STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157538	A. BUILDING B. WING	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROCARE HOME HEALTH SERVICES	8300 BROADWAY STREET STE F2A, MERRILLVILLE, IN, 46410

(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 complaint survey. Survey Dates: 8/19/2022, 8/22/2022, 8/23/2022, and 8/24/2022. Facility ID: 003042 Complaint: IN00071520: Substantiated with related findings.	N0000		2022-09-13
G0000	INITIAL COMMENTS This visit was for a Federal and State complaint survey of a Home Health Agency. Survey Dates: 8/19/2022, 8/22/2022, 8/23/2022, and 8/24/2022 Facility ID: 003042 Complaint: IN00071520: Substantiated.	G0000		2022-09-13

	Related State and Federal deficiencies cited. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. ProCare Home Health is precluded from providing its own home health aide training and competency evaluation for a period of two years from 8/24/2022 - 8/23/2024, due to being found out of compliance with Condition of Participation 42CFR 484.60 Care planning, coordination of services, and quality of care.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable	N0488	N0488The Administrator and the Director of Nursing (DON) reveiwed Discharge Policy 3.4For Patient #2, Patient was notified on 8-4-22 that her services would be transferredto another agency due to notification that ProCare Home Healths MedicaidValidation was not approved. Informed patient that ProCare needs to followprocedures in order to transfer her services with notifying the new Home CareAgency (Cannan) and notifying her Primary Care Physician for orders to transfer hercare. Patient agreed to notify her physician in order to expidite the transfer process.The Administrator and DON to follow the (15) calendar days notification of dischargeof service to the patient, the patients legal representative, or other individualresponsible for the patients care before services are stopped.The Administrator and DON will notify patients of transfers to other agencies ifrequired within the 15 calendar days notification of discharge service to the patientin writing either to Skilled Nursing note or MD order.The Administrator and DON are responsible to ensure that this deficiency dos notrecur.	2022-08-30

	regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review and interview, the agency failed to ensure patient's received a 15 day notice of discharge in 1 of 2 discharge records reviewed. (#2) The findings include: Record review on 8/24/2022, evidenced an agency policy revised 1/21/2022, titled "Discharge Policy" which stated, "... Additional planning with the patient shall occur throughout the course of care and shall include documentation of specific plans and the expected date of discharge at least fifteen calendar days before the			

	services are stopped ….” Clinical record review for patient #2 was completed on 8/24/2022, for certification period 8/2/2022 – 9/3/2022. Record review evidenced the patient was discharged on 8/12/2022. Record review evidenced the patient was notified of discharge on 8/12/2022. During an interview on 8/22/2022, at 4:30 PM, patient #2 indicated the agency notified her of discharge on 8/12/2022, due to paperwork they submitted late to the insurance company. During an interview on 8/24/2022, at 11:11 AM, administrator #1 indicated the agency provided patients with 10 days discharge notice. Clinical manager #2 indicated the agency typically provided 7 days discharge notice.			
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment.	G0544	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C155: PATIENT REASSESSMENT/UPDATE OF	2022-08-26

	The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on record review and interview, the agency failed to update the comprehensive assessment due to a major decline in the patient's health status in 1 of 1 clinical records reviewed in which there was a decline in patient status. (#3) The findings include: Record review on 8/24/2022, evidenced an agency policy revised 1/21/2021, titled "Patient Reassessment/Update of Comprehensive Assessment" which stated, "... Patients are reassessed when significant changes occur in their condition ...." Clinical record review for patient #3 was completed on 8/24/2022, for certification period 6/28/2022 – 8/26/2022. Record review evidenced a start of care/comprehensive assessment dated 6/28/2022,		COMPREHENSIVE ASSESSMENT POLICY; The Comprehensive Assessment will be updated and revised as often as the patient's condition warrants due to major decline or improvement in health status. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients with wounds and found 65% to be correctly completed, 20% were noted to be lacking the correct physician orders and 15% were lacking wound measurements. Skilled Nurses have been in-serviced to ensure the Comprehensive Assessment is being revised due to a major decline or improvement in the patient's health status.	

	skin tears to her chest, back, and bilateral thighs, diabetic ulcers (wounds caused by diabetes, a problem regulating blood sugars) to bilateral shins, and blisters to her right arm, back, and chest. This document indicated the patient also had a stage 4 pressure ulcer (wound caused by pressure, in which bone, tendon, or muscle is visible) to her sacrum (area where the base of the spine meets the pelvis). Clinical record review evidenced a skilled nurse visit note dated 8/2/2022, which indicated a new wound measuring 10cm (centimeters) x 2cm was noted to the left posterior thigh. Record review evidenced a skilled nurse visit note dated 8/8/2022, which indicated a new wound measuring 7cm x 5cm was noted to the left buttock. Record review failed to evidence an updated comprehensive assessment was		Patient #3 case has been reviewed and Cert Period 6-28-22 to 8-26-22 Plan of Care has been reviewed. Updated Comprehensive assessment Oasis has been completed and the new Plan of Care with wound assessment has been sent to the physician since survey completed on 8-24-22 with indication of new wounds and measurements to left posterior thigh and left buttock. Every Oasis will have a QA review for accuracy prior to being exported to ensure 100% compliance for the next 4 weeks, and then every other week for another 4 weeks, and then quarterly on an ongoing basis. The Administrator and DON are responsible to ensure that this deficiency does not recur.	

	developing 2 new wounds. During an interview on 8/24/2022, at 2:01 PM, clinical manager #2 indicated an updated comprehensive assessment should have been performed due to patient developing new wounds, and not meeting goals. 410 IAC 17-14-1(a)(1)(B)			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care.	G0570	The Director of Nursing and Administrator reviewed the following policies for reeducation and clarification of procedures. C120: Patients are accepted for treatment in the home based on reasonable criteria and under the expectation that the patient's medical, nursing, and social needs can be met adequately by the Agency in the patient's place of residence. C873: Medical records are legal documents that support the delivery of patient services. Any changes or revisions of information documented in the	2022-09-06

	Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review and interview, the home health agency failed to: ensure patients were accepted for care based on the expectation the home health agency was able to meet their needs (see tag G0570); ensure each patient received home health services written in their plan of care and the plan of care was individualized (see tag G0572); ensure services and treatments were administered only as ordered by a physician (see tag G0580); ensure the plan of care was reviewed and revised by the physician (see tag G0588); ensure the home health agency staff promptly alerted the primary care physician to changes in the patient's condition (see tag G0590); ensure the plan of care was revised and updated to reflect information from the comprehensive assessment (see tag G0592); and integrate all services to ensure the coordination of care and treatment effectiveness (see tag G0606). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care. A standard citation was also evidenced at this		patient record must follow accepted legal requirements. C660: Each patient will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs. C680: Agency will document each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the patient's care. C360: The agency will integrate services, whether they are provided directly or under contract, to assure the identification of patient needs and factors that could affect patient safety and the effectiveness of treatment. The coordination of care is provided by all disciplines and included communication with physicians. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients with wounds and found 65% to be correctly completed, 20% were noted to be lacking the correct physician orders and 15% were	

	level as follows: Based on observation, record review, and interview, the home health agency failed to ensure patients were accepted for treatment based on the expectation that the home health agency could meet the patients' medical, nursing, rehabilitative, and social needs in his or her place of residence in 3 of 5 clinical records reviewed. (#1, 2, 3) The findings include: 1. Record review on 8/24/2022, evidenced an agency policy revised 1/21/2021, titled "Admission Policy" which stated, "... Patients are accepted for treatment in the home based on reasonable criteria and under the expectation that the patient's medical, nursing, and social needs can be met adequately by Agency in the patient's place of residence ...." 2. Observation of a home visit for patient #1 was conducted on 8/22/2022, at 2:30 PM, to		lacking wound measurements. These deficiencies have now been corrected. 25 % of all active clinical records were reviewed and 30% were noted to be missing head to toe assessments and 15% were noted to be lacking the correct physician orders. These deficiencies have now been corrected. A. Inservice was performed, on 9/6/2022 and they were reeducated on: 1. Documentation of wound care treatment changes and orders or those changes, notification to physician as to changes in condition and appearance of any new wounds 2. Notifying caregiver and DON of requirement for other services. Including such recommendations in patient notes contacting the physician when a visit is missed 3. Obtaining orders for changes to visits 4. Staff will continue to make attempts to ensure that the frequency for that week is met.	

	visit. During the visit, the patient was observed to be alert and oriented, bedbound, and was only able to move her right arm. The patient was lying in a hospital bed and was wearing briefs for incontinence. The patient had a contracture (shortening and stiffening of muscles, which prevents normal movement) to her left arm and hand, and had foot drop (condition in which the front part of the foot cannot be lifted) to bilateral feet. Patient #1 had a pressure ulcer (wound caused by unrelieved pressure) to the left lateral foot, about the size of a quarter, which required dressing changes 3 times per week, and a pink area of healed scar tissue, to the left ischium. Person #1 (family member/caregiver) indicated the patient received skilled nursing visits 2 times per week to complete wound care. Person #1 indicated he worked 5 days per week, anywhere from 8 – 12 hours per day. Person #1 indicated another family member would occasionally stop by while he was at work to check on patient #1. Person #1 indicated the patient needed incontinent care and help turning or repositioning in bed		5. Nurses also re-educated on completing a head-to-toe assessment on every visit 6. Nurses also received in-service on individualizing the plan of care for the patients as well as for the various conditions with which the patient may present. B. For patient #1, the documentation of 5 additional pressure ulcers in the assessment dated 6/13/2022 was found to be an error and this has been corrected. The plan of care has now been corrected to reflect the ordered frequency of two times a week for the cert period. Spouse agreed to provide Home health aide services with personal care and ADL's and requested that Skilled Nursing service for wound care to be continued.For patient #2 upon review of the Plan of Care noted patient was receiving Home Health Aide services from another agency and Coordination of Care has been initiated and done with the new agency. Patients visits were reviewed and Missed visit notes done for visits not done from	

	to prevent additional pressure sores. Person #1 indicated patient #1 was unable to bear any weight and required the use of a Hoyer lift to transfer out of bed. Person #1 indicated, although he had a bad back and used a lifting belt for himself, he would carry her in his arms to place her in an electric wheelchair, or in the bathtub to wash up, when he was home. Person #1 indicated no home health aide services were currently being provided, but it would be helpful. During the visit, registered nurse #3 indicated the patient and caregiver needed much more help at home. Clinical record review for patient #1 was completed on 8/24/2022, for certification periods 6/16/2022 - 8/14/2022 and 8/15/2022 - 10/13/2022. Record review evidenced a referral order dated 12/2/2021, which indicated patient #1 was referred to the home health agency to receive skilled nursing, occupation/physical therapy, and home health aide services. Record review evidenced a comprehensive		8-10-22 to 8-15-22. Patient #3 The correct orders have been obtained to comply with the ordered frequency. An individual plan of treatment for the various wounds that the patient has been obtained from the physician and this is currently being carried out The director of nursing (DON) and the quality assurance will monitor the documentation for the next 4 weeks every week, and then every other week for another 4 weeks, and then quarterly on an ongoing basis; to ensure that clinical documentation is according to policies including head to toe assessments, inclusion of individualized plan of care and emerging conditions noted, updating the plan of care, treatment changes and correct notification to physician.The attempts by staff to ensure that the treatment frequency is met will also be monitored. For patients with other contracted agencies, proper coordination and the provision of continuity of care until the patient is admitted by the new agency including but not limited to	

	re-assessment dated 6/15/2022, which indicated the patient was totally dependent in all activities of daily living, including bathing, transfers, turning, dressing, and grooming, due to paraplegia (paralysis of legs and lower body), and left arm paralysis. This document indicated the patient had a pressure ulcer to left ankle requiring wound care, and the patient was incontinent of bowel and bladder. Record review evidenced a plan of care for certification period 6/16/2022 - 8/14/2022, which indicated the patient was receiving skilled nurse visits 2 times per week but failed to evidence the patient was receiving home health aide services. Record review evidenced a comprehensive re-assessment dated 8/13/2022, which indicated the patient was totally dependent in all activities of daily living, including bathing, transfers, turning, dressing, and grooming, due to paraplegia and left arm paralysis. This		authorizations for extended services and care to ensure such continuity will be ensured through this weekly monitoring. The director of nursing (DON) is responsible to ensure that this deficiency does not recur.	

document indicated the patient now had 1 wound to left ankle, and 5 additional pressure ulcers (wounds caused by pressure to the tissue). This document indicated the patient was incontinent of bowel and bladder.

Record review evidenced a plan of care for certification period 8/15/2022 - 10/13/2022, which indicated the patient was receiving skilled nursing visits 2 times per week but failed to evidence the patient was receiving home health aide services. This document failed to include any wound care orders for 5 new wounds. Record review failed to evidence any communication with patient #1 or person #1 regarding need for home health aide services.

During an interview on 8/24/2022, at 10:15 AM, when queried why patient #1 did not receive home health aide services, clinical manager #2 stated, "... we discussed it ... we didn't have the staff ...." When

	agency met patients' needs if they could not provide home health aide services to patients, clinical manager #2 stated, "... we didn't have staff ... but we were just providing wound care ...." Administrator #1 stated, "... we need to transfer the patient ... we can't accept the patient if we can't provide all the services ...." 3. Clinical record review for patient #2 was completed on 8/24/2022, for certification periods 6/3/2022 - 8/1/2022 and 8/2/2022 - 9/30/2022, discharged 8/12/2022. Record review evidenced a plan of care for certification period 6/3/2022 - 8/1/2022, which included but was not limited to the following diagnoses: paraplegia, complete (paralysis of legs and lower body), colostomy (an opening created in the abdominal wall connecting to the colon, to allow stool to exit the body), and neuromuscular dysfunction of bladder (condition in which person has no control over bladder, which can cause a person to retain urine or urine incontinence). This document indicated the patient had a urinary catheter (catheter			

	inserted into the bladder to drain urine), and a wound to the right foot requiring dressing changes. This document indicated the patient lived alone and had no willing or available caregiver. The plan of care indicated the patient used a Hoyer lift for transfers, and human assistance was required for transfer from the bed to the wheelchair. This document indicated the patient was receiving skilled nursing visits 3 times per week for 9 weeks. The plan of care failed to evidence the patient was receiving home health aide services. Record review evidenced a comprehensive re-assessment dated 8/1/2022, which indicated the patient was a paraplegic, totally dependent for transfers, dressing, grooming, and bathing, had a colostomy, and urinary catheter, and lived alone with no able or willing caregiver. Record review evidenced a plan			

8/2/2022 - 9/30/2022, which indicated the patient was receiving skilled nursing 3 times per week, but failed to evidence patient was receiving any home health aide visits.

Record review evidenced patient was discharged from the home health agency on 8/12/2022, and transferred to home health agency #2. Record review indicated the last skilled nurse visit was provided on 8/8/2022. Review of the electronic medical record indicated the patient was to start care with home health agency #2 on 8/13/2022.

Record review evidenced a faxed document from home health agency #2 which indicated the patient started home health services on 8/19/2022. Review indicated patient #2 did not receive any skilled nurse visits for 10 days, due to discharge.

During an interview on 8/24/2022, at 11:10 AM, when queried why home health aide services were not provided to patient #2, clinical manager #2 stated, "... we were unable to provide her service in that area ...." Clinical manager #2 indicated the patient was receiving home health aide services from home health agency #3. When queried what services the home health aides

	#2 was not sure. When queried how the agency coordinated care with home health agency #3, clinical manager indicated home health agency #3 would send them a care coordination paper, and they would fill it out and send it back to home health agency #3. When queried why there was no care coordination documented in patient #2's medical record, clinical manager #2 indicated she did not know. Clinical manager #2 indicated any care coordination should have been documented. When queried how the agency could ensure the patient #2's needs were being met by home health agency #3's home health aides, if there was no communication or care coordination, clinical manager #2 indicated the nurse would document it in the visit notes. No care coordination was noted in any visit notes. At 11:14 AM, administrator #1 indicated patient #2 had been discharged due to issues on the agency's end with billing. Administrator #1 indicated the home health agency should have coordinated care with home health agency #2 and continued services for patient until home health agency #2 had physician orders to start care. 4. Clinical record review for patient #3 was completed on 8/24/2022, for certification			

	period 6/28/2022 – 8/26/2022. Record review evidenced a start of care/comprehensive assessment dated 6/28/2022, which indicated the patient was completely dependent for toileting, dressing, transferring, nutrition, and activities of daily living, bedbound, oriented only to self, and had a gastrostomy tube (tube inserted through skin of abdomen directly into stomach for nutrition), right arm PICC line (peripherally inserted central catheter/large catheter inserted into a large vein for administration of medication, fluids, or nutrition), foley catheter (tube inserted into the urethra which drains urine from the bladder), and a stage 4 pressure ulcer (wound caused by pressure, in which bone, tendon, or muscle is visible from the bottom of the wound bed). The comprehensive assessment indicated patient #3 had skin tears to her chest, back, and bilateral thighs, diabetic ulcers (wounds caused by diabetes, a problem regulating blood sugars) to bilateral shins, and blisters to her right arm, back, and chest. The comprehensive assessment indicated the patient lived with another person, but failed to			

	indicate their ability, willingness, or availability to care for patient. This document indicated the patient would receive home health aide services 2 times per week for 9 weeks. Clinical record review evidenced the patient received 2 home health aide visits on 7/14/2022 and 7/16/2022, but failed to evidence any additional home health aide visits for certification period 6/28/2022 – 8/26/2022, as ordered. Clinical record review evidenced an insurance request form dated 7/14/2022, which indicated patient #3 was approved for 2 home health aide visits. Record review failed to evidence any appeals submitted to the insurance company, or communication with the insurance agency by the home health agency. Record review failed to evidence a consult for social work, or referral to any community resources to ensure patient's home health aide needs were met.			

During a phone interview with person #4 (patient #3's family member) on 8/23/2022, at 1:30 PM, person #4 indicated they lived with patient #3. When queried who provided care for patient #3 for bathing, grooming, incontinent care and linen changes, person #4 indicated they were a dialysis patient, so they couldn't help with much. Person #4 indicated person #5 (family member) comes over sometimes to help take care of patient #3. They indicated person #5 cannot come every day. Person #4 indicated a home health aide would be very helpful, but the home health agency hadn't discussed this with them.

During an interview on 8/24/2022, at 10:15 AM, administrator #1 indicated if the agency couldn't meet the patient's needs by providing home health aide services or other services, they would transfer them to an agency which could meet their needs. Administrator #1 indicated they could not accept patients for

	care unless they could provide all the services needed. At 1:26 PM, when queried why patient #3 was not receiving home health aide services, clinical manager #2 stated, "... the insurance only approved 2 visits ...." Clinical manager #2 indicated the agency would wait until the end of the certification period and then send the insurance more documentation and request aide services again. Clinical manager #2 indicated the insurance denied the aide services because someone lived with the patient. Clinical manager #2 indicated the agency does not provide social work services. 410 IAC 17-13-1(a)			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific	G0572	The Director of Nursing and Administrator reviewed the following policies for reeducation and clarification of procedures. C645: MEDICAL SUPERVISION;	2022-09-06

	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 observation, record review, and interview, the home health agency failed to ensure patients received the home health services which were written in the individualized plan of care in 4 of 5 clinical records reviewed. (#1, 2, 3, 4) The findings include: 1. Record review on 8/24/2022, evidenced an agency policy revised 1/21/2021, titled "Care Plans" which stated, "... Each patient will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs. This plan is .... Based on services needed to achieve specific measurable goals ... The interventions shall correspond to the problems identified, services needed and the patient goals for the episode of care ... A copy of the		Physicians will be informed, at the time their patients are admitted to the agency, of each parties' responsibilities in managing patient care. All patients must be under the care of a licensed, practicing physician, podiatrist, or osteopath when receiving home care services through a Medicare certified agency. The patient's primary physician shall be responsible for providing signed orders, and for establishing and reviewing the patient's Plan of Care throughout the time the patient is receiving services. C660: Each patient will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs. C680: Agency will document each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the patient's care. C873: Medical records are legal documents that support the delivery of patient services. Any	

	Care Plan may be taken with the Nurse on subsequent visits for a guide to the patient's care ...." 2. Observation of a home visit for patient #1 was conducted on 8/22/2022, at 2:30 PM, to observe a routine skilled nurse visit. During the visit, the nurse completed a dressing change to a pressure wound on patient's left lateral foot. During the visit, the nurse failed to complete a head-to-toe skin assessment/complete physical assessment or assess any additional skin areas for wounds or skin breakdown. The nurse failed to measure patient's wound or record measurements. Clinical record review for patient #1 was completed on 8/24/2022, for certification periods 6/16/2022 – 8/14/2022 and 8/15/2022 – 10/13/2022. Record review evidenced a plan of care, which indicated the patient was to receive skilled nursing visits 2 times per week. This document indicated the patient was to receive a complete physical assessment each visit with emphasis on the left lateral foot wound. This document indicated the patient		changes or revisions of information documented in the patient record must follow accepted legal requirements. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients with wounds and found 65% to be correctly completed, 20% were noted to be lacking with failure to provide wound measurements at time of visit, failure of the Skilled nurse documenting missed visits and rescheduling visits later in the week, Skilled nursing providing a head to toe assessment, Plan of Cares with any additional wounds, Skilled nursing notes without accurate wound care done, no notification of additional wounds noted at time of assessment, weekly wound measurements and no Home Health aide missed visit notes with reason that patient could not be seen. 15% of the charts were lacking the correct physicians orders. These deficiencies have now been corrected. A staff inservice was performed, on 9/6/2022 on the above	

	was to have wounds measured and recorded. This document indicated the skilled nurse was to perform the following wound care to left lateral foot 3 times weekly: cleanse with normal saline, apply hydrofera (a wound dressing which prevents bacteria from growing) blue, cover and secure with foam dressing. Clinical record review evidenced the patient received only 1 skilled nurse visit for the weeks of 7/3/2022 and 8/1/2022. Record review evidenced a missed visit note dated 7/7/2022 which indicated the visit was not provided because the patient did not answer the phone. Record review evidenced a missed visit note dated 8/1/2022, which indicated the visit was not provided because the family/caregiver was able to assist the patient. Record review failed to evidence any attempts to reschedule these visits, or additional communication with the patient or caregiver about completing the ordered visits. Record review indicated the skilled nurse provided wound care to left lateral foot 2 times		policies and they were reeducated with emphasis on the following: 1. individualizing the plan of care for the patients as well as for the various conditions with which the patient may present. 2. Completing a head-to-toe assessment on every visit and any additional skin areas for wounds or skin breakdown. 3. Documentation of wound care treatment will include measurements, changes in condition and orders for those changes, notification to physician as to changes in condition and appearance of any new wounds 4. Staff will continue to make attempts to ensure that the frequency for that week is met. Answer to patient #1 deficiency re frequency weeks of 7-3-22 to 8-1-22 and also for the missed visit of 8-1-22. On 8-24-22. SN included previous measurements of the left lateral wound on her Skilled Nursing not dated 8-22-22. Patient #1 deficiency re	

	weekly, instead of 3 as ordered on the plan of care. Clinical record review evidenced a plan of care for certification period 8/15/2022 – 10/13/2022, which indicated the patient was to receive skilled nursing visits 2 times per week. This document indicated the patient was to receive a complete physical assessment each visit with emphasis on the left lateral foot wound. This document indicated the patient was to have wounds measured and recorded. This document indicated the skilled nurse was to perform the following wound care to left lateral foot 3 times weekly: cleanse with normal saline, apply hydrofera (a wound dressing which prevents bacteria from growing) blue, cover and secure with foam dressing. Clinical record review evidenced the patient only received 1 home health aide visit the week of 8/14/2022. Record review failed to evidence a missed visit note for the week of 8/14/2022. Record review indicated the patient was only receiving skilled nursing wound care 2 times weekly for the entire		frequency weeks of 8-15-22 to 10-13-22 conflict 2 visits versus 3 visits. Orders recently received from physician that patient is to have SN visits 2 times a week and that patients Spouse agreed to perform wound care once a week in order for the patient to received wound care a total of 3 times a week. Nurses now take a copy of the individualized plan of care on every visit. SN to take a copy of each patients Plan of Care once it is created in order to document according to the orders on each nursing note and to notify the patient's physician of any medical changes. Frequency weeks of 8-15-22 to 10-13-22 conflict 2 visits versus 3 visits. Orders received from the patient's primary physician that frequency for SN can be changed to 2 times a week due to Spouse agrees to change dressing once a week Home health aide missed visit 8/14/22. Patient #1 was not assigned HHA services due to not Aide available to take her case. Spouse was notified of no HHA services available at time	

	certification period of 8/13/2022 – 10/13/2022, as opposed to 3 times weekly as ordered on the plan of care. During an interview on 8/25/2022, at 10:16 AM, when queried how the agency meets patient needs if they miss ordered visits, clinical manager #2 stated, "… depending on the frequency, we reschedule to make the frequency ordered … If not possible we let the physician know …." Clinical manager #2 indicated if the nurse could not get ahold of the patient, they would try to make a visit another day. Clinical manager #2 did not know why patient #1 did not receive a nurse visit on 8/1/2022. When queried why the patient was not receiving skilled nursing wound care 3 times weekly as ordered, clinical manager #2 indicated the caregiver was completing the wound care 1 day per week. At 10:38 AM, clinical manager #2 indicated the nurse should complete a head-to-toe skin assessment every visit. 3. Clinical record review for patient #2 was completed on 8/24/2022, for certification		of referral and spouse agreed to care for patients personal care and ADL's. Only 2x a week visit for cert period 8-15-22 to 10-13-22 2 visits versus 3 visits in plan of care. Orders received on 8-24-22 from the patient's primary physician that frequency for SN can be changed to 2 times a week due to Spouse agrees to change dressing once a week Patient #2 individualized care to include any orders for the 3 additional wounds also 2 visits for week of 7/3/22 and 1 visit for week of 8/1/2022. Physicians order created stating the additional wounds noted to patients left foot, left buttocks and a stage 1 pressure area to right plantar foot. Orders received in the patient's home and followed per SN. SN to ensure that any orders in the home will be noted in the patients chart and updated on patients Plan of Care. Patient #3 individualize care to include wound measurements and orders for sacral wound and skin tears, why 1 visit for week of 7/24/2022 versus 3	

	periods 6/3/2022 – 8/1/2022 and 8/2/2022 – 9/30/2022. Record review evidenced skilled nurse visit notes dated 7/4/2022, 7/18/2022, 7/29/2022, 8/3/2022, 8/5/2022, and 8/8/2022, which indicated the patient had wounds to right anterior foot, left plantar foot, left buttock, and a stage 1 (area of reddened tissue) wound with no location specified. Record review evidenced plans of care for certification period 6/3/2022 – 8/1/2022 and 8/2/2022 – 9/30/2022, which indicated the patient was to receive skilled nursing visits 3 times per week to apply an alginate (absorbent antibacterial wound dressing) dressing to a right foot wound, perform a complete physical assessment, change colostomy (opening created in abdominal wall connecting directly to colon, which empties stool), and manage a urinary catheter. This document failed to be individualized to include any orders for wound care for 3 additional wounds. Record review evidenced the patient received only 2 skilled nurse visits the week of 7/3/2022 and 1 skilled nurse visit the week of 8/7/2022.		visits. SN noticed additional wounds at time of Start of Care. SN notified MD of additional wounds and skin tears, SN failed to write an order from the MD on care of additional wounds. SN reeducated on writing orders for any changes in the patients conditions or care. Patient #3 wound vac change 7/14/202. SN to document that wound vac dressing was placed on the patient at the time of visit. Patient #3 wound vac change 7/25/202. SN to document that wound vac dressing was placed on the patient at the time of visit. Patient #3 waiting for authorization (timely requests going forwards) SN visited patient 1 time week of 7-24-22 due to patients' insurance being untimely with authorization of more visits for wound care. SN and intake coordinator to ensure that authorizations are completed in a timely order. Patient # 4 only 2 hha visits 12/26/2021 to 2/23/2022. Home Health Aides to be	

	During an interview on 8/24/2022, at 10:49 AM, clinical manager #2 indicated the missed visits were because the patient went to a doctor appointment, so the nurses weren't required to go if the dressing was already changed. Clinical manager #2 indicated they should have tried to reschedule the visits for another day. Clinical manager #2 did not know why these visits weren't rescheduled. Clinical manager #2 indicated there were other tasks the nurses provided during the visits other than wound care. At 11:40 AM, clinical manager #2 indicated the plan of care should include wound care orders for all wounds including frequency of dressing changes, type of dressing, and location of wound. 4. Clinical record review for patient #3 was completed on 8/24/2022, for certification period 6/28/2022 – 8/26/2022. Record review evidenced a start of care/comprehensive assessment dated 6/28/2022, which indicated the patient had skin tears to her chest, back, and bilateral thighs, diabetic ulcers (wounds caused by		prior to changing their work schedule. The DON will ensure that a Physician's order will be created stating the patients new frequency for any discipline on a case. Patient # 4 no hha visits week of 2/13/2022. The DON and Quality Assurance staff will ensure that staff is scheduled according to physicians orders for all patients. Patient # 4 hha missed visit note dated 2/15/2022. Home Health Aides to be inserviced on the correct way to submit a missed visit only in case of the patient refusing visits. The Home Health Agency will try to staff the case and if no staff is available, the Home Health agency will notify the patient and caregiver. The director of nursing (DON) and the quality assurance will monitor the documentation for the next 4 weeks every week, and then every other week for another 4 weeks, and then quarterly on an ongoing basis; to ensure that clinical documentation is according to policies including head to toe assessments, inclusion of	

	diabetes, a problem regulating blood sugars) to bilateral shins, and blisters to her right arm, back, and chest. Record review evidenced a plan of care for certification period 6/28/2022 – 8/26/2022, which failed to be individualized to include any wound care orders, assessment, or treatment to be performed for skin tears, diabetic ulcers, or blisters. The plan of care failed to be individualized to include any wound measurement orders for sacral wound, skin tears, diabetic ulcers, or blisters. This plan of care indicated the skilled nurse was to provide wound care 2 times per week to a sacral (area at the base of the spine and the pelvis) wound as follows: cleanse with saline, dry with gauze, prepare skin to peri-wound with skin prep, fill wound cavity with black foam, cover and secure with drape, and apply tubing. Apply negative pressure device at -125 mmhg (millimeters of mercury) continuously. Record review evidenced the patient only received 1 skilled nurse visit the week of 7/24/2022. Clinical record review evidenced a skilled nurse visit note dated 7/14/2022, which stated, "…		individualized plan of care and emerging conditions noted, updating the plan of care, treatment changes and correct notification to physician.The attempts by staff to ensure that the treatment frequency is met will also be monitored. For patients with other contracted agencies, proper coordination and the provision of continuity of care until the patient is admitted by the new agency including but not limited to timely request for Insurance authorizations for extended services and care to ensure such continuity will be ensured through this weekly monitoring. The director of nursing (DON) is responsible to ensure that this deficiency does not recur.	

	wound vac in place with minimal leak ….” This document failed to evidence the nurse changed the wound vac dressing as ordered on the plan of care. Clinical record review evidenced a skilled nurse visit note dated 7/25/2022, which indicated a wound vac dressing was assessed, but failed to evidence the dressing was changed during the visit as ordered on the plan of care. During an interview on 8/24/2022, at 1:44 PM, clinical manager #2 indicated the physician should have been contacted for wound care orders for patient’s blisters, skin tears, and diabetic ulcers, and wound care orders should have been included on the plan of care. Clinical manager #2 indicated wounds were to be measured once per week. At 1:48 PM, clinical manager #2 indicated she did not know if the wound vac change was performed, because it was not documented whether the nurse changed the wound vac on 7/14/2022 or 7/25/2022. At 1:57 PM, clinical manager #2 did			

	only received 1 skilled nurse visit the week of 7/24/2022, because they were waiting for insurance approval for more visits. 5. Clinical record review for patient #4 was completed on 8/24/22, for certification period 12/26/2021-2/23/2022. Clinical record review evidenced a plan of care for certification period 12/26/2021-2/23/2022, which indicated the patient was to receive home health aide visits 3 times per week for 7 weeks and 1 time per week for 1 week. Record review evidenced the patient only received 2 home health aide visits per week for the entire certification period 12/26/2021-2/23/2022. Record review failed to evidence any home health aide visits the week of 02/13/2022. Record review evidenced a missed note dated 2/15/2022, which indicated the home health aide called off and no visit was complete During an interview on 8/24/2022, at 1:20 PM, clinical manager #2 indicated the patient's orders were not updated to reflect home health aide visits 2 times per week but			

	should have been. Clinical manager #2 did not know why the patient did not receive any home health aide visits the week of 2/13/2022. 410 IAC 17-13-1(a)			
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 services and treatments were administered only as ordered by the physician in 3 of 3 clinical records reviewed with wounds. (#1, 2, 3) The findings include: 1. Record review on 8/24/2022, evidenced an agency policy revised 1/21/2022, titled "Physician Orders" which stated, "... All medications, treatments and services provided to patients must be ordered by a physician ...."	G0580	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C-635 All medications, treatments and services provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients with wounds and found 65% to be correctly completed, 15% were noted to be lacking the correct physician orders and 20% were lacking correct wound care. These deficiencies have now been corrected. (to be consistent with 0572) A staff inservice was performed, on 9/8/2022 on the above	2022-09-08

	2. Clinical record review for patient #1 was completed on 8/24/2022, for certification periods 6/16/2022 – 8/14/2022 and 8/15/2022 – 10/13/2022. Record review evidenced a plan of care for certification period 6/16/2022 – 8/15/2022, which indicated the skilled nurse was to perform the following wound care to left lateral foot 3 times weekly: cleanse with normal saline, apply hydrofera (a wound dressing which prevents bacteria from growing) blue, cover and secure with foam dressing. Clinical record review evidenced skilled nurse visit notes dated 7/5/2022, 7/11/2022, 7/25/2022, 8/4/2022, 8/8/2022, and 8/18/2022, which all indicated the following left lateral foot wound care was completed: cleansed with normal saline, applied silver alginate (an absorbent antimicrobial wound dressing), and covered with foam dressing. Record review evidenced a plan of care for certification period 8/15/2022 – 10/13/2022, which indicated the skilled nurse was to perform the following wound care to left lateral foot 3 times weekly: cleanse with normal		policy and they were reeducated with emphasis on : 1. Ensuring that Physicians orders are followed as issued 2. Timely Identification and reporting of any new wounds/sores to the physician 3. Obtaining Orders for the management of all new conditions and changes to the patient's status/wounds 4. Any changes or need for substitution to be reported to physician and new/ change order received 5. Documentation of all orders reflecting the changes to the original plan of care. 6. Timely request for required Supplies by care team For Patient #1 Order created on 8-24-22 with clarification of wound care provided. The correct orders have been obtained to comply with the ordered frequency. An individual plan of treatment for the wound that the patient has been obtained from the physician and this is currently being carried out	

	saline, apply hydrofera (a wound dressing which prevents bacteria from growing) blue, cover and secure with foam dressing. Clinical record review evidenced skilled nurse visit notes dated 8/8/2022 and 8/18/2022 which indicated the following left lateral foot wound care was completed: cleansed with normal saline, applied silver alginate, and covered with foam dressing. During an interview on 8/24/2022, at 10:21 AM, clinical manager #2 indicated maybe the wound care order had been changed. Clinical manager #2 indicated ordered wound care to be applied was hydrofera blue. Clinical manager #2 indicated she did not see any order for silver alginate to be applied. 3. Clinical record review for patient #2 was completed on 8/24/2022, for certification periods 6/3/2022 – 8/1/2022 and 8/2/2022 – 9/30/2022. Record review evidenced plans of care for certification period 6/3/2022 – 8/1/2022 and 8/2/2022 – 9/30/2022, which indicated the patient was to receive skilled nursing visits 3		For Patient #2, SN reviewed physicians order dated on 8-8-22 for wound care instructions. SN to document on following wound care orders per MD orders. For Patient #3 An individual plan of treatment for the various wounds that the patient has was obtained from the physician and this is currently being carried out To prevent this deficiency from reoccurring, all wound care cases will be reviewed weekly by the Director of Nursing and the quality assurance team to ensure physicians instructions are followed as ordered, and also ensure all required supplies are available for care team Administrator and the Director of Nursing will be responsible to ensure that this deficiency does not recur.	

	times per week to apply an alginate (absorbent antibacterial wound dressing) dressing to a right foot wound. Clinical record review evidenced skilled nurse visit notes dated 7/4/2022, 7/18/2022, 7/29/2022, 8/3/2022, 8/5/2022, and 8/8/2022, which indicated the nurse was applying collagen dressing to the right foot wound. During an interview on 8/24/2022 at 11:40 AM, clinical manager #2 indicated the nurses were applying collagen instead of Alginate because there was an order from April 2022, to apply collagen. Clinical manager #2 indicated the nurses should perform dressing changes as ordered on the plan of care. 3. Clinical record review for patient #3 was completed on 8/24/2022. Record review evidenced a plan of care for certification period 6/28/2022 – 8/26/2022, which included the following sacral (area where the base of the spine meets the pelvis) wound care orders: cleanse with saline, dry with			

	peri-wound with skin prep, fill wound cavity with black foam, cover and secure with drape, and apply tubing. Apply negative pressure device at -125 mmhg (millimeters of mercury) continuously. Clinical record review evidenced a skilled nurse visit note dated 7/11/2022, which stated, "... Wound care was provided using normal saline, Teri honey gauze tape, and kerlix ... Wound-vac dressing changed to promote excellent seal ...." Clinical record review evidenced a skilled nurse visit note dated 7/14/2022, which stated, "... Leg wound care done using normal saline, tera honey, gauze, kerlix and tape ... Wound vac in place with minimal leak ...." Clinical record review evidenced a skilled nurse visit note dated 8/2/2022, which stated, "... Wound dressing was applied to the wound on the left calf ...." Clinical record review evidenced a skilled nurse visit note dated 8/8/2022, which stated, "... Wound care of normal saline, medi-honey, and gauze was provided ... A newly ruptured			

	[centimeters] was noted to the left button [sic] ... Wound care of normal saline and medi-honey applied ...." Clinical record review evidenced a skilled nurse visit note dated 8/15/2022, which stated, "... wound care was provided to the posterior left lower leg using normal saline, medi-honey, gauze, and tape ...." Clinical record review evidenced a skilled nurse visit note dated 8/22/2022, which stated, "... wound care was provided to the sacrum and the lower anterior left calf ...." During an interview on 8/24/2022, at 1:48 PM, clinical manager #2 indicated she did not see any orders for wound care other than to sacral wound. Clinical manager #2 indicated the clinicians should have been completing wound care only as ordered. 410 IAC 17-13-1(a)			

G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Based on record review and interview, the home health agency failed to ensure the plan of care was reviewed and revised by the physician responsible for the home health plan of care as frequently as the patient's need or condition required in 1 of 3 clinical records reviewed with wounds. (#1) The findings include: Record review on 8/24/2022, evidenced an agency policy revised 1/21/2022, titled "Plan of Care" which stated, "... The total Plan of Care shall be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days ... Verbal/telephone orders shall	G0588	The Director of Nursing and Administrator reviewed the following policies for reeducation and clarification of procedures C – 580 PLAN OF CARE: ProCare Home Health services are furnished under the general supervision and direction of the patient's physician. The Plan of Care is based on a comprehensive assessment and information provided by the patient/caregiver and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. With emphasis on Section 2 sub sections 8 & 12 12. Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients with	2022-08-30

	be obtained from the patient's physician for changes in the plan of care ...."		correctly completed, 20% were noted to be lacking the correct physician orders and 15% were lacking wound care orders. These deficiencies have now been corrected. For patient #1, for certification periods 6-16-22 to 8-14-22 and 8-15-22 to 10-13-22 a follow up Oasis was completed on 8-25-22 informing the Primary care physician that new wound care orders received since patients last wound clinic visit on 4-13-22. The patient's wound care was changed to apply Silver Alginate to left heel after cleansing wound with Saline, cover with gauze and wrap with Kerlix then secure Kerlix with tape. Also orders received from the wound clinic visit from 4-13-22 visit and uploaded into the patient's chart. Follow-up Oasis also states frequency of SN and Spouse to assist with changing dressing once weekly or if SN is unable to provide a visit.	

	Clinical record review for patient #1 was completed on 8/24/2022, for certification periods. Record review evidenced plans of care for certification periods 6/16/2022 – 8/14/2022 and 8/15/2022 -10/13/2022, which indicated the patient was to receive wound care to a left lateral foot wound as follows: cleanse with normal saline, apply hydrofera (a wound dressing which prevents bacteria from growing) blue, cover and secure with foam dressing. Clinical record review evidenced skilled nurse visit notes dated 7/5/2022, 7/11/2022, 7/25/2022, 8/4/2022, 8/8/2022, and 8/18/2022, which all indicated the following left lateral foot wound care was completed: cleansed with normal saline, applied silver alginate (an absorbent antimicrobial wound dressing), and covered with foam dressing. Record review failed to evidence the physician had reviewed the plan of care and revised the wound care orders to match wound care being provided. During an interview on 8/24/2022, at 10:26 AM, clinical manager #2 indicated patient		Homecare agency to perform daily quality inspection of all Oasis and any new orders received for the patient's care will be included on a Follow Up oasis and sent to the physician. The Director of Nursing will be responsible to ensure that this deficiency does not recur	

	#1's family member had indicated the wound care orders had changed silver alginate after a visit to a wound clinic. Clinical manager #2 indicated if the agency was aware of new wound orders, the physician should have been called to revise and review the plan of care by adding updated wound care orders. Clinical manager #2 indicated there was no documentation that the physician reviewed and signed these orders as should have been done. 410 IAC 17-13-1(a)(2)			
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 home health agency failed to promptly alert the relevant physician of changes in patient condition that suggested that outcomes were not being achieved and the plan of care should have	G0590	The Director of Nursing and Administrator reviewed the following policies for reeducation and clarification of procedures. C-580 PLAN OF CARE POLICY ProCare Home Health services are furnished under the general supervision and direction of the patient's physician. The Plan of Care is based on a comprehensive assessment and information provided by the patient/caregiver and health team members. Planning for care is a dynamic process that	2022-09-06

	been altered in 3 of 5 clinical records reviewed. (#1, 2, 3) The findings include: 1. Record review on 8/24/2022, evidenced an agency policy revised 1/21/2022, titled "Plan of Care" which stated, "… Professional team members shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care … Changes in vital signs, other significant out of range parameters and events must be reported immediately through the hierarchy to supervising RN [registered nurse] or physician …." 2. Clinical record review for patient #1 was completed on 8/24/2022, for certification periods 6/16/2022 – 8/14/2022 and 8/15/2022 – 10/13/2022. Record review evidenced a comprehensive re-assessment/recertification dated 6/15/2022, which indicated the patient had 1 pressure wound. Record review evidenced a comprehensive re-assessment/recertification dated 8/13/2022, which indicated the patient had 6		addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days C 580 – SS 10 & 11 10. Professional team members shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care. 11. Changes in vital signs, other significant out of range parameters and events must be reported immediately through the hierarchy to supervising RN or physician. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients with wounds for this deficiency and found 90% to be correctly completed, 10% were noted to be lacking the amount of wounds and notification to the physician of new wounds. These deficiencies have now been corrected. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients with	

	pressure wounds. Record review failed to evidence the physician was notified of change in skin integrity and increasing number of wounds. During an interview on 8/24/2022, at 10:21 AM, clinical manager #2 indicated the physician should have been notified of the patient's 5 new wounds. 3. Clinical record review for patient #2 was completed on 8/24/2022, for certification period 8/2/2022 – 9/30/2022. Record review evidenced a skilled nurse visit note dated 8/1/2022, which indicated the patient had a new open wound to her peri-area. Record review failed to evidence the relevant physician was notified of new wound or need for revisions to the plan of care. During an interview on 8/24/2022, at 11:25 AM, clinical manager #2 indicated the physician should have been notified of the new wound. 4. Clinical record review for patient #3 was completed on 8/24/2022, for certification period 6/28/2022 – 8/26/2022. Record review evidenced a start		wounds for this deficiency and found 75% to be correctly completed, 20% were noted to be lacking the correct HHA orders. These deficiencies have now been corrected. A staff In-service was performed, on 9/6/2022 on the above policies and they were reeducated with emphasis on the following: 1. Documentation of wound care treatment changes and orders for those changes, notification to physician as to changes in condition and appearance of any new wounds For patient #1, the documentation of 5 additional pressure ulcers in the assessment dated 6/13/2022 was found to be an error and this has been corrected. For Patient #2, signed orders received on 8-8-22 with acknowledgement of new wound to peri-area and care that needs to be provided to area. Plan of Care to be updated with new orders at time of Recertification. For Patient #3, Patients caregivers indicated that she	

	of care/comprehensive assessment dated 6/28/2022, which indicated the patient was completely dependent for toileting, dressing, transferring, nutrition, and activities of daily living, bedbound, oriented only to self, and had a gastrostomy tube (tube inserted through skin of abdomen directly into stomach for nutrition), right arm PICC line (peripherally inserted central catheter/large catheter inserted into a large vein for administration of medication, fluids, or nutrition), foley catheter (tube inserted into the urethra which drains urine from the bladder), and a stage 4 pressure ulcer (wound caused by pressure, in which bone, tendon, or muscle is visible from the bottom of the wound bed). The comprehensive assessment indicated the patient lived with another person, but failed to indicate their ability, willingness, or availability to care for patient. Clinical record review evidenced a plan of care for certification period 6/28/2022 – 8/26/2022, which indicated the patient was to receive 2 home health aide visits per week for 9 weeks. This document included a goal		will be provided care 24 hours a day amongst 3 members at time of Start of Care. Caregivers notified that patients insurance will be notified for an authorization for Home Health Aide visits. Caregiver was notified that patient was approved for 2 HHA visits. Orders done on 8-24-22 that patient was approved for 2 HHA visits and that insurance was unable to provide more visits due to caregivers living in the home. Notified Northwestern Indiana Community Action that patient requires more home care assistance on 8-2-33. Also physician notified of new abrasion to left thigh and left buttock. Plan of care to be revised at time of recertification on 8-26-22 if patient is recertified. SN reeducated on notifying patients MD of any new changes to patients care. Notified patients insurance on 8-2-22 that she will need more Home Health Aide care due to denial for more HHA visits for Home Care agency. Also notified Northwest Community Action that patient needs more assistance with home care services.	

	which stated, "... Patient will receive safe and effective personal care during this episode of care ...." Record review indicated patient #3 only received 2 home health aide visits during the certification period because her insurance only approved 2 home health aide visits. Record review failed to evidence the physician was notified of patient only receiving 2 home health aide visits, and inability to meet goal of receiving safe and effective personal care. Clinical record review evidenced a skilled nurse visit note dated 8/2/2022, which stated "... New abrasion measuring 10 x 2 cm [centimeters] was noted to the left posterior thigh ...." Record review evidenced a skilled nurse visit note dated 8/8/2022, which indicated a new wound measuring 7cm x 5cm was noted to the left buttock. Record review failed to evidence the physician was notified of the new wounds, which required alterations to the plan of care. During a phone interview with person #4 (patient #3's family member) on 8/23/2022, at 1:30		The director of nursing (DON) is responsible to ensure that this deficiency does not recur.	

	PM, person #4 indicated they lived with patient #3. When queried who provided care for patient #3 for bathing, grooming, incontinent care and linen changes, person #4 indicated they were a dialysis patient, so they couldn't help with much. Person #4 indicated person #5 (family member) comes over sometimes to help take care of patient #3. They indicated person #5 cannot come every day. Person #4 indicated a home health aide would be very helpful, but the home health agency hadn't discussed this with them. During an interview on 8/24/2022, at 1:41 PM, clinical manager #2 indicated she did not see any documentation that the physician was notified that patient #3 would not be receiving home health aide visits due to insurance denial. Clinical manager #2 indicated the physician should have been notified if the patient was unable to have goals of safe and effective personal care met. At 2:01 PM, clinical manager #2 indicated the physician should have been notified of new wounds, but did not see any			

	documented. 410 IAC 17-13-1(a)(2)			
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Based on record review and interview, the home health agency failed to ensure the plan of care was revised to include current information from the patient's comprehensive assessment and information concerning patient's progress toward measurable outcomes and goals on the plan of care in 1 of 5 clinical records reviewed. (#1) The findings include: Record review on 8/24/2022, evidenced an agency policy revised 1/21/2021, titled "Care Plans" which stated, "... The Care Plan shall be reviewed,	G0592	The Director of Nursing and Administrator reviewed the following policies for reeducation and clarification of procedures. C-660 CARE PLANS POLICY Each patient will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs. This plan is developed with the patient and family, as indicated, and is based on services needed to achieve specific measurable goals... Section 2. "The Care Plan shall be reviewed, evaluated, and revised...and the effectiveness of the interventions in achieving progress toward goals " The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients with wounds and found 90% to be correctly completed, 10% were noted to be lacking the specific number of wounds. These deficiencies have now been	2022-09-08

	upon the patient's health status and/or environment, ongoing patient assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals ...." Clinical record review for patient #1 was completed on 8/24/2022, for certification periods 6/16/2022 – 8/14/2022 and 8/15/2022 – 10/13/2022. Record review evidenced a comprehensive re-assessment/recertification dated 6/15/2022, which indicated the patient had 1 pressure wound. Record review evidenced a comprehensive re-assessment/recertification dated 8/13/2022, which indicated the patient had 6 pressure wounds. Record review evidenced a plan of care for certification period 6/16/2022 – 8/15/2022, which included the following goal, "... Patient will have promotion of healing and restoration of skin integrity without complications by EOE [end of episode] ..." Record review evidenced a plan of care for certification period 8/15/2022 – 10/13/2022, which failed to be revised to include any wound care orders for 5		corrected. A staff In-service was performed, on 9/8/2022 on the above policy and they were reeducated with emphasis on: 3. Documentation of wound care treatment will include measurements, changes in condition and orders for those changes, notification to physician as to changes in condition and appearance of any new wounds 2. Timely Identification and reporting of any new wounds/sores to the physician 3. Obtaining Orders for the management of all new conditions and changes to the patient's status/wounds 4. Any changes or need for substitution to be reported to physician and new/ change order received 5. Documentation of all orders reflecting the changes to the original plan of care. Patient #1 the documentation of 5 additional pressure ulcers in the assessment dated 8/13/2022 was found to be an	

	new wounds. During an interview on 8/24/2022, at 10:21 AM, clinical manager #2 indicated if the patient has a change in status, or is not meeting goals, the plan of care would be revised, and the agency would get orders for care.		error and this has been corrected. Follow up visit on 8-24-22 and Oasis created and sent to the Physician for clarification of wound that is receiving care and orders for wound care. SN reeducated on proofreading her documentation before submitting her notes. Homecare agency to ensure that Oasis are QA'd Thoroughly and if any discrepancies are noted to have them corrected before Plan of Care is submitted to the physician The director of nursing (DON) is responsible to ensure that this deficiency does not recur.	
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the agency failed to integrate all services provided directly and/or under arrangement, to assure	G0606	The Administrator and Director of Nursing (DON) reviewed the Home Health Agency's policy C 360 for reeducation and clarification of procedures. COORDINATION OF PATIENT SERVICES POLICY The agency will integrate services, whether they are provided directly or under contract, to assure the identification of patient needs and factors that could affect patient safety and the	2022-09-13

	identification of patient needs, coordination of care by all disciplines, and treatment effectiveness in 1 of 2 clinical records reviewed which were shared with another home health agency. (#2) The findings include: Record review on 8/24/2022, evidenced an agency policy revised 1/21/2021, titled "Coordination of Patient Services" which stated, "... The agency will integrate services, whether they are provided directly or under contract, to assure the identification of patient needs and factors that could affect patient safety and the effectiveness of treatment ... The coordination of care is provided by all disciplines and included communication with physicians ...." Clinical record review for patient #2 was completed on 8/24/2022, for certification periods Clinical record review for patient #2 was completed on 8/24/2022, for certification periods 6/3/2022 - 8/1/2022 and 8/2/2022 - 9/30/2022. Record review evidenced a plan of care for		effectiveness of treatment. The coordination of care is provided by all disciplines and includes communication with physicians. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients with wounds and found 80% to be correctly completed, 20% were noted to be lacking Coordination of Care with other agencies in the patients home. These deficiencies have now been corrected. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients with wounds and found 75% to be correctly completed, 25% were noted to be lacking the correct HHA orders. These deficiencies have now been corrected. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients with wounds and found 75% to be correctly completed, 25% were noted to be lacking discharge in a timely manner. These deficiencies have now been corrected.	

	certification period 6/3/2022 - 8/1/2022, which included but was not limited to the following diagnoses: paraplegia, complete (paralysis of legs and lower body), colostomy (an opening created in the abdominal wall connecting to the colon, to allow stool to exit the body), and neuromuscular dysfunction of bladder (condition in which person has no control over bladder, which can cause a person to retain urine or urine incontinence). This document indicated the patient had a urinary catheter (catheter inserted into the bladder to drain urine), and a wound to the right foot requiring dressing changes. This document indicated the patient lived alone and had no willing or available caregiver. The plan of care indicated the patient used a Hoyer lift for transfers, and human assistance was required for transfer from the bed to the wheelchair. This document indicated the patient was receiving skilled nursing visits 3 times per week for 9 weeks. The plan of care failed to evidence the patient was receiving home health aide services. Record review evidenced a		100% of Active Clinical records of all patients with all or part of their care contracted to another agency was reviewed on 9/13/2022 there were no further deficiencies. A staff Inservice was performed, on 9/13/2022 on the above policy and they were reeducated with emphasis on: 1. Importance of all health care providers to familiarize themselves with each other and know which disciplines are on the patient's case with their frequencies and visit schedule for the patient. 2. Staff were reeducated on documenting the coordination of care and services with each other and outside agencies on the patient's case. 3. Document all services being received by patient either directly or through a contracted Agency, and specify the Agency providing such care The DON will now review all progress notes weekly to ensure that staff is in compliance with	

	comprehensive re-assessment dated 8/1/2022, which indicated the patient was a paraplegic, totally dependent for transfers, dressing, grooming, and bathing, had a colostomy, and urinary catheter, and lived alone with no able or willing caregiver. This document indicated the patient went to an unknown wound clinic. Record review evidenced a plan of care for certification period 8/2/2022 - 9/30/2022, which indicated the patient was receiving skilled nursing 3 times per week, but failed to evidence patient was receiving any home health aide visits. Record review evidenced a skilled nurse visit note dated 8/3/2022, which indicated the patient had a new wound to her peri-area. Record review evidenced a skilled nurse visit note dated 8/5/2022, which stated, "... Patient was informed by wound clinic, she has open areas ... Patient also informed this recorder the CNA [certified nursing assistant] accidentally threw away the MD [doctor] orders for the new areas ... Informed patient MD's office will be called for a copy of the orders but without the orders this recorder would be unable to provide treatment at this time to the new areas ...." Record review evidenced a skilled nurse visit note dated 8/8/2022, which stated, "... Patient informed this recorder on Friday, 8/5/2022 she received orders for open areas on her buttocks and vaginal area ... Informed patient this recorder would follow up with DON [director of nursing] to see if orders were received over the weekend ... we would order wound care supplies once MD orders were		the coordination of care of the patient and documenting the care and communication. Also, during the monthly case conference meetings, coordination of care will be emphasized. 10% of clinical records will be selected and reviewed weekly for documentation of coordination and communication between disciplines. The DON will be responsible to ensure that this deficiency does not recur.	

were obtained for wound care to new areas after skilled nurse visit 8/8/2022 (8 days after wound development).

Record review evidenced patient was discharged from the home health agency on 8/12/2022, and transferred to home health agency #2. Record review indicated the last skilled nurse visit was provided on 8/8/2022. Review of the electronic medical record indicated the patient was to start care with home health agency #2 on 8/13/2022.

Record review evidenced a faxed document from home health agency #2 which indicated the patient started home health services on 8/19/2022. Review indicated patient #2 did not receive any skilled nurse visits for 10 days, due to discharge.

During an interview on 8/24/2022, at 10:57 AM, clinical manager #2 indicated patient #2 was receiving home health aide services through home health agency #3. Clinical manager #2 did not know what services home health agency #3 was providing. Clinical manger #2 indicated care coordination should be documented in a note, but didn't see anything documented. Clinical manager #2 indicated the agency did not have the staff to provide home health aide services to patient #2. Clinical manager #2 did not know how patient #2 was completing activities of daily living. Clinical manager #2 did not know which wound clinic the patient was going to. Clinical manager #2 indicated the wound clinic would sometimes call the agency and update home health staff. At 11:14 AM, administrator #1 indicated the home health agency should have coordinated care with home health agency #2 and continued services for patient until home health agency #2 had physician orders to start care. At 11:29 AM, clinical manager #2 indicated home health agency #3 was going to request the wound care orders from the physician. Clinical manager #3 indicated she talked to the patient's physician, and had the physician's office fax the wound care orders to home health agency #3, who would in turn fax

	to ProCare Home Health. 410 IAC 17-12-2(h)			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on observation, record review, and interview, the agency failed to ensure skilled professionals accurately and completely prepared clinical notes in 3 of 3 clinical records reviewed with wounds. (#1, 2, 3) The findings include: 1. Record review on 8/24/2022, evidenced an agency policy revised 1/21/2022, titled "Skilled Professional Services" which stated, "... Skilled professionals must assume responsibility for, but not be restricted to the following: ... Preparing clinical notes ...." 2. Observation of a home visit for patient #1 was conducted on 8/22/2022, at 2:30 PM, to observe a routine skilled nurse	G0716	The Director of Nursing and Administrator reviewed the following policies for reeducation and clarification of procedures. C220: Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services and occupational therapy, as specified in the §409.44 of this chapter. Skilled professionals who provide services to home health agency patients directly or under contract must participate in the coordination of care. C680: Agency will document each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the patient's care. C873: Medical records are legal documents that support the delivery of patient services. Any	2022-09-08

	visit. During the visit, the nurse was observed performing wound care to a left lateral foot wound. The nurse failed to measure the wound. Clinical record review for patient #1 was completed on 8/24/2022. Record review evidenced plans of care for certification periods, 6/16/2022 – 8/14/2022 and 8/15/2022 – 10/13/2022, which indicated the skilled nurse was to measure and record wound measurements during visits. Record review evidenced a comprehensive re-assessment dated 8/15/2022, which indicated the patient had 6 pressure ulcers/wounds. This document failed to include any measurement or assessment of these 6 wounds. Record review failed to evidence any further documentation of 6 wounds in visit notes during the certification period. Record review evidenced a skilled nurse visit note dated 8/22/2022, which included wound measurements for the patients' left lateral foot wound. Clinical record review evidenced skilled nurse visit notes dated 7/5/2022, 7/11/2022,		information documented in the patient record must follow accepted legal requirements. 100 % of clinical records for active patients with wound care was reviewed and these deficiencies have been corrected. Additionally, 25 % of active clinical records were reviewed and corrected for these deficiencies on 9/6/2022. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients with wounds and found 65% to be correctly completed, 15% were lacking wound measurements and 20% were noted to be lacking the correct physician orders and. These deficiencies have now been corrected. A staff inservice was performed, on 9/8/2022 on the above policies and they were reeducated on: Documentation being done according to policies with emphasis on measuring wounds when care is done for dressing changes. The wounds on patient #1 has	

	7/25/2022, 8/4/2022, 8/8/2022, 8/18/2022, and 8/22/2022, which all included the following left lateral foot wound measurements: 1.5 cm (centimeters) x 0.5 cm x 0.1 cm. These documents all stated, "... Wound is decreasing in size ...."		will continue every visit until healing of the wounds. The conflict in the number of wounds for patient #2 has now been resolved. It is noted that the patient had 4 wounds. For patient #3, the area where the wound care was performed is now being documented. The type of dressing change or wound care done is also now being documented, as well as the area of the body to which wound care was done. It has now been corrected to be the right leg. The type of wound care that was done is now being recorded For patient #3, the wound measurements are now being documented in the patient's chart along with the tracking document that is being sent to the wound vac company. The wound measurements provided to the wound care company have now been reconciled with the measurements in the patient's chart. The wounds measurements are now being documented in the patient's visit notes. The director of nursing (DON)	

	During an interview on 8/24/2022, at 10:40 AM, clinical manager #2 stated, "… we use the measurements from previous visit …." Clinical manager #2 indicated the nurse used the wound measurements from a previous visit because they were pressed for time. Clinical manager #2 indicated the skilled nurse visit notes shouldn't have said the wound was decreasing if the wound size was the same. Clinical manager #2 indicated the notes copy from the previous visit, but each nurse should be making the proper changes. Clinical manager #2 indicated she did not know why there was no documentation of patient's 6 wounds from the comprehensive assessment. Clinical manager #2 indicated wound documentation should include measurements, assessment, appearance, and orders for wound care. 3. Clinical record review for patient #2 was completed on 8/24/2022, for certification period 8/2/2022 – 9/30/2022. Record review evidenced a skilled nurse visit note dated 7/29/2022, which indicated the patient had 4 wounds. Record		for the next 4 weeks, weekly, and then every other week for another 4 weeks, and then quarterly on an ongoing basis The Director of Nursing will ensure that this situation does not occur again.	

	review evidenced a comprehensive re-assessment/recertification dated 8/1/2022, which indicated the patient only had 2 wounds. Record review of skilled nurse visit notes dated 8/3/2022, 8/5/2022, and 8/8/2022, indicated the patient had 4 wounds. During an interview on 8/24/2022, at 11:25 AM, clinical manager #2 did not know which wound documentation was accurate. Clinical manager #2 and administrator #1 did not know how many wounds patient #2 had. 4. Clinical record review for patient #3 was completed on 8/24/2022. Record review evidenced a start of care/comprehensive assessment dated 6/28/2022, which indicated the patient had skin tears to her chest, back, and bilateral thighs, diabetic ulcers (wounds caused by diabetes, a problem regulating blood sugars) to bilateral shins, and blisters to her right arm, back, and chest. Record review evidenced a plan of care for certification period 6/28/2022 – 8/26/2022, which indicated the			

	skilled nurse was to provide wound care 2 times per week to a sacral (area at the base of the spine and the pelvis) wound as follows: cleanse with saline, dry with gauze, prepare skin to peri-wound with skin prep, fill wound cavity with black foam, cover and secure with drape, and apply tubing. Apply negative pressure device at -125 mmhg (millimeters of mercury) continuously. Clinical record review evidenced a skilled nurse visit note dated 7/8/2022, which stated, "... wound care was done ...." This document failed to specify location of wound care or what wound care was completed. This document failed to include an assessment of any wounds. Clinical record review evidenced skilled nurse visit noted dated 7/14/2022, which indicated wound care was completed to a leg wound, but failed to include, left or right leg, assessment of wound, or measurement of wound. Clinical record review evidenced a skilled nurse visit note dated 7/14/2022, which indicated a wound vac dressing was			

assessed, but failed to document the assessment of the wound, wound location, or measurements.

Clinical record review evidenced a skilled nurse visit note dated 8/2/2022, which indicated a wound dressing was applied to a wound on the left calf but failed to document what wound care was performed.

Clinical record review evidenced a wound progress tracking document which was faxed to a wound vac company on 8/22/2022. This document indicated the sacral wound measured 7cm (centimeters) x 4cm x 2 cm. Record review evidenced a skilled nurse visit note dated 7/18/2022, which indicated the sacral wound measured 10cm x 8cm x 4cm. The wound progress tracking sheet also included sacral wound measurements for the following dates: 7/4/2022 and 7/11/2022, which were not documented in the patient's chart or any visit notes.

During an interview on 8/24/2022, at 1:46 PM, clinical manager #2 indicated the nurse

	care was completed, but the nurse probably did a wound vac change. Clinical manager #2 indicated the nurse should have documented specific wound care completed and location. Clinical manager #2 indicated the nurse should have been completing a complete head-to-toe skin assessment every visit, documenting assessment of any wounds including drainage, location, and appearance of wound bed, wound measurements, and any specific wound care that was completed. At 2:14 PM, clinical manager #2 did not know why the wound measurements provided to the wound vac company were different than the documented wound measurements. Clinical manager #2 indicated the nurse had given her the wound measurements over the phone, and maybe the nurse had them written down somewhere. Clinical manager #2 did not know why the wound measurements were not documented in the patient's visit notes. 410 IAC 17-14-1(a)(1)(E)			

G0814	Non-skilled direct observation every 60 days 484.80(h)(2) If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the registered nurse must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in order to observe and assess each aide while he or she is performing care. Based on record review and interview, the agency failed to ensure the registered nurse made an on-site visit every 60 days to observe and assess the home health aide for patients only receiving home health aide services in 1 of 1 clinical record in which no skilled services were provided. (#4) The findings include: Record review on 8/24/2022, evidenced an agency policy revised 1/21/2021, titled "Supervision of Team Members" which stated, "... If patients are receiving only home health aide services and there is no skilled service provided, a Registered Nurse will make a supervisory visit while the aide is providing	G0814	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C-340 Agency shall provide Home Health Aide services under the direction and supervision of a Registered Professional Nurse/Therapist when personal care services are indicated and ordered by the physician. The frequency of supervision will be in response to Medicare regulations, agency policy and other state or federal requirements. With emphasis on: Subsection 3E: Home Health Aide services only: • When Home Health Aide services are being furnished to a patient, who does not require the skilled service of a nurse or therapist, a Registered Nurse or qualified therapist must make a supervisory visit to the patient's residence at least once every sixty (60) days. Each supervisory visit must occur when the Home Health Aide is providing patient care. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients	2022-08-30

	days ….” Clinical record review for patient #4 was completed on 8/24/22 for certification periods 12/26/2021 - 2/23/2022, and 6/24/2022 - 8/22/2022. Clinical record review evidenced a plan of care for certification period 12/26/2021-2/23/2022, which indicated the patient was to receive home health aide visits 3 times per week for 7 weeks and 1 time per week for 1 week. Record review evidenced recertifications/comprehensive re-assessments dated 12/25/2022, and 6/23/2022, which failed to evidence the nurse made an on-site visit to observe and assess the home health aide every 60 days. Record review failed to evidence a patient signature on the comprehensive re-assessments, confirming the nurse completed the visit in person. During an interview on 8/23/2022, at 1:40 PM, person #5 (patient #4’s family member/medical power of attorney) indicated no registered nurse had made an on-site visit to the patient’s home in over a year. Person #5 indicated the nurse made 2 on-site visits since February 2021, and all other aide supervisory visits had been phone calls. During an interview on		requiring HHA only services, and found 75% to be correctly completed with correct SN Onsite Supervisory visit frequency, 25% were noted to be lacking the correct HHA onsite SN supervisory visits. These deficiencies have now been corrected on 08/30/2022 The situation with patient #4 has now been corrected. An onsite supervisory visit was made on August 30 2022. The Director of Nursing and the quality assurance team will monitor our 60 Day documentation on an ongoing basis to ensure that the situation does not recur The Director of Nursing will ensure that this situation does not occur again.	

	manager #2 indicated if the patient was only receiving home health aide services, the nurse only completed an on-site visit during the recertification assessments. Clinical manager #2 indicated the agency did not require a patient signature during recertification visits, but they were supposed to go see the patient every 60 days.			

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