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	12/22/2022

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 was a revisit for a State Re-Licensure survey of a home health agency, in conjunction with a Federal Post Condition Revisit survey performed by the Indiana Department of Health. Facility ID: 003155 Survey dates: 12/12/2022 – 12/16/2022, 12/19/2022 – 12/22/2022 Census: 14	N0000	A Plan of Correction is being submitted	2023-01-23

	At this revisit survey, 5 state regulations were put back into compliance; 3 state regulations remained out of compliance; 1 additional state regulation was cited.			
G0000	INITIAL COMMENTS This survey was a Federal Post Condition Revisit (PCR) survey for a home health agency conducted by the Indiana Department of Health. Survey Dates: 12/12/2022 – 12/16/2022, 12/19/2022 – 12/22/2022 Facility ID: 003155 Census: 14 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. At this PCR survey, 14 Federal	G0000	A Plan of Correction is being submitted	2023-01-23

	compliance; 2 Federal citations were put back into compliance; 4 additional Federal citations cited to be NOT in compliance. 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 01/11/2022			
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.	N0456	Consultant Nurse in serviced the HHA staff how to monitorand evaluate the quality and appropriateness of patient care. 1- 1-How to improve patient care 2- 2-To resolve identified problems 3- 3-To improve quality	2023-01-23

	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 evaluate the quality and appropriateness of patient care, resolved identified problems, and improve patient care. Findings include: Record review of an undated agency policy retrieved on 12/22/2022, 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		4- 4-To improve outcomes 5- 5-Evaluate strengths and weaknesses 6- 6-Chart Audits A ACTION COMPLETED: HHA appointed a Quality Assurance nurse who will beresponsible for chart audits, in services and performance improvement.**100% personalrecords are reviewed and found to be 100 % in compliance.** **FuturePlan:** **Quality Assurance Nurse will audit charts 100%** **Administrator will pull OBQI reports** **Plan of Action will be made for each weakness to improve care process.** **Administratorwill be responsible to make sure this deficiency will not recur.**	

	outcomes for measurable improvement. D. Identify and participate in benchmarking activities ... Measuring current performance against past performance Measuring against internally established goals. 2. Processes and protocols. 3. Practice or service guidelines...." Record review of the agency's QAPI binder on 12/21/2022, was conducted with administrator #1, clinical manager #1, office manager #1, and intake coordinator #1. Record review evidenced aggregated data pulled from the agency's electronic health record (EHR). Review evidenced the data was percentages for where the agency and region measured up to the national average. Record review failed to evidence an adequate plan for improvement with specific measurable outcomes. During an interview on 12/21/2022, at 2:22 PM, when queried which quality measures or indicators were selected and why, administrator #1 indicated the EHR system would aggregate data from the patients' charts. Administrator #1 indicated the agency was			

	below the national average with re-hospitalizations, bathing, and transferring. When queried how the current performance improvement plan was being implemented, administrator #1 indicated the agency has requested the patients/caregivers call the agency before going to the hospital.			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.	N0458	Consultant Nurse in serviced the staff on HHA personalpolicy and how 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 **<u>Action Completed:</u>** Allemployees personal and medical files are updated. All Licensesare online verified. All non-Licensedemployees are tested for drug testing. All employeesNational Background checks are done.	2022-12-22

	Based on record review and interview, the home health agency failed to ensure all personnel records were current to include verified professional licenses for 1 of 2 licensed practical nurse (LPN) records reviewed. (LPN #1) The findings include: Record review of an undated agency policy retrieved on 12/22/2022, titled "Licensure/Certification/Registration" revised August, 2011, which stated "Purpose ... To ensure that all personnel have current licensure/certification ... Procedure ... 3. A current copy or other proof of licensure, certification, and/or registration will be kept in the personnel file ...." Personnel record review on 12/19/2022, for LPN #1, first patient contact date 9/14/2022, evidenced a document from the online professional license verification search which stated the license was expired on "10/31/2022 ...." Record review failed to evidence all licenses were verified for all clinicians who conducted patient care. During an interview on		**Future Plan:** The Office Manager will update personal files on monthly basis to make sure all personal records are updated. Office Manager will be responsible to make sure this deficiency is corrected and will not recur.	

	12/21/2022, at 2:40 PM, intake coordinator #2 indicated the agency would ensure license verification was maintained for each clinician by utilizing the online verification search engine. During an interview on 12/21/2022, at 2:45 PM, administrator #1 submitted a piece of paper to verify LPN #1's license was current and stated "Maybe they [office staff] didn't put it in there."			
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. (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	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. ACTION COMPLETED: Administrator revised the	2022-12-22

	periodic patient evaluation. (7) The procedures for payment for services furnished under the contract. Based on record review and interview, the agency failed to ensure agency contracts included which services would be controlled, coordinated, and evaluated by the primary home health agency for 1 of 1 therapy contracts reviewed. The findings include: Record review of an undated agency policy retrieved on 12/22/2022, 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. Procedures for scheduling visits, and periodic patient evaluation..." Record review on 10/4/2022, evidenced a document titled "Business Contract Agreement". This document indicated it was		Business Contract Agreement, andall services are mentioned. New Contract is executed. FUTURE PLAN: Administrator will be responsible to sign the contract to make sure all services are mentioned.	

	a contract for therapy services between the home health agency and Entity #11. This document failed to include dates the contract became effective, and the manner in which the services will be controlled and coordinated by the primary agency. During an interview on 12/21/2022, at 2:33 PM, when queried when the contract with entity #11 became effective, administrator #1 indicated probably since 2002. During an interview on 12/21/2022, at 2:38 PM, when queried how contractors are made aware of referrals, administrator #1 indicated the agency will fax the referral to the contractor, then the contractor will communicate with the physician.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j)	N0488	Nurse Consultant in serviced the clinical staff on QUALITYASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) 1- Discharge planning, make sure patient gets anotice 15 days prior to discharge.	2023-01-23

	Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.		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 ACTION COMPLETED: Patient handbook is revised, and it’s been changed from 5 to15 days. QA Nurse is appointed. FUTURE PLAN OF ACTION: Quality Assurance Nurse will make sure at the time of discharge 15 days notice is served and discharge planning is made.	

	Based on record review and interview, the home health agency failed to ensure a policy was developed to implement a 15-day discharge notice to agency patients. The findings include: Record review of the agency's handbook retrieved on 12/13/2022, 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. Record review of an undated agency policy retrieved 12/22/2022, 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 for the required 15-day discharge notice.			

	During an interview on 12/13/2022, at 2:50 PM, administrator #1 indicated the discharge policy was updated and would be in the new patient handbook.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review and interview, the home health agency failed to ensure: The plan of care was followed by all agency staff (See tag G0572); The plan of care included all required individualized information for the treatment of the patient (See tag	G0570	The Director of Nursing in serviced all clinical staff about 1-ComprehensiveAssessment 2- CarePlanning 3-Coordination of Services 4-Quality of Care 5-Patient's rights 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	2023-01-20

	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); Plan of Care was reviewed and revised at least every 60 days (see tag G0588); Physicians were promptly notified of a change in the patient's condition (See tag G0590); Documentation of patients response to education and training (See tag 610); A written visit schedule was provided to patients (See tag G0614); Written instructions were provided to the patient for the patient's medication schedule (See tag G0616); Patients received in writing any treatments to be administered by agency personnel (See tag G0618); Patients received in writing the contact information for the agency's clinical manager (See tag G0622). 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:		the patient-specific needs according tocomprehensive assessment. Office Manager will get preauthorization for HMO patientsfrom private insurances. The Director of Nursing will audit 100% charts to make surethat this deficiency is corrected and will not recur. **ActionCompleted:** **HHA hasapplied to join Aetna, Humana and United Health Care networks as provider, socan get fast prior authorizations. Also instructed PT staff to start servicesASAP according to Plan of Care.** **FuturePlan:** DON will beinvolved with each case manager for each and every patient's Plan of Care to makesure that a patient is getting all services ASAP according to Plan of Care. The DON will be responsible to make sure that this deficiency should not recur.	

	Based on record review and interview, the home health agency failed to ensure their patient's needs were being met for 4 of 4 clinical records reviewed where the patient required services that were not provided by the agency. (patient #1, #2, #3, #5) The findings include: 1. Clinical record review on 12/13/2022, for patient #1, start of care10/19/2022, primary diagnosis of heart disease, evidenced a document from the certifying physician at entity #6 on 10/17/2022, titled "Order Details" that stated, "... I certify that, based on my findings, the following services are medically necessary skilled home health services: Physical Therapy ... Occupational Therapy ... Skilled Nursing ... Therapy Services to: Evaluate & Treat ... Diagnosis ... S/P [status post] CABG [coronary artery bypass graft; a surgical procedure used to treat coronary heart disease to improve blood flow and oxygen supply to the heart] ...." Record review evidenced skilled nursing services were provided. Record review evidenced a physical therapy (PT) evaluation.			

	Record review failed to evidence the patient was treated by the agency's PT services. Record review failed to evidence a referral was made for occupational therapy (OT). Record review evidenced the home health agency failed to meet the needs which were deemed medically necessary by the certifying physician. Record review failed to evidence the agency assisted the patient in finding another agency who could meet the patients needs. 2. Clinical record review on 12/14/2022, for patient #2, start of care 11/3/2022, pertinent diagnoses of anorexia, dehydration, and abnormal weight loss, evidenced a document signed by the patient's primary physician on 10/14/2022, that stated "Subject: Patient Referral … Nursing PT and OT for eval and treat .. Dx [diagnosis] Impaired mobility and self care deficit …." Record review failed to evidence a referral for OT services as ordered by the physician. Record review evidenced an			

	agency document titled "Communication Note" electronically signed by clinical manager #1 on 11/29/2022. This document stated, "Patient referred to Social Worker for community resources [NWICA] and home environment assessment…." Record review failed to evidence care communication with a community case worker. Record review failed to evidence the agency referred the patient to a medical social worker (MSW) contracted with Prime Care.			

	An observation of a home visit was conducted on 12/14/2022, from 2:04 PM to 2:34 PM, for patient #2, with Licensed Practical Nurse (LPN) #1. Observation during the visit evidenced the patient was saturated with urine and had not consumed food or water yet that day, as reported by person #8. Person #8 indicated the patient was just released from entity #1 the previous day for dehydration. Observation evidenced the patient was unable to stand or ambulate independently and evidenced the patient's home was cluttered and had a strong foul odor. Record review of an agency document titled "Communication Note" electronically signed by clinical manager #1 on 12/15/2022, stated "[LPN #1] called and spoke to me about condition of client home condition making it difficult to properly provide nursing care to both clients [patient #2] & [person #8]. Social services re contacted to both clients priority for community resources and home assessment…."			

	Record review evidenced the agency was aware of the unsafe living conditions for patient #2 for 17 days prior to a follow up with social services. Record review failed to evidence a referral for a medical social worker. Record review failed to evidence the agency made referrals to the appropriate therapies for patient safety. Record review failed to evidence the agency assisted the patient in finding another agency who could meet the patients needs. During an interview on 12/21/2022, at 11:54 AM, clinical manager #1 stated the patient "... definitely needed more resources." 3. Clinical record review on 12/20/2022, for patient #3, start of care 9/7/2022, primary diagnosis of multiple sclerosis, evidenced an agency document titled "Communication Note" electronically signed by office manager #1 on 12/14/2022, which stated "Adult Protective Services were contacted today via an online report due to lack of care by family...."			

	Record review failed to evidence the patient received adequate pain management and treatment for their primary diagnosis for over 70 days (see tag G0590). Record review evidenced documentation of caregiver burnout and poor quality of life for the patient. Record review failed to evidence the agency referred the patient to social service community groups. Record review failed to evidence the agency made a referral to MSW services contracted with the Prime Care. Record review failed to evidence the agency provided services required to meet the needs of this patient. Record review failed to evidence the agency referred the patient to another home health agency that could meet the patient's needs. During an interview on 12/21/2022, at 1:47 PM, when queried if a referral was made to a MSW to assist the patient, administrator #1 stated "We did not have a medical social worker in October." Then indicated the MSW was hired in November. When queried if a			

	referral was made to another agency that could meet the need of the patient, clinical manager #1 indicated they did not see one in the chart, then stated "[alternate clinical manager #2] can answer this question." Alternate clinical manager #2 was not present for the interview. 4. Clinical record review on 12/19/2022, for patient #5, start of care 7/11/2022, primary diagnosis of type 2 diabetes, evidenced an agency document titled "Communication Note" electronically signed by office manager #1 on 11/2/2022. This document stated, "Received an order for PT [physical therapy] and OT [occupational therapy] from [person #10]. Patients recert [recertification] is due on the 7th of the month. Informed PT would start after recert is done…." Record review failed to evidence the agency had PT services evaluate the patient. Record review failed to evidence a referral for OT was made as ordered. Record review failed to evidence the agency assisted the patient in finding			

	another agency who could meet their needs. During an interview on 12/21/2022, at 1:55 PM, when queried why the patient failed to receive PT and OT services, administrator #1 indicated the patient's insurance denied services. 5. During an interview on 12/21/2022, at 10:28 AM, when queried when a discipline should evaluate a patient after referral, administrator #1 stated "48 hours, but sometimes the family requests a different date." 6. During an interview on 12/21/2022, at 1:17 PM, administrator #1 indicated the reason PT was not implemented more often was due to patients' insurance not approving PT services because Prime Care was out of network. Administrator #1 indicated the agency would not be reimbursed for the cost. 410 IAC 17-13-1(a)			

G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the home health agency failed to ensure all frequencies of disciplines and treatments were provided as instructed on the plan of care for 2 of 4 active clinical records reviewed. (patient #2, #3) The findings include: 1. Record review of an undated policy retrieved on 12/22/2022, titled "Physician's Plan of Treatment/Change Orders" stated "The physicians plan of treatment (Medicare's Plan of Care) is an individualized plan for care and treatment prepared by the client's physician with assistance from the nurse and/or therapist who establish	G0572	The Consultant Nurse in serviced the HHA staff to improvecommunication with patient and physician for any missed visit. **ActionCompleted:** **Alldisciplines are educated, 100% clinical charts are audited and are monitored continuously.** **FuturePlan of Action:** **DON willbe involved and supervise each discipline for each patient's plan of care and tocommunicate with physician for any missed visit make sure this deficiency willnot recur.**	2023-01-17

	assessment of the client … The agency will provide care/services consistent with the plan of treatment ….” 2. Clinical record review on 12/14/2022, for patient #2, start of care 11/3/2022, pertinent diagnoses of dehydration and abnormal weight loss, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 11/3/2022 – 1/1/2023, and signed by the physician on 11/12/2022. This document had an area subtitled “Orders for Discipline and Treatment” which stated, “SN [skilled nurse] Frequency: 1w9 [once a week for 9 weeks] ….” Record review failed to evidence a visit was made for the week of 11/20/2022 – 11/26/2022, week 4 of the certification period. Record review failed to evidence the frequency of SN visits was implemented as ordered on the plan of care. During an interview on 12/21/2022, at 11:22 AM,			

	missed visit note should have been entered. 3. Clinical record review on 12/20/2022, for patient #3, start of care 9/7/2022, primary diagnosis of multiple sclerosis (an auto immune disease where nerve damage disrupts communication between the brain and the body), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/6/2022 – 1/4/2023, and signed by the physician on 11/11/2022. This document had an area subtitled "Orders for Discipline and Treatment" which stated "HHA [Home Health Aide] Frequency: 2w9 [twice a week for 9 weeks] …." Review of frequency of visits made for week 1 of the certification period 11/6/2022 – 11/12/2022 failed to evidence HHA visits. Record review failed to evidence the physician was notified of the missed HHA visits. Record review failed to evidence the plan of care was followed as ordered by the physician on the plan of care. During an interview on			

	12/21/2022, at 1:52 PM, office manager #1 indicated the HHA had a family emergency and could not make the visits. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and	G0574	The Consultant Nurse 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	2023-01-13

	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 record review and interview, the home health agency failed to ensure the plan of care contained all pertinent information to include, but not limited to, indications for PRN (as needed) orders, safety precautions, and functional limitations for 4 of 5 clinical records reviewed. (patient #1, #2, #4, #5) The findings include: 1. Record review of an undated policy retrieved on 12/22/2022, titled "Physician's Plan of Treatment/Change Orders" stated "The physicians plan of treatment (Medicare's Plan of Care) is an individualized plan for care and treatment prepared by the client's physician with assistance from the nurse and/or therapist who establish the plan based upon the current assessment of the client ... The plan of treatment shall include but not be limited to: ... functional limitations; safety precautions ... Homebound status ... Diet ... Orders for		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 the underlying riskfactors 14- Patient and caregiver education and training 15- Measurable outcomes and goals 16- Information related to Advance Directives **ActionCompleted:** **100 %charts are reviewed, clinical staff is educated, A medical Social Worker Agencyis contracted.** **FuturePlan of Action:** **Directorof Nursing will be involved in each patient's plan of care and will superviseand monitor 100% patients to make sure this deficiency will not recur.**	

	treatments, treatment modalities ….” 2. Clinical record review on 12/13/2022, for patient #1, start of care10/19/2022, primary diagnosis of heart disease, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 10/19/2022 – 12/17/2022. An area of this document subtitled “Medications” stated, “… Aspirin [mild pain reliever; lower doses can be effective at preventing heart attack or stroke] Oral Chew 81 mg [milligrams] …” An area subtitled “Orders for Discipline and Treatment” stated, “… SN [skilled nurse] Frequency: … 2 PRN [as needed] … SN to assess efficacy/complications of anticoagulation [commonly known as blood thinners, prevent or reduce coagulation of blood] therapy. SN to instruct patient/caregiver on anticoagulation monitoring and intervene to prevent complications ….” Record review failed to			

would warrant a SN visit as needed. Review failed to evidence the patient was placed on anticoagulant or bleeding precautions. Record review failed to evidence the patient had safety precautions individualized to their needs.

During an interview on 12/21/2022, at 10:55 AM, clinical manager #1 indicated Aspirin was the patient's anticoagulation regimen.

3. Clinical record review on 12/14/2022, for patient #2, start of care 11/3/2022, pertinent diagnoses of dehydration and abnormal weight loss, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/3/2022 – 1/1/2023. This document had an area subtitled "Nutritional Requirements" which remained blank. An area subtitled "Medications" stated, "Aspirin 81 mg …."

Record review failed to evidence the patient had a diet or nutritional supplements listed on the plan of care.

	patient was placed on anticoagulant or bleeding precautions. Record review failed to evidence the patient had safety precautions and nutritional requirements individualized to their needs listed on the plan of care. During an interview on 12/21/2022, at 11:34 AM, when queried why the patient failed to have nutritional requirements, having considered their diagnoses, clinical manager #1 stated, "[Patient #2] has strong gums and eats whatever [the spouse] prepares." 4. Clinical record review on 12/20/2022, for patient #4, start of care 9/19/2022, primary diagnosis of muscular dystrophy, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/18/2022 – 1/16/2022. This document had an area subtitled "Medications" which stated "... Albuterol [inhaled medication used to prevent and treat difficulty breathing, wheezing, short of breath, coughing, and			

	chest tightness] ... 2 puffs every 4 hours as needed ...." Record review failed to evidence indications for when to use Albuterol as needed. Record review failed to evidence vital sign parameters individualized to the patient. Record review failed to evidence individualized indications for medications and skilled nurse assessments. During an interview on 12/21/2022, at 12:59 PM, clinical manager #1 indicated vital signs should be assessed by the skilled nurse every visit and parameters should be on the plan of care to alert the clinician when out of range. 5. Clinical record review on 12/19/2022, for patient #5, start of care 7/11/2022, primary diagnosis of type 2 diabetes, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/8/2022 – 1/6/2022. This document had an area subtitled "Functional Limitations" which remained blank. An area subtitled "Caregiver Status" had			

	for this section ...” Another area subtitled “Medications” stated “... Eliquis [anticoagulant medication] ... 1 tablet daily ...” An area subtitled “Homebound Narrative” had the statement “There is no data for this section. ...” Record review failed to evidence functional limitations, caregiver status, and homebound reason listed on the plan of care. Record review evidenced the patient was taking an anticoagulant medication. Review failed to evidence bleeding precautions listed on the plan of care. Record review evidenced agency documents titled “HHA [home health aide] Visit” electronically signed by HHA #1 on 11/16/2022, and 11/30/2022. Record review failed to evidence orders for HHA frequency and services on the plan of care. During an interview on 12/21/2022, at 1:54 PM, clinical manager #1 indicated functional limitations, caregiver status, and homebound reason should be listed on the plan of care.			

	During an interview on 12/21/2022, at 2:10 PM, administrator #1 indicated the patient received skilled nursing and home health aide services. 6. During an interview on 12/21/2022, at 10:10 AM, when queried what safety precautions should be taken when on anticoagulation therapy, clinical manager #1 indicated the patient and clinician should watch for bleeding, such as cuts, bruises, tarry stools, and bleeding gums. Clinical manager #1 stated "Aspirin thins the blood." 7. During an interview on 12/21/2022, at 10:27 AM, clinical manager #1 indicated PRN orders should include parameters and indications for what not to exceed. 410 IAC 17-13-1(a)(D)(iv, vii, ix, x, xi)			

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 ensure all physicians orders were a part of the plan of care for 1 of 1 active clinical record reviewed where occupational therapy was ordered. (patient #1) The findings include: Clinical record review on 12/13/2022, for patient #1, start of care10/19/2022, primary diagnosis of heart disease, evidenced a document from entity #6 on 10/17/2022, titled "Order Details" that stated, "... I certify that, based on my findings, the following services are medically necessary skilled home health services: Physical Therapy ... Occupational Therapy ... Skilled Nursing ... Therapy Services to: Evaluate & Treat ... Diagnosis ... S/P [status post] CABG [coronary artery bypass graft; a surgical procedure used to treat coronary heart disease to improve blood flow and oxygen supply to the heart] ...."	G0576	The Director of Nursing in serviced all clinical staff about 1- 1- Care Planning Process 2- 2-Diagnoses 3- 3-Medications 4- 4-Physician's Verbal Orders 5- 5-Additions and Interventions in Plan of Care 6- 6-Pain Management 7- 7-Improving strength and bed mobility 1- 8-Balance 2- 9-Transfer 3- 10- Gait and to establish a home exercise program 4- 11-Wound Care management 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**	2023-01-23

	Record review evidenced an agency document titled "Physician Order" from 10/19/2022, that stated "Admit to Prime Care Home Health Services Skilled Nurse to do Assessment and Follow-up Care ...." Record review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 10/19/2022 – 12/17/2022, which stated "Orders for Discipline and Treatment" stated, "... SN [skilled nurse] Frequency: 2w4 [twice a week for 4 weeks], 1w5 [once a week, for 5 weeks], 2 prn [as needed] ... PT [physical therapy] Frequency: 1w1 [once a week for one week] PT Eval [evaluate] ...." This document failed to evidence PT and occupational therapy (OT) was ordered to evaluate and treat. Record review failed to evidence the agency notified the physician of PT and OT services not being provided as ordered. Record review failed to evidence the agency applied all physician orders into the plan of care.		**physician and patient is improved, applied to join providernetworks of private insurances for fast prior authorizations.** **<u>FuturePlan:</u>** **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.**	

	During an interview on 12/21/2022, at 10:29 AM, administrator #1 indicated PT #1 performed an evaluation which concluded the patient was not a candidate for physical therapy. Administrator #1 indicated the patient refused OT services, so a referral was not made.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the home health agency failed to ensure specific treatments were ordered by a physician for 1 of 1 clinical record reviewed where wound care was active. (patient #3) The findings include: Record review of an undated policy retrieved on 12/22/2022, titled "Physician's Plan of Treatment/Change Orders" stated "... Verbal Change Orders	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**	2023-01-23

	… Verbal change orders shall be recorded on the designated form and submitted to the physician for signing … Verbal change orders shall be maintained in the clinical record ….” Clinical record review on 12/20/2022, for patient #3, start of care 9/7/2022, primary diagnosis of multiple sclerosis (an auto immune disease where nerve damage disrupts communication between the brain and the body), evidenced an agency document titled “Skilled Nurse Visit” from 10/26/2022, and electronically signed by Licensed Practical Nurse (LPN) #1. This document had an area subtitled “Visit Narrative” which stated “… Obtained urine sample for UA/C&S [urine analysis/ culture and sensitivity; laboratory test performed on urine specimen], dropped off at [Entity #2] ….” Record review failed to evidence an order for the skilled nurse to perform urine collection on the patient. During an interview on 12/21/2022, at 1:39 PM, office manager #1 indicated there was		**physician and patient is improved,** **100%charts are reviewed, educational material is ordered.** **<u>FuturePlan:</u>** **DON willmonitor each Plan of care and make sure case manager follows physician ordersstrictly.**	

	physician but was not documented. Record review evidenced agency documents titled "Skilled Nurse Visit" which were electronically signed by LPN #1, from the following dates: 11/9/2022, 11/30/2022, 12/7/2022, and 12/14/2022. These documents had an area subtitled "Wound Care Flowsheet" which stated "Treatment Performed: Removed previous dressing, cleansed with NS [Normal Saline], applied ointment, covered with gauze, wrapped with kerlix [roll of gauze dressing], covered with ace wrap. Client tolerated well…." Record review failed to evidence an order for wound care treatment to include but not limited to ointments, dressings, and frequency of treatment should be performed. Record review failed to evidence the clinicians provided treatments only as ordered by the physician. Record review failed to evidence verbal orders maintained as stated in their policy. During an interview on			

	12/21/2022, at 1:40 PM, when queried where the wound care order was for the specific wound care treatment to be provided, intake coordinator #2 indicated there was not an order for the actual treatment. 410 IAC 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 home health agency failed to alert the patient's physician when significant changes occurred for 2 of 4 active clinical records reviewed. (patient #2, #3) The findings include: 1. Record review of an agency document retrieved on 12/22/2022, titled "Monitoring Patient's Response/ Reporting to Physician" revised August	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	2023-01-23

	provide guidelines for monitoring the patient's response to care, and for reporting to the patient's physician … Policy … Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient … Procedure … 3. The patient's physician will be contacted on the same day when any of the following occur: A. Significant changes in the patient's condition … B. Significant changes in the patient's psychosocial status, family/caregiver support, home environment …F. When there is any problem implementing the plan of care … 4. All conferences or attempts to communicate with physician will be documented in the clinical record …." 2. Record review of a policy retrieved on 12/22/2022, titled "Physician's Plan of Treatment/Change Orders" which stated "… Verbal Change Orders … The physician shall be notified immediately of any changes in the client's condition which indicate changes to the		not recur **<u>Action Completed:</u>** **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.**	

	plan of treatment ….” 3. Record review of an article titled “Multiple Sclerosis: Diagnosis and Treatment” from the Mayo Clinic website (https://www.mayoclinic.org/diseases-conditions/multiple-sclerosis/diagnosis-treatment) posted on 12/24/2022, stated “There is no cure for multiple sclerosis. Treatment typically focuses on speeding recovery from attacks, reducing new radiographic and clinical relapses, slowing the progression of the disease, and managing MS symptoms ... Treatments to Modify Progression … Interferon beta medications. These drugs used to be the most prescribed medications to treat MS. They work by interfering with diseases that attack the body and may decrease inflammation and increase nerve growth. They are injected under the skin or into muscle and can reduce the frequency and severity of relapses ….” 4. Clinical record review on			

	of care 9/7/2022, primary diagnosis of multiple sclerosis (MS - an auto immune disease where nerve damage disrupts communication between the brain and the body) and recent history of pain, evidenced an agency document titled "Skilled Nurse Visit" from 10/5/2022, and electronically signed by Licensed Practical Nurse (LPN) #1. An area subtitled "Care Coordination" had a checked box next to the statement "N/A [not applicable] …." An area subtitled "Health Management" had a checked box to indicate "Medication issues identified" and stated " … Non Adherence … Medication(s) Name and Description of Issue: … AVONEX [interferon beta medication used to slow the reduce the frequency of MS relapses], an MS med not given per daughter, claims doesn't need it … Clinical Manager notified: medication issue identified … Comment … Daughter sets up meds for client, only gives client what daughter feels client needs …" Another area subtitled "Visit Narrative" stated "[Person #3] shared that she only gives client meds [medications] she feels client needs. Has stopped giving client AVONEX, ms			

	injection to client as she doesn't feel it helps client. Also not administering NORCO [hydrocodone-acetaminophen – medication for moderate to severe pain] often, as client doesn't 'need it'. Educated on paim [sic] management and speaking with physician regarding meds before making decisions ... [person #3] claimed notified physician in February would no longer be administering and [person #3] claimed physician agreed ...." Record review failed to evidence the agency discussed and verified the medication issue with the patient's physician. Record review failed to evidence the agency notified the physician of the lack of medication treatment of the patient's primary diagnosis of MS. Record review failed to evidence the agency notified the physician that pain medication was not being administered per the patient's needs. Record review evidenced an agency document titled "Skilled Nurse Visit" from 10/7/2022, and electronically signed by LPN #1. An area subtitled "Care			

	Coordination" had a checked box to indicate "N/A ...." An area subtitled "Health Management" had a checked box to indicate "Home Environment, Altered" and stated "... Caregiver burnout, Lack of caregiver/family support, Limited social contact, Poor home environment ... Comment [person #3] sets up meds for client and only gives client was [sic] she feels is necessary. MS/neuro [neurologist; medical doctor who diagnoses, treats, and manages disorders of the brain and nervous system] Physician aware per daughter ...." Record review failed to evidence the agency notified the physician of an altered home environment including but not limited to lack of caregiver/family support and caregiver burnout. Record review evidenced an agency document titled "Skilled Nurse Visit" from 11/30/2022, and electronically signed by LPN #1. An area subtitled "Pain Profile" stated, "... Primary site: right side, right foot ... Current Pain Intensity: 5 – Very Distressing ... Nonverbal Pain			

	Cues: … Grimacing … Pain is Relieved/Mitigated By: Medication … Current Pain Management Effectiveness: Decline in mood, Decline in sleep pattern, Decline in physical function, Decline in psychosocial function … Patient is in constant pain … Client has had severe pain to foot for past 3 – 4 weeks. Experiencing new pain to right side for past 2 weeks …" An area subtitled "Care Coordination" had a checked box to indicate "N/A …." An area subtitled "Health Management" stated "Comment … [Person #3] sets up meds for client. [Person #4] … refused to administer another Tylenol [over the counter medication used to treat mild aches and pains], said needed to wait for [person #3] to administer anything else …." Record review evidenced the patient's pain was very distressing and had interfered with their quality of life. Record review failed to evidence the patient's increasing pain was reported to the physician. Record review failed to evidence the patient received pain medication used to treat moderate to severe pain, as it			

	was reported by the patient. Record review failed to evidence the agency notified the physician of the inadequate pain regimen that was reportedly dictated by person #3. Record review evidenced an agency document titled "Skilled Nurse Visit" from 12/7/2022, and electronically signed by LPN #1. An area subtitled "Pain Profile" stated, "... Primary site: RLE [right lower extremity] ... Current Pain Intensity: 6 – Intense ... Pain is Relieved/Mitigated By: Medication ... Current Pain Management Effectiveness: Decline in mood, Decline in sleep pattern ... Patient is in constant pain ..." An area subtitled "Care Coordination" had a checked box to indicate "N/A ...." Record review failed to evidence the agency notified the physician of the increasing pain level and inadequate pain mitigation regimen, as reported by the patient. Record review evidenced an agency document titled "Skilled Nurse Visit" from 12/14/2022,			

	and electronically signed by LPN #1. An area subtitled "Pain Profile" stated, "... Primary site: generalized pain, increased pain to RLE ... Current Pain Intensity: 8 – Severe ... Nonverbal Pain Cues: ... Grimacing ... Pain is Relieved/Mitigated By: Medication ... Current Pain Management Effectiveness: Decline in mood, Decline in sleep pattern, Decline in physical function, Decline in psychosocial function ... Patient is in constant pain ... per client, always experiencing pain, but, family not giving anything but acetaminophen [generic name for Tylenol] ..." An area subtitled "Health Management" stated "Medication issues identified ... Duplicate therapy, Missing Drugs from Ordered Regimen ... Medication(s) Name and Description of Issue: hydrocodone, [person #3] claims [entity #5] out of stock and has no idea when will be in stock ... [Person #3] sets up meds for client ...."			

	Record review failed to evidence the agency notified the physician of the patients increasing pain and inadequate pain mitigation regimen, as reported by the patient. Record review evidenced an agency document titled "Communication Note" from 12/14/2022, electronically signed by office manager #1 which stated, "Adult Protective Services were contacted today via an online report due to lack of care by family…." Record review evidenced pertinent issues that impacted the patient's overall health and well-being were documented as early as 10/5/2022. Record review evidence the patients pain increased. Record review failed to evidence interventions to manage pain to make the patient more comfortable. Record review failed to evidence the patient received adequate pain management for over 70 days according to skilled nurse documentation. Record review evidenced the patient had not been taking Avonex, or another form of MS treatment since February 2022,			

Record review failed to evidence the patient received adequate treatment for their primary diagnosis for over 70 days. Record review failed to evidence the agency promptly notified the physician for changes in the patient's condition prior to contacting adult protective services.

During an interview on 12/21/22, at 1:38 PM, office manager #1 indicated LPN #1 called the physician every week due to the client's condition.

5. Clinical record review on 12/14/2022, for patient #2, start of care 11/3/2022, pertinent diagnoses of dehydration and abnormal weight loss, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/3/2022 – 1/1/2023, and signed by the physician on 11/12/2022. This document had an area subtitled "Orders for Discipline and Treatment" which stated, "SN Frequency: 1w9 [once a week for 9 weeks] …."

Record review evidenced an

	Visit" electronically signed by LPN #1 on 12/8/2022. This document stated, "Physician Office Notified: No ... Reason ... Patient – Family Uncooperative ... Comments ... [Relative] refused visit, was too busy...." Record review failed to evidence the agency notified the physician of the missed visit. Record review failed to evidence the agency notified the physician of patient #2's family being uncooperative. Record review evidenced an agency document titled "Communication Note" electronically signed by intake coordinator #2 on 12/13/2022. This document stated, "Patient went to ER [emergency room] at [entity #1] on 12/12/2022 due to Hypernatremia [high sodium in the blood; commonly associated with dehydration] ...." Record review failed to evidence the agency promptly notified the physician of a change in the patient's condition, prior to being admitted to the hospital. During an interview on 12/21/2022, at 11:22 AM, when queried if the physician should			

	be notified of a missed visit, clinical manager #1 stated "Yes." 410 IAC 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 timely discharge. Based on record review and interview, the home health agency failed to ensure documentation of the patient's response to information provided for 1 of 1 closed clinical record reviewed. (patient #5) The findings include: Clinical record review on 12/19/2022, for patient #5, start of care 7/11/2022, primary diagnosis of type 2 diabetes, evidenced an agency document titled "OASIS-D1 Discharge" electronically signed by clinical manager #1 on 12/1/2022. An	G0610	The Director of Nursing gave in service to all clinicalstaff to educate patient and caregiver 1-Ongoing education and training to patientand caregiver 2-Discharge Planning 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 and caregiversand by sending Medical Social Worker to patient for use of community resources. Administrator will be responsible to make sure that thisdeficiency is corrected and	2023-01-20

	area subtitled “Interventions” which remained blank. Another area subtitled “Response to Teaching Procedure” also remained blank. Record review failed to evidence the patient’s response was documented to teaching provided by the agency. During an interview on 12/21/2022, at 2:06 PM, when queried what information was provided administrator #1 indicated the information provided to the patient was to follow up with their physician. 410 IAC 17-14-1(a)(1)(G)		will not recur	
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 and interview, the home health agency failed to ensure every patient received a visit schedule for all services provided by the agency, in writing for 2 of 2 patients where a home visit was conducted. (patient	G0614	The Director of Nursing in serviced the HHA staff to followstrictly of their visit schedules 1- Visit Schedule 2- Patient’s Rights and Responsibilities 3- Patient’s/caregiver participation in care	2023-01-20

	#1, #2) The findings include: 1. An observation of a home visit was conducted on 12/14/2022, from 11:11 AM to 12:01 PM, for patient #1, start of care 10/19/2022, with clinical manager #1. During the visit, the agency home folder was requested for review. The patient pulled the folder out from a stack of papers on the bedside table and handed it to clinical manager #1. Clinical manager #1 pulled a folder from their bag and slid it inside the patient folder. Review of the folder brought in by Clinical manager #1 evidenced a current schedule. Review of the folder obtained from the patient's home failed to evidence a current schedule. Observation failed to evidence the patient had a visit schedule prior to the home visit conducted. During an interview on 12/14/2022, at 11:59 AM, when queried how the patient knew when staff from Prime Care was coming, patient #1 indicated staff will call the day of their		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. **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 placedin-home folder.**	

visit. Patient #1 indicated someone called shortly before clinical manager #1 arrived. Clinical manager #1 agreed and stated "[office manager #1] called when we were en-route."

2. An observation of a home visit was conducted on 12/14/2022, from 2:04 PM to 2:34 PM, for patient #2, start of care 11/3/2022, with Licensed Practical Nurse (LPN) #1. At 2:06 PM, the patient's spouse indicated Thursdays would be better for skilled nurse visits. The agency home folder was requested for review. A folder was obtained from LPN #1 which had been brought in for the visit. Review of the folder brought in by LPN #1 on 12/14/2022, evidenced only a current schedule inside. Observation failed to evidence an admission folder in the home. Observation failed to evidence the patient had a visit schedule in writing prior to the home visit conducted on 12/14/2022.

During an interview on 12/14/2022, at 2:06 PM, LPN #1 indicated usually they call the

	patient the night before a visit, but the office staff already confirmed with the caregiver.			
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 home health agency failed to ensure the patient received a medication list with a schedule and instructions, for 2 of 2 patients where a home visit was conducted. (patient #1, #2) The findings include: 1. Review of an undated agency policy retrieved on 12/22/2022, titled "Medication Profile" revised in August 2011, stated "Purpose ... To define the use of the medication profile in evaluating a patient's medication regimen, over the counter (OTC) medications, nutrition supplements, herbal remedies, vitamins and minerals ... Procedure ... 4. Each patient	G0616	The Director of Nursing in serviced the HHA staff to followstrictly of 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. **ActionCompleted:** **OfficeManager printed the visit schedules for every patient and clinical managersgave those schedules to every patient and placed in home folders.**	2023-01-20

	will receive appropriate written material for specific medications he/she is receiving. The material will contain information on actions of the medications, potential side effects, contraindications the patient should be aware of, and any special instructions when taking the specific medication ….” 2. An observation of a home visit was conducted on 12/14/2022, from 11:11 AM to 12:01 PM, for patient #1, start of care 10/19/2022, with clinical manager #1. During the visit, the home folder was requested for review. The patient pulled the folder out from a stack of papers on the bedside table and handed it to clinical manager #1. Clinical manager #1 pulled a folder from their bag and slid it inside the patient folder. Review of the folder brought in by clinical manager #1 failed to evidence a current list of medications. Review of the folder obtained from the patient’s home failed to evidence a list of current medications. 3. An observation of a home visit was conducted on 12/14/2022, from 2:04 PM to		**<u>FuturePlan:</u>** **OfficeManager will make sure that every patient gets visit schedule and its placedin-home folder.**	

	2:34 PM, for patient #2, start of care 11/3/2022, with Licensed Practical Nurse (LPN) #1. During the visit, the home admission folder was requested for review and could not be found in the patient's room. At 2:32 PM, a folder was obtained from LPN #1 which had been brought in for the visit. Review of the folder brought in by LPN #1 failed to evidence a medication list. Observation failed to evidence the patient had a medication list with schedule and instructions in the home. 4. During an interview on 12/21/2022, at 11:00 AM, administrator #1, clinical manager #1, office manager #1, and intake coordinator #2 were notified of the patient's home folder missing information, including but not limited to a current medication list. Administrator #1 stated "OK."			
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	G0618	Administrator in serviced the staff to follow HHA Policy forwritten instructions regarding HHA services in patient's home folder 1- Treatmentsand Therapy	2023-01-23

	review, and interview, the home health agency failed to ensure the patient received a current plan of treatment in writing for 2 of 2 patients where a home visit was conducted. (patient #1, #2) The findings include: 1. Review of an undated agency policy retrieved on 12/22/2022, titled "Patient Education Process" revised in August 2011, stated "Purpose To provide guidelines for the provision of health information and instruction to patients and family/caregivers ... Policy Patients and family/caregivers will receive education in verbal, visual, and written format as appropriate ... Education will be the responsibility of each clinician and will focus on: ... 1. Facilitating the patient's and family/caregiver's understanding of his/her health status, health care options, and consequences of options ... 2. Encouraging patient participation in decision-making about health care options ... 3. Increasing patient and family/caregiver potential to follow the plan of care ... Procedure ...6. Unless otherwise		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.**	

	ordered by the physician (or other authorized licensed independent practitioner), the patient and family/caregiver will receive verbal and, as appropriate, written instructions on: ... B. The medical regimen ... F. Prescribed treatments ...." 2. An observation of a home visit was conducted on 12/14/2022, from 11:11 AM to 12:01 PM, for patient #1, start of care 10/19/2022, with Registered Nurse (RN) #1. During the visit, the home folder was requested for review. The patient pulled the folder out from a stack of papers on the bedside table and handed it to RN #1. RN #1 pulled a folder from their bag and slid it inside the patient folder. Review of the folder brought in by RN #1 failed to evidence a current plan of treatment. Review of the folder obtained from the patient's home failed to evidence a current plan of treatment. 3. An observation of a home visit was conducted on 12/14/2022, from 2:04 PM to			

	care 11/3/2022, with Licensed Practical Nurse (LPN) #1. During the visit, the home admission folder was requested for review and could not be found in the patient's room. At 2:32 PM, a folder was obtained from LPN #1 which had been brought in for the visit. Review of the folder brought in by LPN #1 failed to evidence a plan of treatment. Observation failed to evidence the patient had a plan of treatment in the home. 4. During an interview on 12/21/2022, at 11:00 AM, administrator #1, clinical manager #1, office manager #1, and intake coordinator #2 were notified of the missing information from the patient's home folders, including but not limited to a plan of treatment. Administrator #1 stated "OK."			
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager. Based on observation and interview, the home health agency failed to ensure the patient received contact information for the clinical	G0622	The Nurse Consultantin serviced the HHA Staff for home folders and contact names of the HHA. **<u>ActionCompleted:</u>** **A formhas been created, printed, and delivered to all patient regarding the contacts ofall disciplines of**	2023-01-13

	manager for 2 of 2 patient's where a home visit was conducted. (patient #1, #2) The findings include: 1. An observation of a home visit was conducted on 12/14/2022, from 11:11 AM to 12:01 PM, for patient #1, start of care 10/19/2022, with clinical manager #1. During the visit, the home folder was requested for review. The patient pulled the folder out from a stack of papers on the bedside table and handed it to clinical manager #1. Clinical manager #1 pulled a folder from their bag and slid it inside the patient folder. Review of the folder brought in by clinical manager #1 evidenced contact information written on the front of the folder for the clinical manager. Review of the folder obtained from the patient's home failed to evidence a list of contact information for the clinical manager. Observation failed to evidence the patient received contact information for the clinical manager prior to the home visit. During an interview on		**HHA.** **<u>FuturePlan of Action</u>** **Administratorwill make sure that every patient gets this form at the time of admission.**	

	12/14/2022, at 12:00 PM, patient #1 indicated they would not call the agency if symptoms or issues were to arise, instead they would go to the hospital or call their doctor. 2. An observation of a home visit was conducted on 12/14/2022, from 2:04 PM to 2:34 PM, for patient #2, start of care 11/3/2022, with Licensed Practical Nurse (LPN) #1. During the visit, the home admission folder was requested for review and could not be found in the patient's room. At 2:32 PM, a folder was obtained from LPN #1 which had been brought in for the visit. Review of the folder brought in by LPN #1 evidenced contact information written on the front of the folder for the clinical manager. Observation failed to evidence the patient had contact information for the clinical manager prior to the home visit conducted on 12/14/2022. 3. During an interview on 12/21/2022, at 11:00 AM, administrator #1 indicated all contact information was current in the new folder, and indicated			

	the contact information was not brought to the patient until 12/14/2022.			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the home health agency failed to ensure all clinicians performed hand hygiene to prevent the possible spread of communicable diseases for 1 of 1 home visit with a Registered Nurse (RN). (RN #1) The findings include: Record review of an undated agency policy retrieved on 12/22/2022, titled "Hand Hygiene" revised in August 2011, stated "Purpose ... To prevent cross-contamination and home care-acquired	G0682	NurseConsultant in serviced the clinical staff to follow HHA Policy of Hygiene andUniversal Precautions and change gloves in between the care process. **ActionCompleted:** HHA Staff iseducated **FuturePlan:** Director ofNurses will supervise all disciplines and care process during the visit andmake sure this deficiency is corrected and will not recur.	2023-01-16

	providing care in the home setting will regularly wash their hands, per the most recently published CDC [Center for Disease Control and Prevention] regulations and guidelines for hand hygiene in healthcare settings ... Procedure ... Hand decontamination with an alcohol-based hand rub ... 3. Hand contamination using an alcohol-based hand rub should be performed: A. Before having direct contact with patients ... C. After contact with a patient's intact skin (when taking a pulse, blood pressure or lifting a patient) ... F. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient ... G. After removing gloves ...." Review of the CDC [Center for Disease Control] website on 12/29/2022, for recommendations of hand hygiene for health care providers (www.CDC.gov/handhygiene/providers) stated, "When to Perform Hand Hygiene? ... Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for			

	hand hygiene: … After touching a patient or the patient's immediate environment … Immediately after glove removal ….” An observation of a home visit was conducted on 12/14/2022, from 11:11 AM – 12:01 PM, for patient #1, start of care 10/19/2022, with clinical manager #1. At 11:19 AM, clinical manager #1 donned a new pair of gloves and began the patient's assessment, which included but was not limited to, blood pressure, pedal pulses, heart, lung and stomach sounds. At 11:37 AM, clinical manager #1 removed their gloves and donned a new pair failing to perform hand hygiene in between glove changes. At 11:42 AM, an assessment using an incentive spirometer (a handheld device used to expand and strengthen the lungs) was completed and clinical manager #1 removed their gloves. Clinical manager #1 added information to the patient's home folder before the home visit was completed. Observation failed to evidence clinical manager #1 performed hand hygiene after touching inanimate objects in the			

	patient's home. Observation failed to evidence clinical manager #1 performed hand hygiene after removing gloves. Observation failed to evidence clinical manager #1 performed hand hygiene after patient care. During an interview on 12/21/2022, at 10:13 AM, clinical manager #1 indicated hand hygiene should be performed at the beginning of the visit with soap and water, followed by ABHR [alcohol based hand rub], and stated "The more, the better." They indicated hand hygiene should also be performed after patient care. 410 IAC 17-12-1(m)			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on observation, record review, and interview, the home health agency failed to ensure all clinical record documentation was accurate and complete for 3 of 4 active clinical records reviewed.	G0716	Nurseconsultant educated the clinical staff about vital signs and care process. **ActionCompleted:** HHA Staff iseducated, Nurses are getting computer education. Quality Assurance Nurse ishired. **FuturePlan of Action:**	2023-01-16

	(patient #1, #2, #4) The findings include: 1. An observation of a home visit was conducted on 12/14/2022, from 11:11 AM to 12:01 PM, for patient #1, start of care 10/19/2022, with clinical manager #1. During the visit, clinical manager #1 assessed the patient's vital signs. At 11:22 AM, the vital signs were reported as follows: Blood pressure on left arm – 130/70 mmhg [millimeters of mercury], pulse oximetry [oxygen saturation] – 99% on room air, Temperature - 97.8 using the temporal [forehead] route. Record review evidenced an agency document titled "Skilled Nurse Visit" which was electronically signed by clinical manager #1 on 12/14/2022. This document had an area subtitled "Vital Signs" that stated, "Temperature: 98.4 … O2 [oxygen] Saturation: 98% … BP [blood pressure] …." Record review failed to evidence the documentation of temperature and oxygen saturation accurately reflected		A Quality Assurancenurse is hired, who will make sure data is entered correctly	

what was observed during the home visit on 12/14/2022.

During an interview on 12/21/2022, at 10:55 AM, clinical manager #1 indicated the skilled nurse visit note must have been an error and should be the same as the home visit.

2. An observation of a home visit was conducted on 12/14/2022, from 2:04 PM to 2:34 PM, for patient #2, start of care 11/3/2022, with Licensed Practical Nurse (LPN) #1. Observation during the visit evidenced the patient was saturated with urine and had not consumed food or water yet that day, confirmed by person #8. Observation evidenced one bedroom with the patient in a twin size bed on one side of the room, and person #8 in a hospital bed on the other side of the room. Observation evidenced person #7 in the living room on the couch.

Clinical record review on 12/14/2022, for patient #2, pertinent diagnoses of dementia, dehydration, and history of falling, evidenced an agency document titled

	"OASIS-D1 Start of Care" electronically signed by clinical manager #1 on 11/3/2022. This document had an area subtitled "Caregiver Status" which stated "... lives with Grand [child] and [person #7] ...." Record review evidenced an agency document titled "Skilled Nurse Visit" electronically signed by clinical manager #1 on 11/29/2022. This document had an area subtitled "Plan of Care Review" which stated "...Caregiver Availability Grand [child] and [person #8] lives with patient ...." Record review failed to evidence consistent documentation of caregiver availability. Record review failed to evidence consistency with the observations. Record review failed to evidence accurate documentation of clinical records. During an interview on 12/21/2022, at 11:31 AM, when queried who the patient's caregiver was, clinical manager #1 stated "[Person #9]." Clinical manager #1 indicated person #8 lived with the patient and			

	food and water for the patient. They indicated person #7 and another relative lived there intermittently and helped with daily care. During an interview on 12/21/2022, at 11:43 AM, clinical manager #1 indicated they didn't know who lived in the home other than the patient and person #8. 3. Clinical record review on 12/20/2022, for patient #4, start of care 9/19/2022, primary diagnosis muscular dystrophy (disease that causes progressive weakness and loss of muscle mass), evidenced an agency document titled "OASIS-D1 Recertification" electronically signed by Registered Nurse (RN) #3 on 11/14/2022. This document had an area subtitled "Hospitalization Risk Assessment Tools and Emergency Preparedness" which had an unchecked box next to the statement "Emergency Preparedness Performed..." Another area subtitled "Prognosis" which had an unchecked box next to the statement "Advance Care Plan			

	Performed ...” An area subtitled “Supportive Assistance” stated “Caregiver Availability /Type of Assistance ... 24 hours ....” Record review of the skilled professionals documentation failed to evidence all safety precautions for emergency situations had been discussed with the patient/caregiver. Record review failed to evidence the type and ability for caregiver assistance. Record review failed to evidence the skilled professional completed the comprehensive assessment documentation. Record review failed to evidence an emergency preparedness plan was discussed with the patient. During an interview on 12/21/2022, at 10:24 AM, clinical manager #1 indicated the emergency preparedness plan was reviewed with the patient at every comprehensive assessment and was maintained on the front of the patient's chart. During an interview on 12/21/2022, at 1:26 PM, clinical manager #1 was queried on pertinent safety related			

	limited to who the patient lived with, the closest evacuation shelter, any medical equipment needed in the event of an evacuation. Clinical manager #1 stated they would "have to ask the nurse" for the answer to those questions. The patient's physical chart was reviewed in front of administrator #1, clinical manager #1, office manager #1, and intake coordinator #2, which failed to evidence the emergency preparedness plan was in the paper chart. 14 IAC 17-14-1(a)(1)(E)-RN			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the home health agency failed to ensure all patients had a	G0798	Nurse Consultant educated the Registered Nurses how togenerate HHA Care Plan 1- Home Health Aide assignments and duties 2- Individualized Plan of Care as per patient needs. 3- How to supervise the HHA Plan of Care. **ActionCompleted:** HHA Plan ofCare is added in the	2023-01-20

	home health aide care plan for 1 of 1 active clinical record reviewed where home health aide services were provided. (patient #3) The findings include: Record review of an undated agency policy retrieved on 12/22/2022, titled "Home Health Aide Plan of Care" revised August 2011, stated "Policy ... Each patient receiving home health aide services will have an individualized plan developed by an appropriate professional and utilized to direct the care performed by the assigned aide ... Procedure ... 2. The home health aide plan of care will be individualized to the specific patient and will include at least: ... G. Nutritional requirements ... L. Allergies ... 4. The home health aide plan of care will be revised at least every 60 days based upon a professional reassessment of the patient and at any time the patient's change of condition warrants revision ...." Clinical record review on 12/20/2022, for patient #3, start of care 9/7/2022, evidenced an		frequency scheduling in Axxess Software. **<u>FuturePlan:</u>** The Directorof Nursing will monitor each SOC and Recertification to make sure HHA Care Planis generated and supervised by the RNs.	

	agency document titled "HHA [home health aide] Care Plan" which stated "Episode/Period: 9/7/2022 – 11/5/2022 …" This document failed to evidence the patient's diet and allergies. Record review failed to evidence a current HHA care plan for the episode/period of 11/6/2022 – 1/4/2022. Review failed to evidence the HHA care plan was revised for each recertification. Review failed to evidence the care plan contained all individualized information as stated on the agency policy. During an interview on 12/21/2022, at 10:14 AM, clinical manager #1 indicated the home health aide care plans were created/revised at start of care, with every recertification, and reviewed every 14 days with the supervisory visit. During an interview on 12/21/2022, at 1:30 PM, clinical manager #1 indicated the patient should have a current home health aide care plan in the clinical record. 410 IAC 17-13-2(a)			

N9999	Final Observations These findings were corrected on 11/3/2022.	N9999	**ActionCompleted:** All employee personal and medical files are updated. All non licensed employees are tested for drug testing. All employees National Criminal Back ground checks are done. **FuturePlan:** The OfficeManager will update personal files on monthly basis to make sure all personalrecords are updated. OfficeManager will be responsible to make sure this deficiency is corrected and willnot recur.	2022-12-22

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	1/20/2023 5:51:35 PM