled "OP (outpatient)-Vascular Surg (Surgeon) MD (Medical Doctor) Progress Notes," electronically signed by the physician dated 07-26-22. The note indicated the patient checked their blood sugar twice daily and renewed their prescription for testing strips and lancets. The document further revealed that Patient #5's prescription for BD ultra-fine pen needles was renewed, and the patient used four a day to give themselves insulin. The document evidenced that the patient went to Entity P once weekly for wound care. The note further indicated Patient #5 had a follow-up appointment scheduled for continued treatment in 6 weeks with Person 28 for possible angioplasty to promote healing to the left lower extremity. The document evidenced that Patient #5 received treatment at Entity 29 three times weekly on Mondays, Wednesdays, and Fridays for renal dialysis treatments and monitoring.

4. During an interview with the administrator on 08-09-22 at 3:15 PM, the Administrator confirmed the clinicians were not including all physicians involved in providing care to the patients on the plan of care.

	During the exit conference on 08-11-22 at 4:00 PM, the Alternate Administrator/Alternate Clinical Manager confirmed the plan of care should contain the specific renal diets, and any fluid restrictions, and all DME patients were prescribed.			
N0549	Scope of Services 410 IAC 17-14-1(a)(1)(J) Rule 14 Sec. 1(a) (1)(J) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (J) Direct the activities of the licensed practical nurse. Based on observation, record review, and interview, the agency failed to ensure the Licensed Practical Nurse's (LPN #1) direct activities were overseen by the Registered Nurse (RN) for 1 of 1 LPNs. (LPN #1) Findings Include: 1. Review of an agency policy with a revision date of 12-01-21, titled "LPN/LVN Supervision," indicated, "Purpose: To ensure patient care and services meet the patient's needs and to promote positive patient outcomes. Policy: Nursing services are provided by a registered nurse (RN) or delegated to a licensed practical nurse/licensed vocational nurse (LPN/LVN), as appropriate. LPN/LVN will provide care under the direction of an RN …." 2. During a home visit on 08-10-22 at 11:00	N0549	LPN1 wasgiven immediate 1:1 education and corrections made following their patientobservation visit, with understanding verbalized. Then follow up In-home visits and recordreviews performed to ensure compliance and understanding with education given,with 100% compliance. All Threenurses were given education and Standards for Nursing Care and Practice (LPN)Policy #6.012 and LPN/LVN Supervision Policy#6.006 were reviewed and copies ofthese policies given. In home visits and recordreviews being done with LPN to ensure compliance and understanding ongoing. LicensedPractical Nurse resigned; her Last day is 9/8/22. ExecutiveDirector held a mandatory meeting for all staff on 8/18/22. Review of Standardsfor Nursing	2022-08-18

	AM, at Patient #2's residence, observed LPN #1 obtain a blood pressure of 130/58 and a pulse of 58. The LPN was informed by Patient #2's family member, Person C, of medication changes over the weekend. Person C told the LPN they called Patient #2's physician due to a weight gain and difficulty breathing over the weekend. The LPN indicated they were calling the cardiologist due to the call parameters for patient #2's orders for call parameters for diastolic pressure being 60-90 and the need for clarification of the changes in the medication. 3. During an interview on 08-10-22 at11:40 AM, when queried about the process when the patient had a change in condition observed during their visits and what they are to do, the LPN stated, "I need to call the cardiologist." During an interview on 08-10-22 at 12:40 PM, the administrator confirmed the LPN was supposed to call the RN first to report on the patient's condition and to receive further direction. During an interview on 08-11-22 at 9:30 AM, the alternate administrator/alternate clinical manager, who was the case manager for Patient #2, confirmed the LPN did not call her regarding Patient #2's changes noted on 8-10-2022. The Alternate Administrator/Alternate Clinical Manager further confirmed that the LPN was to call the RN first to report any changes in a patient's vital signs, symptoms, and medication changes. The Alternate Administrator indicated Patient #2's medication changes and symptoms warranted physician notification.		Care and Practice (LPN) Policy #6.012 and LPN/LVN SupervisionPolicy#6.006 were reviewed with all Staff. Responsible Person: Executive Director Date of Completion: 8/18/22 ED and/ortrained designee will perform 2 in-home visits per week to ensure continuedcompliance with this element of performance per policy for 3months and until 100% compliant for 2 consecutive months, and then to be monitoredquarterly with home observation visits and reported to QAPI Team.	
N0580	Scope of Services 410 IAC 17-14-1(e)(8) Rule 14 Sec. 1(e) The social worker shall do	N0580	Patient wascalled to confirm refusal of Social Worker. Patient Acknowledged that sherefused Social Worker. Order written.	2022-08-18

	the following: (8) Accept and carry out physician orders for social work services. Based on record review and interview, the agency failed to provide a social worker visit as ordered for a patient who had a social worker ordered in the plan of care in 1 or 1 clinical record reviewed with social worker ordered. (Patient #1) Findings Include: 1. A review of the clinical record of Patient #1, with a start care date of 07-22-22, and an initial certification period of 07-22-22 to 09-19-22, evidenced an agency document titled "Home Health Certification and Plan of Care," with physician signed and dated 07-29-22. The document had a section subtitled "Frequency/Duration of Visits" that indicated Patient #1 was to receive a Medical Social Worker (MSW) visit effective 07-31-22 for 1 week 1. The section subtitled "Orders of Disciplines and Treatment" indicated "Start of Care Clinical Summary Date of Admission: 7-22-22 Disciplines ordered: PT (Physical Therapy), OT (Occupational Therapy), MSW (Medical Social Worker), and HHA (Home Health Aide) ..." Review of the clinical record failed to evidence the MSW had evaluated Patient #1 and the clinical record failed to evidence an order to discontinue the MSW visit. 2. During an interview on 08-10-22 at 2:28 PM, Person F, the family member of Patient #1, confirmed a social worker had not been to their home. 3. During an interview on 08-09-22 at 1:15		Audit of 100% of SocialWorker orders. Executive Director held a mandatory meeting for all staff on 8/18/22 Review of Physician OrdersPolicy# 2.1.008 Responsible Person: Executive Director Date of Completion: 8/18/22 ExecutiveDirector and/or Trained Designee will perform 4 Chart Audits Per week to ensurecontinued compliance with this element of performanceper policy for 3 months and until 100% compliant for 2 consecutive months, andthen to be reviewed with Quality chart audits.	

	not seen Patient #1 as ordered. The Administrator further confirmed the Registered Nurse had not included in the clinical record documentation Patient #1's refusal of the MSW visit.			

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