STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200387660A	A. BUILDING B. WING	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPOINTS HOME HEALTH CARE INC	9801 PRAIRIE AVE, HIGHLAND, IN, 46322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: 9/13/2022 - 9/15/2022, 9/20/2022 Census: 9 Facility #: 003142 Quality Review Completed 09/28/2022	N0000	Intro Only-	2022-10-14
N0447	Home health agency administration/management	N0447	The Administrator has updated the Welcome Letter for the Start of Care folder. A letter has been sent to the state about the change in	2022-10-07

	410 IAC 17-12-1(c)(4) Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on observation, record review and interview, the home health agency failed to ensure that public information was accurate regarding agency hours and the current administrator. The findings include: Record review of the Indiana Department of Health pre-survey information evidenced the agency address the hours of operation were Monday thru Friday from 9:30 AM to 4:30 PM. Observation upon arrival to the agency on 9/13/2022 at 9:30 AM, found the lights out, doors locked, and no cars in the parking lot. A sign on the door indicated the agency hours are		office hours. All SOC packets will be audited for correct information prior to use. The Administrator will be responsible for ensuring this deficiency will not recur.	

	10 AM - 3 PM Monday through Friday. Review on 9/13/2022 of the agency website, at https://allpointshomehealth.com, evidenced the hours 8:00 AM to 4:30 PM. Review of the agency handbook on 9/13/2022, evidenced the agency hours are 8:00 AM to 4:30 PM. During an interview on 9/13/2022 at 10:37 AM, Administrator #1 indicated the office hours are 10 AM to 3 PM Monday to Friday. When queried as to when the hours changed she indicated the hours of operation changed in February 2022. Review of the agency handbook on 9/13/2022, evidenced an agency letter to their patients signed by Administrator #2.			

	During an interview on 9/13/2022 at 10:37 AM, administrator #1 indicated administrator #2 was terminated and no longer an employee of the agency. During an interview on 9/21/2020 at 4:05 PM, the alternate administrator indicated she did not yet send a letter to the state for the change of hours. She indicated she will get a letter to the state with all the updated information. She will also change the welcome letter in the handbook with the correct administrator and the new hours of operation.			
N0486	Q A and performance improvement 410 IAC 17-12-2(h) Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review and interview the agency failed to ensure coordination between disciplines to ensure patients received all ordered visits in 1 of	N0486	All Staff inserviced regarding coordination of scheduling with patient and patient's family when multiple disciplines involved in care. Field staff will notify Office Manager when unable to make visit so that the visit can be rescheduled. Office manager will audit schedules weekly of patients with multiple disciplines to ensure that visits do not overlap and missed visits are rescheduled. The Director of Nursing is responsible for ensuring this deficiency does not recur.	2022-10-07

2 discharged records reviewed, (#6)

The findings include:

1. Review of an agency policy titled "Coordination of Client Services," revised 12/20/2016, stated, "Purpose To ensure services are coordinated between members of the interdisciplinary team ... to ensure continuity of care...."

2. Clinical record review of an agency document for patient #6, start of care 4/7/2022, titled "Home Health Certification and Plan of Care," for certification period 4/7/2022 – 6/5/2022, evidenced a subsection titled "Orders for Discipline and Treatment." This section indicated that patient #6 would receive skilled nursing services once a week for nine weeks, physical therapy twice a week for four weeks and home health aide services twice a week for eight weeks.

Clinical record review of an agency document for patient #6, evidenced an agency document titled "Missed Visit," dated 4/13/2022. This

	document stated, "When HHA (Home Health Aide) called to go for a visit, family caregiver told her not to go because that time patient was doing PT (physical therapy) Aide was scheduled at 12:20 PM she can not go later she has other patients. The patient wants her to go on there 4/15/22..." Clinical record review of a document for patient #6, evidenced a document titled "Missed Visit," dated 4/15/2022. This document stated. "Schedule for HHA and therapy time do not work out Today when the aide wanted to go patient doesn't want her to due to PT being there at that time..." The agency failed to coordinate care to ensure the patient was getting all her ordered visits. During an interview on 9/20/2022 at 3:45 PM, the clinical supervisor indicated the visits should have been rescheduled but sometimes it was difficult to reschedule due to staffing. She indicated they had another aide see her that can go at a different time.			

N0490	Q A and performance improvement 410 IAC 17-12-2(k) Rule 12 Sec. 2(k) A home health agency must continue, in good faith, to attempt to provide services during the fifteen (15) day period described in subsection (i) of this rule. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented. Based on record review and interview, the home health care agency failed to give patients a 15-day discharge notice in 2 of 2 discharged records reviewed. (#6, #7) The findings include:	N0490	Pt#6: Visit note corrected to show documentation that was given to patient. PT#7: Discharge was not planned but requested by patient during the SN visit therefore appropriate documentation was not given but discharge instruction was given by clinician. MD was notified.All Staff inserviced regarding discharge planning with patient and patient's family and documentation of notice of discharge. Field staff will notify Office Manager when notice of discharge given so that any other disciplines can be notified of discharge plan. QA will audit all charts of planned discharges for necessary documentation and will return chart to clinician if there are deficiencies. The Director of Nursing is responsible for ensuring this deficiency does not recur.	2022-10-07

	1. An agency policy titled "Client Discharge Planning," revised 1/2/2017, stated "A discharge plan should be developed which includes verbal/written instruction regarding the clients ongoing care needs and available resources. Written notice will be given to the client/caregiver fifteen (15) days prior to discharge…." 2. Clinical record review for patient #6, start of care 4/7/2022, evidenced an agency document titled "OASIS Discharge, dated 6/4/2022. This document indicated the patient was discharged from the agency. Review of patient #6's clinical record failed to evidence she was given a 15-day discharge notice. 3. Clinical record review for patient #7, start of care 6/17/2022, evidenced an agency document titled "OASIS Discharge, dated 7/29/2022. This document indicated the patient was discharged from the agency. Review of patient #7's clinical record failed to evidence she was given a 15-day discharge notice. During an interview on			

	9/20/2022 at 3:17 PM, the clinical supervisor indicated patients are told at least the week before discharge they are being discharged.			
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 accepted were based on the expectation the agency could meet the patient's needs in 1 of 1 patients needing services from a medical social worker. (Patient #4) The findings include: 1. An agency policy titled "Plan of Care," revised 1/20/2017, indicated treatments and procedures shall be administered by the appropriate agency staff only as ordered by the physician.	N0520	Pt#4: Upon recertification on 10/14/2022, the OASIS will be corrected to show no community services needed. Family and friends will assist patient as needed. All Staff inserviced on referring patients to appropriate community services and documentation of results. Agency does not have a contract with a social services company at this time but is actively searching for one. QA will audit all admissions for appropriate documentation of need for community services and patient response. The Director of Nursing is responsible for ensuring this deficiency does not recur.	2022-10-14

	2. Clinical record review of an agency document for patient #4, start of care 6/18/2022 titled "Home Health Certification and Plan of Care," for certification period 6/18/2022 – 8/16/2022 evidenced a subsection titled "Psychosocial Status" which stated "MSW [medical social worker] referral for access to community resources…." Clinical record review for patient #4 failed to evidence the patient was referred to a social worker. Review of the current employee list received on 9/13/2022, failed to evidence a Social Worker on staff or contracted. During an interview on 9/20/2022 at 2:50 PM, the clinical manager indicated patient #4 didn't want a social worker. She then said she called Agency #2 to assist him. She indicated the patient told her they called him and let him know he would not qualify for Medicaid.			

N0522	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview, the home health agency failed to ensure the medical plan of care was followed by all staff members in 1 of 6 active clinical records reviewed. (#4) The findings include: 1. An agency policy titled "Plan of Care," revised 1/20/2017 stated "... serves as a measurable guideline to care given by all professional disciplines ... treatments and procedures shall be administered by the appropriate agency staff only as ordered by the physician. 2. Clinical record review of an agency document for patient #4, start of care 6/18/2022,	N0522	Pt#4: SN visit dated 09/12/2022 patient's vital signs were taken and recorded on signature log sheet which was filed with patient's analog chart. Patient's electric visit note was modified to reflect the vital signs. (attachment) Pt#4: No visit made on 07/12/2022.	2022-10-07

	Certification and Plan of Care," for certification period 6/18/2022 – 8/16/2022 evidenced the patient was to have his vital signs taken at every visit including but not limited to blood pressure, pulse, and temperature, O2 [oxygen] saturation, and respirations. Clinical record review of agency documents titled "Skilled Nurse Visit," dated 7/12/2022 and 9/12/2022, failed to evidence the Registered Nurse obtained patient #4's vital signs. During an interview on 9/20/2022 at 2:54 PM, RN (Registered Nurse) #1 indicated vital signs are done every time a visit was made. She indicated she did the visit and if they were not on the note, they are probably on the back of the timesheet, and she will need to add them to the note.			
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	Pt#5: Patient Medication list has been corrected to show correct frequently of daily for the listed Medications: Raloxifene, Vitamin D3, Calcium Carbonate, and Aspirin. Patient being discharged 10/05/2022. Pt#6: Patient was prescribed Tramadol during office visit and given a trial amount to see if effective. When patient was admitted 2 days later, she had complete trial doses and found medication did not help with pain so it was not continued therefore SN did not include it on	2022-10-07

	(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 home health agency failed to ensure the plan of care was complete and included the correct medication frequency in 3 of 8 clinical records reviewed. (#3, #5, #6) The findings include:		medication list. Pt #3: Upon review of SOC OASIS, the advance directive area was populated but due to software glitch did not transfer over to Plan of Care. This is an area discussed with Axxess and corrected by them. Patient at time of admission stated that she was not using the lidoderm patch or Ultracet. It cannot be determined if she used over the counter lidoderm patches or leftovers after admission due to patient being discharged on 09/15/2022. The Eliquis 5mg should have reflected 1/2 tab twice daily. Physical Therapy and Clinical staff inserviced on accurate documentation of medications on admission and documenting of changes in medication as they are reported by patient and physician. QA will audit all admissions for medication errors or ambiguity in doses. The Administrator will be responsible to ensuring this deficiency does not recur	

	1. Review of an agency document titled "Plan of Care," revised 1/20/2017 stated, " ... The plan of care should be completed in full to include ... medications ... treatments and orders ... any other pertinent information...." 2. Review of an agency document for patient #5, start of care 8/8/2022, titled "Home Health Certification and Plan of Care," for certification period 8/8/2022 – 10/6/2022, evidenced a subsection titled "Medications" which indicated the patient was taking Crestor (for lowering cholesterol) 5 mg (milligrams) 1 tablet by mouth 4 times a week, Raloxiefene (for treatment of weak and brittle bones) 60 mg 1 tablet by mouth one time, vitamin D3 (supplement) 25 mcg (micrograms) 1 tablet by mouth one time, Calcium carbonate (supplement) 1 gram by mouth one time Aspirin (to thin blood) 81 mg one tablet by mouth one time. This document failed to evidence the daily frequency for Raloxiefene, Vitamin D, Calcium			

	carbonate, and Aspirin. During an interview on 9/20/2022 at 3:08 PM, the clinical supervisor indicated the medications should be taken daily by the patient. 3. Clinical record review for patient #6, start of care 4/7/2022, Primary diagnosis pain of right hip, evidenced a face-to-face evaluation signed by Physician #3 and dated 4/5/2022. This document indicated the physician was starting the patient on tramadol (a pain reliever) for hip pain. Clinical record review for patient #6, evidenced an agency document titled "Home Health Certification and Plan of Care, for certification period 4/7/2022 – 6/4/2022. This document failed to include patient #6's new order for Tramadol.			

During an interview on 9/20/2022 at 3:41 PM, the clinical supervisor indicated medications are reconciled with the medications the patient has in the home.

4. Clinical records for patient #3, start of care 07/20/22, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 07/20/22-09/17/22. This document had a subsection titled "Advanced Directives" which evidenced no documentation.

During an interview on 09/20/22 at 2:45 PM the clinical supervisor indicated the plan of care would say "none" if the advanced directives were addressed and the patient did not have an advanced directive.

Clinical record review evidenced an office visit note with physician #1 dated 07/12/22. This document evidenced the following medication Lidoderm patch (used to relieve pain) 12

	ultracet (pain reliever used to treat mild to extreme pain) every 12 hours as needed, Eliquis (an anticoagulant medication used to prevent and treat blood clots) dose was 2.5mg BID (twice a day). Clinical record review for evidenced an agency documented titled "Home Health Certification and Plan of Care," for certification period 07/20/22-09/17/22. This document failed to evidence the Lidoderm patch or ultracet and indicated Eliquis dose was 5mg BID. During an interview on 09/20/22 at 2:45 PM the clinical supervisor indicated medications for patient #3 should be reconciled with doctor's medication list at start of care date.			
N0542	Scope of Services 410 IAC 17-14-1(a)(1)(C) Rule 14 Sec. 1(a) (1)(C) Except where services	N0542	Pt #5: Physical Therapy did the SOC for this patient andwanted to be sure that occupational therapy was mentioned on the POC. A verbal order dated 8/10/2022 was sent tothe	2022-10-07

	are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on record review and interview, the home health agency failed to ensure the registered nurse made necessary revisions to the medical plan of care in 4 of 6 active clinical records reviewed. (#1, #2, #5, #8) The findings include: 1. An agency policy titled "Plan of Care," revised 1/20/2017 stated, "purpose: To ensure that a plan of care is regularly approved by the physician. 2. Serves as a measurable guideline to care given by all professional disciplines involved in the client care … 12. Verbal/Telephone orders shall be obtained from the client's physician for changes in the Plan of Care…." 2. Clinical record review of an agency document for patient #5, start of care 8/8/2022, titled "Home Health Certification and Plan of Care," for certification		physician regarding patient request for OT to start on 08/18/2022 after PThad made some visits. VO's and therapy POC signed by the physician amend theoriginal POC as needed when there are changes in discipline and visitfrequency. Pt#2: Patient was ordered Meclizine in ER on 09/09/22 on aPRN basis for vertigo. A VO was written to the primary MD on 09/14/22 regardingthe addition of Meclizine to the patient's medications. Meclizine was added topatient's Medication list and a copy left in patient's home with patient's son.Verbal Orders signed by the physician amend the original POC when there arechanges in orders, treatment and medication. Pt#1: SN notified PCP's officeat time of admission regarding a new BP med (Losartan) being prescribed for thepatient by hospitalist. POC wasgenerated from the OASIS information at the time of admission. Orders were not received for the changes inLosartan (HOLD) and Carvedilol (with parameters) until after 5PM by the on-callnurse who notified the	

	period 8/8/2022 – 10/6/2022, evidenced a subsection titled "Orders for Discipline and Treatment." This section indicated that patient #5 would receive Physical therapy twice a week for four weeks and occupational therapy twice a week for four weeks. Clinical record review of an agency document for patient #5, evidenced an agency document titled "OT (Occupational Therapy) Plan of Care dated 8/18/2022. This plan of care indicated the patient was to receive occupational therapy once a week for seven weeks. During an interview on 9/20/2022 at 2:45 PM, the clinical supervisor indicated they only update the plan of care during the recertification. Clinical record review on 09/14/22 for patient # 2, start of care 09/02/22, evidenced an agency document titled "Physician Order," dated 09/14/22. This document evidenced a new medication titled meclizine which was prescribed by the hospital		SN. Both the Verbal Order and a Communication Note were signedby the physician and are part of the EMR. Patient's family was notified ofchanges with medication and verbalized understanding to SN Verbal Orders signedby the physician amend the original POC when there are changes in orders, treatmentand medication. Pt#8: At time of SOC on 08/18/2022, in the admissionnarrative on POC, SN noted that patient started Doxycline 100mg Bid for 30 dayson 07/22/2022 and was almost finished with medication. Staff has 5 days tocomplete SOC paperwork. If end date of medication had been put on med profile,medication would not have appeared on POC. With the primary diagnosis ofcellulitis it was deemed necessary that the history of antibiotic on the medprofile. Physical Therapy and Nursing Field Staff inserviced oncorrect documentation of disciplines and frequencies, medications includinginteractions, and any changes requiring a physician order.	

	emergency room visit due to ıdache and dizziness. Clinical record review evidenced an agency documented titled "Home Health Certification and Plan of Care," for certification period 09/02/22-10/31/22. This document failed to be updated with the patient's new medication meclizine. 4. Clinical record review for patient #1, start of care 08/25/22, evidenced an agency document titled "Physician Order," dated 08/25/22. This document evidenced a verbal order to hold losartan (blood pressure medication) 50mg BID (twice a day) and patient's blood pressure was to be assessed prior to administration of carvedilol (medication affects the blood flow through the arteries and veins) 3.125mg BID, if systolic BP (blood pressure) was less than 140 to skip dose. Clinical record review on 09/14/22 evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 08/25/22-10/23/22. This document failed to evidence an		QA and the Office Manager will audit all SOCs to ensuredocumentation all disciplines and frequencies, medications includinginteractions, and any changes requiring a physician order. The Director ofNursing will be responsible for ensuring this deficiency does not recur.	

	hold, and failed to evidence new blood pressure parameters for use of carvedilol. During an interview on 09/20/22 at 2:45 PM, the clinical supervisor indicated the plan of care medications were to be updated at recertification time period or with change in condition. 5. Clinical record review on 09/14/22 for patient #8, start of care date 08/18/22, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period for 08/18/22-10/16/22. This document failed to evidence change of skilled nursing visits from 2 days per week to 1 day per week that was requested by patient on 08/30/22. An agency document titled "Skilled Nurse Visit," dated 09/06/22 in a subsection titled "Visit Narrative," stated skilled nursing for wound care assessment 2 times per week however patient requests once a week visits. During an interview on			

	09/20/22 at 2:45 PM the clinical supervisor indicated the plan of care for skilled nursing visits were to be updated at recertification of plan of care. Clinical record review evidenced an agency documented titled "Home Health Certification and Plan of Care," for certification period for 08/18/22-10/16/22. This document failed to evidence the doxycycline (an antibiotic) was to be discontinued after 30 days prescribed on 07/21/22 and started on 07/22/22. Clinical record review evidenced an agency document titled "Skilled Nurse Visit," dated 08/23/22 under subsection titled "Interventions," a note indicated the patient has taken his last dose of antibiotic to treat cellulitis.			

	During an interview on 09/20/22 at 2:45 PM the clinical supervisor indicated the doxycycline should have had an end date on the plan of care.			
N0546	Scope of Services 410 IAC 17-14-1(a)(1)(G) Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on record review and interview, the agency failed to ensure the skilled nurse promptly informed the physician of patient assessment findings outside of the patient's normal parameters in 4 of 8 clinical records reviewed. (#1, #3, #4, #8) The findings include: 1. An agency policy titled "Skilled Nursing Services,"	N0546	Pt#4: On 09/15/2022,on quarterly chart audit, it was noted that the vital sign parameters did notreflect patient condition of quadriplegia. Verbal order was written tophysician to change parameters to reflect that vital signs are lower in patientswith quadriplegia due to decreased activity. Pt#8 : On SOC OASIS section M2003 SN noted that she hadnotified physician of possible drug-to-drug interactions and ineffectiveness ofanalgesics. Pt#3: At SOC SN reviewedmedications with physician's office and patient's caregiver. These medicationswere prescribed by the PCP and are long term medications. On SOC OASIS,interventions section SN noted: "SNreviewed and reconciled patient's medications, possible drug to druginteractions between Buspirone/Escitalopram (increased risk for serotoninsyndrome) and Amiodrome/Escitalopram (increased risk of prolongation of QTinterval)...pt having no s/s of any adverse affects from prescribedmedications, caregiver aware of s/s of adverse affects to monitor for andimmediately report to MD and HH nurse" SN did not mark box that physician was	2022-10-07

	revised 1/20/2017, stated, "... the registered nurse shall inform the physician and other appropriate medical personnel of the changes in the client's condition and needs...." 2. Review of an agency document for patient #4, start of care 6/18/2022, titled "Home Health Certification and Plan of Care," for certification period 6/18/2022 – 8/16/2022, evidenced a subsection titled "Orders for Discipline and Treatment." This section indicated the physician was to be notified if patient #4's vital signs were out of range: Heartrate greater than 100 or less than 60, Systolic blood pressure greater than 160 or less than 90, and diastolic blood pressure greater than 90 or less than 60. 3. Clinical record review of an agency document titled "Skilled Nurse Visit," dated 7/6/2022, indicated the patient's blood pressure was 108/58 and his heart rate was 58. This document failed to evidence the Registered Nurse notified the physician of patient #4's vital		notified. Pt#1:Patient, physician and patient's family are aware of drug to drug interactionbetween Carvedilol and Symbicort and Albuterol. Patient had experienced interactions earlier in the year – May of 2022. Due to SN intervention reason for patientexperienced interactions were remedied, these medications are no longeradministered together. Field Staff inserviced on correct documentation medicationsincluding interactions and reporting of interaction to physician. QA and the Office Manager will audit all SOCs to ensure medicationsincluding interactions and physician notification are documented. The Director of Nursing will be responsible for ensuringthis deficiency does not recur.	

	signs being outside of normal parameters. Clinical record review of an agency document titled "Skilled Nurse Visit," dated 8/1/2022, evidenced the patient's blood pressure was 118/58. This document failed to evidence the Registered Nurse notified the physician of patient #4's vital signs being outside of normal parameters. During an interview on 9/20/2022 at 2:54 PM, the clinical supervisor indicated vital signs for quadriplegics (unable to use arms or legs) is often lower. She indicated their charting system puts in automatic parameters for vital signs, it was the same for everyone. She indicated she was not sure how that could be fixed. Clinical record review for patient #8, start of care date 08/18/22, evidenced an agency document titled "Oasis-D1 Start of Care," for visit date 08/18/22. The comprehensive assessment indicated a major drug interactions between gabapentin (used to relieve nerve pain) and tramadol			

	ioid analgesic medication scribed for pain relief). This :ument failed to evidence the ysician was notified of the major g interaction. Clinical record review for patient #3, start of care date 07/20/22, evidenced an agency document titled "Oasis-D1 Start of Care," for visit date 07/20/22. The comprehensive assessment indicated a major drug interaction between amiodarone (medication used to treat irregular heartbeat) and escitalopram (medication used to treat depression), and a major drug interaction was noted between buspirone (anti-anxiety medication) and escitalopram. This document failed to evidence the physician was notified of the major drug interactions. :linical record review for patient #1, start of care date 08/25/22, evidenced an agency document titled, "Oasis-D1 Start of Care,". The comprehensive assessment indicated a major drug interaction between albuterol (medication relaxes muscles in the airways and increases air flow to the lungs) and carvedilol (medication affects the blood			

	v through the arteries and ns), and indicated a major drug eraction between carvedilol and nbicort (a medication used to at asthma). This document ed to evidence the physician s notified of the major drug eractions. During an interview on 09/20/22 at 3:00 PM, the clinical supervisor indicated major drug interactions are checked by AXXESS (electronic medical record), and the physician should be notified. The clinical supervisor also indicated major drug interactions are on the plan of care which was signed by the physician and the physician was notified by plan of care note. The clinical supervisor indicated patients were to be notified to monitor for all adverse medication reactions.			
N0547	Scope of Services 410 IAC 17-14-1(a)(1)(H)	N0547	Pt#4: Visit note dated08/01/2022, SN documented under infection control that universal precautionswere being observed, under interventions patient was instructed on	2022-10-07

	Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on record review and interview, the home health agency failed to ensure all physician orders were carried out in 3 of 8 clinical records reviewed. (#4, #6, #7) The findings include: 1. An agency policy titled "Skilled Nursing Services," revised 1/20/2017, stated, "... the registered nurse shall inform the physician and other appropriate medical personnel of the changes in the client's condition and needs...."		medication (Baclofen)and under patient response patient states understanding of need for plenty offluids. Visit note dated 07/18/2022, SN documented under infection control thatuniversal precautions were being observed, under interventions patient wasinstructed on medication(Diazepam) and not to drink alcoholic beverages whiletaking this medication and under patient response patient states understandingof need for plenty of fluids. Visit note dated 07/06/2022, SN documented underinfection control that universal precautions were being observed, underinterventions patient reported taking medications on time and under patientresponse patient states understanding of need for plenty of fluids. Pt#6: Patient and patient's family had desire for aspecific home health aide who tried to see patient but was unable to seepatient due to scheduling conflicts with other patients and therapy. When aidewas able to see her, patient refused care. Scheduler was able to get another aide and patient was satisfied withcare. It was	

	2. Review of an agency document titled "Plan of Care," revised 1/20/2017, stated, "Home care services are furnished under the direction and care of the client's physician … serves as a measurable guideline to care given by all professional disciplines involved in client care…." 3. Clinial record review of an agency document for patient #4, start of care 6/18/2022, titled "Home Health Certification and Plan of Care," for certification period 6/18/2022 – 8/16/2022, evidenced a subsection titled "Orders for Discipline and Treatment." This section indicated the skilled nurse was to instruct the patient on disease process, hydration measures, medication management, infection control, instruct on indwelling catheter (a tube placed in the bladder to drain urine) care, and hygiene. Clinical record review of an agency document titled "Skilled Nurse Visit," dated 7/6/2022, failed to evidence the Registered Nurse educated patient #4 on disease process,		documented that Physicianwas notified of each missed visit. SN visit of 4/15/2022 shows documentation of instruction onmitigating pain with non-pharmacological means and medication, universalprecautions were discussed under infection control, and disease process underpatient response. SN visit of 4/29/2022 shows documentation of instruction on pressureulcer prevention, universal precautions was noted under infection control,medications reviewed and instruction on Xarelto including bleeding precautions.SN visit of 5/07/2022 shows medications reviewed, universal precautions werediscussed under infection control, and under interventions section instructedon hypertension, shortness of breath, medication and diet restrictions. SNvisit of 5/21/2022 shows documentation noted on medication review, universalprecautions were discussed under infection control, and documentation underinterventions regarding pain management and pressure	

	infection control, medication management, and hygiene. Clinical record review of agency documents titled "Skilled Nurse Visit," dated 7/6/2022, 7/18/2022, and 8/1/2022, failed to evidence the Registered Nurse educated patient #4 on disease process, infection control, and hygiene. During an interview on 9/20/2022 at 2:56 PM, the clinical supervisor indicated teaching should be done at every visit, and indicated sometimes they don't document everything. 4. Clinical record review of an agency document for patient #6, start of care 4/7/2022, titled "Home Health Certification and Plan of Care," for certification period 4/7/2022 – 6/5/2022, evidenced a subsection titled "Orders for Discipline and Treatment." This section indicated that patient #6 would receive home health aide services twice a week for eight weeks. Clinical record review of an agency document for patient #6 evidenced they did not recieve a home health aide visit the		ulcer prevention. SN visitof 5/27/2022 shows documentation noted on medication review, universalprecautions were discussed under infection control, and documentation underinterventions regarding management of hypertension, diet restrictions andexercise. Pt#7: SN visit note of 07/13/2022 and 07/22/2022 shows SNdiscussed primary disease process – heart failure and activity and restprogram. Patient showing progress toward goals. SN visit note of 06/24/2022 and07/01/2022 shows SN discussed primary disease process – heart failure and self-managementprogram. SN instructs on different areas of patient's disease process with eachvisit so that all areas are instructed on without overwhelming frail patientswith too much information. SN visit of 07/04/2022 – visit missed – upon interview withSN it was found that patient and family refused visit that week due to holidayand numerous family was in town to visit. Field Staff inserviced on correct	

	week of 4/10/2022, only received one visit the week of 4/17/2022, and only received one visit the week of 5/29/2022. During an interview on 9/20/2022 at 3:15 PM, the clinical supervisoits as ordered.r indicated the visits should have been rescheduled but sometimes it was difficult to reschedule due to staffing. Clinical record review of an agency document for patient #6, start of care 4/7/2022, titled "Home Health Certification and Plan of Care," for certification period 4/7/2022 – 6/4/2022, evidenced a subsection titled "Orders for Discipline and Treatment." This section indicated the skilled nurse was to instruct the patient on disease process, medication management, self-management of Osteoporosis (weak and brittle bones), and assess for signs and symptoms of depression (low mood) and Alzheimer's (memory loss) disease. Clinical record review of agency documents titled "Skilled Nurse Visit," dated 4/15/2022,		documentation of patientinstruction, scheduling and documentation of missed visits QA and the Office Manager will audit all charts for 30 daysuntil 100% complience to ensure documentation is done correctly The Director of Nursing will be responsible for ensuringthis deficiency does not recur.	

	5/21/2022, and 5/27/2022, failed to evidence the Registered Nurse educated the patient on disease process, infection control, medication management, and hygiene. During an interview on 9/20/2022 at 3:54 PM, the clinical supervisor indicated teaching and assessments are done every visit, but sometimes not everything gets documented. 5. Clinical record review of an agency document for patient #7, start of care 6/17/2022, titled "Home Health Certification and Plan of Care," for certification period 6/17/2022 – 7/29/2022, evidenced a subsection titled "Orders for Discipline and Treatment." This section indicated the skilled nurse was to instruct the patient on disease process, medication management, self-management of hypertension (high blood pressure), heart failure, foot care precautions, blood sugar monitoring, and Hypo/hyperglycemia (high low blood sugar) management. Clinical record review of agency			

	documents titled "Skilled Nurse Visit," dated 7/13/2022, and 7/22/2022, failed to evidence the Registered Nurse educated the patient on heart failure and hypertension. Clinical record review of agency documents titled "Skilled Nurse Visit," dated 6/24/2022, and 7/1/2022, failed to evidence the Registered Nurse educated the patient on foot care precautions, blood sugar monitoring, and Hypo/hyperglycemia management. During an interview on 9/20/2022 at 4:07 PM, the clinical supervisor indicated she doesn't educate on everything every visit she takes her time with each patient. Clinical record review of an agency document titled "Home Health Certification and Plan of Care," for certification period 6/17/2022 – 8/17/2022, evidenced a subsection titled "Orders for Discipline and Treatment." This section indicated patient #7 would be receiving skilled nursing visits once a week for nine weeks. Clinical record review evidenced			

	an agency document titled "Missed Visit," dated 7/4/2022. This document indicated the patient did not have a skilled nurse visit because the caregiver was able to assist the patient. During an interview on 9/20/2022 at 3:17 PM, the clinical supervisor indicated they should have tried to reschedule the visit			
N9999	Final Observations IAC 16-27-2.5 effective July 1, 2017, stated, "Sec. 2. (a) A home health agency must: (1) have a written drug testing policy that is distributed to all employees; and (2) require each employee to acknowledge receipt of the policy. (b) A home health agency shall randomly test: (1) at least fifty percent (50%) of the home health agency's employees who: (A) have direct contact with patients; and (B)	N9999	Policy has been updated to reflect that 50% of non-skilledfield staff will be randomly drug screened annually. Field Staff inserviced on change to drug testing program. Administrator will audit all personnel charts to ensure drugtesting done each year. Drug testingdone on aide #2 to fulfill this year's requirement. Aide #2 was screened prior to employment and results were found in her employee file The Administratorwill be responsible for ensuring this deficiency does not recur.	2022-10-07

commission under IC 25; at least annually; or (2) when the home health agency has reasonable suspicion that an employee is engaged in the illegal use of a controlled substance ...."

Based on record review and interview, the home health agency failed to ensure 50% of agency unlicensed staff was annually drug tested.

The findings include:

An agency policy titled "Drug Testing," revised 4/24/2022, indicated all drug testing will be kept in the employee's medical file. Each employee will be required to participate in pre-employment, random, post-accident, and reasonable suspicion testing upon request.

	Review of personnel records on 9/20/2022, for agency home health aides failed to evidence random drug testing was being done. Review of HHA (Home Health Aide) #2's personnel filed evidenced she was hired on 11/20/2019. Review failed to evidence she had ever been drug tested. During an interview on 9/13/20 at 11:40 AM, the administrator indicated they do not randomly drug test employees when queried on the agency's drug testing policy The administrator indicated she was unaware they were supposed to be randomly drug testing 50% of their employees.			

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