STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157543	A. BUILDING B. WING	10/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIME CARE HOME HEALTH SERVICES INC	2632 W 81ST AVE, MERRILLVILLE, IN, 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This visit was for a State Re-Licensure survey of a home health agency. Facility ID: 003155 Survey dates: 9/30/2022, 10/3/2023 - 10/7/2022 Census: 12	N0000	HHA has created a Plan of Correction	2022-11-04
G0000	INITIAL COMMENTS This survey was a Federal complaint and a State licensure survey for a home health agency. Survey Dates: 9/30/2022,	G0000	HHA has created a Plan of Correction	2022-11-04

	10/3/2022 - 10/7/2022 Facility ID: 003155 Census: 12 Complaint #: IN0093800 - Substantiated: with Federal and State deficiencies cited. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Prime Care Home Health is precluded from providing its own home health aide training and competency evaluation for a period of two years from 10/7/2022 - 10/7/2024, due to being found out of compliance with Conditions of Participation 42CFR 484.60 Care Planning, Coordination of Services and Quality of Care.			

	Quality Review Completed 10/26/2022			
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the agency failed to ensure the patient/caregiver consented to in advance, to the frequency of services that were being furnished in 7 of 7 complete clinical records reviewed. (#1, #2, #3, #4, #5, #6, #7) The findings include:	G0434	The Administrator in serviced all clinical staff about HHAPolicy of establishing Plan of Care after comprehensive assessment involvingpatient/care giver, physician, and all disciplines about 1- The frequency of visits 2- Expected outcomes of care 3- Patient specific goals to be achieved 4- Safety measurements 5- Anticipated risks and benefits 6- Any factors that could impact treatment 7- Any changes in the care to be furnished The Director of Nursing will audit 100% SOC and Recertsassessments and Plan of Care to make sure coordination of services for better qualityof care and outcomes.	2022-10-31

	1. An agency policy titled "Patient Bill of Rights," revised August 2011, stated, "Each patient will be an active, informed participant in his/her plan of care…." 2. An undated agency policy obtained on 10/4/2022, titled "Home Care Patient Rights and Responsibilities/Transfer and Discharge," stated "you have the right to participate in and be informed about … The care to be furnished … the disciplines that will furnish the care; the frequency of visits…." 3. Clinical record review for patient #1, start of care 8/23/22, evidenced a plan of care for certification period 8/23/2022 – 10/21/2022. This plan of care evidenced patient was to receive skilled nursing services once a week for nine weeks. The skilled nurse was to assess the patient, instruct on disease processes, and perform medication review and education. Clinical record review of patient #1's record failed to evidence patient #1 was informed of and consented to the treatment to		The Director of Nursing will be responsible to monitor and correctthis deficiency.	

	be provided in the plan of care. During an interview on 10/5/22 at 3:27 PM, the clinical manager indicated the patient was informed and consented to the care to be provided. She was unsure why the document did not indicate he consented to the skilled nursing services. 4. Clinical record review for patient #2, start of care 9/7/2022, evidenced a plan of care for certification period 9/7/2022 – 11/5/2022. This plan of care evidenced patient was to receive skilled nursing services once a week for nine weeks, home health aide services twice a week for nine weeks, and physical therapy twice a week for nine weeks Clinical record review for patient #2 failed to evidence they were informed of and consented to the treatment to be provided in the plan of care. 5. Clinical record review for patient #6, start of care 5/24/2022, evidenced a plan of care for certification period 7/23/2022 – 9/20/2022. This plan of care evidenced patient was to receive skilled nursing services once a week for nine			

	weeks. Clinical record review of patient #6's record failed to evidence the patient was informed of and consented to the treatment to be provided in the plan of care. 6. Clinical record review for patient #7, start of care 5/19/22, evidenced a plan of care for certification period 7/18/2022 – 9/15/2022. This plan of care evidenced patient was to receive skilled nursing services once a week for nine weeks. The skilled nurse was to assess the patient, instruct on disease processes, and perform medication review and education. Clinical record review for patient #7 failed to evidence the patient was informed of and consented to the treatment to be provided in the plan of care. 7. Clinical record review for patient #3, start of care 9/19/2022, evidenced a plan of care for certification period 9/19/2022 – 11/17/2022. This plan of care evidenced patient was to receive skilled nursing services once a week for nine weeks. The skilled nurse was to			

	medication review. Clinical record review of patient #3's record failed to evidence the patient was informed of and consented to the treatment to be provided in the plan of care. 8. Clinical record review for patient #4, start of care 8/25/2022, evidenced a plan of care for certification period 8/25/2022 – 10/23/2022. This plan of care evidenced patient was to receive skilled nursing services once a week for nine weeks. Clinical record review for patient #4 failed to evidence the patient was informed of and consented to the treatment to be provided in the plan of care. 9. Clinical record review for patient #5, start of care 8/30/2022, evidenced a plan of care for certification period 8/30/2022 – 10/28/2022. This plan of care evidenced patient was to receive skilled nursing services once a week for one week as needed, and physical therapy twice a week for nine weeks. Clinical record review for patient #5 failed to evidence the			

	patient was informed of and consented to the treatment to be provided in the plan of care. During an interview on 10/5/22 at 2:30 PM, the clinical manager indicated patients are always informed and consent to the care to be provided. 17-12-3(b)(2)(D)(ii)(AA) and (BB) 17-12-3(b)(2)(D)(iii)			
N0456	Home health agency administration/management 410 IAC 17-12-1(e) Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based on record review and interview, the administrator failed to ensure the ongoing quality assurance and performance improvement program (QAPI) was designed to objectively monitor and	N0456	Consultant Nurse in serviced the HHA staff how to monitorand evaluate the quality and appropriateness of patient care. 1- How to improve patient care 2- To resolve identified problems 3- To improve quality 4- To improve outcomes 5- Evaluate strengths and weaknesses 6- Chart Audits HHA appointed a Quality Assurance nurse who will be responsiblefor chart audits, in	2022-11-02

	evaluate the quality and appropriateness of patient care, resolved identified problems, and improve patient care. Findings include: Review of an agency policy titled "Responsibilities in Improving Performance" revised August 2011, stated, "To establish patient outcomes as the primary focus of the organization's performance improvement activities. ... The governing body is responsible for ensuring that the performance improvement program is defined, implemented, and maintained, and is evaluated annually. ... Senior management will: ... B. Adopt a structured framework for performance improvement. The problem-solving approach will stress the interrelationship of quality services provided ... Identify and set specific outcomes for measurable improvement. D. Identify and participate in benchmarking activities ... Measuring current performance against past performance Measuring against internally established goals. 2.		services and performance improvement. Administrator will be responsible to compare outcomes with Stateand National average and to improve them.	

	Processes and protocols. 3. Practice or service guidelines...." Review of the agency QAPI binder on 9/30/2022, failed to include any updated information since October 2011. This review failed to evidence the agency conducted an ongoing quality improvement program. During an interview on 9/30/2022 at 3:02 PM, the administrator indicated the agency had a consultant who used to do QAPI , but the administrator does all of the QAPI now. He indicated there was no further information he could provide.			
N0462	Home health agency administration/management 410 IAC 17-12-1(h) Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.	N0462	Consultant Nurse in serviced the staff on HHA personal policy andhow to maintain personal records. 1- How to maintain personal files on all directpatient contact staff and contract staff 2- Health and Physical done by a physician within 180days prior to patient contact A form has been created for	2022-11-02

	Based on record review and interview, the home health agency failed to ensure all employees who have direct patient contact received a physical examination that ensured the employee was free of infectious and/or communicable diseases in 2 of 4 personnel records with direct patient contact reviewed. (RN #2, LPN#2) The Findings include: 1. Review of an undated agency document, titled "Personnel Record Contents," received 10/3/2022, stated "... Agency will maintain current and complete personnel files on all direct and personnel and independent contractors. ... The content of the personnel files for regular full or part-time personnel will include: ... Physician's statement of health ...." 2. Personnel record review on 10/3/2022 for RN (registered		onfront of the personal file with completion dates. Administrator will be responsible to correct this deficiencyand to make sure it will not recur. **ActionCompleted:** **100% personalrecords are reviewed and found to be 100 % in compliance.** **FuturePlan:** **A formhas been created and placed on the top of each personal file to make sure nothingis overlooked or missed.** **Administratorwill be responsible to make sure this deficiency will not recur.**	

	and first patient contact date 9/26/2022, evidenced a completed physical dated 9/29/2022. Review failed to evidence RN #1 had a physical examination completed no more than 180 days prior to having direct patient contact. During an interview on 10/3/2022 at 10:02 AM, the administrator indicated the employee had a difficult time scheduling her physical. She indicated she had an appointment for today and would have the documentation before the end of the day. 3. Personnel record review on 10/3/2022 for LPN #2, hire date 9/14/2022, and first patient contact date 9/14/2022, evidenced a completed physical dated 10/3/2022. Review failed to evidence LPN #2 had a physical examination completed no more than 180 days prior to having direct patient contact. During an interview on 10/3/2022 at 10:05 AM, the administrator indicated the employee had a hard time scheduling her appointment for her physical, so that was the first available appointment.			

N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was	N0464	Consultant Nurse in serviced the staff for compliance of HHApersonal policy 1- How to obtain and maintain all medical recordsincluding two-step tuberculin skin test using the Mantoux method during theprevious 12 months as negative. 2- After baseline testing, tuberculosis screeningmust be completed annually Office Manager will obtain all medical records beforepatient first contact. Administrator will be responsible to correct this deficiencyand to make sure it will not recur. **<u>ActionCompleted:</u>** **100% personalrecords are reviewed and found to be 100 % in compliance.** **<u>FuturePlan:</u>** **A formhas been created and placed on the top of each personal file to make sure nothingis overlooked or**	2022-11-02

	subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on record review and interview the home health agency failed to ensure all employees had a two-step tuberculin skin test, chest x-ray, quantiferon-TB [tuberculosis] assay, or completion of the TB questionnaire prior to having direct patient contact in 2 of 4 employee files reviewed with patient contact. (RN #1, LPN #2) These findings include: 1. An undated agency policy titled "Personnel Record Contents" received 10/3/2022, stated, "Purpose To specify the content of personnel files ... 2 The content of a separate file,		**missed.** **Administratorwill be responsible to make sure this deficiency will not recur.**	

	information will contain: ... TB Mantoux test documentation...." 2. Personnel record review on 10/3/2022 for LPN [licensed practical nurse] #2, hire date 9/14/2022, and first patient contact date 9/14/2022, failed to evidence a two-step TB skin test, chest x-ray, or TB questionnaire. 3. Personnel record review on 10/3/2022 for RN (registered nurse) #1, hire date 9/19/2022 and first patient contact date 9/26/2022. Review failed to evidence a two-step TB skin test, chest x-ray, or TB questionnaire. 4. During an interview on 10/5/2022, at 1:02 PM, the office manager indicated they will get all of the files up to date. Some employees are going now for their physicals and will get TB at the same time.			
N0466	Home health agency administration/management 410 IAC 17-12-1(j)	N0466	All medical records are maintained in separate files which are kept under lock and only office manager has access to those medical records Office Manager will make sure	2022-11-02

	Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on record review and interview, the home health agency failed to ensure the health information for personnel was maintained in separate medical files for 2 of 2 personnel records reviewed that contained medical information. (LPN #1, HHA #1) The findings include: 1. Review of an agency policy, titled "Record Keeping" dated August 2011, stated, "Prime Care Home Health Services, Inc. will ensure that personnel health records are kept confidential." 2. Personnel record review on 10/3/2022, for LPN (licensed practical nurse) #2, hire date 9/14/2022, failed to evidence her health information was kept in a separate file to maintain confidentiality.		that the HIPA law is in complianceand all medical records are kept separate and confidential Administrator will be responsible to correct this deficiencyand to make sure it will not recur.	

	3. Personnel record review on 10/3/2022, for HHA (home health aide) #1, hire date 9/14/2022, failed to evidence her health information was kept in a separate file to maintain confidentiality. 4. During an interview on 10/3/2022 at 10:30 AM, the alternate clinical manager indicated the medical information for personnel should be maintained separately.			
N0478	Q A and performance improvement 410 IAC 17-12-2(d) Rule 12 Sec. 2(d) If personnel under contracts are used by the home health agency, there shall be a written contract between those personnel and the home health agency that specifies the following: (1) That patients are accepted for care only by the primary home health agency. (2) The services to be furnished. (3) The necessity to conform to all applicable home health agency policies including personnel qualifications. (4) The responsibility for participating in developing plans of care.	N0478	Consultant Nurse in serviced the staff to follow the HHApolicy on Written Agreements for Contracted Services 1- Contract services to be provided 2- Mechanism for the contractor to participate inperformance improvement process 3- Procedures for scheduling visits and periodicpatient evaluation. Administrator revised the	2022-11-03

	(5) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency. (6) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation. (7) The procedures for payment for services furnished under the contract. Based on record review and interview the home health agency failed to include the services to be provided in the contractual agreement, the responsibility for participation in developing the plan of care, the manner in which the services will be controlled, coordinated, and evaluated by the primary agency, and the procedures for scheduling visits. The findings include: An agency policy titled "WRITTEN AGREEMENTS FOR CONTRACTED SERVICES" revised August 2011, stated " ... 2. The written agreement will stipulate the following: A. Services to be provided ... D. Mechanisms for the contractor to participate in performance improvement activities E.		Business Contract Agreement, and allservices are mentioned. Administrator will be responsible to correct this deficiencyand to make sure that it will not recur.	

	and periodic patient evaluation... Record review on 10/4/2022, evidenced a document titled "Business Contract Agreement". This document indicated it was a contract for therapy services between the home health agency and Entity #1. This document failed to include what therapy services would be provided under the contract, the responsibility for participation in developing the plan of care, the manner in which the services will be controlled, coordinated, and evaluated by the primary agency, and the procedure for scheduling visits. During an interview on 10/4/2022 at 2:23 PM, the administrator indicated they would update the contract to ensure all items needed are included.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient,	N0488	Nurse Consultant in serviced the clinical staff on QUALITYASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) 1- Discharge planning, make	2022-11-04

	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. Based on record review and interview, the agency failed to		sure patient gets anotice 15 days prior to discharge. HHA revised the discharge policy from 5 to 15 days priornotice before stopping the services. Director of Nursing will make sure that all dischargedpatients will get notice 15 days prior to discharge Patient handbook is revised, and it’s been changed from 5 to15 days.	

ensure patients were given a notice of discharge at least 15 calendar days before the agency's services were stopped in 2 of 2 discharged records reviewed. (#6. #7)

The findings include:

1. Review of the agency's handbook obtained on 9/30/2022 evidenced a section titled "Discharge, Transfer and Referral," which stated, "We will give you, your legal representative, or another individual responsible for your care at least five (5) calendar days' notice before services are stopped…." Review failed to evidence the agency developed a policy providing a 15-day discharge notice to the patient.

2. Review of an undated agency policy, obtained 10/5/2021, titled "Home Care Patient rights and Responsibility/Transfer and Discharge" stated, "... to be informed in a reasonable time of anticipated termination and/or transfer of service…." Review failed to evidence the agency developed a policy providing a 15-day discharge notice to the patient.

3. Clinical record review on 10/3/2022 for patient #6, start

	of care 5/24/2022, evidenced an agency document titled "OASIS-D1 Discharge Non-Visit", dated 9/5/2022, and digitally signed by registered nurse #3. This Oasis document indicated the patient was discharged from the agency on 9/5/2022. Review evidenced agency documents titled "RN - Skilled Nursing Visit", dated 8/30/2022, 8/23/2022, and 8/16/2022 and digitally signed by registered nurse #3, evidenced a section titled “Discharge Planning,” which indicated discharge planning was not applicable at those visits. Review failed to evidence the registered nurse provided a 15-day notice of discharge to the patient. During an interview on 10/3/2022 at 2:26 PM, the clinical manager indicated the patient should receive a 5-day discharge notice and the notice should be documented in the patient’s chart. She indicated it is unknown when the patient was given discharge notice as it was not documented in the patient chart. 4. Clinical record review on			

	of care 5/19/2022, evidenced an agency document titled "OASIS-D1 Discharge Non-Visit", dated 9/5/2022, and digitally signed by registered nurse #3. This Oasis document indicated the patient was discharged from the agency on 9/5/2022. Review evidenced agency documents titled "RN - Skilled Nursing Visit", dated 8/29/2022, 8/22/2022, and 8/15/2022 and digitally signed by registered nurse #3, evidenced a section titled “Discharge Planning,” which indicated discharge planning was not applicable at those visits. Review failed to evidence the registered nurse provided a 15-day notice of discharge to the patient. During an interview on 10/3/2022 at 2:37 PM, the clinical manager indicated the patient should receive a 5-day discharge notice. She indicated it the discharge notice should have been documented in his chart, so she is not sure what day they gave him the discharge notice.			
N0547	Scope of Services	N0547	The Nurse Consultant in	2022-11-03

	410 IAC 17-14-1(a)(1)(H) 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 skilled nurse failed to provide the patient and caregiver education in 5 of 7 clinical records reviewed. (#1, #2, #4, #6, #7) The findings include: 1. The agency policy titled "Care planning process" with a revised date of August 2011, stated, "... the plan of care will be based upon the physician's orders." 2. Clinical record review for patient #1, start of care 8/23/2022, evidenced a plan of care for certification period 8/23/2022 – 10/21/2022. This plan of care evidenced the patient was to receive education on lung cancer, medication management, infection control measures, stress anxiety,		serviced the staff about Scope ofServices 1- Care Planning 2- Compliance of physician orders, oral andwritten. 3- Trainingand Education to patient/caregiver 4- Medication Management 5- Infection Control 6- COVID precautions 7- Patient and Caregiver safety 8- Incontinent Care 9- Pain Management 10- Monitoring vital signs and communicating withphysician if out of described parameters. Director of Nursing will be responsible to correct thisdeficiency and to make sure it will not recur. **ActionCompleted:** **100% activecharts are audited, A RN has laid off, 2 new SOC and 4 Recerts Plan of Care areestablished and are**	

	hypertension, and heart failure. Clinical record review evidenced Skilled Nurse Visits dated 8/30/2022, 9/6/2022, 9/12/2022, 9/20/2022, and 9/26/2022. These documents failed to evidence the skilled nurse provided education to the patient. 3. Clinical record review for patient #2, start of care 9/7/2022, evidenced a plan of care for certification period 9/7/2022 – 10/5/2022. This plan of care evidenced the patient was to receive education on Multiple Sclerosis (the immune system attacks the protective covering of the nerves), medication management, and depression. Clinical record review evidenced Skilled Nurse Visits dated 9/14/2022, 9/21/2022, and 9/27/2022. These documents failed to evidence the skilled nurse provided education on Multiple Sclerosis to the patient. 4. Clinical record review for patient #6, start of care 5/24/2022, evidenced a plan of care for certification period 7/23/2022 – 9/20/2022. This		**DON.** **<u>FuturePlan:</u>** **DON willbe involved with each case manager and audit 100% charts on regular basis.**	

	patient was to receive education on hypertension (high blood pressure), medications, diet, and the importance of keeping a daily blood pressure log. Clinical record review evidenced Skilled Nurse Visits dated 7/26/2022, 8/2/2022, 8/9/2022, 8/16/2022, 8/23/2022, and 8/30/2022. These documents failed to evidence the skilled nurse provided education on hypertension, medications, diet, and the importance of keeping a daily blood pressure log. 5. Clinical record review for patient #7, start of care 5/19/2022, evidenced a plan of care for certification period 7/18/2022 – 9/15/2022. This plan of care evidenced the patient was to receive education on seizures (uncontrolled electrical disturbance in the brain), medication management, safety, and incontinent care. Clinical record review evidenced Skilled Nurse Visits dated 8/1/2022, 8/8/2022, 8/9/2022, 8/15/2022, 8/22/2022, and 8/29/2022. These documents failed to evidence the patient received education on seizures,			

	medication management, safety, and incontinent care. 6. Clinical record review for patient #4, start of care date 8/25/2022, evidenced an order dated 8/25/2022, and signed by the physician. This document indicated the patient was to receive education on disease process, symptoms and management, diet, medication compliance, safety measures, and pain management. Clinical record review evidenced skilled visit notes dated 8/31/2022, 9/7/2022, 9/14/2022, and 9/27/2022. These documents failed to evidence the skilled nurse provided teaching to the patient or caregiver. 7. During an interview on 10/6/2022 at 10:10 AM, the clinical manager indicated educations should be done on every visit and documented in the skilled visit notes.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning,	G0570	The Director of Nursing in serviced all clinical staff about 1-ComprehensiveAssessment	2022-10-31

	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 accordance with accepted standards of practice. Based on record review and interview, the home health agency failed to ensure: the plan of care was reviewed by the physician, individualized and followed by all agency staff (See tag G0572); the plan of care included all required information for the treatment of the patient (See tag G0574); all patient care orders were recorded in the plan of care (See tag G0576); all treatments provided by agency staff were ordered by a physician (See tag G0580); physicians were promptly notified of a change in the patient's condition (See tag G0590); patients received education and training (See tag 610); the written visit schedule was provided to patients (See		2- CarePlanning 3-Coordination of Services 4-Quality of Care 5- Patient'srights and responsibilities The Director of Nursing in serviced the HHA staff to meetthe patient's medical, nursing, rehabilitative and social needs in his or herplace of residence that each patient must receive an individualized writtenplan of care including any revisions or additions. The individualized plan of care must specify the care andservices necessary to meet the patient-specific needs according tocomprehensive assessment. Office Manager will get pre authorization for HMO patientsfrom private insurances. The Director of Nursing will audit 100% charts to make surethat this deficiency is corrected and will not recur. **<u>ActionCompleted:</u>** **HHA has appliedto join Aetna,**	

	tag G0614); and written instructions were provided to the patient for the patient's medication schedule and instructions (See tag G0616) patients received in writing any treatments to be administered by agency personnel. The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination of Care and Quality of Care. A deficient practice citation was also evidenced at this standard as follows: Based on record review and interview, the home health agency failed to ensure their patient's needs were being met in 4 of 5 active clinical records. (#1, #2, #3, #4, #5) The findings include: 1. Review of an updated agency policy received 10/4/2022 titled "Admission Policy," stated "Admission criteria are standards by which a client is		**Humana and United Health Care networks as provider, so can get fastprior authorizations. Also instructed PT staff to start services ASAP accordingto Plan of Care.** **<u>FuturePlan</u>:** **DON will beinvolved with case manager for each and every patient's Plan of Care to makesure this deficiency should not recur.**	

	assessed for admission. These standards include consideration regarding the adequacy and suitability of agency personnel to me the client's needs, the agency recourses to provide the required services, and a reasonable expectation that the client's needs, the Agency resources to the client's needs can be adequately met in the client's place of residence…." 2. An undated agency policy obtained on 10/4/2022, titled "Home Care Patient Rights and Responsibilities/Transfer and Discharge," stated "you have the right to … receive all services outlined in the plan of care…." 3. Clinical record review for patient #1, start of care 8/23/2022, evidenced a plan of care for certification period 8/23/2022 – 9/21/2022, which indicated patient #1 was to receive skilled nursing services once a week for nine weeks and physical therapy twice a week for nine weeks. Physical therapy was to assess for gait training, strengthening exercises, balance/coordination transfer training, and to establish a home exercise program. Review			

	of the clinical record failed to evidence the patient received any physical therapy services. During an observation on 10/3/2022 at 10:10 AM. Patient #1 indicated he was never contacted by a physical therapist. He indicated the agency told him he would be seen by a therapist but no one ever came out. He indicated since no one had ever come out to his home for therapy, he just did some therapy for himself by walking up and down the stairs and around his home. During an interview on 10/6/2022, at 10:21 AM, the administrator indicated he was not sure why therapy did not see the patient. During an interview on 10/6/2022 at 2:00 PM. the physical therapist indicated he called the patient, and the patient did not want therapy 4. Clinical record review for patient #2 start of care 9/7/2022, evidenced a plan of care for certification period 9/7/2022 – 11/5/2022, which indicated patient #2 was to receive skilled nursing services			

	home health aide services twice a week for nine weeks, and physical therapy twice a week for six weeks. Physical therapy was to assess for gait training, strengthening exercises, balance/coordination transfer training, and to establish a home exercise program. Review of the clinical record failed to evidence the patient received any physical therapy services. During an interview on 10/5/2022 at 2:01 PM, the clinical manager indicated the physical therapist had gone to the home for the initial evaluation on 10/2/2022. When queried as to why he did not see her until a month after her start of care, the administrator indicated the therapist was on vacation. During an observation of a home visit on 10/5/2022 at 10:00 AM, the patient's daughter indicated physical therapy had not come to evaluate her mom. 5. Clinical record review for patient #3, start of care 9/19/2022, evidenced an agency document titled "Face			

	9/20/2022 and signed by the physician. This document evidenced the patient was to receive skilled nursing and physical therapy services. Clinical record review for patient #3 failed to evidence the patient received physical therapy. During an interview on 10/6/2022 at 2:02 PM, the physical therapist indicated she did not want physical therapy. Review of the clinical record failed to evidence any documentation of the patient refusing services. 6. Clinical record review for patient #4, start of care 8/25/2022, evidenced an agency document titled "Face to Face Encounter", dated 8/25/2022 and signed by the physician. This document evidenced the patient was to receive skilled nursing and physical therapy services. Clinical record review failed to evidence the patient received physical therapy. Clinical record review evidenced a plan of care for certification period 8/25/2022 – 10/23/2022,			

	which indicated patient #4 was to receive skilled nursing services once a week for nine weeks. Clinical record review failed to evidence the patient received a skilled nurse visit the week of 8/18/2022. During an interview on 10/5/2022 at 2:20 PM, the clinical manager indicated she was unsure why there was no visit that week and she would look into it. During an interview on 10/5/2022, at 2:10 PM, the administrator indicated the physical therapist was on vacation. When queried as to why they did not use another therapist he indicated they had PTA (physical therapy assistant) but then would have an issue with supervisory visits.			

	7. Clinical record review for patient #5, start of care 8/30/2022, evidenced an agency document titled "OASIS D1- Start of Care, dated 8/30/2022 and signed by RN #4. This document indicated patient #4 needed assistance with grooming, bathing, and toileting. During an interview on 10/4/2022 at 10 AM, the patient indicated she informed the agency on 10/3/2022 that she would no longer need services as she found an agency to provide her with a home health aide. When queried as to why she did not have one with the agency she indicated the agency did not have a home health aide that would come to where she lives. Clinical record review evidenced a plan of care for certification period 8/30/2022 – 10/28/2022. This plan of care evidenced patient was to receive skilled nursing services once a week for one week and as needed, and physical therapy twice a week for nine weeks. Clinical record review evidenced			

	was done on 9/3/2022, and physical therapy visits were completed on 9/10/2022 and 9/13/2022. This review failed to evidence the patient received physical therapy twice a week and failed to evidence the agency met the patient's needs by initialing home health aide services Clinical record review evidenced skilled nurse visit notes for 8/31/2022, 8/7/2022, 8/14/2022, and 8/28/2022. Record review failed to evidence patient #5 had a physical therapy evaluation on 9/3/2022, and physical therapy visits on 9/10/2022 and 9/13/2022. The clinical record review failed to evidence she received all services outlined in the plan of care. During an interview on 10/4/2022, at 11:45 AM, the office manager indicated patient #5 was not receiving services due to the agency not having a home health aide to go to the residence. During an interview on 10/5/2022 at 2:22 PM, the administrator indicated the			

	therapy. Clinical record review failed to evidence any documentation of patient refusal for physical therapy services. During an interview with the clinical manager on 10/6/2022 at 11:31 AM, when queried if the patient could benefit from a home health aide, the clinical manager stated "absolutely. When queried as to why she did not receive these services she indicated there was not an aide to go to that area to which the administer indicated he was not aware the aide would not go there and he would have gotten someone for her. 17-13-1(a)			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific 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	G0572	The Director of Nursing in serviced all clinical staff about 1-Comprehensiveassessment and patient needs 2- Planof Care 3- CareCoordination 4- Patient/CaregiverTeaching	2022-10-31

	to approve additions or modifications to the original plan. Based on observation, record review, and interview, the home health agency failed to ensure the patient received all services as ordered on the plan of care, and/or had an individualized plan of care which included patient-specific, measurable goals and outcomes in 5 of 7 clinical records reviewed. (#1. #2, #3, #4, #7) The findings include: 1. The agency policy titled "Care planning process" with a revised date of August 2011 stated, "A written plan of care will be initiated within 5 days of start of care and updated at least every 60 days or as patient's condition warrants ... the clinical plan of care included Specific procedures to be performed by the therapies, including amount, frequency, and duration, goals ... the plan of care will be based upon the physician's orders." 2. The agency's policy titled "Physician Participation in Plan of Care" dated August 2011 stated, "A physician will direct the care of every home health care patient admitted per service. The attending physician		5- Education to manage medicalconditions, depressive disorders, muscle weakness, morbid obesity, anxiety, bedconfinement and hyperlipidemia. 6- Individualized Goals for thepatient 7- Management of Medications The Director of Nursing will audit and monitor 100% Plan ofCares to make sure that this deficiency is corrected and will not recur. **<u>ActionCompleted:</u>** **Clinicalstaff is educated, problematic RN is laid off, 100% clinical charts are auditedand are monitored continuously.** **<u>FuturePlan:</u>** **DON willbe involved and supervise each case manager for each patient’s plan of care tomake sure this deficiency will not recur.**	

	will certify that medical, skilled, rehabilitative, and social services provided by the organization are medically required for the patient. ... Physician orders will be individualized, based on patient needs, and include: A. Patient diagnoses. B. Treatments and/or procedures needed, including type, frequency, duration, and goals." 3. Clinical record review for patient #1 evidenced a plan of care, for start of care 08/23/2022, certification period 8/23/2022 – 10/21/2022. The plan of care included but was not limited to the following diagnoses, type 2 diabetes (regulation of blood sugar), hypertension (high blood pressure), prostate cancer, abnormal weight loss, and gastritis 9inflamed stomach lining). This document indicated the patient was on a regular diet. The document also indicated the skilled nurse was to assess the respiratory status, instruct on the management and self-care of lung cancer, and instruct on heart failure. The document evidenced the patient's goals were to demonstrate self-management			

	of arthritis, patient seeks assistance with personal hygiene. The plan of care failed to be individualized to include signs/symptoms of hypo/hyperglycemia, failed to indicate teaching on the correct cancer diagnosis, and failed to have individualized goals for the patient. 4. Clinical record review for patient #2 evidenced a plan of care, for start of care 9/7/2022, certification period 9/7/2022 – 11/5/2022. The plan of care included but was not limited to the following diagnoses: Multiple Sclerosis (immune system destroys the covering of nerves), major depressive disorder, muscle weakness, morbid obesity, anxiety, bed confinement, and hyperlipidemia (high cholesterol). The document also indicated the skilled nurse was to complete an assessment with an emphasis on hypertension. This document failed to be individualized for the patient's diagnoses During an interview on 10/5/2022 at 2:04 PM, the clinical manager indicated she			

	on pertinent diagnoses for the patient. She was unsure why there would be an emphasis on hypertension when the patient does not have a diagnosis of hypertension. 5. Clinical record review for patient #7 evidenced a plan of care, for start of care 08/19/2022, certification period 7/18/2022 – 9/15/2022. The plan of care included but was not limited to the following diagnoses: heart disease, hypertension (high blood pressure), and seizures. This document failed to have individualized goals for the patient. 6. Clinical record review for patient #3 evidenced a plan of care, for start of care 9/19/2022, certification period 9/19/2022 – 11/17/2022. The plan of care included but was not limited to the following diagnoses: Lupus (disease where the immune system attacks organs and tissues), hypertension (high blood pressure), and seizures (uncontrolled electrical disturbance in the brain). This document indicated the patient's goals were to			

	regimen, and no hospitalizations and ER visits. This document failed to have individualized goals for the patient. 7. Clinical record review for patient #4 evidenced a plan of care, for start of care 8/25/2022, certification period 8/25/2022 – 10/23/2022. The plan of care included but was not limited to the following diagnoses: hypertension (high blood pressure) and seizures (an uncontrolled electrical disturbance in the brain). This plan of care failed to have any goals for the patient. During an interview on 10/6/2022 at 2:25 PM, the clinical manager indicated the computer helps create goals and assessments based on diagnoses. She indicated goals should be individualized, and there should be teaching that is appropriate for diagnosis. The clinical manager indicated she would expect to see education on blood sugars, diet, and diabetes on the patient's care plan. 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 or allowed practitioner may choose to include. Based on observation, record review, and interview, the home	G0574	The Director of Nursing in serviced the clinical staff toestablish individualized plan of care that must include 1- All pertinent Diagnoses 2- The Patient's mental, psychosocial, andcognitive status 3- The types of services, supplies and equipmentrequired 4- The frequency and duration of visits to be made 5- Prognosis 6- Rehabilitation potential 7- Functional limitations 8- Activities permitted 9- Nutritional requirements 10- All medications and treatments 11- Safety measures to protect against injury 12- Risk for emergency department visits andhospital re-admissions 13- Interventions to address	2022-10-31

	health agency failed to ensure the medical plan of care was complete and included medications, the indication for medications, and all diagnoses in 6 of 7 records reviewed (#1, #2, #3, #4, #6, #7) 1. The agency's policy titled "Physician Participation in Plan of Care" dated August 2011 states, "A physician will direct the care of every home health care patient admitted per service. The attending physician will certify that medical, skilled, rehabilitative, and social services provided by the organization are medically required for the patient. ... Physician orders will be individualized, based on patient needs, and include: Patient diagnoses Treatments and/or procedures needed, including type, frequency, duration, and goals. Medications, allergies, and diet." 2. During a home visit for patient #1 on 10/3/2022 at 10:25 AM, the patient was observed to be alert and oriented. When asked for his medications he went to the bedroom and brought out a		the underlying riskfactors 14- Patient and caregiver education and training 15- Measurable outcomes and goals 16- Information related to Advance Directives The Director of Nursing will monitor 100% admissions andrecerts to make sure that this deficiency is corrected and will not recur. **ActionCompleted:** **100 %charts are reviewed, clinical staff is educated and Communication is improved.** **FuturePlan:** **Directorof Nursing will be involved in each patient's plan of care and will monitor100% Plan of Care to make sure this deficiency will not recur.**	

	medications bottles. Patient #1 indicated he does not take Losartan or Nitrofurantoin. He indicated he started taking Culturelle and Dicyclomine on 9/14/2022. Clinical record review for patient #1, start of care 8/23/2022, evidenced agency documents titled "Skilled Nurse Visit", dated 9/12/2022 and 9/20/2022. These documents indicated the patient was taking ibuprofen (pain reliever) for right leg pain. The plan of care failed to include ibuprofen in the medications. Clinical record review for patient #1 evidenced a plan of care, for certification period 8/23/2022 – 10/21/2022. The plan of care evidenced medications of: Pantoprazole (for stomach) Montelukast (for allergies), Nitrofurantoin (for infection), Losartan (for blood pressure) Cholecalciferol (vitamin D), atorvastatin (for cholesterol), aspirin (blood thinner), and Janumet (for regulation of blood sugar). The plan of care failed to include all current medications patient #1 was taking.			

	During an interview on 10/5/2022 at 2:20 PM, the clinical manager indicated medications should be updated when the plan of care was revised. We update them on the medication profile until we do a new plan of care. At 2:22 PM, she indicated over-the-counter medications should be on the plan of care also but sometimes they get missed. 3. Clinical record review for patient #2, evidenced a plan of care, for start of care 9/7/2022, certification period 9/7/2022 – 11/5/2022. The plan of care evidenced medications of: Atorvastatin (for cholesterol), Norco (narcotic pain medication), iron, acetaminophen (pain reliever) 325 mg [milligram] take 2 (two) tablets every four hours as needed by mouth, Aspirin (blood thinner), Avonex pen (for treatment of multiple sclerosis), and Colace (stool softener). This document failed to evidence an accurate list of the patient's medication, and failed to include the indication for the acetaminophen. During an interview at a home			

	the patient's family member indicated patient #2 was no longer taking the Avonex pen. The physician discontinued the medication in February 2022. He/She also indicated the patient was taking Metamucil (fiber supplement), calcium (supplement), vitamin D (supplement), and magnesium (supplement). Observation of the Norco medication bottle indicated the medication was prescribed every 6 hours as needed for pain. During an interview on 10/5/2022 at 2:33 PM, the clinical manager indicated the physicians should have been called and the medication list should be updated with the current medications. 4. Clinical record review for patient #6 evidenced an agency plan of care, for start of care 5/24/2022, and certification period 7/23/2022 – 9/20/2022. This plan of care evidenced medications of: Abacavir (antiviral) 300 mg (milligrams) one tablet every twelve hours, Amlodipine (for high blood pressure) 10 mg daily, hydralazine (for high blood pressure) 50 mg three times a			

	day, ibuprofen (for pain) 400 mg every six to eight hours as needed, lisinopril (treats high blood pressure) 10 mg daily, melatonin(sleep supplement) 3 mg nightly as needed, metoprolol (for high blood pressure) 100 mg twice a day, and tramadol 50 mg as needed. This document failed to include the indications for ibuprofen, tramadol, and melatonin. During an interview on 10/5/2022 at 2:45 PM, the clinical manager indicated all as-needed medications should include the indication. 5 Clinical record review for patient #7, start of care 5/19/2022, indicated an agency document titled "Medication Profile." This document evidenced patient #7 was taking the following medications: Phenytoin (for seizures). Folic acid (supplement) Levetiracetam (for seizures), clonidine (for high blood pressure) gabapentin (used for seizures) prednisone (steroid) clopidogrel (prevent blood clots) ibuprofen (for pain) hydrochlorothiazide (for high blood pressure), atorvastatin			

	amlodipine (for high blood pressure). Clinical record review for patient #7 evidenced a plan of care for certification period 7/18/2022 – 9/5/2022. This document failed to list any of the patient's medications. During an interview on 10/6/2022 at 10:56 AM, the clinical manager indicated she was unsure why the medications were not showing on the plan of care. She indicated they should have been on there. 6. Clinical record review for patient #3, start of care 9/19/2022, evidenced a document titled "Referrals/Response Letter" dated 9/21/2022, and signed by Physician #2, which indicated the patient was taking the following medications: Acetazolamide (for seizures), pregabalin (for nerve pain), ropinirole (for restless legs), lamotrigine(for seizures), levothyroxine (for thyroid), Vimpat (for seizures), Pilocarpine (saliva production stimulator), Quetiapine			

	cyclobenzaprine (muscle relaxer), benztropine (anti tremor medication), topiramate (for seizures), Vyvanse (stimulant), Montelukast (for reducing inflammation in asthma), sertraline (antidepressant), prednisone (steroid), hydroxychloroquine (immunosuppressant for Lupus), Xarelto (prevent blood clots), folic acid (supplement), pantoprazole (for stomach acid), alendronate (for weak brittle bones), meloxicam (anti-inflammatory, and Restasis (for dry eyes). Clinical record review for patient #3 evidenced a plan of care for certification period 9/19/2022 – 11/17/2022. This plan of care failed to evidence any medications. 7. Clinical record review for patient #4, start of care 8/25/2022, evidenced a document titled "Face to Face Encounter," dated 8/25/2022 and signed by the physician. This document indicated the patient had the following diagnoses: Impaired mobility, cerebrovascular accident (stroke), osteoarthritis			

knees, high fall risk, chronic kidney disease, Urinary tract infection, and hypertension.

Clinical record review for patient #4, start of care 8/25/2022, evidenced a plan of care for certification period 8/25/2022 – 10/23/2022. This plan of care evidenced the following diagnoses: Hypertension (high blood pressure) and Seizures. The plan of care indicated the patient was taking the following medications: Metoprolol (for high blood pressure), Carbidopa-Levodopa (changes dopamine in the brain), Atorvastatin (for high cholesterol), Aspirin (blood thinner), sertraline (antidepressant), Lisinopril (for blood pressure), Zolpidem (for sleep), Clopidogrel (prevent blood clots), Divalproex (for seizures), and Loperamide (anti-diarrheal) one tablet four times a day as needed. This document failed to evidence the indication for Loperamide and failed to include all of the patient diagnoses.

During an interview on 10/5/2022 at 2:45 PM, the clinical manager indicated all

	as-needed medications should include the indication, and all diagnoses should be on the plan of care. 17-13-1(a)(1)(B) 17-13-1(a)(1)(C) 17-13-1(a)(1)(D)(ix)			
G0576	All orders recorded in plan of care 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review and interview, the agency failed to record all patient care orders, including verbal orders, in the plan of care in 1 of 5 active clinical records reviewed. (#4) The findings include: Review of an agency policy, titled "Care Planning Process," revised August 2011, stated, "... The plan of care will be based upon the physician's (or other authorized licensed independent practitioner's) orders and will encompass the	G0576	The Director of Nursing in serviced all clinical staff about 1- Care Planning Process 2- Diagnoses 3- Medications 4- Physician's Verbal Orders 5- Additions and Interventions in Plan of Care 6- Pain Management 7- Improving strength and bed mobility 8- Balance 9- Transfer 10- Gait and to establish a home exercise program 11- Wound Care management	2022-10-31

	services required to meet the patient's needs…." Clinical record review for patient #4, start of care date 8/25/2022, evidenced an order dated 8/25/2022, and signed by the physician. This document indicated the patient was to receive education on disease process, symptoms, and management, diet, medication compliance, safety measures, and pain management. The patient was also to receive physical therapy for assistance in improving strength, bed mobility, balance, transfer, gait and to establish a home exercise program. Clinical record evidenced a plan of care for certification period 8/25/2022 – 10/23/2022. This plan of care failed to evidence physical therapy and failed to evidence the skilled nurse was to educate the patient as indicated in the physician order. During an interview on 10/6/2022 at 10:21 AM, the administrator indicated all orders should be included on the plan of care.		The Director of Nursing will monitor and assist field nursesto correct this deficiency and will not recur. **ActionCompleted:** **Clinical staff is educated, 100 % charts are reviewed,communication with physician and patient is improved, applied to join providernetworks of private insurances for fast prior authorizations.** **FuturePlan:** **Therapystaff will not wait for prior authorization and will start services ASAPaccording to plan of care.** **Nurseswill follow physician orders and DON will monitor 100% plan of care.**	

G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the home health agency failed to administer services and treatments only as ordered by a physician in 2 of 5 active clinical records reviewed without a home visit. (#2, #3) The findings include 1. An undated agency policy obtained on 10/5/2022, titled "Plan of Treatment/Change Orders," stated, " … The agency will provide care/services consistent with the plan of treatment…." 2. Clinical record review for patient #2, start of care 9/7/2022, evidenced a plan of care for certification period 9/7/2022 – 10/5/2022. This plan of care failed to evidence any wound treatment orders. Clinical record review evidenced skilled nurse visit notes dated 9/14/2022, 9/21/2022, and 9/27/2022 and signed by LPN	G0580	The DON in serviced the clinical staff to follow physician'sorders 1- Drugs, Services, and treatments are administeredonly as ordered by a physician 2- Physician communication for additional orders orinterventions The Director of Nursing will monitor all RNs and LPNs visitsto make sure that this deficiency is corrected and will not recur. **ActionCompleted:** **HHA staffis educated, Communication with physician and patient is improved,** **100%charts are reviewed, educational material is ordered.** **FuturePlan:** **DON willmonitor each Plan of care and make sure case manager follows physician orders strictly.**	2022-10-31

	which stated " ... Wound care performed to right foot. Patient tolerated well ... Removed previous dressing, cleansed with NS [normal saline], applied ointment, covered with gauze, wrapped with Kerlix [gauze wrap], covered with ace wrap...." During an interview on 10/5/2022 at 2:13 PM. The clinical manager indicated she did not see an order for wound care. She indicated there should be orders on the plan of care, but it must have been overlooked. 3. Clinical record review for patient #3, start of care 9/19/2022, evidenced skilled nurse visit notes dated 9/27/2022, signed by RN (registered nurse) #1, and indicated RN #1 filled the patient's mediplanner and removed all medication still in there from the previous week. The RN then called medications into the pharmacy and reconciled medications. Clinical record review evidenced a plan of care for certification period 9/19/2022 – 11/17/2022. This plan of care failed to			

	orders to set up medications. During an interview on 10/5/2022 at 2:42 PM, the clinical manager indicated the plan of care should include all medications and orders. 17-13-1(a)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to promptly alert the physician to changes in the patients' conditions which suggested outcomes were not being achieved in 2 of 5 active clinical records reviewed. (#1, #2) The findings include: 1. An agency policy titled "Monitoring Patient's Response/Reporting to Physician," revised August 2011, stated, "The patient's physician will be contacted on the same day when any of the following	G0590	The Director of Nursing in serviced all clinical staff forbetter communication with physician to promptly alert of changes 1- Any changes in the patient's condition or needsthat suggest that outcomes are not being achieved 2- Alterations in Plan of Care 3- Monitoring patient's response and reporting tophysician 4- Significant changes in patient's condition The Director of Nursing willmonitor daily visits of nurses to make sure that this deficiency is correctedand will not recur. **<u>Action Completed:</u>**	2022-11-04

	occur: Significant changes in the patient's condition … inability to achieve goals within the specified time frame … Changes in the patient's expected response to treatment or medications…." 2. Clinical record review for patient #1, start of care 8/23/2022, evidenced agency documents titled, "Skilled Nurse Visit" dated 9/12/2022 and 9/20/2022. These documents indicated the patient was complaining of right leg pain. The visit note for 9/22/2022, evidenced the patient had 7/10 pain [scale of 0-10, with 0 being no pain and 10 the most severe] in the lower legs. Visit notes for 8/30/2022 and 9/12/2022, indicated the patient had bladder distention and a 5-pound weight loss for each visit. These patient changes in condition failed to be evidenced in the clinical record as reported to the physician.		**Clinical staff is educated, communicationwith physician is improved, 100% charts are reviewed, adjustments are made.** **<u>Future Plan</u>:** **QA nurse has been appointed who will audit 100% notes ofnurses and make sure they are reporting any significant change to physician inpatient's condition.**	

	During an interview on 10/5/2022 at 2:24 PM, the clinical manager indicated the physician should have been notified of the bladder distention, pain, and weight loss. 3. Clinical record review for patient #2, start of care 9/7/2022, evidenced an agency document titled, "Skilled Nurse Visit" dated 9/14/2022.This document indicated the patient was complaining of right heel pain 8/10. This document failed to evidence the skilled nurse notified the physician of the pain. During an interview on 10/5/2022 at 2:45 PM, the clinical manager indicated the physician should have been notified of the patient's pain. 17-13-1(a)(2)			
G0610	Patients receive education and training 484.60(d)(5) Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a	G0610	The Director of Nursing gave in service to all clinical staffto educate patient and caregiver 1-Ongoing education and training to patientand caregiver 2-Discharge Planning	2022-10-31

	timely discharge. Based on record review and interview, the agency failed to ensure the patient received appropriate discharge teaching in 2 of 2 discharged records reviewed (#6, #7). The findings include: 1. Record review evidenced an agency policy titled, "Discharge Planning", revised August 2011, which stated, " ... To promote patient independence, safety, and use of community resources prior to patient discharge from the organization ... All communication and information regarding discharge planning will be documented in the clinical record...." 2. Clinical record review for patient #6, start of care 5/24/2022, certification period 7/19/2022 to 9/5/2022, evidenced an agency discharge document which indicated the skilled nurse was to ensure the patient educate patient on		3-Use of Community resources 4-Healthy eating and safety measures 5-Maintaining Daily blood pressure log forhypertension patients 6-Incontinent care DON will monitor the nurses education to patients andcaregivers and by sending Medical Social Worker to patient for use of communityresources. Administrator will be responsible to make sure that thisdeficiency is corrected and will not recur	

	blood pressure log, healthy eating, management of hypertension, and home safety measures Review of the clinical record failed to evidence the nurse instructing on medications, keeping a daily blood pressure log, healthy eating, management of hypertension, and home safety measures 3. Clinical record review for patient #7, start of care 5/19/2022, certification period 7/18/2022 to 9/15/2022, evidenced an agency discharge document which indicated the skilled nurse was to ensure the patient was educated on hypertension (high blood pressure), diet, incontinent care medications and home safety. Review of the clinical record failed to evidence the nurse instructed the patient on hypertension, diet, incontinent care medications, and home safety.			

	During an interview on 10/5/2022 at 2:33 PM, the clinical manager indicated the education was probably done, but it was not documented correctly in the chart. 17-14-1(a)(1)(G)			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review, and interview, the home health agency failed to ensure a written schedule was provided to patients in 2 of 2 home visits conducted (#1. #2) The findings include: 1. An undated agency policy obtained on 10/5/2022, titled Home Care Patient Rights and Responsibilities" stated "The	G0614	The Director of Nursing in serviced the HHA staff to follow strictlyof their visit schedules 1- Visit Schedule 2- Patient's Rights and Responsibilities 3- Patient's/caregiver participation in care 4- Patient's consent and refuse 5- Updating home folder if there is a change invisits frequency Office Manager will monitor the staff visit schedules tomake sure that this deficiency is corrected and will not recur.	2022-10-31

	Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to ... The care to be furnished, based on the comprehensive assessment ... The frequency of visits...." 2. During an interview at a home visit for patient #1 on 09/04/2022 at 9:47 AM, the patient stated he did not have a home folder or written information from the home health agency. Observation failed to evidence the patient received a schedule of visits. 3. During an interview at a home visit for patient #2 on 09/05/2022 at 10:10 AM, the patient's family member indicated she did not have a home folder or written information from the home health agency. Observation failed to evidence the patient received a schedule of visits.		**ActionCompleted:** **OfficeManager printed the visit schedules for every patient and clinical managersgave those schedules to every patient and placed in home folders.** **FuturePlan:** **OfficeManager will make sure that every patient gets visit schedule and its placed in-homefolder.**	

	During an interview on 10/5/2022 at 2:11 PM, the administrator indicated the staff called the patient the night before to confirm their visit time.			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review and interview, the agency failed to provide written instructions to the patient for the patient's medication schedule and instructions in 2 of 2 home visits conducted. (#1, #2) The findings include: 1. Review of an agency policy titled "Medication Profile," revised August 2011, stated " ... Each patient will receive appropriate written material for specific medications he/she is receiving. The material will contain information on the	G0616	The Director of Nursing in serviced the clinical staff tomaintain medication profile 1- Patient medication schedule/instructions 2- Updating Medication Profile 3- Management of pills box The Director of Nursing will make home visits to make surethat medication management is done properly The Director of Nursing will be responsible to correct thisdeficiency and make sure will not recur. **ActionCompleted:** **Allclinical managers have reconciled the medication profiles for their patientsand has printed medication schedules and informative material and delivered to**	2022-11-03

	actions of the medication, potential side effects, contraindications, and any special instructions when taking specific medication…." 2. During a home visit for patient #1 on 10/4/2022 at 9:47 AM, the patient indicated he did not have a home folder or written information from the home health agency. Observation failed to evidence patient had received a medication schedule or instructions in writing. 3. During a home visit for patient #2 on 10/5/2022 at 10:00 AM, the patient's family member indicated she did not have a home folder or written information from the home health agency. Observation failed to evidence patient had received a medication schedule or instructions in writing. 4. During an interview on 10/5/2022 at 2:30 PM, the clinical manager indicated the patient should have a medication list in the home and it should be updated by the nurse with the current medications.		**patientsat their homes.** **<u>FuturePlan:</u>** **DON willmake sure that all clinical managers are maintaining medication profiles, whichare printed and delivered to every patient along with educational material.**	

G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation, record review, and interview, the home health agency failed to ensure patients received in writing any treatments to be administered by personnel and personnel acting on behalf of the home health agency in 2 of 2 home visits conducted (#1, #2). The findings include: 1. Review of an agency policy titled "Care Planning Process," revised August 2011, stated, "... The organization shall provide the patient and caregiver with a copy of written instructions outlining: ... Any treatments to be administered by the organization's personnel and personnel acting on behalf of the organization, including therapy services ...." 2. During a home visit for patient #1 on 09/04/2022 at	G0618	Administrator in serviced the staff to follow HHA Policy forwritten instructions regarding HHA services in patient's home folder 1- Treatmentsand Therapy services 2- Written Instructions 3- Home Folder Administrator will monitor that home folders that allwritten instructions are present and make sure that this deficiency iscorrected and will not recur. **ActionCompleted:** **A formhas been created, printed, and delivered to all patient regarding the servicesare provided by the HHA.** **FuturePlan:** **Administratorwill make sure that every patient gets this form at the time of admission.**	2022-11-04

	he did not have a home folder or written information from the home health agency. Observation failed to evidence patient had received any written information on treatments to be administered by agency personnel. 3. During a home visit for patient #2 on 09/05/2022 at 10:10 AM, the patient's family member indicated he/she did not have a home folder or written information from the home health agency. Observation failed to evidence the patient had received any written information on treatments to be administered by agency personnel. 4. During an interview on 09/5/2022 at 2:40 PM, the clinical manager indicated there should have been folders in the patient's homes with treatment instructions. The patients may have misplaced them.			
G0622	Name/contact information of clinical manager	G0622	Office Manager updated HHA contact form and put all requirednames and phone no's	2022-11-01

	484.60(e)(5) Name and contact information of the HHA clinical manager. Based on observation, record review, and interview, the home health agency failed to ensure patients received the name and contact information for the clinical manager in writing in 2 of 2 home visits conducted (#1, #2). The findings include: 1. Review of an agency policy titled "Care Planning Process," revised August 2011, stated, "... The organization shall provide the patient and caregiver with a copy of written instructions outlining: ... Name and contact information of the organization's clinical manager ...." 2. During a home visit for patient #1 on 09/04/2022 at 9:47 AM. the patient stated he did not have a home folder or written information from the home health agency. Observation failed to evidence patient had received any written information with the clinical manager's name or contact information.		of clinical staff and clinical manager Office Manager will be responsible to correct thisdeficiency and make sure will not recur.	

	3. During a home visit for patient #2 on 09/5/2022 at 10:00 AM, the patient's family member stated he/she did not have a home folder or written information from the home health agency. Observation failed to evidence the patient had received any written information with the clinical manager's name or contact information. 4. During an interview on 09/5/2022 at 2:22 PM, the clinical manager indicated there should be a home folder in all the homes.			
G1016	Goals in the patient's plans of care 484.110(a)(3) Goals in the patient's plans of care and the patient's progress toward achieving them; Based on record review and interview, the agency failed to ensure the clinical record included the patient's goals and progress towards the goals in the plan of care in 1 of 2 closed clinical records reviewed. (#7) The findings include: 1. Review of an agency policy titled "Care Planning Process,"	G1016	The Director of Nursing gave in service to clinical staff todetermine and achieve goals of patient's care 1- Care Planning 2- Setting and achieving goals 3- Measuring outcomes 4- Monitoring progress towards achieving the goals 5- Alterations and additions in Plan of Care toachieve goals.	2022-11-04

	revised August 2011, stated, "... Individualized Plan of Care: The patient-specific clinical plan of care includes: Measurable outcomes and goals identified by the organization and the patient anticipated to occur as a result of implementing and coordinating the plan of care...." 2. Clinical record review for patient #7, evidenced an agency document titled "Oasis D1 Recertification," dated 7/19/2022. This document indicated the patient had a primary diagnosis of hypertension (high blood pressure), was incontinent (loss of control) of bladder at times, had difficulty with ambulation, had poor balance, was dependent for grooming, dressing, bathing, and toileting and was at risk for falls. Clinical record review for patient #7, start of care 5/24/2022, evidenced a plan of care for certification period 5/24/2022 – 7/22/2022. This plan of care evidenced the patient was to receive nursing care twice a week for one week and once a		The Director of Nursing will monitor 100% Plan o Cares tomake sure that goals are determined and achieved **<u>ActionCompleted:</u>** **Clinicalstaff is educated about goals achievement and progress, 100% charts arereviewed, Goals are mentioned in new SOC and Recerts.** **Future Plan:** **DON willmonitor each plan of care and make sure goals are mentioned and progress is notedand communicated.**	

	week for eight weeks. This document indicated the patient's goals were to have no hospitalizations or emergency visits and to demonstrate the ability to manage medication regimen. This document failed to have patient-specific measurable goals related to nursing care. During an interview on 10/5/2022 at 2:26 PM, the clinical manager indicated there were no patient-specific goals on the plan of care, but there should be.			
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	N9999	The Nurse Consultant in serviced the staff to follow Drug TestingPolicy 1- HHA will test at least 50% non-licensed employeesannually HHA has tested 100% employees for drugs and controlledsubstance.	2022-11-03

	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) are not licensed by a board or 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 the agency's unlicensed staff was annually drug tested. The findings include: An undated agency policy titled "Drug Testing," obtained on 10/3/2022, stated "Under the agency's drug and alcohol testing policy, current and prospective employees who work or will work in high-risk or safety-sensitive positions will be asked to submit to drug and		Administrator will be responsible to correct this deficiencyand make sure it will not recur.	

alcohol testing. No prospective employee will be asked to submit to testing unless an offer of employment has been made. The agency's policy is intended to comply with all state laws governing drug and alcohol testing and is designed to safeguard employee privacy rights to the fullest extent of the law...."

Review of personnel records on 10/3/2022, for agency home health aides failed to evidence random drug testing was being done.

Review of HHA (Home Health Aide) #1's personnel filed evidenced she was hired on 4/3/2002. Review failed to evidence she had ever been drug tested.

During an interview on 10/3/2022 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 he

	was unaware they were supposed to be randomly drug testing 50% of their employees. He indicated the HHA had been employed since 2002 and they didn't have to do drug testing at that time.			

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
AFZAL J MALIK	Administrator	12/1/2022 7:22:07 PM