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	10/25/2022

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 was a revisit survey to a state complaint conducted by the Indiana Department of Health.	N0000		2022-11-09
G0000	INITIAL COMMENTS This visit was for a Federal Post Condition Revisit survey of a Home Health Agency. Survey Dates: 10/19/2022, 10/20/2022, 10/21/2022, 10/24/2022 and 10/25/2022. Facility ID: 003042	G0000		2022-11-09

	Census: 41 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. At this survey, Condition of Participation 42CFR 484.60 Care planning, coordination of services, and quality of care, was put back into compliance. Quality Review Completed 11/09/2022			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j)	N0488	The Director of Nursing and Administrator reviewed the following policies for re-education and clarification of	2022-10-31

	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 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.		procedures. C – 495 DISCHARGE POLICY Patients are discharged from treatment in the home when the expectations that the patient's medical, nursing, and social needs have been met adequately by Agency in the patient's place of residence, upon death of the patient, or for another reason. With emphasis on the following: 1. Discharge planning shall begin at the time of admission with patients being advised as to the expected duration of treatment. 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 (15) calendar days before the services are stopped. 2. Prior to discharging the patient, the attending physician shall be consulted for discharge orders. A written discharge summary, which shall be prepared within fifteen (15) calendar days of discharge, will be sent to the physician with a	

	Based on record review and interview, the home health agency failed to ensure a 15 day discharge notice occurred according to agency policy for 1 of 1 discharged patient clinical record reviewed due to goals being met. (#4) The findings include: Record review of an agency policy titled "Discharge Policy" revised 1/21/2021, stated "Policy ... Patients are discharged from treatment in the home when the expectations that the patient's medical, nursing, and social needs have been met adequately by agency and the patient's place of residence, upon death of patient, or for another reason ... Special Instructions ... 1. Discharge planning shall begin at the time of admission with patients being advised as to the expected duration of treatment. 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 (15) calendar days before the services are stopped ... 2. Prior to discharging the patient, the		record. C - 120 ADMISSION POLICY 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. With emphasis on Sub Section 18: 18. Discharge planning is started at patient admission. The patient will be informed of the policy at admission by the admitting clinician. In case the patient is short term, that is less than 30 days, the information will serve as the 15-day notice A "Notice of Discharge Form" has now been included in the admission packet for the Clinician to complete prior to discharge of the patient. On 10/31/2022 Skilled Nurses were oriented in an In-Service to ensure that the Notice of Discharge Form is completed prior to discharging of the patient. The clinician will also complete a "Communication Note" in the Patient's Chart reflecting the notice of	

	attending physician shall be consulted for discharge orders. A written discharge summary, which shall be prepared within fifteen (15) calendar days of discharge, will be sent to the physician with a copy maintained in the clinical record ….” Clinical record review on 10/21/2022, for patient #4, primary diagnosis of cancer of the blood, evidenced an agency document titled “Discharge Patients” retrieved on 10/19/2022. This list revealed patient #4, start of care 8/5/2022, was discharged due to goals being met on 10/3/2022. Record review failed to evidence the patient received a 15-day discharge notice as indicated in the agency’s policy. During an interview on 10/21/2022, at 1:59 PM, administrator #1 indicated in a planned discharge, the patient would receive a discharge notice at the initial assessment and 15 days prior to discharge. During an interview on 10/25/2022, at 10:22 AM, administrator #1, after checking		discharge. Patient #4 was discharged on 10-3-2022 We reviewed 100% of clinical records of patients with recent discharges and found 100% were not compliant. This deficiency is now corrected with the above policy and procedure. The Quality Assurance team will monitor all patients with upcoming discharges weekly to ensure that this deficiency does not recur. The Administrator and Director of Nursing are responsible to ensure that this deficiency does not recur.	

	the "30 day summary" indicated the discharge notice was not documented.			
N0520	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. Based on 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 2 of 3 active clinical records reviewed. (#1, #2) The findings include: 1. Record review on 8/24/2022, evidenced an agency policy titled "Admission Policy" revised 1/21/2021, 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	N0520	The Director of Nursing and Administrator reviewed the following policy for re-education and clarification of procedures. C - 120 ADMISSION POLICY POLICY 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. With emphasis on Subsections: 5,7 and 10 5. Reasonable expectation shall consider: a. Whether the agency's personnel and resources are adequate and suitable for providing the services the patient requires. b. The attitudes of patient/caregiver toward care at home. c. The benefits of care at home as compared to care in a hospital, extended care facility or alternate setting. d. Whether the physical facilities in the	2022-10-26

	patient's place of residence ...." 2. Clinical record review on 10/21/2022, for patient #1, start of care 12/18/2021, diagnoses include but were not limited to, paraplegia and stage 2 pressure ulcer, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 10/14/2022 – 12/12/2022. This plan of care stated "Safety ... 24 hour supervision, seizure precautions ... Fall Precautions ... Prone to skin Breakdown ..." Another area stated "Caregiver Status ... around the clock ..." This document had an area subtitled "Orders For Discipline and Treatment" which stated "Frequency: 2WK9 [2 times weekly for 9 weeks] Patients Spouse agrees to change dressing 1 time a week so that patient receives [his/her] wound care 3 times week per MD [doctor of medicine] orders ...." Record review evidenced an agency document titled "Communication Note" electronically signed by Registered Nurse (RN) #3 on 8/22/2022. This document		patient's home are adequate for giving the patient proper care. 7. When determined necessary based on the patient's condition, a competent caregiver and/or family member may assume responsibility for patient care with intermittent services provided by the agency. 10. Agency services must be appropriate and available to meet the specific needs and requests of the patient and caregiver. For patient #1, the patient's spouse agreed to be responsible for the patient's personal care and ADL's and also, the patient will receive care from family members when he is at work. Physician's order about caregiver services was obtained on 10-26-22 We reviewed 100% of active patients for this deficiency and noted that all the charts were compliant. This deficiency is now corrected. Intake personnel and the Director of Nursing will ensure the agency will be able to	

	stated "... SN [skilled nurse] contacted [administrator #2] request referral be sent to [Entity 7] to apply for available resources for disabled persons that patient may qualify for. Patient's [person #5] needs assist providing care [to the patient], as [he/she] is paralyzed and [person 5] works outside the home...." Record review failed to evidence documentation of attempt to find another home health agency that may meet the needs of the patient and caregiver. During an interview on 10/24/2022, at 10:31 AM, person #5, caregiver, indicated the patient could be left home alone for 10-14 hours a day during the week. Person #5 indicated they purchased a Pure Wick system [urine collection system with an external catheter for females] which is costly but needed to prevent skin breakdown. Person #5 stated "It is a constant battle dealing with the pressure ulcers" and indicated one needed a skin graft to the buttocks and is very "fragile." Person #5 indicated if the patient had a bowel		provide all the services required by the patient before any patient is taken for care. The Administrator and Director of Nursing are responsible to ensure that this deficiency does not recur.	

	work, the patient would have to wait until they returned home to be cleaned. Person #5 indicated the patient can not get out of bed. Before they leave for work, person #5 indicated they would leave a cooler with a drink and "something you can eat with one hand, like a sandwich." Person #5 indicated the patient needs assistance with sitting up, bathing, dressing, grooming, and they are "doing the best they can." They indicated therapy services were not offered to help with mobility or strength. Person 5 indicated an adult child recently moved into the home but also worked, so was not an available caregiver. During an interview on 10/25/2022, at 9:56 AM, administrator #2 indicated they tried to get a HHA [home health aide] for the patient but was unable. They indicated they could not remember if it was the patient's mother or mother in law who was supposed to assist with care, according to the patient's spouse.			

	Review failed to evidence this information documented in the clinical record. During an interview on 10/25/2022, at 10:06 AM, when queried if physical therapy or occupational therapy was not offered to increase strength and bed mobility, administrator #1 indicated it was not documented and they always needed the spouse to let someone in. 3. Clinical record review on 10/20/2022, for patient #2, start of care 6/27/2016, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 9/24/2022 – 11/22/2022. This plan of care stated "Safety … 24 hour supervision, seizure precautions … Fall Precautions … Prone to skin Breakdown …" Another area stated "Caregiver Status … Parents care for patient when they are available and not working …" This document had an area subtitled "Orders For Discipline and Treatment" which stated "Frequency: … SN [skilled nurse]			

	for 8 weeks], 2W1 [twice a week for 1 week] ... HHA Frequency: 5W8, 2W1, 9hours/visit/Monday-Friday=45 hours/week ...." Record review evidenced since the start of the certification period, the patient had failed to receive their weekly HHA hours. Record review failed to evidence the patient received 9 hours a day of HHA services as ordered on the plan of care. Record review failed to evidence an attempt was made in assisting the patient to find and agency/service that would meet the patient's needs. During an interview on 10/24/2022, 10:13 AM, person #6, primary caregiver, indicated they worked multiple jobs and the spouse works full time. The hours needed were from 8:00 AM to 6:00 PM, Monday through Friday. During an interview on 10/25/2022, at 9:50 AM, administrator #1 indicated they tried to assist with help from another agency but did not document the attempts. When queried who was home with the			

	ordered 24 hour supervision. Administrator #1 indicated the parents were able to get help when HHA visits were unfulfilled. 4. During an interview on 10/21/2022, at 1:58 PM, when queried what clinicians should do to ensure safety for a patient prone to skin breakdown, administrator #2 indicated the procedure to follow would be to turn the patient frequently (every 2 hours), bed mobility, and prevention of friction and sheering to the patient's skin.			
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the home health agency failed to ensure a discharge or	G0564	The Director of Nursing and Administrator reviewed the following policies for re-education and clarification of procedures. C-840 PATIENT TRANSFER POLICY Home care services shall not be arbitrarily terminated. A patient may be transferred as determined by the Director of Nursing or designated Registered Nurse/Therapist in response to the patient's	2022-10-31

	transfer summary was sent when appropriate per agency policy for 2 of 2 closed clinical records reviewed. (#4, #5) The findings include: 1. Record review of an agency policy titled "Patient Transfer" revised 1/21/2021, stated "Purpose ... To assure continuity of care by providing pertinent information to another home health care company or facility when a patient chooses another provider ... Special Instructions ... 3. A transfer summary shall be completed by the registered nurse/ therapist. This summary will be based on data collected on the last visit and shall be documentation of services received, reason for transfer/ discharge from agency, the patient's physical and psychosocial status, current medications, continuing symptom management needs, instruction and referrals provided to the patient, summary of care, any existing advanced directives, and any relevant changes in caregiver support or lab results ... 4. The original transfer summary form shall be sent to the new		that cannot be met by the agency. A transfer from the agency to another provider will be documented as a discharge from the agency. C – 495 DISCHARGE POLICY POLICY Patients are discharged from treatment in the home when the expectations that the patient's medical, nursing, and social needs have been met adequately by Agency in the patient's place of residence, upon death of the patient, or for another reason. With emphasis on Sub Section 2: 2. Prior to discharging the patient, the attending physician shall be consulted for discharge orders. A written discharge summary, which shall be prepared within fifteen (15) calendar days of discharge, will be sent to the physician with a copy maintained in the clinical record. A "Notice of Discharge Form" has now been included in the admission packet for the Clinician to complete prior to discharge of the patient. On 10/31/2022 Skilled Nurses were oriented in an In-Service to	

	provider or facility, and a copy shall be retained for the patient's chart ... 9. If the patient is transferred to another home care provider, the agency will complete a discharge Oasis and a discharge summary. The discharge summary will be sent to the physician …." 2. Record review of an agency policy titled "Discharge Policy" revised 1/21/2021, stated "Policy ... patients are discharged from treatment in the home when the expectations that the patient's medical, nursing, and social needs have been met adequately by agency and the patient's place of residence, upon death of patient, or for another reason ... Special Instructions ... 3. When the patient is transferred to another facility, relevant information regarding the patient's condition and care requirements will be provided either verbally or in writing to the facility within 48 hours of the agency becoming aware of the transfer …."		ensure that the Notice of Discharge Form is completed prior to discharging of the patient. The clinician will also complete a "Communication Note" in the Patient's Chart reflecting the notice of discharge. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of patients with recent Transfer and Discharges and found 100% were incorrectly completed. This deficiency is now corrected with the above policy and procedure. The QA team will monitor all patients with upcoming discharges weekly to ensure that this deficiency does not recur. The Administrator and Director of Nursing are responsible to ensure that this deficiency does not recur.	

	3. Clinical record review on 10/21/2022, for patient #5, start of care 8/27/2022, pertinent diagnosis of a tracheostomy (an opening created in the front of the neck, where a tube is inserted into the windpipe) evidenced an agency document titled "Discharge Patients" retrieved on 10/19/2022. This list revealed patient #5, start of care 8/27/2022, was transferred to another home health agency on 9/23/2022. Record review of the agency's electronic health records (EHR) evidenced a communication note entered on 9/2/2022, by administrator #2. This note indicated the patient was taken to the emergency department at entity 2 on 9/1/2022, due to "Trach [Tracheostomy] issues…." Record review of an agency document titled "Home Health Transfer Summary (Auto-Generated)" had and area that stated "Narrative … Caregiver reported patient was admitted to the hospital for problems with trachea [windpipe] and respiratory…." Another area of this document subtitled "Copy of Transfer			

	next to the to complete the listed inpatient receiving facility, physician, and dates sent which were left blank. This document was signed by Registered Nurse #1 on 9/10/2022 (9 days after the patient was transferred to entity 2, and 13 days prior to discharge). On 10/24/2022, patient #5's admission records were requested from entity 2 for the timeframe of 9/1/2022 to 9/23/2022. Record review of entity 2 documents evidenced the patient had 2 hospital admissions during the timeframe requested: 9/1/2022 to 9/2/2022, and again 9/7/2022 to 9/20/2022. Record review of an entity 2 document titled "H&P [history and physical]/Discharge Notes" stated "Discharge Placement/Home Care Information … Home Medical Care … [ENTITY 3] … Service: Home Health Services …." Record review evidenced the patient was discharged from the hospital to the care of entity 3. Record review failed to evidence the patient transferred to another agency as indicated			

	on ProCare documents received on 10/19/2022. Record review failed to evidence transfer and discharge summaries were created within 48 hours following each event. Record review failed to evidence the transfers and discharge occurred according to agency policy. During an interview on 10/21/2022, at 1:59 PM, administrator #1 indicated a transfer summary was sent at the time of transfer. During an interview on 10/25/2022, at 10:34 AM, administrator #2 indicated a transfer summary was not sent to entity 3, nor was a discharge summary sent to the patient's physician. 4. Clinical record review on 10/21/2022, for patient #4, start of care 8/5/2022, primary diagnosis of cancer of the blood, evidenced an agency document titled "Home Health Discharge Summary" signed by Registered Nurse (RN) #2 on 10/14/2022, 11 days after discharge. This document failed to evidence medications the			

	patient was taking at time of discharge and when the physician was notified of discharge. Record review failed to evidence the discharge summary was completed and sent to the physician. During an interview on 10/25/2022, 10:21 AM, administrator #1 indicated the physician would only be notified of discharge and the agency would not send them a discharge summary, as there would be no place for them to sign it.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services 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	G0570	The Deficiency and Condition were corrected on 9-6-2022	2022-11-09

	accordance with accepted standards of practice. Deficiency corrected 09/06/2022. Condition corrected 9/6/2022.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the home health agency failed to ensure the treatments, services, frequencies, and durations were followed as ordered on the plan of care for 1 of 2 active clinical records reviewed where home health aide services were received. (#2) The findings include: Record review of an agency policy titled "Plan of Care"	G0572	The Director of Nursing and Administrator reviewed the following policies for re-education 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 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-120 ADMISSION POLICY POLICY Patients are accepted for treatment in the home based on reasonable criteria and under the expectation that	2022-10-28

	revised 1/21/2021, stated "Policy … Planning for care is a dynamic process that addresses care, treatment, and services to be provided … Special Instructions … 1. The Plan of Care may be prepared as a written record by the ProCare Home Health Services agency based on the physicians verbal orders … 2. The Plan of Care shall be completed in full to include: … d. Type, frequency, and duration of all visits/services …."		the patient's medical, nursing, and social needs can be met adequately by the Agency in the patient's place of residence. Patient #2, was provided the home health aide on 10/28/2022 as ordered. The Director of Nursing and the quality assurance team reviewed 100 % of the active patients' clinical records and found 90% followed the Plan of Care as ordered but 10% did not. We have now provided the services that were missing from the 10% of active patients that were not compliant. THIS deficiency is now corrected. Intake personnel and the Director of Nursing will ensure the agency will be able to provide all the services required by the patient before any patient is taken for care. The Director of Nursing is responsible to ensure that this deficiency does not recur.	

	Clinical record review on 10/20/2022, for patient #2, start of care 6/27/2016, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 9/24/2022 – 11/22/2022. An area stated "Safety … 24 Hour Supervision … Caregiver Status … Parents care for patient when they are available and not working …" This document had an area subtitled "Orders For Discipline and Treatment" which stated "Frequency: … HHA [home health aide] Frequency: 5W8 [5 times a week for 8 weeks], 2W1 [twice a week for 1 week] 9hours/visit/Monday-Friday=45 hours/week …." Record review of HHA visits for the week of 9/25/2022, evidenced the patient received 31 hours of 45 hours of HHA services. Record review of HHA visits for the week of 10/2/2022, evidenced the patient received 30 hours of 45 hours of HHA services. Record review of HHA visits for the week of 10/9/2022,			

	26 hours of 36 hours of HHA services. Record review failed to evidence the agency provided HHA services as ordered in the plan of care. During an interview on 10/24/2022, at 10:13 AM, person #6, parent/primary caregiver of patient #2, indicated that one of the ProCare clinicians assigned to the patient resigned and they had to find a replacement. Person #6 indicated the patient needed caregiver assistance from about 8:00 AM to 6:00 PM. Person #6 indicated when a clinician was not available, they would have to leave work to assist with care. During an interview on 10/25/2022, at 9:41 AM, administrator 2 indicated one of the patient's parents were home during the day because one of the HHA's resigned and the parents were able to obtain outside help when HHA visits were unfulfilled. 410 IAC 17-13-1(a)			

G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician	G0574	The Director of Nursing and Administrator reviewed the following policies for re-education 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 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- 635 PHYSICIAN ORDERS POLICY 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	2022-10-28

	or allowed practitioner may choose to include. Based on record review and interview, the home health agency failed to ensure all orders on the plan of care were individualized to the patient's needs for 2 of 2 patients who received home health aide services, from a total of 3 active clinical records reviewed. (#2, #3) The findings include: 1. Record review of an agency policy titled "Plan of Care" revised 1/21/2021, stated "Policy ... Planning for care is a dynamic process that addresses care, treatment, and services to be provided ... Special Instructions ... 1. The Plan of Care may be prepared as a written record by the ProCare Home Health Services agency based on the physicians verbal orders ... 2. The Plan of Care shall be completed in full to include: ... d. Type, frequency, and duration of all visits/services ... e. Specific procedures and modalities for therapy services ... m. Medications, treatments, and procedures ... 13. The PRN [as needed] orders will be accompanied by a description of the patient's needs that		must be countersigned by the physician in a timely manner. For Patient #2 , the Plan of Care has been revised and we have discontinued the use of Tylenol with Codeine and Lovenox injections. PRN care orders for bathing have now been obtained for the occasional periods that the patient becomes soiled. For patient #3, the current address has been updated in the patient's profile. On 10/28/2022 the Director of Nursing and the Quality Assurance team reviewed 90 % of clinical records of active patients and found that the plans of care were individualized but 10% were not individualized in the area of frequency and personal care. These have now been corrected. All the deficiencies have now been corrected.	

	could warrant a visit ….” 2. Clinical record review on 10/20/2022, for patient #2, start of care 6/27/2016, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 9/24/2022 – 11/22/2022. This document had an area subtitled “Medications” which stated “… Acetaminophen/Codeine [analgesic combined with narcotic medication] … Q [every] 4 – 6 hrs [hours] PRN [as needed]…” Another area subtitled “Orders For Discipline and Treatment” stated “ … Nursing … HHA [home health aide] to perform am [morning] bath and PRN … SN [skilled nurse] to inject Lovenox [anticoagulant/blood thinning medication] injections Sub Q [subcutaneous, under the skin] PRN ….” Review failed to evidence indications for Acetaminophen codeine specific to the patients needs. Review failed to evidence indications for the HHA to give a bath as needed. Review failed to evidence indications for the SN to give Lovenox PRN. Record review failed to evidence the		To prevent this deficiency from recurring, all new plans of care will be reviewed weekly by the Director of Nursing and the quality assurance team to ensure they are individualized for each patient. Administrator and the Director of Nursing will be responsible to ensure that this deficiency does not recur.	

	plan of care was individualized to the patient's needs as indicated in the agency policy. During an interview on 10/21/2022, at 1:54 PM, administrator #1 indicated as needed instructions should be included with any PRN order. During an interview on 10/21/2022, at 1:57 PM, administrator #1 indicated a patient might need an anticoagulant ordered PRN after a procedure or if the patient had a problem with blood clotting. During an interview on 10/25/2022, at 9:38 AM, administrator #2 indicated acetaminophen/codeine would have been taken for pain and Lovenox was not an active medication. Administrator #2 indicated the order came from the hospital and should have been revised. They also indicated the patient would receive a bath as needed if they were soiled. 3. Clinical record review on 10/20/2022, for patient #3, start of care 4/19/2022, evidenced an agency document titled "Home			

	Care" for certification period 10/16/2022 – 12/14/2022. This document had an area subtitled "Patient Name, Address, and Phone Number" which listed this information for patient #3. Record review of an entity 1 document titled "Home Health Certification and Plan of Care" for certification period 10/6/2022 – 12/4/2022. This document had an area subtitled "Patient Name, Address, and Phone Number" which listed this information for patient #3. Review of ProCare Home Health and entity 1's Plans of Care documents failed to evidence the same address listed for the patient. During an interview on 10/24/2022, at 3:40 PM, patient #3 confirmed their address. Review evidenced the information provided by entity 1's Plan of Care had the correct address. During an interview on 10/25/2022, at 10:08 AM, administrator #2 indicated the plan of care was not revised and stated "I know [he/she] moved. I thought we updated it."			

	410 IAC 17-13-1(a)(1)(D)(xiv)			
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 demographic information as often as necessary for 1 of 1 active clinical records reviewed who received nutrition through a feeding tube. (#2) The findings include: Record review of an agency policy titled "Plan of Care" revised 1/21/2021, stated "Policy ... Planning for care is a dynamic process that addresses care, treatment, and services to be provided ... Special Instructions ... 8. The total Plan of Care shall be reviewed by the attending physician and agency personnel as of as the severity of the patient's condition	G0592	The Director of Nursing and Administrator reviewed the following policy for re-education 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 8. 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	2022-10-27

	requires, but at least one time every sixty (60) days ….” Clinical record review on 10/20/2022, for patient #2, start of care 6/27/2016, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 9/24/2022 – 11/22/2022. This document had an area subtitled “Orders For Discipline and Treatment” which stated “ … Nursing … SN [skilled nurse] to Lovenox [anticoagulant/blood thinning medication] injections Sub Q [subcutaneous, under the skin] PRN ….” Review of this document failed to evidence Lovenox listed under the “Medications” section. Review failed to evidence the Plan of Care was revised to reflect the current treatment plan for the patient. During an interview on 10/25/2022, at 9:38 AM, administrator #2 indicated Lovenox was not an active medication and the plan of care should have been revised.		at least one time every sixty (60) days 12. Verbal/telephone orders shall be obtained from the patient’s physician for changes in the Plan of Care (refer to the Physician Orders policy) and reduced to writing, signed by a ProCare Home Health RN, and countersigned by the attending physician as soon as possible. Changes are documented through written and signed Plans of Modifications. For patient #2, a Physician's order was obtained on 10-27-2022 to discontinue the Lovenox injection and the Plan of Care has now been revised. The Director of Nursing and the quality assurance team reviewed 100% of clinical records of active patients and found that 90% of the medication profiles were correctly completed, 10% were noted to be incomplete and these have now been completed with the needed physicians orders. This deficiency is now corrected. To prevent this deficiency from	

			recurring, the quality team will review new plans of care weekly with emphasis on the medication profile completion. 10% of active patients will also be reviewed quarterly for this deficiency. The Director of Nursing will be responsible to ensure that this deficiency does not recur.	
G0714	Patient and caregiver education 484.75(b)(5) Patient and caregiver education; Based on record review and interview, the skilled nurse failed to ensure caregiver training was provided for 1 of 1 clinical record review where a tracheostomy (opening in the front of the neck for airway access) was present. (#5) The findings include: Record review of an agency policy titled "Patient/Caregiver Education" revised 1/21/2021, stated "Policy ... The education and training for patients and	G0714	The Director of Nursing and Administrator reviewed the following policy for re-education and clarification of procedures.	2022-10-31

	patient's ability to improve outcomes through promotion of healthy behavior and involvement in their care, treatment, and service decisions ... Patient/ caregiver education begins with the initial assessment and continues throughout the time patients receive care from the agency ... Special Instructions ... 1. All patients and caregivers will receive verbal and written instructions as appropriate and is required by regulation in the following areas: ... c. Patient's disease process, medical regimen, medications, and diet ... i. safety management and infection control according to agency policy ... 3. All patient and/ or caregiver education and instruction, as well as their perceived comprehension and demonstrated competency, as appropriate, will be documented in the patient's record ...." Clinical record review on 10/21/2022, for patient #5, start of care 8/27/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 8/27/2022 – 10/25/2022. This document had an area subtitled		C - 400 PATIENT/CAREGIVER EDUCATION POLICY Patients and their caregivers or representatives will be provided with information necessary to make decisions and to take responsibility for self-management activities related to their needs. The education and training for patients and caregivers will target the patient's ability to improve outcomes through promotion of healthy behavior and involvement in their care, treatment, and service decisions. With emphasis on Sub Subsections 3,4,6 3. All patient and/or caregiver education and instruction, as well as their perceived comprehension and demonstrated competency, as appropriate, will be documented in the patient's record. 4. Agency team members will recognize that the educational needs of patients and caregivers may change or decrease over time. Therefore, the educational needs and response to these needs will be regularly assessed	

	"Orders For Discipline and Treatment" which stated "... SN [skilled nurse] to teach tracheostomy [care including supplies needed], care of stoma [airway opening in front of neck] and trach, dressing changes, suctioning, infection control and signs and symptoms to report ...." Record review of an agency document titled "OASIS-D1 Start of Care" electronically signed by administrator #2 on 8/27/2022, failed to evidence documentation of patient/caregiver instructions to manage the tracheostomy. During an interview on 10/24/2022, at 11:17 AM, person #4, caregiver to patient #5, indicated tracheostomy care was demonstrated once prior to discharge from the hospital and not from ProCare skilled nurses. During an interview on 10/25/2022, at 10:40 AM, administrator #2 indicated caregiver training should be conducted at start of care and reinforced at every visit.		and re-assessed throughout the episode of care. 6. Teaching methods will be tailored to individual patient needs and the resources available and material used. The persons providing patient/caregiver education will have the necessary training and education to provide these services For Patient #5, on 10/31/2022 Registered Nurse #1 was instructed to document all teachings in the comprehensive assessment. A Clinical staff In-service was performed, on 10/31/2022 on the above policy and they were reeducated with emphasis on the following: 1. Documentation of Patient/Caregiver instructions to manage individualized care.	

	410 IAC 17-14-(a)(2)(E)		The Director of Nursing and the quality assurance team reviewed 100% of clinical records of active patients for inclusion of needed teachings and found 90% to be correctly completed, 10% were noted to be incomplete and these have now been completed. This deficiency is now corrected To prevent this deficiency from reoccurring, all clinical notes will be reviewed weekly by the Director of Nursing and the quality assurance team to ensure that all notes are completed with the needed teachings. The Director of Nursing is responsible to ensure that this deficiency does not recur.	
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the home health agency failed to ensure all clinical notes were completed accurately and	G0716	The Director of Nursing and Administrator reviewed the following policies for re-education and clarification of procedures. C - 200 SKILLED PROFESSIONAL SERVICES POLICY Skilled professional services include skilled nursing services, physical	2022-10-31

	timely for 2 of 3 active clinical records reviewed. (#1, #3) The findings include: 1. Record review of an agency policy titled "Skilled Professional Services" revised 1/21/2021, stated "Policy ... Skilled professionals who provide services to home health agency patients directly or under contract must participate in the coordination of care ... Special Instructions ... 1. Skilled professionals must assume responsibility for, but not restricted to the following: ... f. Preparing clinical notes ...." 2. Record review of an agency policy titled "Flow Sheets" revised 1/21/2021, "Policy ... Agency personnel shall use appropriate flow sheets to document ongoing patient assessment, care, and needs when visits are made frequently, when specific services are provided during each visit, or when specific parameters are to be followed. The Flow Sheets will include date, time, assessment and teaching parameters/ interventions, response to intervention and		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 C - 710 FLOW SHEETS POLICY Agency personnel shall use appropriate flow sheets to document ongoing patient assessment, care, and needs when visits are made frequently, when specific services are provided during each visit, or when specific parameters are to be followed. The Flow Sheets will include date, time, assessment and teaching parameters/interventions, response to intervention and comments as appropriate. Each entry will be signed and dated C - 145 COMPREHENSIVE PATIENT ASSESSMENT POLICY The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the patient's return home, or on the physician ordered start of care date. A thorough, well-organized, comprehensive,	

	comments as appropriate … Purpose … To provide a coordinated multi-visit record when specific parameters for assessment or treatment are to be completed on each visit ... Special Instructions … 6. The appropriate areas on the flow sheets shall be completed on the day service is rendered and incorporated into the clinical record within seven (7) days of that date ….” 3. Record review of an agency policy titled “Comprehensive Patient Assessment” revised 1/21/2021, stated “Policy … A thorough, well-organized, comprehensive, and accurate assessment, consistent with the patient’s immediate needs will be completed for all patients in a timely manner … The assessment identifies facilitating factors and possible barriers to patient reaching his or her goals including presenting problems … Purpose … to determine the appropriate care, treatment, and services to meet patient's initial needs and his/ her changing needs … Special Instructions … 2. The assessment will identify the patient’s primary caregiver(s), if any, and other available		and accurate assessment, consistent with the patient's immediate needs will be completed for all patients in a timely manner, but no later than five (5) calendar days after start of care. All skilled Medicare and Medicaid patients except pediatric and post-partum will have comprehensive assessments that include the OASIS data set specific to mandated time points. C - 800 HOME HEALTH AIDE DOCUMENTATION POLICY Home Health Aides will document care/services provided on the home health aide charting form. Care/services provided should be in accordance with direction provided in the Home Health Aide Care Plan. For patient #1, the notes for 10-17-2022 and 10-24-2022 have now been completed. There was no visit scheduled for 10-14-2022. A staff In-service was performed, on 10/31/2022 on the above policy and they were re-educated with emphasis on: 1). Documentation notes are to	

	supports, including their willingness and ability to provide care, and availability and schedules ….” 4. Record review of an agency policy titled “Home Health Aide Documentation” revised 1/21/2021, stated “Policy … Home Health Aides will document care/services provided on the home health aide charting form. Care/services provided should be in accordance with direction provided in the Home Health Aide Care Plan …. Special Instructions ... 5. The designated Registered Nurse is responsible for reviewing the Home Health Aide's charting before its placed in the chart ...." 5. Clinical record review on 10/21/2022, for patient #1, start of care 12/18/2021, diagnoses include but not limited to paraplegia and stage 2 pressure ulcer, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 10/14/2022 – 12/12/2022. An area stated, “Caregiver Status: … Around the Clock.” This document had an area subtitled “Orders For Discipline and		48 hours after a visit for each patient 2). Quality of Care assistants to review documentation weekly and notify staff of any corrections needed and to notify office staff if documentation is not returned within 48 hours For Patient # 3, HHA #1 was instructed to provide accurate information on her notes including the accurate and timely documentation of vital signs going forwards. The Director of Nursing and the quality assurance team reviewed 100 % of clinical records of active patients’ Flow Sheets and found 90% to be correctly completed, and 10% were not. The incomplete 10% have been updated. The deficiencies were corrected as of 10-31-2022. To ensure that this deficiency does not recur, the Quality Assurance team will monitor all patients’ documentation notes weekly to ensure that the flowsheets are completed accurately and timely.	

	Treatment" which stated "... Frequency: SN [skilled nurse] Frequency: 2WK9 [twice a week for 9 weeks] ...." During an interview on 10/24/2022, at 10:31 AM, person #5, patient #1's primary caregiver, indicated the patient is alone 10 – 14 hours a day while they are at work. Person #5 indicated their adult child had recently moved back in the home but did not assist in providing care. Review failed to evidence accurate caregiver information documented by the skilled nurse. Review of the agency's electronic health record [EHR] on 10/25/2022, evidenced the patient was scheduled SN visits 10/14/2022, 10/17/2022, and 10/24/2022. Review failed to evidence documentation had been started in the EHR. During the entrance conference on 10/19/2022, at 11:03 AM, when queried about the timeframe allowed to turn in documentation following a visit, administrator 1 stated "48 hours." When queried what the timeframe was for documents		The Director of Nursing is responsible to ensure that this deficiency does not recur.	

patient records, administrator 1 stated "48 hours."

During an interview on 10/25/2022, at 10:10 AM, when queried why SN visits had not been started since 10/14/2022 (11 days prior to interview), administrator 2 questioned "Were they assigned?" Review evidenced the visits were assigned to Registered Nurse (RN) #1, and administrator #2 provided no further comment.

6. Clinical record review on 10/20/2022, for patient #3, start of care 4/19/2022, primary diagnosis quadriplegia (paralysis of upper and lower extremities), evidenced an agency document titled "OASIS-D1 Recertification" electronically signed by administrator 2 on 10/15/2022, which stated the patient's blood pressure was 90/70 mmhg (millimeter of mercury) and their heart rate was 79. This document had an area that stated "Caregiver Availability/Type of Assistance Patient lives alone with no willing or available caregiver …."

Record review of an entity 1

	document titled "Home Health Certification and Plan of Care" for certification period 10/6/2022 – 12/4/2022. This document had an area that stated "Caregiver Status … Lives with children with a caregiver that comes daily …." During an interview on 10/24/2022, at 3:49 PM, patient #3 indicated they do not live alone; They live at home with their children who provide caregiver support. During an interview on 10/25/2022, at 10:08 AM, when queried to confirm the patient's caregiver situation, administrator 2 indicated the patient lived alone. Review of agency documents titled "HHA [home health aide] Visit" from 9/1/2022 through 10/20/2022, evidenced documentation for the patient's blood pressure to be 90/70 mmhg and their heart rate 79 (50 days in a row). These documents were electronically signed by HHA #1. During an interview on			

	administrator #1 indicated vital signs are reviewed for quality assurance separately and were supposed to be reviewed everyday by an office assistant who was "medically trained" by ProCare and Physical Therapist (PT) #1. During an interview on 10/25/2022, at 10:09 AM, administrator #2 stated "Something is not right there!" when queried about a patient having the same blood pressure and heart rate every day from 9/1/2022 – 10/20/2022. Administrator #2 indicated she took the patient's blood pressure at the recertification on 10/15/2022, and stated "That's just how [he/she] runs." 410 IAC 17-14-1(a)(1)(E)-RN			
G0808	Onsite supervisory visit every 14 days 484.80(h)(1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a	G0808	The Director of Nursing and Administrator reviewed the following policy for re-education and clarification of procedures. C - 340 HOME HEALTH AIDE SUPERVISION POLICY Agency	2022-10-31

registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit.

Based on record review and interview, the home health agency failed to ensure home health aide (HHA) supervisory visits were conducted every 14 days for 1 of 1 clinical record reviewed where HHA and skilled services were provided. (#2)

The findings include:

Record review of an agency policy titled "Home Health Aide Supervision" revised 1/21/2021, stated "Policy ... ProCare Home Health Services will conduct supervisory visits at least every two (2) weeks ... Purpose ... To observe the aide while providing care to patients, and to assess competency in basic skills as well as delegated nursing tasks ... Special Instructions ... 3. Supervisory visits of Home Health Aides shall be according to the following frequency: a. When skilled services are being provided to a patient, a Registered Nurse/Therapist must make a supervisory visit to

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. ProCare Home Health Services will conduct supervisory visits at least every two (2) weeks

For patient #2, HHA supervisory visits are now scheduled.

A staff In-service was performed, on 10/31/2022 on the above policy and they were reeducated with emphasis on:

1). Ensuring that Home Health Aide supervisory visits have been scheduled every 14 days and are completed within 48 hours

The Director of Nursing and the Quality Assurance team reviewed 100 % of clinical records of active patients requiring supervisory visits and found 85% to be correctly scheduled but 15% were not scheduled. All supervisory visits

	the patient's residence no later than every 14 days (either when the Home Health Aide is absent to assess relationships and determine whether goals are being met) ... 4. Supervisory visits are to be documented in the patient's chart on the Home Health Aide Supervision Form. The patient/caregiver will be notified of all changes ...." Clinical record review on 10/20/2022, for patient #2, start of care 6/27/2016, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 9/24/2022 – 11/22/2022. This document had an area subtitled "Orders For Discipline and Treatment" which stated "Frequency: ... SN [skilled nurse] Frequency: 5W8 [5 times a week for 8 weeks], 2W1 [twice a week for 1 week] ... HHA [home health aide] Frequency: 5W8, 2W1 ...." Review evidenced the patient was receiving skilled services and HHA services and failed to evidence a HHA supervisory visit was conducted every 14 days for the certification period. During an interview on		supervisory visits have now been scheduled. This deficiency has been corrected as of 10-31-2022. The Quality Assurance team will monitor all patient charts weekly to ensure that all required supervisory visits including Home Health Aide supervisory visits are scheduled. The Director of Nursing is responsible to ensure that this deficiency does not recur.	

	queried the reason a HHA supervisory visit had not been conducted, administrator #2 stated "One should have been scheduled on 10/7/2022."			

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
ABEL DAFIAGHOR	ADMINISTRATOR	11/17/2022 1:14:10 PM