STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	300022646	A. BUILDING B. WING	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST CARE HOME HEALTH SERVICES	1119 KEYSTONE WAY N, SUITE 108B, CARMEL, IN, 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This visit was for a State Re-Licensure of a deemed Home Health Agency. Survey Dates: 8-30-22, 8-31-22,9-1-22, and 9-2-22. Census 468 QR by Area 3 on 9-7-22	N0000		2022-10-05
N0486	Q A and performance improvement	N0486	The Administrator has educated the Director of Nursing andall Professional Direct Care Staff on standard **410 IAC17-12-2(h)** and the agency policy **5.19 "Coordination ofCare"** to	2022-10-05

	410 IAC 17-12-2(h) Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review and interview, the agency failed to ensure all services were coordinated with other health service providers that provided care to their patients in 3 of 6 active patient records reviewed who received services from other health care providers (Patients #9, 10, and 12) from a total sample of 17 patient clinical records reviewed. Findings Include: 1. A review of an agency policy dated 2021, titled "Coordination of Care," policy number 5.19, stated, "... 3. Integrating orders, from all physicians/allowed practitioners, ... involved in the plan of care, to ensure coordination of all services, and interventions, provided to the patient, to ensure continuity of care ... 6. Coordinating care delivery to meet the patient's needs, and involve the patient ... in the coordination of care activities ..."		ensure there is understanding that the agencymust coordinate services with other health or social serviceproviders who are providing care to their patients to ensurecontinuity of care.All client charts will be audited monthly to ensure that thereis documented evidence that the professional direct carestaff has coordinated services with any other health orsocial service providers that are providing care to theirpatients. The threshold is 95% a month for three monthsand then 10% of client charts will be audited monthly fortwo quarters. If noncompliance is found the agency willrevert to 100% audits until 100% compliance is met andmaintained for one quarter. The Director of Nursing willreport all findings to the QAPI Committee whose memberswill determine what action in addition to education isrequired to maintain95% compliance.	

2. A review of the clinical record of Patient #9, with a state of care date of 08-17-22, and an initial care period of 08-22-22 to 10-15-22, evidenced by an agency document titled "Home Health Certification and Plan of Care." The initial plan of care and the clinical record failed to evidence any documentation of coordination of care with Entity E, a dialysis facility from whom Patient #9 received health care services.

A review of agency documents titled "Communication Note," dated 08-22-22 through 09-01-2, failed to evidence any documentation of coordination of care with Entity E, to include Patient #9's dietary and fluid restrictions as a dialysis patient, care and maintenance of Patient #9's dialysis access site, and any medications received at the dialysis center, etc.

A review of facility documents received on 09-01-22, provided to the surveyor from Entity E,

	"Provider Note," indicated "... Albumin not adequate. Encourage protein ... Ferritin is not within range. Iron loading protocol ordered ... Access left forearm AVF (Arteriovenous Fistula) Access without Thrombosis ...Access without Infection ... Access with adequate blood flow ... Schedule: T-Th-S 1st shift hemodialysis ... Treatment Medications: Vitamin D (Calcitriol) oral 1.50 mcg (micrograms) during dialysis 3x a week; Mircera 225 mcg IVP (intravenous push) Every 2 weeks; Cinacalcet (Sensipar) 30 mg oral post dialysis with snack 3 x week ... Nutrition: Diet Order: ... Protein (gm (gram)/kg (kilograms))1.4; Sodium (gm): 2.5; Phosphorus (mg(milligrams)) 1000; Fluid (ml(milliliter)) 1500; ..." dated 09-01-22 and electronically signed by Person I, the patient's nephrologist at Entity E. During a home visit to Patient #9's residence on 08-31-22 at 9:30 AM, observed RN #2 provide wound care to the surgical wound on Patient#9's chest. The RN failed to assess			

	Patient #9's left arm fistula. Patient #9 confirmed they had a fistula in their left arm for 12 years and received medications at Entity E; during their treatment, they were on a fluid restriction of 1 liter with diet restrictions and confirmed they went to Entity E for treatment every Tuesday, Thursday, and Saturday 1st shift. During a phone interview on 09-01-22 at 1:56 PM, Person F, the Director of Entity E, confirmed Patient #9 was receiving treatment at their facility. Person F confirmed they would send the medication list and the last nephrologist visit note for Person I, the patient's nephrologist. 3. A review of the clinical record of Patient #10, with a start of care date of 07-26-22, and an initial care period of 07-26-22 to 09-23-22, evidenced by an agency document titled "Home Health Certification and Plan of Care." The initial plan of care and the clinical record failed to evidence any documentation of			

	coordination of care with Entity G, a dialysis facility from whom Patient #10 received health care services. A review of agency documents titled "Communication Note," dated 07-26-22 through 09-01-22, failed to evidence any documentation of coordination of care with Entity G, to include Patient #10's dietary and fluid restrictions as a dialysis patient, care and maintenance of Patient #10's dialysis access site, medications received at the dialysis center, etc. During a phone interview on 09-02-22 at 10:15 AM, the family member of Patient #10 confirmed that Patient #10 received dialysis treatment at Entity G three times a week. 4. A review of the clinical record of Patient #12, with a start of care date of 06-06-22, and a care period of 08-05-22 to 10-03-22, evidenced by an agency document titled "Home Health Certification and Plan of			

	Care." The plan of care and the clinical record failed to evidence any documentation of coordination of care with Entity A, a dialysis facility from whom Patient #12 received health care services. A review of agency documents titled "Communication Note," dated 06-06-22 through 09-01-22, failed to evidence any documentation of coordination of care with Entity A, to include Patient #12's dietary and fluid restrictions as a dialysis patient, care and maintenance of Patient #12's dialysis access site, medications received at the dialysis center, etc. A review of facility documents received on 09-01-22, provided to the surveyor from Entity A, titled "Patient Transfer," and "Provider Note," indicated "...Access upper arm-right AV Fistula ... Schedule: T-Th-S 2nd shift hemodialysis ... Treatment Medications: Vitamin D (Calcitriol) oral 0.25 mcg during dialysis 3x a week; Mircera 200 mcg IVP Every 2 weeks; ... Nutrition: Diet Order: ... Protein			

	(gm/kg)1.2; Sodium (gm): 2; Phosphorus (mg) 1000; Fluid (ml) 1500; …" dated 08-25-22, and electronically signed by Person K, the patient's nephrologist, at entity A. During a home visit to Patient #12's residence on 08-31-22 at 11:30 AM, observed RN #4 provide 2-layer wraps to Patient #12's bilateral lower extremities. The RN failed to assess Patient #12's right upper arm fistula. Patient #12 confirmed they had a fistula in their right arm for dialysis treatments at Entity A and received medications at Entity A, they were on a fluid restriction with dietary restrictions and confirmed they went to Entity A for treatment every Tuesday, Thursday, and Saturday 2nd shift. During a phone interview on 09-01-22 at 11:20 AM, and a phone interview on 09-01-22 at 1:56 PM, Person B, the Unit Secretary of Entity A, confirmed Patient #12 was receiving treatment at their facility. Person B confirmed they would			

	last nephrologist visit note for Person K, the patient's nephrologist. During an interview on 09-01-22 at 3:50 PM, the Quality Director and Alternate Administrator confirmed that care coordination should be completed and documented in the clinician's communication notes with other healthcare providers and it had not been done for the above patients. During an interview on 09-02-22 at 12:21 PM, the Clinical Manager confirmed the clinical staff should coordinate care and document the coordination of care in the clinical record for all healthcare providers.			
N0524	Patient Care 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff.	N0524	The Director of Nursing has educated all Professional DirectCare Staff on standard **410 IAC 17-13-1(a)(1)** and agencypolicies **5.3 "Patient Assessments/Plan of Care,"** and**5.17 "Care Follows The Plan of Care,"** to ensure there isunderstanding that the medical plan of care must: (A) Be developed in consultation with the home healthagency staff. (B) Include all services to be provided if a skilledservice is being provided.	2022-10-05

	(B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview, the agency failed to ensure all medical supplies were listed on the plan of care; all ordering physicians were listed on the plan of care, and failed to ensure all nutritional requirements were listed on the plan of care for 6 of 12 active clinical records reviewed (Patients #7, 8, 9, 10, 11, and 12,) out of a total sample of 17 patients.		(C) Cover all pertinent diagnoses. (D) Include the following: (i) Mental status. (ii) Types of services and equipmentrequired. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect againstinjury. (xi) Instructions for timely discharge orreferral. (xii) Therapy modalities specifying length oftreatment. (xiii) Any other appropriate items to includebut not limited to medical supplies, and all orderingphysicians. All client charts will be audited monthly to ensure that thereis documented evidence that the professional direct carestaff develop a plan of care that includes but is not limited to A. Services to be provided if a skilled service is beingprovided. B. All pertinent diagnoses. C. Mental status. D. Types of services and equipment required. E. Frequency and duration of visits. F. Prognosis. G. Rehabilitation potential. H. Functional limitations.	

	Findings Include: 1. A review of an agency policy dated 2021, titled "Patient Assessments/Plan of Care," policy number 5.3, stated, "... There is evidence that the plan of care is reviewed by personnel involved in the patient's care and the attending physician/allowed practitioner... Physician/allowed practitioner's Plan of Treatment and Orders: ... The types of services, supplies, and equipment; ... Nutritional Requirements; All medications and treatments ..." 2. A review of an agency policy dated 20211, titled "Care Follows The Plan of Care," policy number 5.17, stated "... Care delivery, in accordance with the plan of care, and is directed at the achievement of established goals ... Responsibility of Agency: ... Any other pertinent instructions related to the patient's care and treatments ..." 3. A review of the clinical record		I. Activities permitted. J. Nutritional requirements. K. Medications and treatments. L. Any safety measures to protect against to preventinjury M. Instructions for a timely discharge. N. Therapy modalities specifying length of treatment O. Any other appropriate items to include but not limited tomedical supplies and all ordering physicians. The threshold is 95% a month for three months and then10% of client charts will be audited monthly for two quarters.If noncompliance is found the agency will revert to 100%audits until 100% compliance is met and maintained for onequarter. The Director of Nursing will report all findings to theQAPI Committee whose members will determine whataction in addition to education is required to maintain95%compliance.	

	care date of 07-01-22, with an initial care period of 07-01-22 to 08-29-2022, evidenced an agency document titled "Home Health Certification and Plan of Care," dated 08-29-22 and signed by the physician. The plan of care evidenced diagnoses, including but not limited to; Type 2 diabetes mellitus, essential hypertension, hyperlipidemia, depression, muscle weakness, dysuria, chronic fatigue, and long-term (current) use of insulin. The section subtitled "DME and Supplies" indicated, "DME: Other (Rollator walker), grab bars, cane Durable Medical Equipment Provider: Name: Phone: were left blank. DME/Supplies Provided Supplies: Gloves, non-sterile, per 100, mask, probe Covers, Alcohol wipes, per box, gown." The plan of care failed to evidence diabetic supplies: insulin pen needles, glucometer, glucometer strips, and lancets. During a phone interview on 09-02-22 at 10:52 AM, Person H, the family member of Patient # 7, confirmed the patient is an insulin-dependent diabetic,			

	required insulin with an insulin pen, and used a blood sugar monitoring system with strips and lancets. 4. A review of the clinical record for Patient #8, with a start of care date of 07-20-22, with an initial care period of 07-20-22 to 09-17-2022, evidenced by an agency document titled "Home Health Certification and Plan of Care," dated 08-10-22, and signed by the physician. The plan of care evidenced diagnoses, which included but were not limited to; Hypertensive heart & chronic kidney disease with heart failure, acute and chronic combined systolic and diastolic heart failure, Type 2 diabetes mellitus, chronic kidney disease stage 3, acute kidney failure, pulmonary hypertension, chronic obstructive pulmonary disease, unspecified cirrhosis of the liver, bipolar disorder and long term (current) use of insulin. The section subtitled "DME and Supplies" indicated, "DME: Cane, grab bars, Tub/Shower bench, walker, Other (Rollator walker; CPAP (Continuous Positive Airway			

	Pressure), Oxygen Durable Medical Equipment Provider: Name: Phone: sections were left blank. DME/Supplies Provided Supplies: Mask, alcohol wipes, Gloves, probe Covers, gown, cannula, nasal, Continuous airway pressure (CPAP) device." The plan of care failed to evidence the inclusion of diabetic supplies: insulin pen needles, glucometer, glucometer strips, and lancets. The care plan contained a section subtitled "Nutritional Requirements: Low Cholesterol, Sodium Restriction (Low sodium), Heart Healthy, No Concentrated Sweets, Other (Diabetic Diet). The plan of care failed to evidence Patient #8 had a fluid restriction of 2 liters. During a home visit on 08-31-22 at 3:30 PM, at Patient #8's residence, observed Physical Therapist #1 question the patient's sliding scale for insulin. Patient #8 indicated they are on 16 units before meals, plus an extra 2 units of blood sugar over their sliding scale when they check it three times a day. The patient also			

	fluid restriction. 5. A review of the clinical record of Patient #9, with a state of care date of 08-17-22, and an initial care period of 08-22-22 to 10-15-22, evidenced by an agency document titled "Home Health Certification and Plan of Care," dated 08-29-22, and signed by the physician. The plan of care evidenced diagnoses which included, but were not limited to; Disruption of external operation (surgical) wound, infarction following a procedure, enterococcus as the cause of disease, methicillin-susceptible staph infection causing disorder, pleural effusion, hypertensive heart & chronic kidney disease with heart failure stage 5 chronic kidney/ESRD, end-stage renal disease, dependence on renal dialysis, systemic lupus erythematosus, and epilepsy. The plan of care contained a section titled "Nutritional Requirements: Renal diet" but failed to list fluid restriction and type of renal diet. The Plan of care failed to list all the healthcare providers providing orders for Patient #9, including			

	Person I, with Entity E, who provided renal treatment orders and medical monitoring. A review of facility documents received on 09-01-22, provided to the surveyor from Entity E, titled "Patient Transfer" and "Provider Note," indicated "... Albumin not adequate. Encourage protein ... Ferritin is not within range. Iron loading protocol ordered ... Access left forearm AVF (Arteriovenous Fistula) Access without Thrombosis ...Access without Infection ... Access with adequate blood flow ... Schedule: T-Th-S 1st shift hemodialysis ... Treatment Medications: Vitamin D (Calcitriol) oral 1.50 mcg (micrograms) during dialysis 3x a week; Mircera 225 mcg IVP (intravenous push) Every 2 weeks; Cinacalcet (Sensipar) 30 mg oral post dialysis with snack 3 x week ... Nutrition: Diet Order: ... Protein (gm (gram)/kg (kilograms))1.4; Sodium (gm): 2.5; Phosphorus (mg(milligrams)) 1000; Fluid (ml(milliliter)) 1500; ..." dated 09-01-22 and electronically signed by Person I, the patient's			

	nephrologist, at Entity E. During a home visit on 08-31-22 at 9:30 AM, Patient #9 confirmed they have a cardiologist appointment on Friday, and their nephrologist is Person I, with Entity E. Patient #9 further indicated they were on a fluid restriction of 1 liter and received medications while at Entity E for dialysis treatments. 6. A review of the clinical record of Patient #10, with a state of care date of 07-26-22, and an initial care period of 07-26-22 to 09-23-22, evidenced by an agency document titled "Home Health Certification and Plan of Care," dated 08-19-22, and electronically signed by the physician. The plan of care evidenced diagnoses, which included, but were not limited to; Encounter for change or removal of surgical wound dressing, encounter for orthopedic aftercare following amputation, acquired absence of right leg above the knee, chronic systolic heart failure,			

	end-stage renal disease, dependence on renal dialysis, long term use of inhaled steroids, type 2 diabetes mellitus with diabetic autonomic neuropathy, mild intermittent asthma, anemia, and hypertensive heart disease with heart failure. The section titled "DME and Supplies" indicated, "DME: Grab bars, Wheelchair, Tub/Shower bench, Bedside commode, Other (Bedpan, Stand Up Lift), Hospital bed, Durable Medical Equipment Provider: Name: Phone: sections were left blank. DME/Supplies Provided: Supplies: mask, gown, Probe Covers, alcohol wipes, per box, Gloves. Non-sterile, per 100, dialysis" The plan of care failed to evidence the inclusion of diabetic supplies: glucometer, glucometer strips, and lancets and failed to list the nebulizer, nebulizer hand help tubing, and mask. The plan of care contained a section titled "Nutritional Requirements: Renal diet, Fluid Restriction (1500 ml), No added Salt, No Concentrated Sweets" but failed to list the type of renal diet. The Plan of care failed to list all the healthcare providers providing orders for Patient #9, including			

	the nephrologist with Entity G, who provided renal treatment orders and medical monitoring. During a phone interview on 09-02-22 at 10:15 AM, the family member of Patient #10 confirmed that Patient #10 received dialysis treatment at Entity G three times a week, and Patient #10 checked their blood sugar 2 times a day. 7. A review of the clinical record of Patient #11, with a state of care date of 06-28-22, and an initial care period of 06-28-22 to 08-26-22, evidenced an agency document titled "Home Health Certification and Plan of Care," dated 07-29-22, and signed by the physician. The plan of care evidenced diagnosis, which included, but was not limited to; pressure ulcer of right heel, stage 2, type 2 diabetes mellitus with hyperglycemia, hypertensive heart disease with heart failure, heart failure, unspecified dementia, schizoaffective disorder, iron deficiency anemia, constipation, dysphagia, and long-term use			

	of insulin. "DME and Supplies" indicated, "DME: Wheelchair Durable Medical Equipment Provider: Name: Phone: sections were left blank. DME/Supplies Provided: Supplies: Gloves. Non-sterile, per 100, mask, Probe Covers, Alcohol wipes, per box, gown." The plan of care failed to evidence diabetic supplies: insulin pen needles, glucometer, glucometer strips, and lancets. 8. A review of the clinical record of Patient #12, with a state of care date of 06-06-22, and a care period of 08-22-22 to 10-15-22, evidenced by an agency document titled "Home Health Certification and Plan of Care," dated 08-01-22, and electronically signed by RN #4. The plan of care evidenced diagnosis, which included but was not limited to; hypertensive heart & kidney disease with stage 5 chronic kidney/ESRD, heart failure, type 2 diabetes mellitus, end-stage renal disease, anemia, dysphagia, chronic obstructive pulmonary disease, hypotension, anxiety, sleep apnea, chronic respiratory			

	dependence on renal dialysis. The subtitled "DME and Supplies" section indicated, "DME: Walker, Tub/Shower bench, Wheelchair, Oxygen. Durable Medical Equipment Provider: Name: Phone: sections were left blank. DME/Supplies Provided Supplies: Cannula, nasal, alcohol wipes, per box, Gloves, non-sterile, per 100, mask, gown, Probe Covers, dialysis." The plan of care failed to evidence the inclusion of diabetic supplies: insulin pen needles, glucometer, glucometer strips, and lancets. The care plan contained a section subtitled "Nutritional Requirements: No Concentrated sweets, No added Salt, Heart Healthy. The plan of care failed to evidence Patient #12 had a fluid restriction of 1.5 liters and failed to list renal diet restrictions. The Plan of care failed to list all the healthcare providers providing orders for Patient #12, including Person K, the patient's nephrologist with Entity A, who provided renal treatment orders and monitoring. A review of facility documents			

	received on 09-01-22, provided to the surveyor from Entity A, titled "Patient Transfer" and "Provider Note," indicated "...Access upper arm-right AV Fistula ... Schedule: T-Th-S 2nd shift hemodialysis ... Treatment Medications: Vitamin D (Calcitriol) oral 0.25 mcg during dialysis 3x a week; Mircera 200 mcg IVP Every 2 weeks; ... Nutrition: Diet Order: ... Protein (gm/kg)1.2; Sodium (gm): 2; Phosphorus (mg) 1000; Fluid (ml) 1500; ..." dated 08-25-22, and electronically signed by Person K, the patient's nephrologist, at Entity A. During a home visit on 08-31-22 at 11:30 M, observed Patient #12's caregiver administer the patient's insulin via insulin pen to Patient #12. Patient #12 confirmed they received medications during their dialysis treatment at Entity A, per Person K's orders during their dialysis treatment, and they were on a fluid restriction. During an interview on 09-01-22 at 4:05 PM, the			

	Administrator confirmed all DME and Supplies, fluid restrictions, and specific individualized diets should be listed on the plan of care. During an interview on 09-02-22 at 12:21 PM, the Clinical Manager confirmed when they reviewed the clinical record plans of care for Patients #7, 8, 9, 10, 11, and 12, that diabetic supplies, special dietary needs, and medications received outside the home should be identified in the plans of care.			
N0539	Scope of Services 410 IAC 17-14-1(a)(1) Rule 14 Sec. 1(a)(1) The registered nurse shall perform nursing duties in accordance with the Indiana Nurse Practice Act (IC 25-23).	N0539	The Director of Nursing has educated all Professional directcare staff on standard **410 IAC 17-14-1(a)(1)** and agencypolicies **5.25 "Skilled Professional Services"** and **5.3"Patient Assessment/Plan of Care,"** to ensureunderstanding that the Registered Nurse (RN) must performa complete nursing assessment in accordance with theaccepted standards of the Indiana Nurse Practice Act oftheir patient during their visits. All client charts will be audited monthly to ensure that thereis documented evidence that the Registered Nurse (RN)performed a complete nursing assessment in accordancewith the accepted standards of clinical practice. Thethreshold is 95% a month for three months and then 10% ofclient charts will be audited monthly for two quarters. Ifnoncompliance is found the agency will revert to 100%audits until 100% compliance is met and maintained for onequarter. The	2022-10-05

	Based on observation, record review, and interview, the agency failed to ensure the Registered Nurse (RN) performed a complete nursing assessment in accordance with the accepted standards of clinical practice of their patient during their visits in 2 of 3 RN home visits. (RN #2 and 4) Findings Include: 1. A review of an agency policy dated 2021, titled "Skilled Professional Services," policy number 5.25, stated, "The HHA (Home Health Agency) furnishes skilled professionals ... Patient records must show evidence that skilled professional assumes responsibility for ...1. Ongoing interdisciplinary assessment of the patient ...3. Providing services that are ordered, by the physician/allowed practitioner ... as indicated in the plan of care...." 2. A review of an agency policy, dated 2021, titled "Patient Assessment/Plan of Care," policy number 5.3, stated, "... Written policies and procedures are established that describe		Director of Nursing will report all findings to the QAPI Committee whose members will determinewhat action in addition to education is required to maintain95% compliance.	

the process for assessment ... 1. The process for a patient assessment ...."

3. A review of Constantine, L., MSN, RN, C-FNP (2004, June 15). Overview of Nursing Health Assessment Retrieved January 16, 2019, from rn.com "... PULMONARY ASSESSMENT: When examining pulmonary system ... Inspect the thoracic cage, Auscultate the anterior and posterior chest. Have the patient breathe slightly deeper than normal through their mouth; Auscultate from C-7 to approximately T-8, in a left to the right comparative sequence. You should auscultate between every rib ... Identify any adventitious breath sounds ...."

4. A review of Nurse.org, dated April 7, 2020, indicated, "How to Conduct a Head-to-Toe-Assessment: ... LENGTH OF ASSESSMENT ... the duration of the exam is directly in correlation to the patient's overall health status. Health patients with limited health histories may be completed in less than 30 minutes. The Order

	of a Head-To-Toe-Assessment 1. GENERAL STATUS: Vital signs, … Temperature, … Pain. 2. HEAD, EARS, EYES, NOSE, THROAT … 3. NECK … 4. RESPIRATORY: Listen to lung sounds front and back, Assess respiratory expansion level, Ask about coughing, and Palpate thorax. 5. CARDIAC: Palpate the carotid and temporal pulses bilaterally; Listen to the heartbeat. 6. ABDOMEN: … Listen to bowel sounds … Ask about problems with bowel or bladder. 7. PULSES: Check pulses in arms/legs/feet, including, Radial, Femora, Posterior tibial, Dorsalis pedis. 8. EXTREMITIES: … Check capillary refill on fingernails/toenails. 9. SKIN: Check skin turgor. Check for lesions, abrasions, and rashes; Check for tenderness, lumps, lesions; Check if the patient is pale, clammy, dry, cold, hot, or flushed. 10. NEUROLOGICAL: Oriented x3; assess gait; Check coordination; Assess reflexes; Check Glasgow Coma Scale." 5. During a home visit on 08-31-22 at 9:30 AM, with Patient #9, RN #2 was observed			

completing their patient assessment. RN #2 obtained the pulse oximetry to obtain oxygen saturation, then auscultated Patient #9's posterior left upper, right upper, and left middle lung sounds. RN #2 failed to assess all lung fields posterior, failed to listen to anterior lung fields, failed to listen to Patient #9's bowel sounds, failed to obtain apical heart sounds, and failed to assess Patient #9's dialysis access site for the thrill, bruit, signs of infection and thrombosis.

A review of the clinical record of Patient #9, with a start of care date of 08-17-22, and an initial care period of 08-17-22 to 10-15-22, evidenced an agency document titled "Home Health Certification and Plan of Care," dated 08-29-22, and signed by the physician. The plan of care evidenced diagnosis, which included, but was not limited to; Disruption of external operation (surgical) wound, infarction following a procedure, enterococcus as the cause of disease, methicillin-susceptible staph infection causing

	hypertensive heart & chronic kidney disease with heart failure stage 5 chronic kidney/ESRD, unspecified diastolic (congestive) heart failure, end-stage renal disease, unspecified asthma, dependence on renal dialysis, systemic lupus erythematosus, unspecified atrial fibrillation, presence of other heart-valve replacement, and epilepsy. The plan of care contained a subsection titled "Orders for Discipline and Treatments," which indicated, "...SN (Skilled Nurse) to assess integumentary status ... SN to assess respiratory status ... SN to assess cardiovascular status ...." During an interview on 08-31-22 at 9:30 AM, Patient #9 indicated they had been hospitalized for open heart surgery from May to July this year, then went back just a few days after getting home and had another open-heart surgery and was in the hospital from July 19th to August 16th of this year, which was why they now have this open wound over their chest area with a wound vac at			

Patient #9's previous surgical wound on their chest.

6. During a home visit on 08-31-22 at 11:30 AM, with Patient #12, RN #4 was observed completing their respiratory assessment. RN #4 auscultated posterior left upper lobe, left middle lobe, right upper lobe, and right middle lobe. The RN failed to auscultate all lung fields posteriorly and failed to auscultate any anterior lung sounds. RN #4 was then observed to remove the two-layer compression wraps from Patient #12's bilateral extremities. The RN then obtained new compression dressings and applied them to Patient #9's lower extremities. RN #4 failed to obtain pedal pulses, assess capillary refill, and assess Patient #12's dialysis access site for bruit, thrill, signs of infection, or thrombosis.

A review of the clinical record of Patient #12, with a state of care date of 06-06-22, and a care period of 08-22-22 to 10-15-22,

titled "Home Health Certification and Plan of Care," dated 08-01-22, and electronically signed by RN #4. The plan of care evidenced diagnosis, which included, but was not limited to; hypertensive heart & kidney disease with stage 5 chronic kidney/ESRD, heart failure, type 2 diabetes mellitus, end-stage renal disease, anemia, dysphagia, chronic obstructive pulmonary disease, hypotension, anxiety, sleep apnea, chronic respiratory failure, chronic pain, and dependence on renal dialysis. The plan of care contained a subsection titled "Orders for Discipline and Treatments," which indicated, "... SN to perform complete physical assessment each visit with emphasis on edema management... SN to assess cardiovascular status ...."

During an interview on 08-31-22 at 11:30 AM, Patient #12's caregiver indicated that Patient #12 was on 5 liters of oxygen right now and was supposed to run at 4 liters. The caregiver further indicated that

	is easier for them to breathe on 5 liters per nasal cannula. During an interview on 09-02-22 at 12:25 PM, the clinical manager confirmed access sites should be assessed for bruit and thrill, and assessments should meet acceptable standards for clinical practice at each assessment conducted during care visits by the skilled nurses.			

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