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	02/15/2023

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
G0000	INITIAL COMMENTS This survey was a second Federal Post Condition Revisit (PCR) survey for a home health agency conducted by the Indiana Department of Health. Survey Dates: 2/9/2023-2/10/2023, 2/13/2023-2/15/2023 Active Census: 8 Unduplicated admission for the past 12 months: 11 At this PCR survey, 9 Federal citations remained NOT in compliance; 4 Federal citations were put back into compliance; 25 additional Federal citations cited to be NOT in compliance. One Condition of Participation at 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care remained NOT in compliance, and 3 additional	G0000	PLAN OF CORRECTION IS BEING SUBMITED	

	Conditions of Participation were cited to be NOT in compliance: 42 CFR §484.65 Condition: Quality Assessment/Performance Improvement, 42 GFR §484.70: Infection Prevention and Control, and 42CFR 484.105 Organization and Administration of Services. Prime Care Home Health continues to be precluded from providing its own home health aide training and competency evaluation for a period of two years from 10/7/2022 - 10/6/2024, due to being found out of compliance with Conditions of Participation 42CFR 484.60 Care Planning, Coordination of Services and Quality of Care. QR Completed			
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--	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	2023-03-13

	(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 home health agency failed to ensure the patient/patient representative was informed of and consented to the care to be furnished and was informed of changes in the services to be provided in 3 of 6 clinical records reviewed. (Patient #1, #5, #6) Findings include: 1. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient's diagnoses included dementia (a progressive condition which affects memory and decision making). Review of an agency document		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 8- Patient Consent **ACTION COMPLETED** 100% Staff is educated, 100% Patients are informed, Power ofAttorney information is collected for all patients. **FUTURE PLAN OF ACTION** The Director of Nursing will audit 100% SOC and Recertsassessments and Plan of Care to make sure coordination of services for betterquality of care and outcomes. The Director of Nursing will be responsible to monitor andcorrect this deficiency.	

	Plan" dated 11/3/2022, indicated Person J was the patient's primary caregiver. Review of an agency document titled "Admission Consent and Service Agreement" dated 11/3/2022, indicated the patient's spouse signed the consent to treat. Review failed to evidence the patient's primary caregiver was informed of the patient's rights to be informed of and consent to services. During an interview on 2/10/2023, at 12:36 PM, Person J, patient's primary caregiver, indicated she was the patient's power of attorney (POA). Person J indicated the patient lived with a spouse who was also a patient of the agency who required assistance with care. Person J stated, "[patient] has dementia in a bad way." During an interview on 2/14/2023, at 4:08 PM, the clinical manager indicated the patient's primary caregiver/POA should have signed the consent to treat. 2. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an			

	agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient's diagnoses included dementia (a progressive condition which affects memory and decision making). During an interview on 2/10/2023, at 12:36 PM, Person J, patient's primary caregiver, indicated she was the patient's POA. Review of an agency document titled "Admission Consent and Service Agreement" dated 11/3/2022, indicated the patient signed the consent to treat. Review failed to evidence the patient's primary caregiver/POA was informed of the patient's rights to be informed of and consent to services. During an interview on 2/15/2023, at 2:39 PM, the clinical manager indicated the patient should not sign the consent to treat but the patient's representative should sign.			

	Record review of an agency document dated August 2011, titled, "Patient Notification of Changes in Care," stated, "... The patient will be notified within 24 hours of any significant changes in the agreed-upon schedule or plan of care ... Whenever the plan of care is changed, including services, frequencies, treatments, etc., the patient will be notified at the time of the visit ...." Clinical record review of an agency document titled, "Home Health Certification and Plan of Care," for certification period 01/11/2023-03/11/2023, evidenced patient to receive a home health aide 2 times per week for 8 weeks. Review of an agency document dated 01/30/2023, titled, "Patient Complaint Form," evidence the patient was asking why home health aide stopped coming to the home. Review indicated on 01/30/2023, administrative staff #4 indicated the patient was called and explained the insurance denied home health aide services and			

	an appeal for home health aide services was completed. Review of an agency document dated 01/31/2023, titled, "Communication Note," indicated the insurance denied the home health aide and the physician was notified. Review evidenced the last home health aide visit to the patient was on 01/23/2023. Review failed to evidence the patient was notified of the change in care regarding the home health aide care being discontinued until the complaint was received from the patient on 01/30/2023. During an interview on 02/14/2023, at 12:35 PM, administrative staff #6 indicated the appeal for home health aide visits was sent on 01/27/2023. Administrative staff #6 indicated there was not documentation of the patient being notified of the discontinuation of home health aide services prior to the 01/30/2023 complaint by the patient. IAC 410 17-12-3(b)(2)(D)(ii)(AA)(BB)			

G0440	Payment from federally funded programs 484.50(c)(7)(i, ii, iii, iv) Be advised, orally and in writing, of- (i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (ii) The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (iii) The charges the individual may have to pay before care is initiated; and (iv) Any changes in the information provided in accordance with paragraph (c)(7) of this section when they occur. The HHA must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f). Based on record review and interview, the home health agency failed to advise the patient the extent to which payment for services may be expected from Medicare, and the charges for services that may not be covered by Medicare in 2 of 3 clinical records reviewed with physical therapy services. (Patient #1, #3) Findings include: 1. Record review of an agency policy dated August 2011, titled, "Medicare Written Notices,"	G0440	**The ConsultantNurse in serviced the HHA Staff** - **To inform the patients or Power of Attorney for the charges not coveredby Medicare.** - **Patient payment responsibilities** - **Insurance coverage and benefits** - **Other Sources** **<u>ACTION COMPLETED</u>** o **Staff is educated,** o **Insurance Coverage and patient'sresponsibility is discussed with 100% patients.** o **Advance Beneficiary Notices areupdated.** o **Admission packet is updated.** o **100% Active charts are audited,** o **Patients and POAs are informed about theservices covered by Insurance and any non-covered charges.**	2023-04-06

	admitting clinician will inform the patient and/or his/her representative of his/her payment responsibilities for home health services. The patient will be informed of any subsequent changes in his/her financial responsibility … Insurance coverage and patient's responsibility for copayment will be discussed, disclosed, and presented in writing to the patient and family/caregiver. The actual costs for care, if any, will be presented in writing to the patient and family/caregiver. If copay responsibilities are not known, the clinician will provide the patient and family/caregiver with total organization charges until more accurate information can be obtained …." 2. Clinical record review on 02/10/2023, for patient #1, start of care 01/11/2023, evidenced an agency document dated 01/12/2023, titled, "Advance Beneficiary Notice of Non-coverage [ABN]," which evidenced blank boxes for service, reason of nonpayment, and estimated cost. The document's blank boxes/lines were not filled in except for the signature of the power of		**<u>FUTURE PLAN OF ACTION</u>** o **The DON will work with Case Managersto make sure that all notices are delivered and discussed with patients andPOAs at the time of admission.** o **Office Manager/Intake Coordinator willmake sure all forms are filled out properly.** **TheDirector of Nursing will be responsible to make sure this deficiency iscorrected and will not recur.**	

	attorney and the date. 3. Clinical record review on 02/14/2023, for patient #3, start of care 01/20/2023, evidenced an agency document dated 01/202023, titled, "Advance Beneficiary Notice of Non-coverage [ABN]," which evidenced blank boxes for reason for nonpayment and estimated cost. 4. During an interview on 02/15/2023, at 2:24 PM, administrative staff #5 indicated the Advance Beneficiary Notice of Non-coverage should be completed at start of care and when services are discontinued.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the home health agency failed to review all medications the patient is currently using in order to identify any potential adverse effects and drug reactions,	G0536	The Nurse Consultant in serviced the clinical staff how to gethelp from EMR for Medications adverse effects and drug reactions. **<u>ACTION COMPLETED</u>** Clinical Staff is educated. Medication Profiles are updated. **100 % Active charts are reviewed, All current medications arechecked for**	2023-03-17

	including significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy in 4 of 6 clinical records reviewed. (Patient #2, #4, #5, #6) Findings include: 1. Clinical record review on 2/14/2023, for Patient #4, start of care 1/26/2023, evidenced an agency document titled "Medication Profile" for episode period 1/26/2023 – 3/26/2023. Review indicated the patient's medications included, but were not limited to, Entresto (a medication used to treat heart failure), potassium chloride (a mineral supplement), metoprolol (a medication used to treat high blood pressure), amlodipine (a medication used to treat high blood pressure and/or heart disease), furosemide (a medication used to rid the body of excess fluid), digoxin (a medication used to treat heart failure and/or abnormal heart rhythms), aspirin (a medication used to reduce pain/fever/inflammation), and atorvastatin (a medication used to lower cholesterol). Review failed to evidence the document		**potential adverse effects and drug reactions including significantside effects, duplicate drug therapy.** **<u>FUTURE PLAN OF ACTION</u>** The Director of Nursing will monitor each patient MedicationProfile at time of SOC and Recertificationto make sure that nurses are using EMR help.	

	was signed by a registered nurse (RN). Review of an agency document titled "Drug-Drug Interactions" dated 2/14/2023, indicated a major drug interaction between potassium chloride and Entresto which could cause kidney failure, muscle paralysis, irregular heart rhythm, and cardiac arrest. Review indicated moderate interactions to include, but not limited to, metoprolol and amlodipine, potentially causing heart failure, severe low blood pressure, and chest pain; furosemide and metoprolol, potentially causing low blood pressure, slowed heart rate, and loss of blood sugar control; furosemide and digoxin, potentially causing abnormal heart rhythms; aspirin and digoxin, potentially causing digoxin toxicity; metoprolol and digoxin, potentially causing lowered heart rate; and digoxin and atorvastatin, potentially causing an increase in digoxin levels. Review failed to evidence the registered nurse reviewed the medications for potential drug interactions. Review of the initial			

	electronically signed by the RN and dated 1/26/2023, indicated the RN reconciled the medications and found no issues. During an interview on 2/15/2023, at 2:40 PM, the clinical manager indicated there was no record the registered nurse was aware of drug interactions. 2. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Recertification" and identified as the comprehensive assessment, signed by the RN and dated 12/30/2022. Review evidenced an agency document titled "Medication Profile", which was last signed by the clinical manager on 12/1/2022. Review failed to evidence the RN reviewed the medications for potential drug interactions and adverse side effects at the time of the comprehensive assessment. 3. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Recertification" and identified			

	as the comprehensive assessment, signed by the RN and dated 12/30/2022. Review evidenced an agency document titled "Medication Profile", which was last signed by the clinical manager on 12/1/2022. Review failed to evidence the RN reviewed the medications for potential drug interactions and adverse side effects at the time of the comprehensive assessment. 4. During an interview on 2/14/2023, at 3:44 PM, the clinical manager indicated medications should be reviewed at every recertification assessment. 1. Record review of an agency policy dated August 2011, titled, "Medication Profile," stated, "... Patient receiving medications administered by the organization will have a current, accurate medication profile in the clinical record. Medication profiles will be updated for each change to reflect current medications, new, and/or discontinued medications. Upon admission to the organization, the admitting clinician will initiate a			

	medication profile to document the current medication regimen. A drug regimen review will be performed at the time of admission, when updates to the comprehensive assessments are performed, when care is resumed after a patient has been placed on hold, and with the addition of a new medication. The review will identify drug/food interactions, potential adverse effects and drug reactions, ineffective drug therapy, duplicative drug therapy, and noncompliance with drug therapy ... Any conclusions and findings of patient medication use or monitoring should be communicated to the pharmacist, when appropriate, and other clinicians ...." 2. Clinical record review on 02/10/2023, of patient #2, start of care 10/14/2022, evidenced an agency document titled, "OASIS (outcome and assessment information set) D-1 Recertification," for certification period 02/11/2023-04/11/2023, indicated medication review was completed and assessed for drug interactions. The comprehensive assessment evidenced a blank box for			

	physician contacted regarding medication review. Review of an agency document dated 02/10/2023, titled, "Drug-Drug Interactions," indicated major drug interactions between sucralfate (medication for stomach ulcers) and cholecalciferol (vitamin D) , amlodipine (blood pressure medication) and simvastatin (cholesterol lowering medication), simvastatin and dronedarone (medication of irregular heart rhythms), and aspirin (pain reliever) and apixaban (blood thinning medication). Review of a web based source on 02/13/2023, https:drugs.com/drug-interactions.html, evidenced the following 3 major medication interactions between medications on patient #2's medication list: Aspirin and apixaban may increase risk of bleeding, simvastatin and amlodipine may increase liver damage and may cause rare condition that breaks down the skeletal muscles and causes kidney damage, simvastatin and dronedarone may increase liver damage and may cause rare condition that breaks down the			

	skeletal muscles and causes kidney damage. Review failed to evidence the physician was notified of the patient's major drug interactions. During an interview on 02/15/2023, at 1:48 PM, the director of nursing indicated there is no documentation the physician was informed of the major drug interactions. The director of nursing indicated the physician should be notified of major drug interactions and going forward would notify physician of major drug interactions. 410 IAC 17-14-1(a)(1)(B)			
G0562	Discharge Planning 484.58(a) Standard: Discharge planning. An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality	G0562	**The Nursein serviced the HHA staff on 03/06/2023 about** o **Discharge Planning.** o **Patient's Power of Attorneyinformation** o **Patient/Care Giver Teaching andEducation.** o **Care Coordination with otherproviders.**	2023-04-06

	measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. Based on record review and interview, the agency failed to implement a discharge planning process that assisted patients and their caregivers in selecting a care provider using quality measures that are applicable to the patient's goals of care and treatment preferences in 2 of 2 clinical records with pending discharge. (Patient #5, #6) The findings include: 1. Review of an agency policy revised August 2011, titled "Discharge Planning" stated, "... Information will be provided to assist the patient in planning his/her discharge, including referral and transfer ... Clinicians will assist patients regarding their discharge by: ... Serving as a referral source for patient and family/caregiver in obtaining follow-up support services ...." 2. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient was to receive skilled nursing services 1		o **Quality of Care.** **ACTIONAOMPLETED** o **Care Coordination form is created andplaced in admission packet.** o **Other providers' information iscollected for 100% patients.** o **Discharge Notices are updated.** o **100% of the patient's POA informationis collected.** **FUTUREPLAN** o **15 days prior to discharge noticewill be given.** o **If goals are not met, and patient is transferredto another facility or provider, Care Coordination will be done.** o **100% discharges will be auditedweekly until compliance is achieved, then monthly.** **TheDirector of Nursing will be responsible to make sure this deficiency iscorrected and will not recur.**	

	time a week for 9 weeks. Review indicated the patient's diagnoses included dementia (a progressive condition which affects memory and decision making). Review indicated the patient was to discharge when the caregiver was able to demonstrate necessary skills to aid patient in managing the disease process and activity. Review indicated the patient lived with a spouse who was also a patient of the agency. Review of agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/26/2023, and 2/8/2023, indicated the patient had muscle weakness, poor balance, shuffling unsteady gait, had difficulty breathing with minimal exertion, incontinent of bowel and bladder, and poor hydration. Review indicated the nurse assessed the patient to have poor oral and personal hygiene. Review of an agency document titled "Physician Order" dated 2/1/2023, and electronically signed by the office manager, indicated the patient was being discharged due to noncompliance. Review failed to			

	caregiver/power of attorney (POA) was provided a list of providers to assist the patient with care as required. Review failed to evidence referrals for care were made for the patient's post discharge care. During an interview on 2/10/2023, at 12:36 PM, Person J, patient's primary contact, indicated she was the patient's POA. Person J indicated the patient lived with spouse who was also a patient of the agency who required assistance with care. Person J stated, "[patient] has dementia in a bad way." Person J indicated she was unaware of patient's discharge from the agency and was not provided a list of agencies who could provide care to the patient. Person J indicated the patient required daily care. During an interview on 2/14/2023, at 4:06 PM, the administrator indicated the patient does have care needs and indicated he was unsure who would be providing the care the patient required. During an interview on 2/14/2023, at 4:06 PM, the clinical manager indicated the			

	agency had made no other efforts to find care the patient required. The clinical manager indicated no referrals had been made and no list of other agencies had been provided to the patient's caregiver. 3. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks. Review indicated the patient's diagnoses included dementia. Review indicated the patient was to discharge when the caregiver was able to demonstrate necessary skills to aid patient in managing the disease process and activity. Review indicated the patient lived with a spouse who was also a patient of the agency. Review of agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/26/2023, and 2/8/2023, indicated the patient was forgetful, had poor balance, shuffling gait, incontinent of bowel and bladder, and poor			

	hydration. Review indicated the patient had an altered home environment to include caregiver burnout, cluttered/soiled living conditions, and lack of caregiver support. Review of document dated 2/8/2023, indicated the patient appears to be wearing the same clothes at every visit and has dirty hands and feet. Review of an agency document titled "Physician Order" dated 2/1/2023, and electronically signed by the office manager, indicated the patient was being discharged due to noncompliance. Review failed to evidence the patient's primary caregiver/POA was provided a list of providers to assist the patient with care as required. Review failed to evidence referrals for care were made for the patient's post discharge care. During an interview on 2/10/2023, at 12:36 PM, Person J, patient's primary contact, indicated she was the patient's POA. Person J indicated the patient lived with spouse who was also a patient of the agency who required assistance with			

	unaware of patient's discharge from the agency and was not provided a list of agencies who could provide care to the patient. Person J indicated the patient required daily care. During an interview on 2/14/2023, at 4:06 PM, the administrator indicated the patient does have care needs and indicated he was unsure who would be providing the care the patient required. During an interview on 2/14/2023, at 4:06 PM, the clinical manager indicated the agency had made no other efforts to find care the patient required. The clinical manager indicated no referrals had been made and no list of other agencies had been provided to the patient's caregiver.			
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,	G0570	The Director of Nursing in serviced all clinical staff about 1-ComprehensiveAssessment 2- CarePlanning 3-Coordination of	2023-03-13

	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 / elements for the treatment of the patient (See tag G0574); 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); revisions to the plans for patient discharge were communicated to the physician responsible for the plan of care (See tag G0598); all orders were integrated into the plan of care (See tag G0604); coordination of care for all services provided to the patient (See tag G0606); education and training was provided to the caregiver prior to the discharge visit (See tag G0610); and the treatments to be administered		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 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	

	by agency personnel were provided to the patient and caregiver in writing (See tag G0618). The cumulative effect of these systemic problems has resulted in the home health agency's 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. In regards to G0570: Based on record review and interview, the agency failed to ensure the patients needs were met in 3 of 6 clinical records reviewed. (Patient #4, #5, #6) The findings include: 1. Review of an undated agency policy on 2/15/2023, titled "Admission Policy" stated, "… Admission criteria are standards by which a client is assessed for admission. These standards include consideration regarding the adequacy and suitability of Agency personnel to meet the client's needs, … and a reasonable expectation that the client's needs … can be adequately met …." 2. Clinical record review on 2/14/2023, for Patient #4, start		authorizations. Also instructed PT staff to start servicesASAP according to Plan of Care. **<u>FuturePlan Of Action</u>** DON will beinvolved with case manager for each patient's Plan of Care to make sure thisdeficiency should not recur. The Director of Nursing will be responsible to make sure this deficiency is corrected and will not recur.	

	of care 1/26/2023, evidenced an untitled document dated 1/19/2023, from Person H, nurse practitioner, which indicated the patient was being referred for home health services to include aide services due to hemiplegia (paralysis on one side of the body). Review of an agency document titled "Start of Care" and identified to be the initial comprehensive assessment dated 1/26/2023, indicated the patient was alert and oriented to person, place and time, and had zero episodes of confusion in the 14 days prior to start of care. Review indicated the patient required assistance for grooming, dressing, bathing, toileting, transferring, and feeding. Review indicated the patient lived with a family member who helped provide personal care. Review of an undated document titled "Patient Profile" indicated Person I was the primary contact for the patient. Review of an agency document titled "Admission Consent and Service Agreement" dated 1/26/2023, indicated home			

	health aide services were refused by the family member that signed the document. Review failed to evidence the form was signed by the patient or the patient's primary contact, Person I. Review failed to evidence home health aide services were offered to the patient. During an interview on 2/14/2023, at 2:19 PM, Person I, the patient's primary contact, indicated 2 of the patient's family members were employed by Entity F to provide care for the patient and indicated she had expressed to the agency's intake coordinator that the patient needed additional hours of assistance for personal care. Person I indicated she had not received any follow-up to her request for additional services. During an interview on 2/15/2023, at 3:28 PM, Person G from Entity F indicated Entity F provided 100 hours a month of attendant care and 60 hours a month of homemaker services to the patient. Person G indicated Entity F did not provide home health aide services.			

	During an interview on 2/15/2023, at 2:45 PM, the clinical manager indicated she was unsure why the consent form indicated home health aide services were refused and indicated she could not verify home health aide services were offered to the patient. The clinical manager indicated based on assessment the patient's needs included home health aide services. 3. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Medical Social Services Evaluation" dated 12/22/2022. Review indicated the medical social worker (MSW) recommended Meals On Wheels and homemaker services for the patient. Review failed to evidence follow-up on the MSW's recommendations and failed to evidenced Meals On Wheels and homemaker services were provided. During an interview on 2/14/2023, at 3:38 PM, the clinical manager indicated there was no follow-up on the MSW's recommendations and indicated she was unaware of the MSW			

	referral. The clinical manger indicated there should have been follow-up on the MSW recommendations. Review of an agency document titled "Recertification" and identified as the comprehensive assessment dated 12/30/2022, indicated the patient's diagnoses included, but were not limited to, dementia (a progressive condition impairing the ability to remember, thing, and make decisions), muscle weakness, limitation of activities due to disability, and need for assistance with personal care. Review indicated the patient requires 24 hour supervision, is forgetful and disoriented, has poor balance and muscle weakness, has a history of falls, has unsteady gait, is incontinent of bowel and bladder, and requires assistance for grooming, dressing, bathing, and toileting. Review of agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/26/2023, and 2/8/2023, indicated the patient had muscle weakness, poor balance, shuffling unsteady gait, had difficulty breathing with minimal exertion, and poor			

	hydration. Review indicated the nurse assessed the patient to have poor oral and personal hygiene. Review of the agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, failed to evidence the patient was to receive home health aide services. During an interview on 2/10/2023, at 12:36 PM, Person J indicated she was the Power of Attorney (POA) for the patient. Person J indicated the patient required assistance due to left-sided weakness after having a stroke and patient is left hand dominant. Person J indicated a family member sometimes stays at the patient's home, but he is "in and out" and indicated although the family member may be able to do some things to help the patient, the family member is not willing to bathe, toilet, and provide personal care for the patient due to being of the opposite sex than the patient. Person J indicated the patient lived with a spouse who is also a patient of the agency and is			

	unable to provide personal care for the patient. Person J indicated she has requested of the agency multiple times home health aide, physical and occupational therapy services for the patient and has been told by the agency that they would talk to the doctor. Person J indicated she has received no follow-up regarding the additional services. Review of an agency document titled "Admission Consent and Service Agreement" signed by the patient's spouse on 11/3/2022, indicated home health aide services were refused. Review failed to evidence the consent was signed by the patient's POA. Review failed to evidence the agency offered home health aide services after the comprehensive assessment on 12/30/2022. During an interview on 2/10/2023, at 3:15 PM, licensed practical nurse (LPN) #1, the primary nurse for the patient, indicated she believed the patient does not eat right and indicates the patient is unable to tell the nurse how often she eats or who prepares it. LPN #1			

	indicated she felt the patient needed home health aide and therapy services. LPN #1 indicated the family member that sometimes stays with the patient is “useless”. During an interview on 2/14/2023, at 3:20 PM, the clinical manager indicated the patient needed to be in an assisted living facility because the patient needed 24 hour care. At 3:52 PM, the clinical manager indicated the patient’s POA was not offered home health aide or occupational therapy services. During an interview on 2/14/2023, at 4:06 PM, the administrator indicated the patient does have care needs that are not being met and indicated he did not think of it like this before. 4. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled “Recertification” and identified as the comprehensive assessment dated 12/30/2022. Review indicated the patient’s diagnoses included, but were			

	progressive condition impairing the ability to remember, thing, and make decisions). Review indicated the patient is forgetful and depressed, has poor balance and muscle weakness, is at high risk of falls, has unsteady gait, is incontinent of bowel and bladder, and requires assistance for dressing, bathing, transferring, and toileting. Review of agency documents titled "Skilled Nurse Visit" dated 1/26/2023 and 2/8/2023, indicated the patient was forgetful, had poor balance, shuffling gait, and poor hydration. Review indicated the patient had an altered home environment to include caregiver burnout, cluttered/soiled living conditions, and lack of caregiver support. Review of document dated 2/8/2023, indicated the patient appears to be wearing the same clothes at every visit and has dirty hands and feet. Review of the agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, failed to evidence the patient was to			

services.

Review evidenced an agency document titled "Medical Social Services Evaluation" dated 12/22/2022. Review indicated the MSW recommended Meals On Wheels and homemaker services for the patient. Review failed to evidence follow-up on the MSW's recommendations and failed to evidenced Meals On Wheels and homemaker services were provided.

During an interview on 2/14/2023, at 3:38 PM, the clinical manager indicated there was no follow-up on the MSW's recommendations and indicated she was unaware of the MSW referral. The clinical manger indicated there should have been follow-up on the MSW recommendations.

During an interview on 2/10/2023, at 12:36 PM, Person J indicated she was the Power of Attorney (POA) for the patient. Person J indicated a family member sometimes stays at the patient's home, but he is "in and out" and indicated although the family member may be able to do some things to help the patient, the family

	member is not willing to bathe, toilet, and provide personal care for the patient. Person J indicated the patient lived with a spouse who is also a patient of the agency and is unable to provide personal care for the patient. Person J indicated she has requested of the agency multiple times home health aide, physical and occupational therapy services for the patient and has been told by the agency that they would talk to the doctor. Person J indicated she has received no follow-up regarding the additional services. Review of an agency document titled "Admission Consent and Service Agreement" signed by the patient on 11/3/2022, indicated home health aide services were refused. Review failed to evidence the consent was signed by the patient's POA. Review failed to evidence the agency offered home health aide services to the patient's POA after the comprehensive assessment on 12/30/2022. During an interview on 2/10/2023, at 3:15 PM, licensed practical nurse (LPN) #1, the			

	indicated she believed the patient does not eat right and is very depressed. LPN #1 indicated she felt the patient needed home health aide and therapy services. LPN #1 indicated the family member that sometimes stays with the patient is “useless”. During an interview on 2/14/2023, at 3:20 PM, the clinical manager indicated the patient needed to be in an assisted living facility because the patient needed 24 hour care. At 3:52 PM, the clinical manager indicated the patient’s POA was not offered home health aide or occupational therapy services. During an interview on 2/14/2023, at 4:06 PM, the administrator indicated the patient does have care needs that are not being met and indicated he did not think of it like this before.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized	G0572	The Director of Nursing in serviced all clinical staff about 1-Comprehensiveassessment and patient needs	2023-03-13

	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 observation, record review, and interview, the home health agency failed to provide the services that were written in the individualized patient plan of care in 6 of 6 clinical records reviewed. (Patient #1, #2, #3, #4, #5, #6) Findings include: 1. Clinical record review on 2/14/2023, for Patient #4, start of care 1/26/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/26/2023-3/26/2023, which was signed by Person H, nurse practitioner, on 1/27/2023. Review of an agency document titled "Physician Order" dated 1/27/2023, indicated the patient's family requested physician services by Person A, physician. Review failed to evidence the plan of care was reviewed and signed by Person A, physician.		2- Planof Care 3- CareCoordination 4- Patient/CaregiverTeaching 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. **ActionCompleted:** Clinicalstaff is educated, problematic RN is laid off, 100% clinical charts are auditedand are monitored continuously. **FuturePlan:**	

	During an interview on 2/15/2023, at 3:01 PM, the clinical manager indicated the patient's primary care provider was Person A and indicated Person A had not yet reviewed or signed the plan of care because the agency had not yet sent it to the physician. Review of the plan of care indicated the agency was to notify the physician for a diastolic blood pressure (the pressure against the arteries while the heart is at rest, noted as the bottom number of a blood pressure reading) of less than 60. Review of an agency document titled "PT [physical therapy] Visit" dated 2/1/2023, noted the patient's diastolic blood pressure was 57. Review failed to evidence the physician was notified of the diastolic blood pressure. During an interview on 2/15/2023, at 2:48 PM, the clinical manager indicated there was no documentation the physician was notified of the diastolic blood pressure and indicated the physical therapist		DON will beinvolved and supervise each case manager for each patient's plan of care tomake sure this deficiency will not recur. The Director of Nursing will monitor 100% admissions andrecerts to make sure that this deficiency is corrected and will not recur.	

	manager who should have notified the physician. 2. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the physician needed to be contacted if either the systolic (the pressure against the arteries when the heart contracts and represented by the top number of a blood pressure reading) or the diastolic (the pressure against the arteries when the heart is at rest and represented by the bottom number of a blood pressure reading) blood pressure was less than 60. Review indicated the primary diagnosis was hyposmolality (a condition where levels of electrolytes, nutrients, and proteins in the blood are lower than normal) and hyponatremia (a condition where sodium level in the blood is lower than normal). Review failed to evidence the plan of care included interventions and goals related to the primary diagnosis. Review indicated the patient's diet was a heart			

	healthy diet. Review of the plan of care indicated the patient's homebound status included oxygen dependency. Review indicated the skilled nurse was to assess the patient's pain. During an interview on 2/14/2023, at 3:10 PM, the administrator indicated it was impossible for the systolic blood pressure to be that low. At 3:38 PM, the administrator indicated the patient was not on oxygen and indicated the oxygen dependence for homebound status was part of standard verbiage in the template for the plan of care in the electronic medical record. During an interview on 2/14/2023, at 3:10 PM, the intake coordinator indicated the systolic blood pressure parameter was incorrect and indicated the plan of care was not individualized. During an interview on 2/14/2023, at 3:11 PM, the clinical manager indicated interventions should include the assessment of sodium intake, intake and output, edema, and skin turgor as related to the			

	clinical manager indicated there were not individualized goals related to the primary diagnosis but there should be. At 3:36 PM, the clinical manager indicated a heart healthy diet included low sodium and low fat. When queried why the plan of care included a low sodium diet for a patient with a primary diagnosis of abnormal low sodium levels, the clinical manager indicated the diet order was carried over from a previous plan of care but should have been changed on the current plan of care. Review of agency documents titled "Recertification" dated 12/30/2022 and "Skilled Nurse Visit" dated 1/18/2023, 1/26/2023, and 2/8/2023, indicated the patient had edema (swelling) to the lower extremities. Review failed to evidence the plan of care was individualized to include interventions related to the assessment of edema. During an interview on 2/14/2023, at 3:37 PM, the clinical manager indicated individualized interventions that should have been included in the plan of care was to educate the patient on elevating the			

	legs. Review of agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/25/2023, and 2/8/2023, indicated the patient had pain less often than daily and failed to indicate the assessment of pain at the time of the visit as directed in the plan of care. 3. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the physician needed to be contacted if the systolic blood pressure was less than 60. Review indicated the skilled nurse was to assess the patient's pain. During an interview on 2/15/2023, at 2:23 PM, the clinical manager indicated the plan of care was not individualized with an accurate systolic blood pressure parameter. Review of agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/25/2023, and			

	had pain less often than daily and failed to indicate if the patient had any pain at the time of the visit as directed in the plan of care. 4. During an interview on 2/15/2023, the clinical manager indicated pain should be assessed at every skilled nursing visit to include location, intensity, and frequency. 1. Record review of an undated agency policy received on 02/15/2023, titled, "Physician's Plan of Treatment/Change Orders," stated, "The physician's 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 Agency will provide care/services consistent with the plan of treatment ... Physician's orders on the plan of treatment shall relate to the diagnosis ...." 2. Clinical record review on			

	02/10/2023, for patient #1, start of care 01/11/2023, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 01/11/2023-03/11/2023, indicated the primary diagnosis as Type 2 diabetes mellitus with other specified complication (impairment of the way the body uses blood sugar). The plan of care patient medications included metformin (medication used to lower blood sugar), and Ozempic (medication used to control blood sugars). The plan of care orders for nursing indicated skilled nurse to assess diabetic status, identify any signs and symptoms of impaired diabetic function, and report significant changes to the physician. Review of agency documents dated 01/24/2023, 01/31/2023, and 02/08/2023 titled, "Skilled Nurse Visit," failed to evidence blood sugar test results. During an interview on 02/14/2023, at 12:44 PM, the director of nursing indicated a patient with a diagnosis of type 2 diabetes should have the frequency of blood sugar			

parameters for calling the physician on the plan of care. The director of nursing indicated the nurse should check the blood sugar at every skilled nurse visit and document the results.

3. Clinical record review on 02/10/2023, of patient #2, start of care 10/14/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/13/2022-02/10/2023, indicated foley catheter (a flexible tube that a clinician passes into the bladder to drain urine) change every 30 days.

Review of an agency document dated 01/24/2023, titled, "Skilled Nurse Visit," indicated date of last foley catheter change was 11/30/2022 and catheter change managed by home health agency and physician.

Review of an agency document dated 01/30/2023, titled, "Skilled Nurse Visit," indicated date of last foley catheter change was 01/30/2023.

Review failed to evidence the plan of care order to change the foley catheter every 30 days was

	completed by the skilled nurse. During an interview on 02/14/2023, at 11:43 AM, LPN (licensed practical nurse) #1indicated the patient's family member did not want foley catheter changed the week of Christmas but did not document the discussion. LPN #1 indicated the patient experienced pain with the foley catheter pain in the past and the patient's family member informed LPN #1 that Doctor A's office was going to send staff to home to change foley catheter. LPN #1 indicated she did not speak to Doctor's A's office regarding the family member's discussion with Doctor A. LPN #1 indicated the home health agency then told LPN #1 to change the foley catheter and not to wait for Doctor A's office to change foley catheter and that is when LPN #1 changed the foley catheter. LPN #1 indicated she did not have communication with Doctor A's office regarding foley catheter change or patient's pain during last foley catheter change. During an interview on			

director of nursing indicated there was no documentation why the foley catheter was not changed every 30 days as indicated on the plan of care. The director of nursing indicated the clinician should follow the plan of care foley catheter order to change every 30 days.

4. Clinical record review on 02/14/2023, for patient #3, start of care 01/20/2023, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 01/20/2023-03/20/2023, indicated patient principal diagnosis of type 2 diabetes mellitus without complications. The plan of care medications included metformin. The plan of care orders for skilled nursing included to perform complete physical assessment each visit with emphasis on non-insulin dependent diabetes. The plan of care indicated orders to notify physician for fasting blood sugar less than 60 or greater than 400.

Review of agency documents dated, 01/30/2023, 02/03/2023, and 02/09/2023, titled, "Skilled

	blood sugar test results. During an observation of a home visit on 02/14/2023, at 2:00 PM, LPN (licensed practical nurse) #1 failed to evidence a blood sugar test was performed. During an interview on 02/14/2023, at 3:00 PM, LPN #1 indicated she does not perform blood sugar monitoring for the patient during the nurse visit and the patient does not have a glucometer (machine to monitor blood sugar). LPN #1 indicated she didn't know why the patient was seen by a skilled nurse. During an interview on 02/15/2023, at 2:30 PM, the director of nursing indicated the patient's plan of care should include parameters for blood sugars monitoring and blood sugar monitoring should occur with every skilled nurse visit and documented. 410 IAC 17-13-1(a)			

G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the home health agency failed to ensure the individualized	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	2023-03-13

	diagnoses; medical supplies, and equipment required; all medications, reasons for use, and treatments; and safety measures to protect against injury in 4 of 6 clinical records reviewed. (Patient #1, #2, #5, #6) Findings include: 1. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/25/2023, and 2/8/2023. Review indicated the patient was using laxative (a medication used to treat constipation) and/or enemas (a medication used to treat constipation). Review indicated the nurse educated the patient on the use of pain medication and indicated the patient used a walker. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023 failed to evidence the plan of care included laxatives, enemas, and pain medication in the patient's list of medications. Review failed to evidence the plan of care included the walker in the		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 % chartsare reviewed, clinical staff is educated and Communication is improved. **FuturePlan:** Director ofNursing will be involved in each patient's plan of care and will monitor 100%Plan of Care to make sure this deficiency will not recur. The Director of Nursing will monitor 100% admissions and recerts to make sure that this deficiency is corrected and will not recur.	

	equipment (DME). During an interview on 2/14/2023, at 3:54 PM, the clinical manager indicated any laxative, enema, and pain medication the patient was using should have been included in the plan of care. The clinical manager indicated she observed the patient using the walker to go to the bathroom and all DME should be included in the plan of care. 2. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient's medication included, but was not limited to, acetaminophen (a medication used to treat pain and/or fever) as needed, Ventolin (an inhaled medication used to treat shortness of breath) as needed, Combivent (an inhaled medication used to treat shortness of breath) as needed, and Ipatroprium/Albuterol (an inhaled medication used to treat shortness of breath) as needed. Review failed to			

	evidence the plan of care included the indications for the medications to be used as needed. Review indicated the patient's homebound status included being chair bound. During an interview on 2/15/2023, at 2:26 PM, the clinical manager indicated the plan of care should include the reasons for use for the medications to be used as needed. Review of an agency document titled "Recertification" and identified as the comprehensive assessment dated 12/30/2022, the patient was assessed to be ambulatory with assistive device. Review indicated the patient used a sleep apnea (a condition where breathing stops and restarts while sleeping) machine. Review failed to evidence the type of sleep apnea machine and directions for use in the plan of care. During an interview on 2/15/2023, at 2:28 PM, the clinical manager indicated the patient could use the walker if needed and indicated the plan of care should be corrected. The			

clinical manager indicated the patient had a CPAP machine which was supposed to be worn at night.

1. Record review of an undated agency policy received on 02/15/2023, titled, "Physician's Plan of Treatment/Change Orders," stated, "The physician's 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 limited to: ... Diagnosis primary and secondary ... safety precautions ... Homebound status ... Medications ... Diet, Medical supplies and equipment ... Orders for treatments, treatment modalities, laboratory tests, Goals, and Discharge plans ...."

2. Clinical record review on 02/10/2023, for patient #1, start of care 01/11/2023, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 01/11/2023-03/11/2023

	indicated patient was taking Eliquis (medication to thin the blood) and Ozempic (medication to lower the blood sugar) given by injection. The plan of care failed to evidence safety precautions related to bleeding precautions and failed to evidence sharps (needles) safety related to injectable medication. During an interview on 02/14/2023, at 12:44 PM, the director of nursing indicated a patient on a blood thinning medication and taking an injectable medication should have bleeding precautions and sharps safety on the plan of care. Review of the agency Plan of Care for certification period 01/11/2023-03/11/2023, indicated patient was exhibiting taxing effort to leave home due to hypertension (elevated blood pressure) and dementia (loss of memory). Review of the Plan of Care indicated diagnosis was type 2 diabetes mellitus (difficulty regulating blood sugar), hemiplegia (weakness on one side of the body), legal			

	blindness, abnormality of mobility, muscle weakness, hypertension, hyperlipidemia (elevated cholesterol), and long-term use of anticoagulation (blood thinning medication). Review failed to evidence a diagnosis of dementia. Review of a referral document from entity D, dated 06/09/2022, evidenced the patient's diagnosis to be but not limited to Parkinson's (degenerative disorder that affects the motor system), transient cerebral ischemia (stroke), old myocardial infarction (heart attack), diabetic neuropathy (pain related to diabetes), glaucoma (eye sight degeneration), hyperthyroidism (thyroid disorder), hypercholesterolemia (elevated blood cholesterol level), edema (swelling), diabetes (disorder affecting blood sugar control), cad (heart disease) and anemia (low blood count). Review failed to evidence a diagnosis of dementia. During an interview on 02/15/2023, at 1:43 PM, the director of nursing indicated the			

	diagnosis of dementia. Review of an agency document titled, PT [physical therapy] Plan of Care," for certification period 01/11/2023-03/11/2023 indicated patient used walker for mobility. The agency's plan of care of care failed to evidence the walker under DME (durable medical equipment) and Supplies. During an interview on 02/14/2023, at 11:37 AM, LPN (licensed practical nurse) #2 indicated the patient ambulated with a walker. During an interview on 02/15/2023, at 1:43 PM, the director of nursing indicated the patient's use of the walker should be included on the plan of care. 3. Clinical record review on 02/10/2023, for patient #2, start of care10/14/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 02/11/2023-04/11/2023, indicated patient was taking medication Eliquis. The plan of			

	safety precautions. During an interview on 02/14/2023, at 12:44 PM, the director of nursing indicated a patient taking Eliquis should have bleeding safety precautions on the plan of care. 410 IAC 17-13-1(a)(1)(C)			
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 observation, record review, and interview, the agency failed to provide services as only ordered by a physician in 3 of 6 clinical record reviewed. (Patient #4, #5, #6) The findings include:	G0580	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	2023-03-13

	1. Review of an undated agency policy on 2/15/2023, titled "Physician's Plan of Treatment/Change Orders" stated, "... The Agency will provide care/services consistent with the plan of treatment...." 2. Clinical record review on 2/14/2023, for Patient #4, start of care 1/26/2023, evidenced an order from the office of Person A, physician, dated 2/6/2023. Review indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) to the sacral region (area of the lower back above the buttocks). Review indicated the nurse was to provide wound care by applying Silvadene (a wound ointment) and cover with a duoderm (a waterproof occlusive dressing) every 72 hours. During an observation of care at the patient's home on 2/15/2023, at 10:45 AM, the clinical manager was observed applying a foam dressing to the wound to the sacral area. Review failed to evidence a physician order for the foam		11- Wound Care management **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. Nurses willfollow physician orders and DON will monitor 100% plan of care. The Director of Nursing will monitor and assist field nurses to correct this deficiency and will not recur.	

dressing to the wound on the sacral area.

During an interview on 2/15/2023, at 2:51 PM, the clinical manager indicated the patient's daughter handed her the gauze foam dressing so that is what she applied to the wound. The clinical manager indicated she did not have a physician order for the gauze foam dressing and indicated she would apply a duoderm dressing at the next visit.

3. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Physician Order" dated 2/1/2023, which indicated the patient was discharged due to noncompliance.

Review evidenced an agency document titled "Skilled Nurse Visit" electronically signed by licensed practical nurse (LPN) #1 and dated 2/8/2023. Review indicated the nurse completed a head-to-toe assessment and provided patient education. Review failed to evidence a physician order for home care services after 2/1/2023.

During an interview on

	2/14/2023, at 4:03 PM, the clinical manager indicated the patient was not to be discharged until 2/14/2023 and the physician order should have been dated with an effective date of 2/15/2023. The clinical manager indicated the agency did not have any additional physician orders after the discharge order on 2/1/2023. 4. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Physician Order" dated 2/1/2023, which indicated the patient was discharged due to noncompliance. Review evidenced an agency document titled "Skilled Nurse Visit" electronically signed by LPN #1 and dated 2/8/2023. Review indicated the nurse completed a head-to-toe assessment and provided patient education. Review failed to evidence a physician order for home care services after 2/1/2023. During an interview on 2/14/2023, at 4:03 PM, the clinical manager indicated the			

	discharged until 2/14/2023 and the physician order should have been dated with an effective date of 2/15/2023. The clinical manager indicated the agency did not have any additional physician orders after the discharge order on 2/1/2023.			
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 physician of any changes in the patients condition or needs that suggest outcomes were not being achieved or that the plan of care should be altered in 3 of 6 clinical records reviewed. (Patient #2, #4, #6)	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	2023-03-13

	Findings include: 1. Clinical record review on 2/14/2023, for Patient #4, start of care 1/26/2023, evidenced an agency document titled "Medication Profile" for episode period 1/26/2023 – 3/26/2023. Review indicated the patient's medications included, but were not limited to, Entresto (a medication used to treat heart failure) and potassium chloride (a mineral supplement). Review failed to evidence the document was signed by a registered nurse (RN). Review of an agency document titled "Drug-Drug Interactions" dated 2/14/2023, indicated a major drug interaction between potassium chloride and Entresto which could cause kidney failure, muscle paralysis, irregular heart rhythm, and cardiac arrest. Review failed to evidence the agency notified the physician of the major drug interaction. During an interview on 2/15/2023, at 2:40 PM, the clinical manager indicated the agency should notify the physician of medication interactions. The clinical manager indicated there was no		4- Significant changes in patient's condition **<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. The Director of Nursing will monitor daily visits of nurses to make sure that this deficiency is corrected and will not recur	

	record the medication interactions were noted by the RN and sent to the physician. 2. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient's diagnoses included, but were not limited to, sleep apnea (a condition where breathing stops and restarts while sleeping) and used a sleep apnea machine (a machine that treats sleep apnea by assisting breathing by delivering oxygen through a tube and into a mask worn on the face while sleeping). Review of agency documents titled "Skilled Nurse Visit" completed by licensed practical nurse (LPN) #1 and dated 1/18/2023 and 1/26/2023, indicated the patient reported using the sleep apnea machine "all of the time" and indicated oxygen saturation (the measurement of oxygen in the blood) dropped without the sleep apnea mask on the patient's face. Review of			

document dated 2/8/2023, indicated the patient used the sleep apnea machine most of the time and oxygen saturation dropped without the sleep apnea mask in place. Review failed to evidence the LPN notified the physician of the patient's use of the sleep apnea machine when not asleep and of decreased oxygen saturation levels.

During an interview on 2/15/2023, at 2:28 PM, the clinical manager indicated the sleep apnea machine should be worn while the patient sleeps. At 2:40 PM, the clinical manager indicated the LPN should have notified the physician of the patient's use when not sleeping and of the decreased oxygen saturation levels.

1. Record review evidenced an undated agency policy received on 02/15/2023, titled, "Physician's Plan of Treatment/Change Orders," stated, "The physician's plan of treatment [Medicare's Plan of Care] is an individualized plan for care and treatment ... The

	immediately of any changes in the client's condition which indicate changes to the plan of treatment ...." 2. Clinical record review on 02/10/2023, for patient #2, start of care 10/14/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/13/2022-02/10/2023, indicated the foley catheter (tube inserted into bladder to drain urine) to be changed every 30 days. Review of an agency document dated 01/24/2023, titled, "Skilled Nurse Visit," indicated patient had foley catheter last catheter change was 11/30/2022. Review failed to evidence the physician was notified the foley catheter was not changed every 30 days per the plan of care order. During an interview on 02/13/2023, at 11:43 PM, LPN (licensed practical nurse) #1 indicated they foley catheter was not changed at end of December due to daughter did not want patient's foley catheter			

	Christmas. LPN #1 indicated daughter spoke to Doctor's office A, and office A was going to send clinician to change the foley catheter due to patient had pain during last foley catheter change. LPN #1 indicated she did not call Doctor A's office to discuss. LPN #1 indicated the home health agency spoke to Doctor A's office and informed LPN #1 to change the foley catheter. During an interview on 02/14/2023, at 12:55 PM, the clinical manager indicated the physician should have been notified if the plan of care order for foley catheter change every 30 days was not performed. Review of an agency document dated 01/30/2023, time in 12:30 PM, indicated LPN #1 changed the patient's foley catheter during visit on 01/30/2023. Review of an agency document dated 01/31/2023, titled, "Communication Note," indicated patient #2 called on 01/30/2023, at 7:30 PM, to inform the office and nurse that the urine bag had a tea cup amount of urine in it. The document indicated LPN #1 was			

notified to call patient and MD (medical doctor) notified by the office manager.

Review failed to evidence the patient's call to the office were addressed. Review failed to evidence LPN #1 documented, addressed, or assessed the patient's call.

During an interview on 02/14/2023, LPN #1 indicated she was not notified of patient's call regarding tea cup amount of urine in the urine bag on 01/30/2023 as she did not take after hours call. LPN #1 indicated the foley catheter was changed on 01/30/2023 during skilled nurse visit.

During an interview on 02/15/2023, at 1:46 PM, the administrator indicated the nurse saw patient on 01/31/2023 to address the patient's 01/30/2023 call.

Review of documentation failed to evidence documentation of a Skilled Nurse Visit on 01/31/2023. The administrator indicated the Skilled Note Visit from 01/30/2023 was dated wrong and left the room and returned with a Skilled Note Visit dated 01/31/2023. The

	Skilled Nurse Visit was the same as the 01/30/2023 Skilled Note Visit which indicated the foley catheter was changed on 01/30/2023. The 01/31/2023 Skilled Note Visit was signed by LPN #1 on 01/30/2023. During an interview on 02/15/2023, at 1:50 PM, the clinical manager indicated the plan of care should be followed by the LPN and and the patient should have been evaluated for the patient call and documentation of the follow up completed. During an interview on 02/15/2023, at 1:56 PM, the clinical manager indicated the office manager's communication note which indicated MD notified should not have been documented by the office manager. 410 IAC 17-13-1(a)(2)			
G0598	Discharge plans communication 484.60(c)(3)(ii)	G0598	**TheConsultant Nurse in serviced the HHA staff on 03/06/2023 about**	2023-04-06

	(ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). Based on record review and interview, the agency failed to communicate discharge plans to the physician and patient's representative in 2 of 2 clinical record reviews with medical social work (MSW) services. (Patient #5, #6) The findings include: 1. Review of an agency policy revised August 2011, titled "Discharge Planning" stated, "... Clinicians will assist patients regarding their discharge by: ... Consulting with the patient and family/caregiver regarding the need for discharge from the organization ... All communication and information regarding discharge planning will be documented in the clinical record...." 2. Review of an agency policy revised August 2011, titled "Monitoring Patient's		- **Discharge Planning** - **Physician Communication** - **Patient Communication** **<u>ACTION COMPLETED</u>** o **Physician Communication form has beencreated for discharge planning.** o **Care Coordination form with otherproviders has been created.** o **Patient's information for Power ofAttorney has been collected.** o **Discharge Notices are updated.** **<u>FUTURE PLAN OF ACTION</u>** o **In case of non-compliance of patient,physician will be notified same day.** o **In case of ineligibility of patient'sdecision power, POA will be contacted.** o **Primary Physician will be contactedfor coordinated services as required to patient.** o **The Director of Nursing**	

	Response/Reporting to Physician" stated, "... The patient's physician will be contacted on the same day when any of the following occur: ... Patient is to be discharged from the organization ...." 3. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks. Review indicated the patient's diagnoses included dementia (a progressive condition which affects memory and decision making). Review indicated the patient was to discharge when the caregiver was able to demonstrate necessary skills to aid patient in managing the disease process and activity. Review of agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/26/2023, and 2/8/2023, indicated the patient had muscle weakness, poor balance, shuffling unsteady gait, had difficulty breathing with		**will workwith Case Managers in discharge planning.** **TheDirector of Nursing will be responsible for correcting this deficiency and tomake sure will not recur.**	

	minimal exertion, and poor hydration. Review indicated the nurse assessed the patient to have poor oral and personal hygiene. Review of document dated 1/18/2023 indicated licensed practical nurse (LPN) #1 provided discharge notice to the patient due to noncompliance and indicated the physician was aware of plans to discharge. Review failed to evidence the LPN provided discharge notice to the patient's caregiver/power of attorney (POA). Review of an agency document titled "Physician Order" dated 2/1/2023, and electronically signed by the office manager, indicated the nurse knocked on the patient's door and no one answered. Review indicated the patient was being discharged due to noncompliance. Review failed to evidence the physician was contacted prior to the discharge regarding the plan to discharge. Review failed to evidence the patient's primary contact and power of attorney (POA) was notified of the discharge. During an interview on 2/10/2023, at 12:36 PM, Person			

	J, patient's primary contact, indicated she was the patient's POA. Person J indicated the patient lived with spouse who was also a patient of the agency who required assistance with care. Person J stated, "[patient] has dementia in a bad way." Person J indicated she was unaware of patient's discharge from the agency and of any noncompliance issues. During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated she was informed by the office manager the week prior that the patient was discharged due to noncompliance. LPN #1 indicated she was then notified this week to conduct a nurse visit and the patient would be discharged next week. LPN #1 indicated she did not provide discharge notice as documented on the visit note on 1/18/2023 because she was not aware the patient was discharging. LPN #1 indicated she added the discharge notice to the visit note on 1/18/2023 when she was informed by the office manager last week the patient was discharged since the note had yet to be completed. LPN #1 indicated			

	she did not contact the physician regarding the plans for discharge because she assumed the office had notified the physician since the office is who told her the patient was discharged last week. During an interview on 2/14/2023, at 3:30 PM, the administrator indicated the agency was discharging the patient due to noncompliance because the family member did not answer the door for visits or took a long time to answer the door. The administrator indicated they notify the physician they are discharging but indicated there was no documentation of physician notification of the plans to discharge prior to the physician order written on 2/1/2023. During an interview on 2/14/2023, at 4:02 PM, the clinical manager indicated there was no communication documented with the physician regarding noncompliance and plans to discharge. At 4:03 PM, the clinical manager indicated the agency did not communicate discharge plans to the family member that			

	patient or the power of attorney. During an interview on 2/15/2023, at 2:37 PM, the clinical manager indicated the office manager does not notify physician of patient changes and does not receive physician orders. The clinical manager indicated the office manager should not have documented the patient's discharge on the physician order form but should have used a communication form. 4. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks. Review indicated the patient's diagnoses included dementia. Review indicated the patient was to discharge when the caregiver was able to demonstrate necessary skills to aid patient in managing the disease process and activity. Review of agency documents			

	titled "Skilled Nurse Visit" dated 1/18/2023, 1/26/2023, and 2/8/2023, indicated the patient was forgetful, had poor balance, shuffling gait, and poor hydration. Review indicated the patient had an altered home environment to include caregiver burnout, cluttered/soiled living conditions, and lack of caregiver support. Review of document dated 1/18/2023 indicated LPN #1 provided discharge notice to the patient due to noncompliance and indicated the physician was aware of plans to discharge. Review failed to evidence the LPN provided discharge notice to the patient's caregiver/POA. Review of an agency document titled "Physician Order" dated 2/1/2023, and electronically signed by the office manager, indicated the nurse knocked on the patient's door and no one answered. Review indicated the patient was being discharged due to noncompliance. Review failed to evidence the physician was contacted prior to the discharge regarding the plan to discharge. Review failed to evidence the patient's primary contact and power of attorney			

	POA was notified of the discharge. During an interview on 2/10/2023, at 12:36 PM, Person J, patient's primary contact, indicated she was the patient's POA. Person J indicated the patient lived with spouse who was also a patient of the agency who required assistance with care. Person J indicated she was unaware of patient's discharge from the agency and of any noncompliance issues. During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated she was informed by the office manager the week prior that the patient was discharged due to noncompliance. LPN #1 indicated she was then notified this week to conduct a nurse visit and the patient would be discharged next week. LPN #1 indicated she did not provide discharge notice as documented on the visit note on 1/18/2023 because she was not aware the patient was discharging. LPN #1 indicated she added the discharge notice to the visit note on 1/18/2023 when she was informed by the office manager last week the			

patient was discharged since the note had yet to be completed. LPN #1 indicated she did not contact the physician regarding the plans for discharge because she assumed the office had notified the physician since the office is who told her the patient was discharged last week.

During an interview on 2/14/2023, at 3:30 PM, the administrator indicated the agency was discharging the patient due to noncompliance because the family member did not answer the door for visits or took a long time to answer the door. The administrator indicated they notify the physician they are discharging but indicated there was no documentation of physician notification of the plans to discharge prior to the physician order written on 2/1/2023.

During an interview on 2/14/2023, at 4:02 PM, the clinical manager indicated there was no communication documented with the physician regarding noncompliance and plans to discharge. At 4:03 PM, the clinical manager indicated the agency did not

	communicate discharge plans to the family member that occasionally stays with the patient or the power of attorney. During an interview on 2/15/2023, at 2:37 PM, the clinical manager indicated the office manager does not notify physician of patient changes and does not receive physician orders. The clinical manager indicated the office manager should not have documented the patient's discharge on the physician order form but should have used a communication form.			
G0604	Integrate all orders 484.60(d)(2) Integrate orders from all physicians or allowed practitioners involved in the plan of care to assure the coordination of all services and interventions provided to the patient. Based on record review and interview, the agency failed to ensure all orders were integrated into the plan of care in 1 of 1 clinical record reviewed with a hospitalization. (Patient #4) The findings include: Review of an undated agency	G0604	The Nurse Consultant in serviced the HHA Staff for - Integrationof Physician Orders - CarePlanning - CareCoordination **<u>ACTION COMLPETED</u>** - ClinicalStaff is Educated - Communicationwith physicians is improved. - CaseConferences are	2023-03-17

	policy on 2/15/2023, titled "Physician's Plan of Treatment/Change Orders" stated, "... The plan of treatment shall include but not be limited to: ... Medications ...." Clinical record review on 2/14/2023, for Patient #4, start of care 1/26/2023, evidenced a document titled "History and Physical" dated 1/24/2023 from Person H, nurse practitioner. Review indicated the patient's medication orders included carvedilol (a medication used to treat high blood pressure and/or heart failure), Eliquis (a medication used to treat and prevent blood clots), Invokana (a medication used to treat high blood sugar), spironolactone (a medication used to treat fluid build-up), and digoxin (a medication used to treat heart failure and/or abnormal heart rhythms). Review indicated digoxin 62.5 micrograms (mcg) was to be taken once every 48 hours. Review of the agency document titled "Home Health Certification and Plan of Care" for certification period 1/26 /2023-3/26/2023 was signed by		scheduled for all patients for all disciplines. - **100% Active charts are reviewed, All orders are integrated in the Plan ofCare. All hospital's discharged patient's orders are integrated, collaborated andreconciled.** **FUTURE PLAN** The DON will work with all clinical staff for improving theintegrated care and make sure this deficiency will not recur. The Director of Nursing will be responsible to make sure this deficiency is corrected and will not recur.	

	Person H on 1/27/2023. Review failed to evidence the patient's medication orders included carvedilol, Eliquis, Invokana, and spironolactone. Review indicated the order for digoxin was 125 mcg daily. Review failed to evidence the medication orders were integrated into the plan of care. During an interview on 2/15/2023, at 2:55 PM, the clinical manager indicated the agency should have included the medication orders listed from the patient's primary physician.			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the agency failed to coordinate care with other agencies providing services to the patient in 1 of 1 clinical record reviewed receiving services from another home care agency. (Patient #4) The findings include:	G0606	**The NurseConsultant in serviced the HHA Staff on 03/06/2023 about,** - **Integrated Care** - **Coordination among all providers** - **Coordination among all disciplines** **<u>ACTION COMPLETED</u>**	2023-04-06

	Review of an agency policy revised August 2011, titled "Coordination of Services with Other Providers" stated, "… The Case Manager will be responsible for the coordination between service providers, which will include, but not be limited to: Organization personnel's understanding of each organization's/individual's responsibility in providing care…." Clinical record review on 2/14/2023, for Patient #4, start of care 1/26/2023, evidenced a document from Entity E titled "After Visit Summary" dated 2/9/2023, which indicated the patient received home services from Entity F. During an interview on 2/15/2023, at 2:45 PM, the clinical manager indicated she was unaware of any other services provided to the patient by another agency. The clinical manager indicated the agency needed to have communication with Entity F. During an interview on 2/15/2023, at 3:28 PM, Person G from Entity F indicated Entity F		o **Care Coordination with otherproviders form has been created and placed in admission packet.** o **Contact persons names are mentionedon Care Coordination form of HHA and another provider.** o **100% Active patient's information forall services and needs are updated.** o **100% of all other providers arecontacted for care coordination.** **<u>FUTURE PLAN OF ACTION</u>** o **Patient or POA will be asked for allservices receiving from all providers at time of admission.** o **The Care Coordination form will be sentright away to other providers for integrated services.** o **The Director of Nurses will monitorCase Managers for coordinating with other providers and among all disciplinesfor integrated care.** **TheDirector of Nursing will be responsible to make sure this**	

	provided 100 hours a month of attendant care and 60 hours a month of homemaker services to the patient.		**not happen again.**	
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 agency failed to provide education and training to the caregiver prior to the discharge visit in 2 of 2 clinical records reviewed with pending discharge. (Patient #5, 6) The findings include: 1. Review of an agency policy revised August 2011, titled "Patient Education Related To Discharge Planning" stated, "... As part of the discharge planning process, the clinician will focus patient instruction on care and service requirements	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.	2023-03-13

	needed. ... Consulting with the patient and family/caregiver regarding the need for discharge instruction ... Discharge instruction will begin prior to the last visit...." 2. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks. Review indicated the patient's diagnoses included dementia (a progressive condition which affects memory and decision making). Review indicated the patient was to discharge when the caregiver was able to demonstrate necessary skills to aid patient in managing the disease process and activity. Review of agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/26/2023, and 2/8/2023, indicated the patient had muscle weakness, poor balance, shuffling unsteady gait, had difficulty breathing with minimal exertion, and poor hydration. Review indicated the		Administrator will be responsible to make sure that thisdeficiency is corrected and will not recur	

	nurse assessed the patient to have poor oral and personal hygiene. Review of document dated 1/18/2023 indicated licensed practical nurse (LPN) #1 provided discharge notice to the patient due to noncompliance and failed to evidence the LPN provided discharge training to the patient's caregiver/power of attorney (POA). During an interview on 2/10/2023, at 12:36 PM, the Person J, patient's primary contact, indicated she was the patient's POA. Person J stated, "[patient] has dementia in a bad way." Person J indicated she was unaware of patient's upcoming discharge from the agency and had not received discharge training. During an interview on 2/14/2023, at 4:03 PM, the clinical manager indicated the agency did not provide discharge education to the patient's primary caregiver/POA. 3. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an			

	Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks. Review indicated the patient's diagnoses included dementia. Review indicated the patient was to discharge when the caregiver was able to demonstrate necessary skills to aid patient in managing the disease process and activity. Review of agency documents titled "Skilled Nurse Visit" dated 1/26/2023 and 2/8/2023, indicated the patient was forgetful, had poor balance, shuffling gait, was incontinent of bowel and bladder, and poor hydration. Review indicated the patient had an altered home environment to include caregiver burnout, cluttered/soiled living conditions, and lack of caregiver support. Review of document dated 2/8/2023, indicated the patient appears to be wearing the same clothes at every visit and has dirty hands and feet. Review of document dated 1/18/2023 indicated LPN #1 provided discharge notice to the patient due to			

	noncompliance and failed to evidence the LPN provided discharge training to the patient's caregiver/POA. During an interview on 2/10/2023, at 12:36 PM, the Person J, patient's primary contact, indicated she was the patient's POA. Person J indicated she was unaware of patient's upcoming discharge from the agency and had not received discharge training. During an interview on 2/14/2023, at 4:03 PM, the clinical manager indicated the agency did not provide discharge education to the patient's primary caregiver/POA.			
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 record review and interview, the home health agency failed to ensure the patient received a current plan of treatment in writing for 1 of 2 patients where a	G0618	The Director of Nursing in serviced the HHA staff to followstrictly HHA Policy to provide written Plan of Care to each patient in theirhome folder. 1- Patient's Rights and Responsibilities	2023-03-13

	home visit was conducted. (#3) Findings include: Record review of an agency policy dated August 2011, titled, "Informed Consent/Refusal of Treatment," stated, "... Upon admission and throughout the course of care/service, the patient and family/caregiver will be given information ... to make informed decision regarding the care/service being provided ... During the admission visit and follow-up visits, the patient and family/caregiver will be given information (verbally and/or in writing) that describes: The services and/or disciplines anticipated to be involved in the care/service of the patient ...." A home visit was conducted on 02/14/2023, from 2:00 PM to 2:58 PM, for patient #3, start of care 01/20/2023. During the visit, the home health patient folder was reviewed. Review of the home health patient folder failed to evidence a current plan of treatment. During an interview on 02/14/2023, at 11:15 AM, the clinical manager indicated the		2- Patient's/caregiver participation in care 3- Patient's consent and refuse 4- Providing written POC to every patient. **ActionCompleted:** - HHAStaff is educated - Allpatient's home folders are updated - Eachpatient has been given written POC. **FuturePlan:** The Director of Nursing will monitor each Plan of Care andmake sure its been given to each patient, Director of Nursing will be responsible to make sure thatthis deficiency is corrected and will not recur.	

	include the emergency preparedness plan, medication profile, plan of care and visit schedule.			
G0640	Quality assessment/performance improvement 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview, the home health agency's QAPI (quality assessment performance improvement) program failed to evidence measurable improvement in indicators (see tag G642); utilize quality indicator data to identify opportunities for improvement (see tag G644); the QAPI data led to an immediate correction of any	G0640	The Consultant Nurse in serviced the HHA staff about. - Quality Assurance and Performance Improvement - Wide Date QAPI Program - How to improve out comes for patients. **ACTION COMPLETED** - Governingbody meeting took place. - OBQIReports are pulled. - Outcomes are marked for improvement. - QAPIProgram has been in placed. **FUTURE PLAN** - GoverningBody meeting will be held quarterly. - OutComes will be measured quarterly.	2023-03-13

	potentially threaten the health and safety of patients (see tag G652); performance improvement activities tracked adverse patient events, analyzed their causes, and implemented preventive actions (see tag G654); conducted a performance improvement project annually (see tag G658); and failed to ensure the governing body was responsible for the implementation and maintenance of the QAPI program (see tag G660). The cumulative effect of these system problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 42 CFR §484.65 Condition: Quality Assessment/Performance Improvement.		- QANurse will audit 100 % charts. The Administrator will be responsiblefor QAPI Program and will make sure this deficiency is corrected and will notrecur.	
G0642	Program scope 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care.	G0642	The Nurse Consultant in serviced the HHA Staff about - Howto improve Out Comes - Howto improve Communication - Howto improve Coordination.	2023-03-13

	(2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. Based on record review and interview, the home health agency failed to ensure measurable improvement indicators were implemented to improve health outcomes and quality of care for the agency's QAPI (quality assessment performance improvement) program, and failed to measure, analyze, or track quality indicators, including adverse patient events. Findings include:		- Howto improve Quality of Care **ACTION COMPLETED** - Outcomesare marked for improvements. - Governing Body meeting had taken place. - DataCollection and Analysis has started. **FUTURE PLAN** - OBQIReports will be pulled on monthly basis. - Outcomeswill be measured monthly. - QAPIprogram will be monitored monthly. - GoverningBody meeting will be held quarterly to monitor QAPI. The Administrator willbe responsible for QAPI Program and will make sure this deficiency is correctedand will not recur.	

	Record review of an agency policy dated August 2011, titled, "Responsibilities In Improving Performance, stated, "... Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety ... The problem-solving approach will stress the interrelationship of quality service provided, management activities, and sound business practices as applicable to the organization's: ... Quality indicators, Data collection and analysis, Identify and set specific outcomes for measurable improvement ...." Record review of an agency policy dated August 2011, titled, "Aggregation of Data/Information," stated, "... Data to be considered for collection to monitor performance of the organization include the following: ... Measures or processes and outcomes for assessing performance as part the performance improvement plan, including analysis of levels, patterns, or trends over time that trigger further evaluation ... Summaries of actions take as			

	improvement activities, including risk management, utilization review, infection control safety management, outcomes reports regarding processes or services, and performance measures from acceptable databases ….” Record review of an agency policy dated August 2011, titled, “Patient Focused Performance Improvement,” stated, “… When an opportunity to improve performance is identified, a focus study [indicator] will be developed to measure and improve associated processes ….” Review of the agency’s QAPI program on 02/09/2023, failed to evidence data showing the measurable improvements in indicators related to the patient health outcomes and quality of care, and failed to measure, analyze, and track quality indicators, including adverse patient events. During an interview on 02/10/2023, at 4:00 PM, the administrator indicated there was not documentation showing measurable improvement in outcomes or			

	analysis of quality indicators. The administrator indicated there is no Quality Assessment nurse and was in the process of trying to hire a Quality Assessment nurse to assist with the QAPI program. 410 IAC 17-12-2(a)			
G0644	Program data 484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. Based on record review and interview, the home health agency failed to ensure the QAPI (quality assessment performance improvement) program utilized data from the measures derived from OASIS (outcome and assessment information set) to	G0644	The NurseConsultant in serviced the HHA Staff about - PerformanceImprovement Projects. - MeasurableActions to improve the Quality of Care. - PatientFocused Performance Improvement **ACTIONCOMPLETED** - PatientFocused Performance Improvement Plan has been developed. - DataCollection and Analysis has been started. - GoverningBody meeting has taken place. **FUTUREPLAN** -	2023-03-13

	services, quality of care, identify opportunities for improvement and monitor the quality of care. Findings include: Record review evidenced an agency policy dated August 2011, titled, "Patient Focused Performance Improvement, stated "... As part of the organization-wide performance improvement process, opportunities for improvement related to patient outcomes will be identified through continuous measurement of ... monitoring of incidents and infection control reports and Adverse Event Outcomes Reports ...." Record review evidenced an agency policy dated August 2011, titled, "Aggregation of Data/Information," stated, "... Data to be considered for collection to monitor performance of the organization include the following: ... Measures or processes and outcomes for assessing performance as part of the performance improvement plan, including analysis of levels, patterns, or trends over time that trigger further evaluation. Summaries		PerformanceImprovement Activities will be monitored monthly. - DataCollection and Analysis will be done monthly. - GoverningBody meeting will be held quarterly. The Administratorwill be responsible for QAPI Program and will make sure this deficiency iscorrected and will not recur.	

	of actions taken as a result of performance improvement activities, including risk management, utilization review, infection control, safety management, outcome reports regarding process or services, and performance measures from acceptable databases ….” Review of an undated agency policy received on 02/15/2023, titled, “Comprehensive Assessment and OASIS Data Collection Start of Care,” stated, “… A comprehensive assessment also includes Outcome Assessment Information or OASIS. OASIS data items measure a client’s health status … The OASIS data items are designed to systematically measure patient health care outcomes with adjustments for patient risk factors affecting those outcomes in order to Establish Quality Based Quality Improvement or QBQI. QBQI will be the basis for benchmarking activities related to patient care outcomes in home health ….” Review of an agency policy dated August 2011, titled, “Responsibilities In Improving			

	Performance," stated, "... The Governing Body is responsible for ensuring that the performance improvement program is defined, implemented and maintained, and is evaluated annually ... Trends identified through performance improvement measurement and analysis will be reported to the Governing Body on a quarterly basis ...." Review of the agency's QAPI program on 02/10/2023, evidenced an agency document dated 02/10/2023, titled, "Hospitalization Log," which indicated the total number of hospitalization were 2 (patient #7, patient #8) from 10/03/2022-11/29/2022, and were received from the OASIS Transfer Assessment. Review failed to evidence the data collected was used to monitor the effectiveness and safety of services, quality of care, and identify opportunities for improvement. Review evidenced an undated agency document received on 02/10/2023, titled, "Hospital Log," evidenced total number of hospitalizations were 2 (patient #5, patient #7) from			

	11/29/2022-12/12/2022. Review failed to evidence patient #5 hospitalization was derived from OASIS data. Review failed to evidence the data collected was used to monitor the effectiveness and safety of services, quality of care, and identify opportunities for improvement. Review of the agency's QAPI program on 02/09/2023, failed to evidence the frequency and detail of the quality indicator data was approved by the Governing Body. During an interview on 02/10/2023, at 4:00 PM, the administrator indicated there was not documentation that quality indicator data derived from OASIS data was used to identify opportunities for improvement. The administrator indicated the last governing body meeting was in 2021 and there was not documentation of Governing Body approval of the frequency of the data collected. The administrator indicated there is no Quality Assessment nurse and was in the process of trying to hire a Quality Assessment nurse to assist with the QAPI			

	program. IAC 410 17-12-2(a)			
G0652	Activities lead to an immediate correction 484.65(c)(1)(iii) (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Based on record review, and interview, the home health agency's performance improvement activities failed to lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Findings include: Record review of an agency policy dated August 2011, titled, "Aggregation of Data/Information," stated, "... Data to be considered for collection to monitor performance of the organization include the following: ... Summaries of actions taken as a result of performance improvement activities, including risk management, utilization review, infection control, safety	G0652	The Nurse Consultant educated the HHA Staff about - Performance Improvement - Data Collection and Analysis. - Performance Improvement Activities. - Quality Assurance. **ACTION COMPLETED** - QAPIProgram has been monitored. - PerformanceImprovement Activities are started. - GoverningBody meeting had taken place. **FUTUR PLAN** - PerformanceImprovement Activities will be monitored monthly.	2023-03-13

	regarding processes or services, and performance measures from acceptable databases ….” Review of an agency document dated 02/10/2023, titled, “Hospitalization Log,” failed to evidence the home health agency’s performance improvement activities led to an immediate correction of identified problems that directly or potentially threaten the health and safety of patients. Review of the agency's QAPI (quality assessment performance improvement) program on 02/09/2023, failed to evidence performance improvement activities led to an immediate correction of identified problems. During an interview on 02/10/2023, at 4:00 PM, the administrator indicated the hospitalization log did not lead to any immediate corrections of the identified problem. 410 IAC 17-12-2(a)		- DataCollection and Analysis will be done monthly. - GoverningBody meeting will be held quarterly. The Administrator will be responsible for QAPI Program and willmake sure this deficiency is corrected and will not recur.	

G0654	Track adverse patient events 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. Based on record review and interview, the home health agency's performance improvement activities failed to track adverse patient events, analyze their causes, and implement preventive actions. Findings include:	G0654	The Nurse Consultant in serviced the HHA Staff about - AdversePatient Events. - PatientSafety. - Analysisof causes for adverse events - PreventiveMeasures to avoid adverse events. **ACTION COMPLETED** - QAPIProgram is being monitored. - DataCollection and Analysis has been started. - GoverningBody meeting has taken place. **FUTURE PLAN** - AdverseEvents will be avoided by taking preventive measures. - DataCollection and Analysis will be done monthly. - GoverningBody meeting will be done quarterly.	2023-03-13

	Record review of an agency policy dated August 2011, titled, "Patient Focused Performance Improvement," stated, "... The organization's performance improvement process will focus on the quality of patient and program outcomes ... As part of the organization-wide performance improvement process, opportunities for improvement related to patient outcomes will be identified through continuous measurement of patient satisfaction survey results, clinical/service record review, monitoring of incidents and infection control reports and Adverse Event Outcomes Reports ...." Review of an agency document dated 02/10/2023, titled, "Hospitalization Log," evidenced 2 patient hospitalizations from 10/03/2022-11/29/2022.		- ConsultantNurse will attend the Performance Improvement Committee meeting quarterly. The Administrator will be responsible for QAPI Program and willmake sure this deficiency is corrected and will not recur.	

	Review of the agency's QAPI (quality assessment performance improvement) program on 02/09/2023, failed to evidence performance improvement activities analyzed causes and implemented preventive actions in adverse events. During an interview on 02/10/2023, at 4:10 PM, the administrator indicated the agency did not analyze causes or implement preventive actions for adverse events. 410 IAC 17-12-2(a)			
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations.	G0658	The NurseConsultant in serviced the HHA Staff about - PerformanceImprovement Projects. - MeasurableActions to improve the Quality of Care. - PatientFocused Performance Improvement **ACTIONCOMPLETED** - PatientFocused Performance Improvement Plan has been developed.	2023-03-13

	(2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the home health agency failed to conduct a performance improvement project annually. Findings include: Record review of an agency policy dated August 2011, titled, "Patient Focused Performance Improvement," stated, "... The organization's performance improvement processes will focus on the quality of patient and program outcomes ... Program, or process related performance improvement activities will focus on opportunities to improve overall organizational performance ... When an opportunity to improve performance is identified, a focus study [indicator] will be developed to measure and improve associated processes. Performance improvement documentation will be maintained by the Performance Improvement Coordinator...." Review of the agency's QAPI (quality assessment performance improvement		- DataCollection and Analysis has been started. - GoverningBody meeting has taken place. **FUTUREPLAN** - PerformanceImprovement Activities will be monitored monthly. - DataCollection and Analysis will be done monthly. - GoverningBody meeting will be held quarterly. The Administratorwill be responsible for QAPI Program and will make sure this deficiency iscorrected and will not recur.	

	program) on 02/09/2023, failed to evidence a performance improvement project was conducted annually. During an interview on 02/10/2023, at 4:12 PM, the administrator indicated the agency's performance improvement project was to reduce hospitalizations but indicated there was no documentation of performance improvement project conducted. The administrator indicated he was trying to hire a nurse to assist with the QAPI program.			
G0660	Executive responsibilities for QAPI 484.65(e)(1)(2)(3)(4) Standard: Executive responsibilities. The HHA's governing body is responsible for ensuring the following: (1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained; (2) That the HHA-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness;	G0660	The NurseConsultant in serviced the HHA Staff about - QualityAssurance and Performance Improvement. - GoverningBody Responsibilities. - Howto monitor QAPI Program **ACTIONCOMPLETED**	2023-03-13

	(3) That clear expectations for patient safety are established, implemented, and maintained; and (4) That any findings of fraud or waste are appropriately addressed. Based on record review and interview, the home health agency's governing body failed to ensure an ongoing program for quality improvement and patient safety is implemented; and failed to ensure the priorities for improved quality of care and patient safety are evaluated for effectiveness, implemented and maintained. Findings include: Record review of an agency document dated August 2011, titled, "Responsibilities In Improving Performance," stated, "... The Governing Body is responsible for ensuring the performance improvement program is defined, implemented and maintained, and is evaluated annually ...." Record review of an agency document dated August 2011, titled, "Governing Body," stated, "... Relevant findings of performance improvement activities are consistently provided to the Governing Body		- PerformanceImprovement Projects are identified and started. - GoverningBody meeting has been taken place. - QAPICommittee has been established. **FUTUREPLAN** - PerformanceImprovement Activities will be monitored monthly. - DataCollection and Analysis will be done monthly. - GoverningBody meeting will be held quarterly. The Administratorwill be responsible for QAPI Program and will make sure this deficiency iscorrected and will not recur.	

	… All actions taken by the Governing Body will be documented in meeting minutes ….” Review of the agency’s QAPI (quality assessment performance improvement) program on 02/09/2023, failed to evidence the governing body ensured the ongoing program for quality improvement and patient safety was implemented and maintained annually. Review of the agency’s last governing body meeting was documented as 01/05/2021. During an interview on 02/10/2023, at 4:15 PM, the administrator indicated the last governing body meeting was 01/05/2021 that included QAPI discussion.			
G0680	Infection prevention and control 484.70 Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and	G0680	TheConsultant Nurse in serviced the HHA clinical staff about - InfectionPrevention and Control - Howto avoid infection in communicable diseases.	2023-03-13

	communicable diseases. Based on record review and interview, the home health agency failed to maintain and document a Covid-19 infection control program (see tag 687); and failed to follow the use of standard precautions to prevent the transmission of infections and communicable diseases (see tag 682). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality healthcare in a safe environment for Condition of Participation 42 GFR §484.70: Infection Prevention and Control.		- COVID19 precautionary measures **ACTIONCOMPLETED** - 100%staff is vaccinated. - 100%contracted staff is vaccinated. - COVID19 Policy is updated. **FUTUREPLAN** - AllHHA employees and Contracted employees will maintain their vaccination recordin their personal files. The OfficeManager will be responsible for maintaining the personal files of Covid 19vaccination.	
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 follow the use of standard precautions, to	G0682	The NurseConsultant in serviced the HHA Staff about - InfectionPrevention and Control - HandHygiene - UniversalPrecautions. **ACTIONCOMPLETED** - ClinicalStaff is educated.	2023-03-13

	prevent the transmission of infectious and communicable diseases during 2 of 2 home visits with a skilled nurse visit. (LPN (licensed practical nurse) #1, clinical manager) The findings include: 1. Record review of an agency policy dated August 2011, titled, "Hand Hygiene," stated, "... Personnel providing care in the home setting will regularly wash their hands, per the most recently published CDC regulations and guidelines for hand hygiene in health care settings ... Hand decontamination using an alcohol-based hand rub should be performed: ... After removing gloves ...." 2. Record review of an agency policy dated August 2011, titled, "Bag Technique," stated, "... The bag will contain a designated clean and dirty area. The clean area contains unused or clean supplies/equipment, and the dirty area is designated for contaminated materials. When the visit is completed, reusable equipment will be cleaned with alcohol, soap and water, or other appropriate solutions, hands will be washed, and		- Reusableequipment's are cleaned. **FUTUREPLAN** - ClinicalStaff will use CDC guidelines for hand hygiene in health care setting. The Directorof Nursing will be responsible to monitor nurses home visits and make sure thisdeficiency is corrected and will not recur.	

	equipment and supplies will be returned to the bag. Hands will be decontaminated prior to returning clean equipment to bag ...." 3. Review of the CDC (Center for Disease Control) website on 02/15/2023, (www.CDC.gov/handhygiene/provider/guidance.html) stated, "... Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: ... After touching a patient or the patient's immediate environment ... Immediately after glove removal ...." 4. An observation of a home visit was conducted on 02/14/2023, from 2:00 PM to 3:00 PM, for patient #3, start of care 01/20/2023 with LPN #1. At 2:48 PM, LPN #1 donned a new pair of gloves and assessed the patient's head and neck. LPN #1 removed the gloves after assessment and picked up a paper and pen for the patient to sign. Observation failed to evidence LPN #1 performed hand hygiene after removing the gloves after the patient assessment. At 2:58 PM, LPN #1 exited the home.			

	Observation failed to evidence LPN #1 performed hand hygiene after patient care. 5. An observation of a home visit was conducted on 02/15/2023, from 10:45 AM to 12:11 PM, with the clinical manager. The clinical manager donned gloves to change the coccyx dressing, gloves were removed, and hand hygiene was performed. The clinical manager donned a new pair of gloves and applied a new brief to the patient, gloves were removed, and the clinical manager picked up the patient's home folder. Observation failed to evidence the clinical manager performed hand hygiene after removing her gloves and the patient's home folder was picked up. The clinical manager removed the blood pressure cuff and machine from the newspaper on the recliner and returned to the nurse's bag. The nurse's bag had one compartment. Observation failed to evidence the blood pressure cuff and machine were cleansed/sanitized prior to returning to the nurse's bag. The patient's family member signed paperwork for the clinical manager. The clinical			

	manager exited the home at 12:11 PM. Observation failed to evidence hand hygiene was performed prior to exiting the patient's home. 6. During an interview on 02/15/2023, at 2:12 PM, the clinical manager indicated hand hygiene should be performed after removing gloves and before donning new gloves. 7. During an interview on 02/15/2023, at 2:12 PM, the clinical manager indicated when leaving a patient's home, she places dirty supplies in a grocery bag to be cleansed when she returned to the office. Discussed with the clinical manager observation failed to observe blood pressure cuff being put into a grocery bag and the nurse's bag had only one compartment and equipment should be cleansed prior to returning to the nurse's bag. The clinical manager indicated she understood the observation. 410 IAC 17-12-1(m)			

G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control. (d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and	G0687	The Administratorin serviced the HHA Staff about - COVID19 Policy - COVID19 Precautionary measures - Patientand Care giver safety. **ACTIONCOMPLETED** - COVID19 Policy has been updated. - 100Employees vaccination record has been updated. **FUTUREPLAN** Allemployees will maintain their vaccination record OfficeManager will be responsible to maintain personal files and to make sure thisdeficiency is corrected and will not recur.	2023-03-13

	(ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients; (ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;			

(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (d)(1) of this section;

(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;

(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;

(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements;

(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains

(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and

(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;

(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and

(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Based on record review and interview, the home health agency failed to implement policies and procedures to ensure the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who were not fully vaccinated; and failed to include policies and procedures that were implemented to ensure tracking of all staff vaccination status.

Findings include:

Record review of an undated agency policy received on 02/09/2023, identified as the Covid-19 policy by the administrator, titled, "Employee Health Requirements/Covid-19 Vaccination," and an agency policy dated August 2011, titled, "Infection Control/Expanded Precautions," failed to evidence the Covid-19 policy was specific

	to Covid-19 tracking of personnel vaccinations, or specific to Covid-19 precautions required. Review of the Covid-19 binder on 02/09/2023, failed to include contracted staff Covid-19 vaccination status tracking; failed to include N95 respiratory masks were to be worn by staff that were unvaccinated for Covid-19, and failed to include a contingency plan for unvaccinated staff to mitigate the transmission of Covid-19. During an interview on 02/10/2023, at 4:00 PM, the administrator indicated the Covid-19 policy was no specific but was included with the Hepatitis B policy. The administrator indicated all Covid-19 policies were reviewed. The administrator indicated all agency staff were vaccinated except for one that had a religious exemption. The administrator indicated unvaccinated staff must wear N95's if unvaccinated during patient care. The administrator indicated he did not get the Covid-19 vaccination status of contracted staff until they were			

	administrator indicated there is not a policy with a contingency plan for unvaccinated staff for Covid-19.			
G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on record review and interview, the agency failed to provide ongoing interdisciplinary involvement in the patient's plan of care in 2 of 2 clinical records reviewed with an impending discharge. (Patients #5, 6) The findings include: 1. Review of an agency policy revised August 2011, titled "Case Conference/Progress Summary" stated, "... Case conferences will be held at the start of care and at least every 60 days to review and discuss all multidisciplinary cases. ... Case conferences will include ... all clinicians – both direct and contract personnel – working with patients will participate in case conferences. ... For each patient, the Case Manager will	G0706	The NurseConsultant in serviced the HHA Staff about - InterdisciplinaryAssessment of the Patient. - DischargePlanning - CaseConferences - PatientCare and Coordination **ACTIONCOMPLETED** - DischargePlanning is completed. - DischargeNotices are updated. - Patientpersonal needs are identified. - **100% Active charts are reviewed for interdisciplinary involvement of caregivers in the Plan of Care.** - **Case Conference for all active patients are done, patient's needs areidentified**	2023-03-17

	lead the conference and discuss: Physical status of the patient … Patient treatment choices … Changes in condition … Interventions for all disciplines and patient response … Teaching plan and its effectiveness … Progress towards goals … Discharge plan ….” 2. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled “Medical Social Services Evaluation” dated 12/22/2022. Review indicated the medical social worker (MSW) recommended Meals On Wheels and homemaker services for the patient. Review failed to evidence the MSW informed the case manager of the recommendations. Review failed to evidence any follow-up on the MSW’s recommendations. During an interview on 2/14/2023, at 3:38 PM, the clinical manager indicated there was no follow-up on the MSW’s recommendations. Review evidenced agency		**and care is coordinated.** **<u>FUTUREPLAN</u>** - TheDON will be involved in each case conference and make sure patient needs areidentified and care is coordinated among all disciplines. The Director of Nursing will be responsible to make sure thisdeficiency is corrected and will not recur.	

	Visit" completed by licensed practical nurse (LPN) #1, which indicated the patient was noncompliant with taking medications as ordered by the physician on 1/18/2023 and 1/26/2023. Review of documents dated 1/18/2023, 1/26/2023, and 2/8/2023 indicated the patient's house smelled of urine and the patient had poor oral and personal hygiene. Review failed to evidence the LPN notified the case manager of the noncompliance and the condition of the patient and patient's residence. Review of an agency document titled "Communication Note" dated 1/26/2022, and completed by LPN #1, indicated the client's home smelled strongly of urine and had a sticky floor. Review indicated the nurse knocked repeatedly with no answer for approximately 5 minutes and indicated the same occurs at every weekly visit. Review failed to evidence the case manager was notified of the repeated difficulty getting into the patient's home. Review of an agency document			

titled "Physician Order" electronically signed by the office manager and dated 2/1/2023, which indicated the patient was discharged due to noncompliance. Review failed to evidence the clinical manager and the LPN providing the routine nursing visits were notified.

During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated there is no coordination of care with the agency personnel. LPN #1 indicated she has not had any communication with the clinical manager since December 2022 and does not know who the alternate clinical manager is. LPN #1 indicated she gets direction regarding the patient's schedule from the intake coordinator or the office manager. LPN #1 indicated she did not get notice of the patient's plan to discharge until last week when the office manager informed her the patient was discharged. LPN #1 indicated she was notified this week by the administrator that the patient needed a visit completed this week before being discharged next week and indicated the agency does not

know what is going on with patient care.

3. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Medical Social Services Evaluation" dated 12/22/2022. Review indicated the MSW recommended Meals On Wheels and homemaker services for the patient. Review failed to evidence the MSW informed the case manager of the recommendations. Review failed to evidence any follow-up on the MSW's recommendations.

During an interview on 2/14/2023, at 3:38 PM, the clinical manager indicated there was no follow-up on the MSW's recommendations.

Review evidenced agency documents titled "Skilled Nurse Visit" completed by LPN #1, which indicated the patient was noncompliant with diet, exercise, and medication administration on 1/18/2023. Review indicated the patient was noncompliant with medication schedule on 1/26/2023. Review of document

	dated 2/8/2023, indicated the patient appears to be wearing the same clothes at every visit and has dirty hands and feet. Review of documents dated 1/18/2023, 1/26/2023, and 2/8/2023, indicated the patient had an altered home environment to include caregiver burnout, cluttered/soiled living conditions, and lack of caregiver support. Review failed to evidence the LPN notified the case manager of the noncompliance and the condition of the patient and patient's residence. Review of an agency document titled "Communication Note" dated 1/4/2022, and completed by LPN #1, indicated the client's home smelled strongly of urine and had a sticky floor. Review indicated the patient had not eaten or drank anything yet for the day when the nurses arrived at noon. Review failed to evidence the LPN notified the case manager of the concerns noted at the nurse visit. Review of an agency document titled "Physician Order" electronically signed by the			

	2/1/2023, which indicated the patient was discharged due to noncompliance. Review failed to evidence the clinical manager and the LPN providing the routine nursing visits were notified. During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated she did not get notice of the patient's plan to discharge until last week when the office manager informed her the patient was discharged. LPN #1 indicated she was notified this week by the administrator that the patient needed a visit completed this week before being discharged next week. Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient's diagnoses included, but were not limited to, sleep apnea (a condition where breathing stops and restarts while sleeping) and used a sleep apnea machine (a machine that treats sleep apnea by assisting breathing by delivering oxygen through a tube and into a mask			

	worn on the face while sleeping). Review of agency documents titled "Skilled Nurse Visit" completed by LPN #1 and dated 1/18/2023 and 1/26/2023, indicated the patient reported using the sleep apnea machine "all of the time" and indicated oxygen saturation (the measurement of oxygen in the blood) dropped without the sleep apnea mask on the patient's face. Review of document dated 2/8/2023, indicated the patient used the sleep apnea machine most of the time and oxygen saturation dropped without the sleep apnea mask in place. Review failed to evidence the LPN notified the case manager of the patient's use of the sleep apnea machine when not asleep and of decreased oxygen saturation levels. During an interview on 2/15/2023, at 2:28 PM, the clinical manager indicated the sleep apnea machine should be worn while the patient sleeps. At 2:40 PM, the clinical manager indicated the LPN should have notified the registered nurse (RN) case manager of the			

	patient's use when not sleeping and of the decreased oxygen saturation levels. 4. During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated there is no coordination of care with the agency personnel. LPN #1 indicated she has not had any communication with the clinical manager since December 2022 and does not know who the alternate clinical manager is. LPN #1 indicated she gets direction regarding the patient's schedule from the intake coordinator or the office manager and indicated the agency does not know what is going on with patient care.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the licensed practical nurse (LPN) failed to prepare notes accurately in 3 of 6 clinical records reviewed. (Patient #1, #5, #6) The findings include:	G0716	The NurseConsultant in serviced the clinical staff about § Preparing Clinical Notes. § Discharge Planning. § Charting § Reviewing the clinical notes **ACTION COMPLETED**	2023-03-13

	1. Review of an agency policy revised August 2011, titled "Clinical Record Review" stated, "... Clinical records will be reviewed ... to assure that documentation entered is reliable, timely, valid, and accurate...." 2. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Medical Social Services Evaluation" dated 12/22/2022. Review failed to evidence the document was signed by the clinician. During an interview on 2/15/2023, at 2:29 PM, the clinical manager indicated the MSW note should have been signed by the MSW. Review of an agency document titled "Skilled Nurse Visit" dated 1/18/2023, and completed by licensed practical nurse (LPN)		§ Clinical Staff is educated. § Clinical Records are reviewed. § For Drugs reaction EMR is being used. **FUTURE PLAN** § The DON will audit and review theclinical notes of 100% charts. The Director of Nursing will be responsible to make sure thisdeficiency is corrected and will not recur.	

	#1, indicated LPN #1 provided discharge notice to the patient due to noncompliance and indicated the physician was aware of plans to discharge. Review of an agency document titled "Physician Order" dated 2/1/2023, and electronically signed by the office manager, indicated the patient was being discharged due to noncompliance. During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated she was informed by the office manager the week prior that the patient was discharged due to noncompliance. LPN #1 indicated she was then notified this week to conduct a nurse visit and the patient would be discharged next week. LPN #1 indicated she did not provide discharge notice as documented on the visit note on 1/18/2023 because she was not aware then the patient was discharging. LPN #1 indicated she added the discharge notice to the visit note on 1/18/2023 when she was informed by the office manager last week the patient was discharged since the note for the visit on			

1/18/2023 had yet to be completed. LPN #1 indicated she did not contact the physician regarding the plans for discharge because she assumed the office had notified the physician since the office is who told her the patient was discharged last week.

During an interview on 2/14/2023, at 3:58 PM, the intake coordinator indicated visit notes should be dated and signed at the time of the visit and should be documented accurately.

During an interview at the entrance conference on 2/9/2023, at 10:39 AM, the administrator indicated any corrections or amendments to a clinical document should be documented as an amendment.

Review evidenced agency documents titled “Skilled Nurse Visit” dated 1/18/2023, 1/25/2023, and 2/8/2023, and electronically signed by LPN #1. Review indicated the patient homebound status included oxygen dependence.

During an interview on 2/14/2023, at 3:38 PM, the administrator indicated the

patient was not on oxygen and indicated the oxygen dependence for homebound status was part of standard verbiage in the template for the plan of care in the electronic medical record which was pulled over into the skilled nursing visit note.

3. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Medical Social Services Evaluation" dated 12/22/2022. Review failed to evidence the document was signed by the clinician.

During an interview on 2/15/2023, at 2:29 PM, the clinical manager indicated the MSW note should have been signed by the MSW.

Review of an agency document titled "Skilled Nurse Visit" dated 1/18/2023, and completed by LPN #1, indicated LPN #1 provided discharge notice to the patient due to noncompliance and indicated the physician was aware of plans to discharge.

Review of an agency document titled "Physician Order" dated

	2/1/2023, and electronically signed by the office manager, indicated the patient was being discharged due to noncompliance. During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated she was informed by the office manager the week prior that the patient was discharged due to noncompliance. LPN #1 indicated she was then notified this week to conduct a nurse visit and the patient would be discharged next week. LPN #1 indicated she did not provide discharge notice as documented on the visit note on 1/18/2023 because she was not aware then the patient was discharging. LPN #1 indicated she added the discharge notice to the visit note on 1/18/2023 when she was informed by the office manager last week the patient was discharged since the note for the visit on 1/18/2023 had yet to be completed. LPN #1 indicated she did not contact the physician regarding the plans for discharge because she assumed the office had notified the physician since the office is who told her the patient was			

	discharged last week. 4. During an interview on 2/14/2023, at 3:58 PM, the intake coordinator indicated visit notes should be dated and signed at the time of the visit and should be documented accurately. 5. During an interview at the entrance conference on 2/9/2023, at 10:39 AM, the administrator indicated any corrections or amendments to a clinical document should be documented as an amendment. 410 IAC 17-14-1(a)(2)(B) 410 IAC 17-14-1(e)(3) 1. Review of an undated agency policy received on 02/15/2023, titled, "Physician's Plan of Treatment/Change Orders," stated, "The physician's 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 established the plan based upon the current assessment of the client … The plan of treatment shall include … Orders for treatments, treatment modalities, laboratory tests ….” 2. Clinical record review on 02/10/2023, for patient #1, start of care 01/11/2023, evidenced an agency document titled, “Home Health Certification and Plan of Care,” for certification period 01/11/2023-03/11/2023, indicated patient is on Eliquis (blood thinning medication). Review of agency documents dated 01/19/2023, 01/24/2023, 01/31/2023, 02/08/2023, titled, “Skilled Nurse Visit,” signed by LPN (licensed practical nurse) #2, indicated the patient was on Eliquis and the patient/caregiver self-monitored PT/INR (blood test for monitoring medication Coumadin (blood thinning medication). Review failed to evidence the PT/INR blood test was monitored by the patient/caregiver or the PT/INR blood test was indicated on the			

	plan of care. During an interview on 12/14/2023, at 12:50 PM, the administrator indicated a patient on Eliquis does not require PT/INR blood tests and should not be on the skilled nurse visit notes that patient performs PT/INR blood tests. 410 IAC 17-14-1(a)(2)(B)-LPN			
G0720	Participate in the HHA's QAPI program; 484.75(b)(8) Participation in the HHA's QAPI program; and Based on record review and interview, the home health agency failed to ensure all skilled profession staff participate in the home health agency's QAPI (quality assessment performance improvement) program. Findings include: Record review of an agency policy dated August 2011, titled, "Responsibilities In Improving Performance," stated, "... All personnel will be active participants in the organization's performance improvement ...."	G0720	The Nurse Consultant in serviced the HHA Staff about § QAPI Program § Participation of all disciplines. § Coordination of Care **ACTION COMPLETED** § QAPI Program is initiated andmonitored. § All Care giver professionals areinstructed to participate in QAPI Program **FUTUREPLAN** § QAPI Committee meeting will be heldmonthly. § All Nurses, Physical Therapists andother care giver	2023-03-13

	During an interview on 02/14/2023, at 3:00 PM, LPN (licensed practical nurse) #1 indicated she did not know what the QAPI program is and does not participate in the program.		professionals will participate in QAPI program. TheAdministrator will be responsible to make sure this deficiency is corrected andwill not recur.	
G0726	Nursing services supervised by RN 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). Based on record review and interview, the home health agency failed to ensure the registered nurse (RN) supervised the nursing services in 3 of 6 clinical records reviewed with services provided by a licensed practical nurse (LPN). (Patient #2, #5, #6) Findings include: 1. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced agency documents titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the skilled nurse was to assess the patient's pain. Review of agency documents	G0726	The NurseConsultant in serviced the HHA Clinical staff about § Nursing services supervised by RN § Clinical Notes § Care Coordination **ACTIONCOMPLETED** § Clinical Staff is educated. § 100% Charts are reviewed. **FUTURPLAN** § New Computer oriented Case ManagersRNs are hired to avoid this deficiency. The Director of Nursing will be responsible to make sure thisdeficiency is corrected and will not recur.	2023-03-13

	titled "Skilled Nurse Visit" completed by licensed practical nurse (LPN) #1 and dated 1/18/2023, 1/25/2023, and 2/8/2023, indicated the patient had pain less often than daily and failed to indicate if the patient had any pain at the time of the visit as directed in the plan of care. Review of an agency document titled "LVN [licensed vocational nurse, also knows as a LPN] Supervisory Visit" electronically signed by the alternate clinical manager and dated 1/26/2023, indicated LPN #1 followed the plan of care and implemented care as directed. Review failed to evidence the registered nurse (RN) provided supervision of the LPN to ensure the LPN was following the plan of care. 2. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced agency documents titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the skilled nurse was to assess the patient's pain. Review of agency documents			

	completed by LPN #1 and dated 1/18/2023, 1/25/2023, and 2/8/2023, indicated the patient had pain that does not interfere with activity or movement. Review failed to indicate the LPN assessed the pain to include the location and intensity of the pain as directed in the plan of care. Review of an agency document titled "LVN Supervisory Visit" electronically signed by the alternate clinical manager and dated 1/26/2023, indicated LPN #1 followed the plan of care and implemented care as directed. Review failed to evidence the RN provided supervision of the LPN to ensure the LPN was following the plan of care. 3. During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated she does not know who the alternate clinical manager is and has not had any communication with her. 4. During an interview on 2/14/2023, at 4:01 PM, the clinical manger indicated the RN should not document the LPN is following the plan of care when care is not provided as			

directed. The clinical manager indicated the RN should educate the LPN to the services to be provided per the plan of care. The clinical manager indicated she can not say when the alternate clinical manger last communicated with LPN #1 and indicated the alternate clinical manager has not returned multiple phone calls.

1. Record review of an undated agency document received on 02/15/2023, titled, "Licensed Graduate Practical Nurse," stated, "The licensed graduate practical nurse provides nursing care and teaching to clients and families. She also functions as an assistant to the physician and registered professional nurse, and is supervised by the RN [registered nurse] ... Responsibilities: Participates in the planning and coordination of total client care in conjunction with the RN and the physician's plan of treatment ...."

2. Clinical record review of an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/13/2022-02/10/2023, which indicated foley catheter (tube

	placed into bladder to drain urine) to be changed every 30 days. Review evidenced LPN (licensed practical nurse) visits on 01/11/2023 and 01/24/2023. Clinical record review on 02/10/2023, for patient #2, start of care 10/14/2022, evidenced an agency document dated 01/18/2023, titled, "LVN (licensed vocational nurse) Supervisory Visit," indicated administrative staff #4 evaluated LPN #1. The evaluation indicated LPN #1 followed the patient's plan of care for completion of tasks assigned. Review of an agency document dated 01/24/2023, titled, "Skilled Nurse Visit," indicated the foley catheter was last changed on 11/30/2022. Review failed to evidence LPN #1 was following the plan of care to change the foley catheter every 30 days. During an observation on 02/13/2023, at 12:54 PM, administrative staff #4 was contacted with no return call.			

	During an interview on 02/15/2023, at 1:45 PM, the administrator indicated administrative staff #4 didn't like to use the electronic medical records and didn't review the electronic medical records to supervise LPN's documentation. 410 IAC 17-14-1(a)(1)(J)-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 the home health aide plan of care had written instructions prepared by the registered nurse in 1 of 1 clinical records reviewed with a home health aide. (#2) Findings include: Record review of an agency	G0798	The NurseConsultant in serviced the HHA Staff about - HomeHealth Aide Assignment - HomeHealth Duties **<u>ACTIONCOMPLETED</u>** - HomeHealth Plans are revised and updated by RN. - HomeHealth Aides are in serviced. - **100% Active patients Home Health Aide Assignments are completed.** - **100% Home Health Aides are educated.** **<u>FUTUREPLAN</u>** - DONwill monitor all Case	2023-03-17

	"Home Health Aide Plan of Care," stated, "... 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. The patient's Case Manager, upon initialization of aide services, will develop the home health aide plan of care, consistent with the comprehensive plan of care ... The home health aide plan of care will be individualized to the specific patient and will include at least: ... Safety measures ...." Clinical record review on 02/10/2023, for patient #1, start of care 01/11/2023, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/10/2022-02/07/2023, which indicated the patient was on Eliquis (blood thinning medication). Review of an agency document dated 01/11/2023, titled, "HHA [home health aide] Care Plan," failed to evidence bleeding precaution for certification period 12/10/2022-02/07/2023.		Managers and Home Health Aides to make sure Home HealthAides are following Home Health Aide Assignments. The Director of Nursing will be responsible to make sure thisdeficiency is corrected and will not recur.	

	During an interview on 02/15/2023, at 3:37 PM, the clinical manager indicated the patient's home health aide plan of care should include safety measures such as fall precautions, and bleeding risk. 410 IAC 17-13-2(a)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review and interview, the home health agency failed to have the home health aide provide services that are ordered by the physician included in the plan of care in 1of 1 clinical records reviewed with a home health aide. (#1) Findings include: Record review of an agency policy dated August 2011, titled, "Home Health Aide Plan of Care," stated, "... Each patient	G0800	The NurseConsultant in serviced the HHA Staff about - HomeHealth Aide Assignment and Duties. - FollowingPhysician orders. **ACTIONCOMPLETED** - RNsand Home Health Aides are educated. - HomeHealth Plans are revised for all patients. **FUTUREPLAN** - DONwill monitor all Case Managers and Home Health Aides to make sure Home HealthAides are following Home Health Aide Assignments. The Directorof Nursing will be responsible to make sure this deficiency is corrected andwill	2023-03-13

	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 … The home health aide plan of care will be individualized to the specific patient and will include at least: Type of services/procedures to be provided ….” Record review of an agency policy dated August 2011, titled, “Orientation of Assigned Home Health Aide,” stated, “… Home health aides will receive patient information in the form of an aide assignment prior to caring for the patient … A home health aide assignment sheet is completed, reviewed with the home health aide, and signed by either the nurse or therapist and the home health aide … The home health aide assignment sheet correlates with the orders on the plan of care. The aide will complete an aide clinical note on each patient ….” Clinical record review on 02/10/2023, of patient #1, start of care 01/11/2023, evidenced		not recur.	

	01/11/2023, titled, "HHA (home health aide) Care Plan," indicated temperature, blood pressure, heart rate, and respirations were not to be completed for the patient. Review of an agency document dated 01/12/2023, titled, "Home Health Aide Assignment," failed to evidence temperature, heart rate, or respirations were to be completed for the patient by the home health aide. Review of agency documents dated 01/16/2023, and 01/18/2023, titled, "HHA Visit," indicated the patient's heartrate was 80 and 86, temperature was 97.8 and 98.3, and respirations were 20 and 20; and were completed by the home health aide. During an interview on 02/14/2023, at 1:25 PM, the clinical manager indicated the home health aide should follow the aide plan of care and aide assignment sheet and should not have performed temperature, heart rate or respirations. The clinical manager indicated the home health aide should follow the			

	perform tasks exactly as indicated, no more and no less than the plan of care directed.			
G0940	Organization and administration of services 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Based on record review and interview, the home health agency failed to ensure the organization and management of the home health agency as follows: the administrator failed to ensure the governing body reviewed the quality assessment and performance improvement program (see tag G0942); the administrator failed to maintain the day-to-day operations of the agency (see tag G0948); the administrator failed to ensure the clinical manager was available during operating hours (see tag G0950); and the clinical manager	G0940	The NurseConsultant in serviced the HHA Staff about - Organizationand administration of services - Dayto Day Operation supervision. **ACTIONCOMPLETED** - HHAStaff is educated. - NewNurses are hired. - NewADON is appointed. - GoverningBody meeting is held. **FUTUREPLAN** - Administratorwill make sure that all Case Managers are available 24/7 - Administratorwill monitor day to day operations closely. - GoverningBody will supervise overall operations of HHA. Administratorwill be responsible to make sure this deficiency is	2023-03-13

	failed to coordinate referrals (see tag G0964). The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.105 Organization and Administration of Services. A deficient practice citation was also evidenced at this standard as follows: Based on record review and interview, the agency failed to set forth in writing the organizational structure to include the lines of authority and the services provided. The findings include: 410 IA 17-12-1(a)(1) Record review of an agency policy dated August 2011, titled, "Use Of Organizational Chart," stated, "... There will be defined lines of authority, which clearly establishes responsibility and accountability for all organization personnel ... The organizational chart will be		corrected and will notrecur.	

	reviewed, revised and dated as changes occur…." Record review of an undated agency document received on 02/09/2023, titled, "Chart Of Organization," indicated the clinicians including registered nurse, physical therapist, medical social worker, home health aide reported to the office manager. The document failed to evidence licensed practical nurse on the organization chart. During an interview on 02/09/2023, at 3:54 PM, the administrator indicated the licensed practical nurse should be on the organizational chart and clinicians including the registered nurse, physical therapist, medical social worker, home health aide report to the director of nursing not to the office manager.			
G0942	Governing body 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall	G0942	The NurseConsultant in serviced the HHA Staff about - GoverningBody Duties. - QAPIProgram. **<u>ACTIONCOMPLETED</u>**	2023-03-13

	management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review and interview, the governing body failed to review the quality assessment and performance improvement program. The findings include: Record review of an agency policy revised August 2011, titled, "Governing Body" stated, "... Relevant findings of performance improvement activities are consistently provided to the Governing Body ... All actions taken by the Governing Body will be documented in meeting minutes ...." Review of the agency's QAPI (quality assessment performance improvement) program on 02/09/2023, failed to evidence the governing body had reviewed the QAPI program. Review of the agency governing body minutes on 2/10/2021 failed to evidence any QAPI		- GoverningBody meeting is held. - QAPIprogram is supervised. **FUTUREPLAN** - QAPImeeting will be held monthly. - Boardmeeting will be held quarterly. - GoverningBody will supervise continuously. Administrator will be responsible to make sure thisdeficiency is corrected and will not recur.	

	to the governing body since 1/5/2021. During an interview on 2/10/2023, at 4:20 PM, the administrator indicated there had not been any meetings with the governing body since 1/5/2021.			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the administrator failed to be responsible for the day-to-day operations of the agency. The findings include: The administrator failed to ensure the day-to-day operations of the home health agency as evidenced by: The administrator failed to ensure the patient/representative was informed of and consented to services to be provided and was	G0948	**The NurseConsultant educated the HHA Staff on 03/06/2023 about,** o **Day to Day Operations supervision.** o **Quick response and Management.** o **Following HHA Policies by alldisciplines and care providers.** o **Governing Body Responsibilities.** o **Administrator Responsibilities.** **<u>ACTIONCOMPLETED</u>** o **Governing Body meeting is held.**	2023-04-06

	Please see tag G0434. The administrator failed to ensure the agency policy was followed for the review of medications. Please see tag G0536. The administrator failed to implement a discharge planning process. Please see tag G0562. The administrator failed to ensure the needs of the patient were met, the patient received an individualized written plan of care and services were provided as directed, services were coordinated with all providers, and written information was provided to the patient. Please see tags associated with federal regulation 42CFR 484.60. The administrator failed to ensure there was a Quality Assessment and Performance Improvement (QAPI) program maintained at the home health agency. Please see tags associated with federal regulation 42CFR 484.65. The administrator failed to ensure the agency maintained an infection control program. Please see tags associated with federal regulation 42CFR		o **New RNs are hired.** o **New ADON is hired.** o **QAPI Program is in placed.** o **Staff are educated.** o **Care Coordination form with otherproviders has been created.** o **Case Conferences for CareCoordination among all disciplines have been held.** **<u>FUTUREPLAN</u>** o **Board meetings will be heldquarterly.** o **The Governing Body will supervise Administratorand Day to Day Operations continuously for better management and outcomes.** o **Administrator will make sure HHAPolicies are being followed.** **Theadministrator will be responsible to make sure this deficiency is corrected andwill not recur.**	

	484.70. The administrator failed to ensure the interdisciplinary involvement in the patient's plan of care. Please see tag G0706. The administrator failed to ensure skilled professionals created clinical notes and/or accurate complete notes for all services provided to patients. Please see tag G0716. The administrator failed to ensure the registered nurse provided supervision of the licensed practical nurse. Please see tag G0726. The administrator failed to ensure all home health aide care plans were complete and individualized. Please see tag G0798. The administrator failed to ensure all services were provided by the home health aide as directed in the aide care plan. Please see tag G0800. The administrator failed to ensure the clinical manager was available during operating hours. Please see tag G0950.			

	The administrator failed to ensure the clinical records contained goals in the plan of care. Please see tag G1016. The administrator failed to ensure clinical records were protected from loss and unauthorized use. Please see tag G1028. During an interview on 2/14/2023, at 3:23 PM, administrator indicated things used to be better but things haven't been running as smoothly in the absence of the alternate administrator. 410 IAC 17-12-1(c)(1) Record review of an agency policy dated August 2011, titled, "Responsibilities In Improving Performance," stated, "To establish patient outcomes as the primary focus of the organization's performance improvement activities. Senior management will have the responsibility: to guide the organization's efforts in improving organizational performance; to define expectations of the performance improvement activities; and to generate the plan and processes the			

	organization will utilize to assess, improve, and maintain quality of care and service. Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety ... The Governing Body is responsible for ensuring that the performance improvement program is defined, implemented, and maintained ... Senior management will ... adopt a structured framework for performance improvement ...." Record review of the agency's QAPI (quality assessment performance improvement) program on 02/09/2023, evidenced aggregated data from, "Medicare.gov/care-compare." Review evidenced the data were percentages from where the agency and region measured up to the national average. Record review failed to evidence the administrator ensured an ongoing QAPI program to improve patient care with specific measurable outcomes. During an interview on 02/10/2023, at 4:00 PM, the administrator indicated the			

	agency is not incorporating the agency's aggregated data for the QAPI program. The administrator indicated the agency was in the process of hiring a Quality Assessment nurse to assist with the QAPI program.			
G0950	Ensure clinical manager is available 484.105(b)(1)(iii) (iii) Ensure that a clinical manager as described in paragraph (c) of this section is available during all operating hours; Based on record review and interview, the home health agency's administrator failed to ensure that a clinical manager was available during all operating hours. Findings include: During an interview on 2/15/2023, at 1:30 PM, the clinical manager and intake coordinator indicated attempted calls were made to the alternate clinical manager without success. Record review evidenced an agency job description dated August 2011, titled, "Clinical	G0950	The NurseConsultant in serviced the HHA Staff about - ClinicalSupervision - Dayto Day Operation supervision. **ACTIONCOMPLETED** - NewADON is hired. **FUTUREPLAN** - Incase of DON absence, ADON will be available 24/7 Administrator will be responsible to make surethis deficiency is corrected and will not recur.	2023-03-13

	Director is responsible for the overall direction of home health clinical services … Coordinates and oversees all direct and indirect patient services provided by clinical organization personnel … Stays informed about changes in the field of nursing and home health care; shares information with appropriate organization personnel ….” Record review evidenced an agency job description dated August 2011, titled, “Home Health Administrator,” stated, “… The home health Executive Director/Administrator position will be responsible for the direction, coordination, and general supervision of all home health services … Establishing and maintaining effective channels of communication … Assuring appropriate staff supervision during all operating hours ….” Record review evidence an agency job description dated August 2011, titled, “Clinical Supervisor,” stated, “… The Clinical Supervisor is responsible for ensuring that patient care is coordinated and			

	Clinical Supervisor is responsible for ensuring that care and services are delivered appropriately as well as the supervision of clinical personnel ...." During an interview on 02/10/2023, at 12:19 PM, the administrator indicated the director of nursing was out of the office until Monday 02/13/2023, and the alternate clinical manager had been unable to be reached by the administrator after 2 attempts. During an interview on 02/10/2023, at 3:00 PM, the administrator indicated the director of nursing is not available and had been unable to reach after 2 attempts. During an interview on 02/13/2023, at 11:50 AM, after a call was placed to the home health agency, the office manager indicated the director of nursing was on her way to the office and the office manager will have the director of nursing call the surveyor once arrives to the office. During an interview on 02/13/2023, at 12:50 PM, after a call was placed to the home			

	health agency, administrative staff #5 indicated the director of nursing was at therapy and would have her call once came to the office, the surveyor asked administrative staff #5 for the alternate nursing manager, administrative staff #5 indicated the alternate nursing manager was not in the office, but I could call her on her cell phone. At 12:54 PM, the surveyor left a message for the alternate nursing manager to call the surveyor with contact information given to return call. At 2:30 PM, the surveyor called the home health agency office and administrative staff #5 indicated the director of nursing had not arrived to the office and for the surveyor to call the director of nursing. At 2:33 PM, the surveyor left a message for the director of nursing with contact information to return call. There was no return call from the director of nursing or of the alternate clinical manager on 02/13/2023.			

	During an interview on 02/14/2023, at 12:15 PM, the administrator indicated he had been unable to reach the alternate clinical manager since 02/09/2023. 410 IAC 17-12-1(d)			
G0964	Coordinate referrals; 484.105(c)(3) Coordinating referrals, Based on record review and interview, the clinical manager failed to provide clinical oversight of the coordination of patient referrals in 2 of 2 clinical records reviewed with referrals. (Patient #5, #6) The findings include: 1. Review of an undated agency job description on 2/15/2023, titled "Clinical Director" stated, "... Coordinates and oversees and direct and indirect patient services provided by clinical organization personnel...." 2. Clinical record review on	G0964	**The NurseConsultant in serviced the HHA Staff on 03/06/2023 about,** o **Coordination of referrals.** o **Continuous Care Supervision** o **Care Quality Improvement** **<u>ACTIONCOMPLETED</u>** o **DON was admitted in the hospital andnow is discharged and started monitoring case managers.** o **New ADON is hired to perform as DONwhenever is required.** o **Case Managers are educated for followup of continuous of care.** **<u>FUTUREPLAN</u>** o **Case Managers will**	2023-04-06

	2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Medical Social Services Evaluation" dated 12/22/2022. Review indicated the medical social worker (MSW) recommended Meals On Wheels and homemaker services for the patient. Review failed to evidence follow-up on the MSW recommendations. 3. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Medical Social Services Evaluation" dated 12/22/2022. Review indicated the MSW recommended Meals On Wheels and homemaker services for the patient. Review failed to evidence follow-up on the MSW recommendations. 4. During an interview on 2/14/2023, at 3:38 PM, the clinical manager indicated there was no follow-up on the MSW's recommendations and indicated she was unaware of the MSW referral. The clinical manger indicated there should have been follow-up on the MSW recommendations.		**supervise andcoordinate among all disciplines for continuous quality care.** o **ADON will audit 100% charts weeklyuntil compliance is achieved and then 50% on a regular basis.** o **The DON will make sure that the MSW andother care provider's recommendations are followed.** **TheDirector of Nursing will be responsible to make sure this deficiency iscorrected and will not recur.**	

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 contained wound-related goals in the plan of care in 1 of 1 clinical record reviewed with wounds. (Patient #4) The findings include: Review of an undated agency policy on 2/15/2023, titled "Physician's Plan of Treatment/Change Orders" stated, "... The plan of treatment shall include but not be limited to: ... Goals ...." Clinical record review on 2/14/2023, for Patient #4, start of care 1/26/2023, evidenced an order from the office of Person A, physician, dated 2/6/2023. Review indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue	G1016	The NurseConsultant in serviced the HHA Staff about - PatientGoals - PatientSafety - CareCoordination **ACTIONCOMPLETED** - ClinicalStaff is educated. - EMRtraining is provided about goals. - **100% Active patients, specially patients with wounds, Plan of Care arereviewed for goals.** - **Each patient's goals are set for achievement.** **FUTUREPLAN** - DONwill monitor each patient Plan of Care. The Directorof Nursing will be responsible to make sure this deficiency is corrected andwill not recur.	2023-03-17

	resulting from prolonged pressure to the skin) to the sacral region (area of the lower back above the buttocks). Review indicated the nurse was to provide wound care by applying Silvadene (a wound ointment) and cover with a duoderm (a waterproof occlusive dressing) every 72 hours. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 1/26/2023-3/26/2023, failed to evidence goals related to the patient's wound. During an interview on 2/15/2023, at 3:02 PM, the clinical manger indicated the plan of care should include goals related to the wound.			
G1028	Protection of records 484.110(d) Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164.	G1028	Administratorin serviced the HHA Staff about - HHAPolicy about Protection of Records. **ACTIONCOMPLETED** - HHAStaff is educated.	2023-03-13

	Based on observation, record review, and interview, the agency failed to safeguard clinical records against loss and unauthorized use. The findings include: Review of an agency policy revised August 2011, titled "Used and Disclosure of PHI [protected health information]" stated, "... Patient information and clinical record documents will not be left in open ...." During an observation on 2/15/2023, at 12:40 PM and again at 2:30 PM, a door labeled "Records Room" was observed open with clinical records unsecured on a desk and on top of boxes as well as clinical records in envelopes and boxes sitting on shelves in the room. The room was observed to be left unattended. During an interview on 3:37 PM, the clinical manager indicated the record room should be locked at all times and indicated she forgot to close the door and lock it after retrieving medical supplies prior to her home visit earlier in the morning.		- Roomis locked. **FUTUREPLAN** - Newrecords are electronical. - OldRecords room will be locked all times. OfficeManager will be responsible to make sure this deficiency is corrected and willnot recur.	

N0000	Initial Comments This was a second revisit for a State Re-Licensure survey of a home health agency, in conjunction with a Federal Post Condition Revisit survey. Facility ID: 00315 Survey dates: 2/9/2023-2/10/2023, 2/13/2023-2/15/2023 Active Census: 8 Unduplicated Admissions in the Last 12 Months: 11 At this revisit survey, 1 state regulation was put back into compliance; 3 state regulations remained out of compliance; and 1 additional state regulation was cited.	N0000	Plan Of Correction is done	
N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of	N0440	The NurseConsultant in serviced the HHA Staff about, - OrganizationalStructure - HomeHealth Agency Administration and	2023-03-14

	authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the agency failed to set forth in writing the organizational structure to include the lines of authority and the services provided. The findings include: Record review of an agency policy dated August 2011, titled, "Use Of Organizational Chart," stated, "... There will be defined lines of authority, which clearly establishes responsibility and accountability for all organization personnel ... The organizational chart will be reviewed, revised and dated as changes occur...." Record review of an undated agency document received on 02/09/2023, titled, "Chart Of Organization," indicated the clinicians including registered nurse, physical therapist, medical social worker, home health aide reported to the office manager. The document failed to evidence licensed practical nurse (LPN) on the		Management. **ACTIONCOMPLETED** - HHAStaff is Educated - OrganizationalChart is updated. - NewRNs are hired. **FUTUREPLAN** - Administratorwill make sure that competent nurses are hired. - OrganizationalChart will be maintained regularly. Administratorwill be responsible to make sure this deficiency is corrected and will notrecur.	

	organization chart. During an interview on 02/09/2023, at 3:54 PM, the administrator indicated the LPN should be on the organizational chart and clinicians including the registered nurse, physical therapist, medical social worker, home health aide report to the director of nursing not to the office manager. During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated she does not know who the alternate clinical manager is and has not had any communication with her.			
N0442	Home health agency administration/management 410 IAC 17-12-1(b) Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency.	N0442	The NurseConsultant in serviced the HHA Staff about, - QualityAssessment and Performance Improvement Program - GoverningBody Responsibilities and Duties. **ACTIONCOMPLETED** - QAPIProgram is supervised. - GoverningBody meeting has been held.	2023-03-14

	Based on record review and interview, the governing body failed to review the quality assessment and performance improvement program. The findings include: Record review of an agency policy revised August 2011, titled, "Governing Body" stated, "... Relevant findings of performance improvement activities are consistently provided to the Governing Body ... All actions taken by the Governing Body will be documented in meeting minutes ...." Review of the agency's QAPI (quality assessment performance improvement) program on 02/09/2023, failed to evidence the governing body had reviewed the QAPI program. Review of the agency governing body minutes on 2/10/2021 failed to evidence any QAPI		**<u>FUTUREPLAN</u>** - GoverningBody will supervise QAPI continuously. - GoverningBody meeting will be held quarterly. - DataCollection and Analysis will be held monthly. Administratorwill be responsible to make sure this deficiency is corrected and will notrecur.	

	information had been reported to the governing body since 1/5/2021. During an interview on 2/10/2023, at 4:20 PM, the administrator indicated there had not been any meetings with the governing body since 1/5/2021.			
N0444	Home health agency administration/management 410 IAC 17-12-1(c)(1) Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions.	N0444	**The NurseConsultant educated the HHA Staff on 03/06/2023 about,** o **Day to Day Operations supervision.** o **Quick response and Management.** o **Following HHA Policies by alldisciplines and care providers.** o **Governing Body Responsibilities.** o **Administrator Responsibilities.** **<u>ACTIONCOMPLETED</u>** o **Governing Body meeting is held.**	2023-04-06

	Based on record review and interview, the administrator failed to be responsible for the day-to-day operations of the agency. The findings include: Record review of an agency policy dated August 2011, titled, "Responsibilities In Improving Performance," stated, "To establish patient outcomes as the primary focus of the organization's performance improvement activities. Senior management will have the responsibility: to guide the organization's efforts in improving organizational performance; to define expectations of the performance improvement activities; and to generate the plan and processes the organization will utilize to assess, improve, and maintain quality of care and service. ... The Governing Body is responsible for ensuring that the performance improvement program is defined, implemented, and maintained ... Senior management will ... adopt a structured framework for performance improvement ...." The administrator failed to		o **New RNs are hired.** o **New ADON is hired.** o **QAPI Program is in placed.** o **Staff are educated.** o **Care Coordination form with otherproviders has been created.** o **Case Conferences for CareCoordination among all disciplines have been held.** **<u>FUTUREPLAN</u>** o **Board meetings will be heldquarterly.** o **The Governing Body will supervise Administratorand Day to Day Operations continuously for better management and outcomes.** o **Administrator will make sure HHAPolicies are being followed.** **Theadministrator will be responsible to make sure this deficiency is corrected andwill not recur.**	

	ensure the day-to-day operations of the home health agency as evidenced by: The administrator failed to ensure the patient/representative was informed of and consented to services to be provided and was informed of changes in services. Please see tag N0505. The administrator failed to ensure the needs of the patient were met. Please see tag N0570. The administrator failed to ensure the plan of care was individualized to include interventions and goals related to the need identified in the comprehensive assessment. Please see tag N0572. The administrator failed to ensure the plan of care was comprehensive to include all necessary items. Please see tag N0574.			

	The administrator failed to ensure there was a Quality Assessment and Performance Improvement (QAPI) program maintained at the home health agency. Please see tag N0472. The administrator failed to ensure the agency maintained an infection control program. Please see tag N0470. The administrator failed to ensure the interdisciplinary involvement in the patient's plan of care. Please see tag N0484. The administrator failed to ensure skilled professionals created clinical notes and/or accurate complete notes for all services provided to patients. Please see tag N0554. The administrator failed to ensure the registered nurse provided supervision of the licensed practical nurse. Please see tag N0549. The administrator failed to ensure the clinical manager was available during operating hours. Please see tag N0453. The administrator failed to			

	protected from loss and unauthorized use. Please see tag N0614. During an interview on 02/10/2023, at 4:00 PM, the administrator indicated the agency is not incorporating the agency's aggregated data for the QAPI program. The administrator indicated the agency was in the process of hiring a Quality Assessment nurse to assist with the QAPI program. During an interview on 2/14/2023, at 3:23 PM, administrator indicated things used to be better but things haven't been running as smoothly in the absence of the alternate administrator.			
N0453	Home health agency administration/management 410 IAC 17-12-1(d) Rule 12 Sec. 1(d) A physician or a registered nurse who has two (2) years of nursing experience, with at least one (1) year of supervisory or administrative experience, shall supervise and direct nursing and other therapeutic services.	N0453	The NurseConsultant in serviced the HHA Staff about, - HomeHealth Agency Administration and Management. - Dayto Day Operations. **ACTIONCOMPLETED** - HHAStaff is educated.	2023-03-17

	Based on record review and interview, the home health agency's administrator failed to ensure that a clinical manager was available during all operating hours. Findings include: Record review evidenced an agency job description dated August 2011, titled, "Clinical Director," stated, "The Clinical Director is responsible for the overall direction of home health clinical services ... Coordinates and oversees all direct and indirect patient services provided by clinical organization personnel ... Stays informed about changes in the field of nursing and home health care; shares information with appropriate organization personnel ...." Record review evidenced an agency job description dated August 2011, titled, "Home Health Administrator," stated, "... The home health Executive Director/Administrator position will be responsible for the direction, coordination, and		- Newcompetent RNs are hired. - Dayto Day Operations are supervised. - **New ADON is hired.** - **DON is discharged from the hospital and is available now 24/7.** **<u>FUTUREPLAN</u>** - Administratorwill make sure that competent nurses are hired. - GoverningBody will supervise QAPI continuously. - GoverningBody meeting will be held quarterly. - DataCollection and Analysis will be held monthly. Administratorwill be responsible to make sure this deficiency is corrected and will notrecur.	

	general supervision of all home health services ... Establishing and maintaining effective channels of communication ... Assuring appropriate staff supervision during all operating hours ...." Record review evidence an agency job description dated August 2011, titled, "Clinical Supervisor," stated, "... The Clinical Supervisor is responsible for ensuring that patient care is coordinated and managed appropriately. The Clinical Supervisor is responsible for ensuring that care and services are delivered appropriately as well as the supervision of clinical personnel ...." During an interview on 02/10/2023, at 12:19 PM, the administrator indicated the clinical manager was out of the office until Monday 02/13/2023, and the alternate clinical manager had been unable to be reached by the administrator after 2 attempts. During an interview on 02/10/2023, at 3:00 PM, the administrator indicated the			

	and had been unable to reach after 2 attempts. During an interview on 02/13/2023, at 11:50 AM, after a call was placed to the home health agency, the office manager indicated the clinical manager was on her way to the office and the office manager indicated the clinical manager would return phone call. During an interview on 02/13/2023, at 12:50 PM, after a call was placed to the home health agency, administrative staff #5 indicated the clinical manager was at therapy and would have her call once came to the office, the surveyor asked administrative staff #5 for the alternate clinical manager, administrative staff #5 indicated the alternate clinical manager was not in the office. At 12:54 PM, phone message left for the alternate clinical manager with instructions to return phone call. At 2:30 PM, administrative staff #5 indicated the clinical manager was not available. At 2:33 PM, a message was left with the clinical manager with contact information to return call. There was no return call from the clinical manager or			

	from the alternate clinical manager on 02/13/2023. During an interview on 02/14/2023, at 12:15 PM, the administrator indicated he had been unable to reach the alternate clinical manager since 02/09/2023. During an interview on 2/15/2023, at 1:30 PM, the clinical manager and intake coordinator indicated attempted calls were made to the alternate clinical manager without success.			
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	N0456	**The NurseConsultant in serviced the HHA Staff on 03/06/23 about,** o **Home Health Agency Administration/Management** o **Monitoring, Evaluating and ImprovingCare** o **Resolving identified problems.** o **QAPI** **<u>ACTIONCOMPLETED</u>** o **QAPI program is in placed.** o **Strengths and weaknesses**	2023-04-06

	assurance program designed to monitor and evaluate the quality of patient care, resolve identified problems, and improve patient care. Findings include: Record review of an agency policy dated August 2011, titled, "Responsibilities In Improving Performance," stated, "To establish patient outcomes as the primary focus of the organization's performance improvement activities. Senior management will have the responsibility: to guide the organization's efforts in improving organizational performance; to define expectations of the performance improvement activities; and to generate the plan and processes the organization will utilize to assess, improve, and maintain quality of care and service. Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety ... The Governing Body is responsible for ensuring that the performance improvement program is defined, implemented, and maintained ... Senior		**of the HHAare evaluated.** o **Problems are identified and resolved.** o **New RNs are hired.** o **New ADON is hired.** o **New Care Coordination forms are created.** o **Communication with other providers isestablished.** o **Communication among all disciplines havebeen improved.** o **Patient's information and POA is updated.** o **For Improvement of outcomes, goalsare marked, and process is started for achieving the goals.** o **Medical Records are separated frompersonal records of employees and contracted persons.** **<u>FUTUREPLAN</u>** o **The Governing Body will supervise theAdministrator and QAPI program.**	

	management will … adopt a structured framework for performance improvement ….” Record review of the agency’s QAPI (quality assessment performance improvement) program on 02/09/2023, evidenced aggregated data from, “Medicare.gov/care-compare.” Review evidenced the data were percentages from where the agency and region measured up to the national average. Record review failed to evidence the administrator ensured an ongoing QAPI program to improve patient care with specific measurable outcomes. During an interview on 02/10/2023, at 4:00 PM, the administrator indicated the agency is not incorporating the agency’s aggregated data for the QAPI program. The administrator indicated the agency was in the process of hiring a Quality Assessment nurse to assist with the QAPI program.		o **The Administrator will supervise QAPICommittee** o **HIPA compliance for employees will beobserved.** o **Medical and personal folders will bekept separately.** **Administratorwill be responsible to correct this deficiency and make sure will not recur.**	
N0466	Home health agency administration/management	N0466	The NurseConsultant in serviced the HHA Staff about,	2023-03-14

	410 IAC 17-12-1(j) 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 agency failed to maintain separate medical files for contracted personnel and treat records as confidential medical records in 3 of 5 contracted personnel files reviewed. (Other Personnel #1, 2, Occupational Therapist (OT) #1) The findings include: 1. Review of an agency policy revised August 2011, titled "Record Keeping" stated, "... Prime Care Home Health Services, Inc. will ensure that the personnel health records are kept confidential ...." 2. Review of the contract binder on 2/9/2023 evidenced a contract for medical social work (MSW) services with Other Staff		- Confidentialityof Medical Records of Employees - Maintainingthe personal files **ACTIONCOMPLETED** - Medicalinformation is separated from personal files - Staffis educated. **FUTUREPLAN** - Personaland Medical Information will be placed separately. OfficeManager will be responsible to make sure this deficiency is corrected and willnot recur.	

	included in the contract binder was the tuberculosis (an infectious disease mostly affecting the lungs) screening, physical exam, and flu declination form for Other Staff #2. Review failed to evidence the medical records were stored separately as confidential medical records. 3. Personnel record review on 2/9/2023, for Other Staff #1, MSW, evidenced the proof of vaccination for COVID-19 included in the personnel file and not kept in a separate medical file. 4. Personnel record review on 2/9/2023, for OT #1, evidenced the proof of vaccination for COVID-19 included in the personnel file and not kept in a separate medical file. 5. During an interview on 2/9/2023, at 12:36 PM, the administrator indicated medical documents for personnel should be kept in a separate file.			
N0470	Home health agency administration/management	N0470	The NurseConsultant in serviced the HHA Staff about,	2023-03-14

	410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review, and interview, the home health agency failed to follow the use of standard precautions, to prevent the transmission of infectious and communicable diseases during 2 of 2 home visits with a skilled nurse visit. (LPN (licensed practical nurse) #1, clinical manager) The findings include: 1. Record review of an agency policy dated August 2011, titled, "Hand Hygiene," stated, "... Personnel providing care in the home setting will regularly wash their hands, per the most recently published CDC regulations and guidelines for hand hygiene in health care settings ... Hand decontamination using an alcohol-based hand rub should be performed: ... After removing gloves ...." 2. Record review of an agency policy dated August 2011, titled, "Bag Technique," stated, "... The		- InfectionControl - HomeHealth Agency Administration and Management - CDCGuidelines - UniversalPrecautions - HandHygienic **ACTIONCOMPLETED** - Staffis educated. - InfectionControl and Prevention has been started. **FUTUREPLAN** - Directorof Nursing will monitor Nurses home visits. The Directorof Nursing will be responsible to make sure this deficiency is corrected andwill not recur.	

	bag will contain a designated clean and dirty area. The clean area contains unused or clean supplies/equipment, and the dirty area is designated for contaminated materials. When the visit is completed, reusable equipment will be cleaned with alcohol, soap and water, or other appropriate solutions, hands will be washed, and equipment and supplies will be returned to the bag. Hands will be decontaminated prior to returning clean equipment to bag ...." 3. Review of the CDC (Center for Disease Control) website on 02/15/2023, (www.CDC.gov/handhygiene/provider/guidance.html) stated, "... Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: ... After touching a patient or the patient's immediate environment ... Immediately after glove removal ...." 4. An observation of a home visit was conducted on 02/14/2023, from 2:00 PM to 3:00 PM, for patient #3, start of care 01/20/2023 with LPN #1.			

	At 2:48 PM, LPN #1 donned a new pair of gloves and assessed the patient's head and neck. LPN #1 removed the gloves after assessment and picked up a paper and pen for the patient to sign. Observation failed to evidence LPN #1 performed hand hygiene after removing the gloves after the patient assessment. At 2:58 PM, LPN #1 exited the home. Observation failed to evidence LPN #1 performed hand hygiene after patient care. 5. An observation of a home visit was conducted on 02/15/2023, from 10:45 AM to 12:11 PM, with the clinical manager. The clinical manager donned gloves to change the coccyx dressing, gloves were removed, and hand hygiene was performed. The clinical manager donned a new pair of gloves and applied a new brief to the patient, gloves were removed, and the clinical manager picked up the patient's home folder. Observation failed to evidence the clinical manager performed hand hygiene after removing her gloves and the patient's home folder was picked up. The clinical manager removed the blood pressure			

	cuff and machine from the newspaper on the recliner and returned to the nurse's bag. The nurse's bag had one compartment. Observation failed to evidence the blood pressure cuff and machine were cleansed/sanitized prior to returning to the nurse's bag. The patient's family member signed paperwork for the clinical manager. The clinical manager exited the home at 12:11 PM. Observation failed to evidence hand hygiene was performed prior to exiting the patient's home. 6. During an interview on 02/15/2023, at 2:12 PM, the clinical manager indicated hand hygiene should be performed after removing gloves and before donning new gloves. 7. During an interview on 02/15/2023, at 2:12 PM, the clinical manager indicated when leaving a patient's home, she places dirty supplies in a grocery bag to be cleansed when she returned to the office. Discussed with the clinical manager observation failed to observe blood pressure cuff being put into a grocery bag			

	one compartment and equipment should be cleansed prior to returning to the nurse's bag. The clinical manager indicated she understood the observation.			
N0472	Q A and performance improvement 410 IAC 17-12-2(a) Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview, the home health agency failed to ensure measurable improvement indicators were implemented to improve health outcomes and quality of care for the agency's QAPI (quality assessment performance improvement) program, and failed to measure, analyze, or track quality indicators, including adverse patient events.	N0472	The NurseConsultant in serviced the HHA Staff about, - QualityAssessment and Performance Improvement Program - GoverningBody Responsibilities and Duties. **ACTIONCOMPLETED** - QAPIProgram is supervised. - GoverningBody meeting has been held. **FUTUREPLAN** - GoverningBody will supervise QAPI continuously. - GoverningBody meeting will be held quarterly. - DataCollection and Analysis will be held monthly.	2023-03-14

	Findings include: Record review of an agency policy dated August 2011, titled, "Responsibilities In Improving Performance, stated, "... Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety ... The problem-solving approach will stress the interrelationship of quality service provided, management activities, and sound business practices as applicable to the organization's: ... Quality indicators, Data collection and analysis, Identify and set specific outcomes for measurable improvement ...." Record review of an agency policy dated August 2011, titled, "Aggregation of Data/Information," stated, "... Data to be considered for collection to monitor performance of the organization include the following: ... Measures or processes and outcomes for assessing performance as part the performance improvement plan, including analysis of levels, patterns, or trends over time that trigger further evaluation		Administratorwill be responsible to make sure this deficiency is corrected and will notrecur.	

	… Summaries of actions take as a result of performance improvement activities, including risk management, utilization review, infection control safety management, outcomes reports regarding processes or services, and performance measures from acceptable databases ….” Record review of an agency policy dated August 2011, titled, “Patient Focused Performance Improvement,” stated, “… When an opportunity to improve performance is identified, a focus study [indicator] will be developed to measure and improve associated processes ….” Review of the agency’s QAPI program on 02/09/2023, failed to evidence data showing the measurable improvements in indicators related to the patient health outcomes and quality of care, and failed to measure, analyze, and track quality indicators, including adverse patient events. During an interview on 02/10/2023, at 4:00 PM, the administrator indicated there			

	showing measurable improvement in outcomes or analysis of quality indicators. The administrator indicated there is no Quality Assessment nurse and was in the process of trying to hire a Quality Assessment nurse to assist with the QAPI program.			
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 periodic patient evaluation. (7) The procedures for payment for services furnished under the contract.	N0478	**The NurseConsultant in serviced the HHA Staff about,** o **Contracted Services** o **Involvement of contractedprofessionals in the development of plan of care.** o **Coordination of Care.** o **Case Conferences.** **<u>ACTIONCOMPLETED</u>** o **The contracts are revised.** o **Physical Therapists and MedicalSocial Workers are involved in developing the Plan of Care for Treatment.** - **Alldisciplines will communicate via case conferences.**	2023-03-23

	Based on record review and interview, the home health agency failed to include responsibility in developing plans of care, the manner in which services will be controlled, coordinated, and evaluated by the primary home health agency, and the procedure for submitting clinical notes, scheduling of visits, and conducting period patient evaluation in written contracts between personnel under contract and the home health agency. Findings include: Record review on 02/09/2023, of an agency policy dated August 2011, titled, "Home Health Contracted Services," stated, "... The written agreement between the organization and the contract service/individual will define the nature and scope of services. The following Medicare COP [condition of participation] requirements for written agreements will be included in all home health contracts ... Primary organization maintains control of, supervises, coordinates, and evaluates care provided. Methods to ensure Primary organization control are described within the contract ...		**Administratorwill be responsible for contracts.** **DON willbe responsible for Developing the Plan of Care with contracted professional's participation.**	

	Mechanism for contracting parties to participate in the patient development of patient's plan of care. Timeframe for placement of contracted staff and contingency staffing plans ...." Record review of an agency contract dated 11/23/2022, between the home health agency and entity B failed to evidence the responsibility for participating in developing plan of care, the manner in which services will be controlled, coordinated, and evaluated by the primary home health agency, the procedures for submitting clinical notes, and conducting periodic patient evaluation. Record review of an agency contract dated 01/24/2023, between the home health agency and entity C failed to evidence the responsibility for participating in developing plans of care, the manner in which services will be controlled, coordinated, and evaluated by the home health agency and the procedures for submitting clinical notes. The contract failed to evidence			

	be provided to the agency. During an interview on 02/09/2023, at 2:50 PM, the administrator indicated all information regarding contracts and coordination of care should be in the contracts.			
N0484	Q A and performance improvement 410 IAC 17-12-2(g) Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on record review and interview, the agency failed to provide ongoing interdisciplinary involvement in the patient's plan of care in 2 of 2 clinical records reviewed with an impending discharge. (Patients #5, 6) The findings include: 1. Review of an agency policy revised August 2011, titled "Case Conference/Progress Summary" stated, "... Case conferences will be held at the start of care and at least every	N0484	**The NurseConsultant in serviced the HHA Clinical Staff about** - **Effective Communication among all disciplines of care** - **How to complement each other and support the achievement of care goals.** - **How to document the communication.** - **Case Conferences** - **Discharge Planning.** **<u>ACTION COMPLETED</u>** - **100% Active patients Plan of Care are reviewed for interdisciplinary involvementof all disciplines.**	2023-03-23

	all multidisciplinary cases. … Case conferences will include … all clinicians – both direct and contract personnel – working with patients will participate in case conferences. … For each patient, the Case Manager will lead the conference and discuss: Physical status of the patient … Patient treatment choices … Changes in condition … Interventions for all disciplines and patient response … Teaching plan and its effectiveness … Progress towards goals … Discharge plan ….” 2. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled “Medical Social Services Evaluation” dated 12/22/2022. Review indicated the medical social worker (MSW) recommended Meals On Wheels and homemaker services for the patient. Review failed to evidence the MSW informed the case manager of the recommendations. Review failed to evidence any follow-up on the MSW’s recommendations. During an interview on		- **Communication tab is included in the patient’s charts.** **<u>FUTURE PLAN</u>** - **Case Conferences will be documented.** - **All disciplines will be involved.** **The Director of Nursing will be responsible to make sure thisdeficiency is corrected and will not recur.**	

	2/14/2023, at 3:38 PM, the clinical manager indicated there was no follow-up on the MSW's recommendations. Review evidenced agency documents titled "Skilled Nurse Visit" completed by licensed practical nurse (LPN) #1, which indicated the patient was noncompliant with taking medications as ordered by the physician on 1/18/2023 and 1/26/2023. Review of documents dated 1/18/2023, 1/26/2023, and 2/8/2023 indicated the patient's house smelled of urine and the patient had poor oral and personal hygiene. Review failed to evidence the LPN notified the case manager of the noncompliance and the condition of the patient and patient's residence. Review of an agency document titled "Communication Note" dated 1/26/2022, and completed by LPN #1, indicated the client's home smelled strongly of urine and had a sticky floor. Review indicated the nurse knocked repeatedly with no answer for approximately 5 minutes and indicated the same occurs at			

every weekly visit. Review failed to evidence the case manager was notified of the repeated difficulty getting into the patient's home.

Review of an agency document titled "Physician Order" electronically signed by the office manager and dated 2/1/2023, which indicated the patient was discharged due to noncompliance. Review failed to evidence the clinical manager and the LPN providing the routine nursing visits were notified.

During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated there is no coordination of care with the agency personnel. LPN #1 indicated she has not had any communication with the clinical manager since December 2022 and does not know who the alternate clinical manager is. LPN #1 indicated she gets direction regarding the patient's schedule from the intake coordinator or the office manager. LPN #1 indicated she did not get notice of the patient's plan to discharge until last week when the office manager informed her the

	patient was discharged. LPN #1 indicated she was notified this week by the administrator that the patient needed a visit completed this week before being discharged next week and indicated the agency does not know what is going on with patient care. 3. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Medical Social Services Evaluation" dated 12/22/2022. Review indicated the MSW recommended Meals On Wheels and homemaker services for the patient. Review failed to evidence the MSW informed the case manager of the recommendations. Review failed to evidence any follow-up on the MSW's recommendations. During an interview on 2/14/2023, at 3:38 PM, the clinical manager indicated there was no follow-up on the MSW's recommendations. Review evidenced agency documents titled "Skilled Nurse Visit" completed by LPN #1,			

	noncompliant with diet, exercise, and medication administration on 1/18/2023. Review indicated the patient was noncompliant with medication schedule on 1/26/2023. Review of document dated 2/8/2023, indicated the patient appears to be wearing the same clothes at every visit and has dirty hands and feet. Review of documents dated 1/18/2023, 1/26/2023, and 2/8/2023, indicated the patient had an altered home environment to include caregiver burnout, cluttered/soiled living conditions, and lack of caregiver support. Review failed to evidence the LPN notified the case manager of the noncompliance and the condition of the patient and patient's residence. Review of an agency document titled "Communication Note" dated 1/4/2022, and completed by LPN #1, indicated the client's home smelled strongly of urine and had a sticky floor. Review indicated the patient had not eaten or drank anything yet for the day when the nurses arrived at noon. Review failed to evidence the LPN notified the			

	case manager of the concerns noted at the nurse visit. Review of an agency document titled "Physician Order" electronically signed by the office manager and dated 2/1/2023, which indicated the patient was discharged due to noncompliance. Review failed to evidence the clinical manager and the LPN providing the routine nursing visits were notified. During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated she did not get notice of the patient's plan to discharge until last week when the office manager informed her the patient was discharged. LPN #1 indicated she was notified this week by the administrator that the patient needed a visit completed this week before being discharged next week. Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient's diagnoses included, but were not limited to, sleep apnea (a			

condition where breathing stops and restarts while sleeping) and used a sleep apnea machine (a machine that treats sleep apnea by assisting breathing by delivering oxygen through a tube and into a mask worn on the face while sleeping).

Review of agency documents titled "Skilled Nurse Visit" completed by LPN #1 and dated 1/18/2023 and 1/26/2023, indicated the patient reported using the sleep apnea machine "all of the time" and indicated oxygen saturation (the measurement of oxygen in the blood) dropped without the sleep apnea mask on the patient's face. Review of document dated 2/8/2023, indicated the patient used the sleep apnea machine most of the time and oxygen saturation dropped without the sleep apnea mask in place. Review failed to evidence the LPN notified the case manager of the patient's use of the sleep apnea machine when not asleep and of decreased oxygen saturation levels.

During an interview on

	clinical manager indicated the sleep apnea machine should be worn while the patient sleeps. At 2:40 PM, the clinical manager indicated the LPN should have notified the registered nurse (RN) case manager of the patient's use when not sleeping and of the decreased oxygen saturation levels. 4. During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated there is no coordination of care with the agency personnel. LPN #1 indicated she has not had any communication with the clinical manager since December 2022 and does not know who the alternate clinical manager is. LPN #1 indicated she gets direction regarding the patient's schedule from the intake coordinator or the office manager and indicated the agency does not know what is going on with patient care.			
N0486	Q A and performance improvement 410 IAC 17-12-2(h) Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.	N0486	**The Nurse Consultant in serviced the HHA Staff on03/06/2023 for** o **Coordination of Services with otherproviders.**	2023-03-31

	Based on record review and interview, the agency failed to coordinate care with other agencies providing services to the patient in 1 of 1 clinical record reviewed receiving services from another home care agency. (Patient #4) The findings include: Review of an agency policy revised August 2011, titled "Coordination of Services with Other Providers" stated, "... The Case Manager will be responsible for the coordination between service providers, which will include, but not be limited to: Organization personnel's understanding of each organization's/individual's responsibility in providing care...." Clinical record review on 2/14/2023, for Patient #4, start of care 1/26/2023, evidenced a document from Entity E titled "After Visit Summary" dated 2/9/2023, which indicated the patient received home services from Entity F. During an interview on 2/15/2023, at 2:45 PM, the clinical manager indicated she was unaware of any other		o **Care Coordination** **<u>ACTION COMPLETED</u>** o **Staff is educated.** o **100% patients' information isupdated.** o **New Coordination of Care form hasbeen created and implemented into the admission packet.** o **100% of all active clinical records have beenaudited and Coordination of Care forms are faxed to other health care providers.** **FUTURE PLAN** o **At time of admission and recertification,Case Manager will ask the patient/POA/Family members for any other services orhealth care providers are providing services.** o **The DON will coordinate andcommunicate.** o **At the time of SOC and Recert patientCommon Working File Report from CMS will be printed to find out which provideris**	

	services provided to the patient by another agency. The clinical manager indicated the agency needed to have communication with Entity F. During an interview on 2/15/2023, at 3:28 PM, Person G from Entity F indicated Entity F provided 100 hours a month of attendant care and 60 hours a month of homemaker services to the patient.		**patient.** o **Through Communication with Physician,patient and Family members, information will be collected about all servicesfrom all providers patient is receiving.** o **DON will document in thecommunication note which will be send to physician.** o **Names of all other providers will belisted on the Plan of Care, like dialysis centers, home maker provider, extendedhours of care, respiratory services, or any other service provider.** o **DON will send a letter to otherproviders to coordinate care with them.** o **100% charts will be audited weeklyfor this compliance.** **The Director of Nursing will be responsible to make sure thisdeficiency is corrected and will not recur.**	

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, 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.	N0488	**The NurseConsultant in serviced the HHA Staff about,** o **Discharge Planning** o **Discharge Notices** o **Patient's Communication** o **Physician Communication.** o **Power of Attorney Communication.** **<u>ACTION COMPLETED</u>** o **Discharge Planning education has beenprovided.** o **Discharge notices are updated.** o **Communication is improved.** **<u>FUTURE PLAN</u>** o **DON will be supervising Case Managersfor discharge planning.** o **Administrator will make sure alldischarge notices are served to patient or patient's POA.** o **Discharge Notice is placed in thepatient orientation book.**	2023-04-06

	Based on observation, record review and interview, the home health agency failed to ensure a 15 day notice of discharge of services was provided to the patient in 1 of 2 clinical records reviewed with a home visit. (#4) Findings include: Record review of an agency policy dated August 2011, titled, "Discharge Planning," stated, "... Discharge planning will be initiated for every patient upon admission to the organization. Patients will not be discharged without proper preparation ... Consulting with the patient and family/caregiver regarding the provision of discharge information ...." During an observation of a home visit on 02/15/2023, of patient #4, start of care 01/26/2023, evidenced a home health agency folder with a home health agency document titled, "Transfer/Discharge Policy," indicated patient to be informed in a reasonable time of anticipated termination and/or transfer of services. The		o **100% Discharges will be auditedweekly until compliance is achieved and then 50% on a regular basis.** - **The Director of Nursing will be responsible to make sure that thisdeficiency is corrected and will not recur.**	

	document failed to evidence a 15 day discharge/transfer notification policy. During an interview on 02/15/2023, at 2:18 PM, the clinical supervisor indicated the nurse should provide the patient upon start of care the 15 day discharge/transfer summary.			
N0505	Patient Rights 410 IAC 17-12-3(b)(2)(D)(ii) Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment. Based on record review and interview, the home health agency failed to ensure the patient/patient representative was informed of and consented to the care to be furnished and was informed of	N0505	The Administratorin serviced the HHA Staff about, - Patient'sRights and Responsibilities - Changesin Care Plan to be communicated with patient. **ACTIONCOMPLETED** - HHAStaff is educated. - 100%Charts are audited. **FUTUREPLAN** - Communicationwith Patients will be improved. - Anychange in Care Plan will be informed to patient. - POAinformation is obtained for all patients. The Director of Nursing will be responsible to	2023-03-14

	changes in the services to be provided in 3 of 6 clinical records reviewed. (Patient #1, #5, #6) Findings include: 1. Record review of an agency document dated August 2011, titled, "Patient Notification of Changes in Care," stated, "... The patient will be notified within 24 hours of any significant changes in the agreed-upon schedule or plan of care ... Whenever the plan of care is changed, including services, frequencies, treatments, etc., the patient will be notified at the time of the visit ...." 2. Clinical record review of patient #1, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 01/11/2023-03/11/2023, evidenced patient to receive a home health aide 2 times per week for 8 weeks. Review of an agency document dated 01/30/2023, titled, "Patient Complaint Form," evidence the patient was asking why home health aide stopped coming to the home. Review indicated on 01/30/2023,		make sure thisdeficiency is corrected and will not recur.	

	administrative staff #4 indicated the patient was called and explained the insurance denied home health aide services and an appeal for home health aide services was completed. Review of an agency document dated 01/31/2023, titled, "Communication Note," indicated the insurance denied the home health aide and the physician was notified. Review evidenced the last home health aide visit to the patient was on 01/23/2023. Review failed to evidence the patient was notified of the change in care regarding the home health aide care being discontinued until the complaint was received from the patient on 01/30/2023.			

	During an interview on 02/14/2023, at 12:35 PM, administrative staff #6 indicated the appeal for home health aide visits was sent on 01/27/2023. Administrative staff #6 indicated there was not documentation of the patient being notified of the discontinuation of home health aide services prior to the 01/30/2023 complaint by the patient. 3. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient's diagnosis included dementia (a progressive condition which affects memory and decision making). Review of an agency document titled "Individualized Emergency Plan" dated 11/3/2022, indicated Person J was the patient's primary caregiver. Review of an agency document titled "Admission Consent and Service Agreement" dated 11/3/2022, indicated the			

consent to treat. Review failed to evidence the patient's primary caregiver was informed of the patient's rights to be informed of and consent to services.

During an interview on 2/10/2023, at 12:36 PM, Person J, patient's primary caregiver, indicated she was the patient's power of attorney (POA). Person J indicated the patient lived with a spouse who was also a patient of the agency who required assistance with care. Person J stated, "[patient] has dementia in a bad way."

During an interview on 2/14/2023, at 4:08 PM, the clinical manager indicated the patient's primary caregiver/POA should have signed the consent to treat.

4. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient's diagnosis included dementia (a progressive condition which affects memory and decision

	making). During an interview on 2/10/2023, at 12:36 PM, Person J, patient's primary caregiver, indicated she was the patient's POA. Review of an agency document titled "Admission Consent and Service Agreement" dated 11/3/2022, indicated the patient signed the consent to treat. Review failed to evidence the patient's primary caregiver/POA was informed of the patient's rights to be informed of and consent to services. During an interview on 2/15/2023, at 2:39 PM, the clinical manager indicated the patient should not sign the consent to treat due to the patient's diagnosis of dementia but the patient's POA should sign.			
N0520	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be	N0520	**The Nurse Consultant in serviced the HHA Staff on 03/06/2023for** o **Comprehensive Assessment of Patient.**	2023-03-31

	adequately met by the home health agency in the patient's place of residence. Based on record review and interview, the agency failed to ensure the patients needs were met in 3 of 6 clinical records reviewed. (Patient #4, #5, #6) The findings include: 1. Review of an undated agency policy on 2/15/2023, titled "Admission Policy" stated, "... Admission criteria are standards by which a client is assessed for admission. These standards include consideration regarding the adequacy and suitability of Agency personnel to meet the client's needs, ... and a reasonable expectation that the client's needs ... can be adequately met ...."		o **Patient's Needs and Requirements.** o **Admission Policy** o **Quality Care** o **Coordination of Services.** **<u>ACTIONCOMPLETED</u>** o **HHA Staff is educated.** o **Quality Assurance is in placed.** o **Patient's information is updated.** o **Patient's needs and requirements arereassessed.** o **Communication with all disciplines and Case Conferences for 100% patients are done.** o **Coordination of Care Form has been created and implemented in admission packet.** o **100% Active patients needs arereviewed and POC was reviewed with physician.** **<u>FUTUREPLAN</u>** o **RN will make**	

	2. Clinical record review on 2/14/2023, for Patient #4, start of care 1/26/2023, evidenced an untitled document dated 1/19/2023, from Person H, nurse practitioner, which indicated the patient was being referred for home health services to include aide services due to hemiplegia (paralysis on one side of the body). Review of an agency document titled "Start of Care" and identified to be the initial comprehensive assessment dated 1/26/2023, indicated the patient was alert and oriented to person, place and time, and had zero episodes of confusion in the 14 days prior to start of care. Review indicated the patient required assistance for grooming, dressing, bathing, toileting, transferring, and feeding. Review indicated the patient lived with a family member who helped provide personal care. Review of an undated document titled "Patient Profile" indicated Person I was the primary contact for the patient. Review of an agency document		**Assessmentfor patient's needs.** o **DON will supervise RN** o **In take coordinator will contact the HMOinsurance for fast approval of needed services.** o **All services will be started rightaway without the prior authorizations.** o **100% of all comprehensive assessmentswill be audited weekly for ongoing admissions and recerts.** o **All disciplines will participate inPlan of Care and Case Conferences.** o **Patient's needs will be assessed attime of admission.** o **If HHA can't meet the needs, patientwill be referred to another provider.**	

	Service Agreement" dated 1/26/2023, indicated home health aide services were refused by the family member that signed the document. Review failed to evidence the form was signed by the patient or the patient's primary contact, Person I. Review failed to evidence home health aide services were offered to the patient. During an interview on 2/14/2023, at 2:19 PM, Person I, the patient's primary contact, indicated 2 of the patient's family members were employed by Entity F to provide care for the patient and indicated she had expressed to the agency's intake coordinator that the patient needed additional hours of assistance for personal care. Person I indicated she had not received any follow-up to her request for additional services. During an interview on 2/15/2023, at 3:28 PM, Person G from Entity F indicated Entity F provided 100 hours a month of attendant care and 60 hours a month of homemaker services to the patient. Person G indicated Entity F did not provide home health aide		- **DON will supervise and monitor Case Managers to make sure ComprehensiveAssessment is completed and Plan of Care is developed according to patient'sneeds and all services are being provided and coordinated.** **TheDirector of Nursing will be responsible to make sure that this deficiency iscorrected and will not recur.**	

services.

During an interview on 2/15/2023, at 2:45 PM, the clinical manager indicated she was unsure why the consent form indicated home health aide services were refused and indicated she could not verify home health aide services were offered to the patient. The clinical manager indicated based on assessment the patient's needs included home health aide services.

3. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Medical Social Services Evaluation" dated 12/22/2022. Review indicated the medical social worker (MSW) recommended Meals On Wheels and homemaker services for the patient. Review failed to evidence follow-up on the MSW's recommendations and failed to evidenced Meals On Wheels and homemaker services were provided.

During an interview on 2/14/2023, at 3:38 PM, the clinical manager indicated there

	recommendations and indicated she was unaware of the MSW referral. The clinical manger indicated there should have been follow-up on the MSW recommendations. Review of an agency document titled "Recertification" and identified as the comprehensive assessment dated 12/30/2022, indicated the patient's diagnoses included, but were not limited to, dementia (a progressive condition impairing the ability to remember, thing, and make decisions), muscle weakness, limitation of activities due to disability, and need for assistance with personal care. Review indicated the patient requires 24 hour supervision, is forgetful and disoriented, has poor balance and muscle weakness, has a history of falls, has unsteady gait, is incontinent of bowel and bladder, and requires assistance for grooming, dressing, bathing, and toileting. Review of agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/26/2023, and 2/8/2023, indicated the patient had muscle weakness, poor balance, shuffling unsteady gait,			

had difficulty breathing with minimal exertion, and poor hydration. Review indicated the nurse assessed the patient to have poor oral and personal hygiene.

Review of the agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, failed to evidence the patient was to receive home health aide services.

During an interview on 2/10/2023, at 12:36 PM, Person J indicated she was the Power of Attorney (POA) for the patient. Person J indicated the patient required assistance due to left-sided weakness after having a stroke and patient is left hand dominant. Person J indicated a family member sometimes stays at the patient's home, but he is "in and out" and indicated although the family member may be able to do some things to help the patient, the family member is not willing to bathe, toilet, and provide personal care for the patient due to being of the opposite sex than the patient.

	lived with a spouse who is also a patient of the agency and is unable to provide personal care for the patient. Person J indicated she has requested of the agency multiple times home health aide, physical and occupational therapy services for the patient and has been told by the agency that they would talk to the doctor. Person J indicated she has received no follow-up regarding the additional services. Review of an agency document titled "Admission Consent and Service Agreement" signed by the patient's spouse on 11/3/2022, indicated home health aide services were refused. Review failed to evidence the consent was signed by the patient's POA. Review failed to evidence the agency offered home health aide services after the comprehensive assessment on 12/30/2022. During an interview on 2/10/2023, at 3:15 PM, licensed practical nurse (LPN) #1, the primary nurse for the patient, indicated she believed the patient does not eat right and indicates the patient is unable			

	to tell the nurse how often she eats or who prepares it. LPN #1 indicated she felt the patient needed home health aide and therapy services. LPN #1 indicated the family member that sometimes stays with the patient is “useless”. During an interview on 2/14/2023, at 3:20 PM, the clinical manager indicated the patient needed to be in an assisted living facility because the patient needed 24 hour care. At 3:52 PM, the clinical manager indicated the patient’s POA was not offered home health aide or occupational therapy services. During an interview on 2/14/2023, at 4:06 PM, the administrator indicated the patient does have care needs that are not being met and indicated he did not think of it like this before. 4. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled “Recertification” and identified as the comprehensive assessment dated 12/30/2022.			

	diagnoses included, but were not limited to, dementia (a progressive condition impairing the ability to remember, thing, and make decisions). Review indicated the patient is forgetful and depressed, has poor balance and muscle weakness, is at high risk of falls, has unsteady gait, is incontinent of bowel and bladder, and requires assistance for dressing, bathing, transferring, and toileting. Review of agency documents titled "Skilled Nurse Visit" dated 1/26/2023 and 2/8/2023, indicated the patient was forgetful, had poor balance, shuffling gait, and poor hydration. Review indicated the patient had an altered home environment to include caregiver burnout, cluttered/soiled living conditions, and lack of caregiver support. Review of document dated 2/8/2023, indicated the patient appears to be wearing the same clothes at every visit and has dirty hands and feet. Review of the agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, failed to			

	evidence the patient was to receive home health aide services. Review evidenced an agency document titled "Medical Social Services Evaluation" dated 12/22/2022. Review indicated the MSW recommended Meals On Wheels and homemaker services for the patient. Review failed to evidence follow-up on the MSW's recommendations and failed to evidenced Meals On Wheels and homemaker services were provided. During an interview on 2/14/2023, at 3:38 PM, the clinical manager indicated there was no follow-up on the MSW's recommendations and indicated she was unaware of the MSW referral. The clinical manger indicated there should have been follow-up on the MSW recommendations. During an interview on 2/10/2023, at 12:36 PM, Person J indicated she was the Power of Attorney (POA) for the patient. Person J indicated a family member sometimes stays at the patient's home, but he is "in and out" and indicated although the family member			

	may be able to do some things to help the patient, the family member is not willing to bathe, toilet, and provide personal care for the patient. Person J indicated the patient lived with a spouse who is also a patient of the agency and is unable to provide personal care for the patient. Person J indicated she has requested of the agency multiple times home health aide, physical and occupational therapy services for the patient and has been told by the agency that they would talk to the doctor. Person J indicated she has received no follow-up regarding the additional services. Review of an agency document titled "Admission Consent and Service Agreement" signed by the patient on 11/3/2022, indicated home health aide services were refused. Review failed to evidence the consent was signed by the patient's POA. Review failed to evidence the agency offered home health aide services to the patient's POA after the comprehensive assessment on 12/30/2022. During an interview on 2/10/2023, at 3:15 PM, licensed			

	practical nurse (LPN) #1, the primary nurse for the patient, indicated she believed the patient does not eat right and is very depressed. LPN #1 indicated she felt the patient needed home health aide and therapy services. LPN #1 indicated the family member that sometimes stays with the patient is “useless”. During an interview on 2/14/2023, at 3:20 PM, the clinical manager indicated the patient needed to be in an assisted living facility because the patient needed 24 hour care. At 3:52 PM, the clinical manager indicated the patient’s POA was not offered home health aide or occupational therapy services. During an interview on 2/14/2023, at 4:06 PM, the administrator indicated the patient does have care needs that are not being met and indicated he did not think of it like this before.			
N0522	Patient Care 410 IAC 17-13-1(a)	N0522	**The NurseConsultant in serviced the HHA Staff on 03/06/2023 about**	2023-03-31

	Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on observation, record review, and interview, the home health agency failed to provide the services that were written in the individualized patient plan of care in 6 of 6 clinical records reviewed. (Patient #1, #2, #3, #4, #5, #6) Findings include: 1. Record review of an undated agency policy received on 02/15/2023, titled, "Physician's Plan of Treatment/Change Orders," stated, "The physician's 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 Agency will provide care/services consistent with the plan of treatment ... Physician's orders on the plan of treatment shall relate to the diagnosis ...."		o **Plan of Care** o **Following Plan of Care** o **Obtaining and monitoring Blood Sugar.** o **Vytal signs parameters** o **Physician's communication** o **High Risk Medications.** o **Drugs reactions and interactions.** **<u>ACTIONCOMPLETED</u>** o **Clinical Staff is educated.** o **LPN is fired and new competent RNsare hired.** o **Quality Assurance program isinitiated.** o **High Risk medications are placed onPlan of Care** o **Education and teaching methods areplaced on Plan of Care.** o **100% Active patients' needs arereviewed and POC are reviewed with physician.** o **Medications are reconciled.**	

	2. Clinical record review on 02/10/2023, for patient #1, start of care 01/11/2023, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 01/11/2023-03/11/2023, indicated the primary diagnosis as Type 2 diabetes mellitus with other specified complication (impairment of the way the body uses blood sugar). The plan of care patient medications included metformin (medication used to lower blood sugar), and Ozempic (medication used to control blood sugars). The plan of care orders for nursing indicated skilled nurse to assess diabetic status, identify any signs and symptoms of impaired diabetic function, and report significant changes to the physician. Review of agency documents dated 01/24/2023, 01/31/2023, and 02/08/2023 titled, "Skilled Nurse Visit," failed to evidence blood sugar test results. During an interview on 02/14/2023, at 12:44 PM, the clinical manager indicated a patient with a diagnosis of type 2 diabetes should have the frequency of blood sugar		o **Vytal signs parameters are verifiedwith physician.** **<u>FUTUREPLAN</u>** o **DON will supervise and monitor Nurses.** o **Clinical notes will be audited.** o **All SOC admissions and Recerts willbe reviewed by DON.** o **Patient's diagnosis and primarydiagnoses is reviewed carefully.** o **All Medications are reconciled.** o **Drug reactions and interactions aredetermined.** o **Visit frequency is followed.** o **Physician's is informed for anychange in patient's condition.** o **Plan of Treatment is revisedperiodically.** o **Administrator will make sure Clinicians haveall required equipment's and medical supplies.** o **100% charts will be**	

	testing, and blood sugar parameters for calling the physician on the plan of care. The director of nursing indicated the nurse should check the blood sugar at every skilled nurse visit and document the results. 3. Clinical record review on 02/10/2023, of patient #2, start of care 10/14/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/13/2022-02/10/2023, indicated foley catheter (a flexible tube that a clinician passes into the bladder to drain urine) change every 30 days. Review of an agency document dated 01/24/2023, titled, "Skilled Nurse Visit," indicated date of last foley catheter change was 11/30/2022 and catheter change managed by home health agency and physician. Review of an agency document dated 01/30/2023, titled, "Skilled Nurse Visit," indicated date of last foley catheter change was 01/30/2023. Review failed to evidence the		**audited weekly.** **The Director of Nursing will be responsible to make sure thatquality care is provided on every nursing visit according to physician'sorders.**	

	foley catheter every 30 days was completed by the skilled nurse. During an interview on 02/14/2023, at 11:43 AM, LPN (licensed practical nurse) #1indicated the patient's family member did not want foley catheter changed the week of Christmas but did not document the discussion. LPN #1 indicated the patient experienced pain with the foley catheter pain in the past and the patient's family member informed LPN #1 that Doctor A's office was going to send staff to home to change foley catheter. LPN #1 indicated she did not speak to Doctor's A's office regarding the family member's discussion with Doctor A. LPN #1 indicated the home health agency then told LPN #1 to change the foley catheter and not to wait for Doctor A's office to change foley catheter and that is when LPN #1 changed the foley catheter. LPN #1 indicated she did not have communication with Doctor A's office regarding foley catheter change or patient's pain during last foley catheter change. During an interview on			

	02/15/2023, at 1:50 PM, the clinical manager indicated there was no documentation why the foley catheter was not changed every 30 days as indicated on the plan of care. The clinical manager indicated the clinician should follow the plan of care foley catheter order to change every 30 days. 4. Clinical record review on 02/14/2023, for patient #3, start of care 01/20/2023, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 01/20/2023-03/20/2023, indicated patient principal diagnosis of type 2 diabetes mellitus without complications. The plan of care medications included metformin. The plan of care orders for skilled nursing included to perform complete physical assessment each visit with emphasis on non-insulin dependent diabetes. The plan of care indicated orders to notify physician for fasting blood sugar less than 60 or greater than 400. Review of agency documents dated, 01/30/2023, 02/03/2023, and 02/09/2023, titled, "Skilled			

blood sugar test results.

During an observation of a home visit on 02/14/2023, at 2:00 PM, LPN (licensed practical nurse) #1 failed to evidence a blood sugar test was performed.

During an interview on 02/14/2023, at 3:00 PM, LPN #1 indicated she does not perform blood sugar monitoring for the patient during the nurse visit and the patient does not have a glucometer (machine to monitor blood sugar). LPN #1 indicated she didn't know why the patient was seen by a skilled nurse.

During an interview on 02/15/2023, at 2:30 PM, the clinical manager indicated the patient's plan of care should include parameters for blood sugars monitoring and blood sugar monitoring should occur with every skilled nurse visit and documented.

5. Clinical record review on 2/14/2023, for Patient #4, start of care 1/26/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period

	was signed by Person H, nurse practitioner, on 1/27/2023. Review of an agency document titled "Physician Order" dated 1/27/2023, indicated the patient's family requested physician services by Person A, physician. Review failed to evidence the plan of care was reviewed and signed by Person A, physician. During an interview on 2/15/2023, at 3:01 PM, the clinical manager indicated the patient's primary care provider was Person A and indicated Person A had not yet reviewed or signed the plan of care because the agency had not yet sent it to the physician. Review of the plan of care indicated the agency was to notify the physician for a diastolic blood pressure (the pressure against the arteries while the heart is at rest, noted as the bottom number of a blood pressure reading) of less than 60. Review of an agency document titled "PT [physical therapy] Visit" dated 2/1/2023, noted the patient's diastolic blood pressure was 57. Review failed			

	to evidence the physician was notified of the diastolic blood pressure. During an interview on 2/15/2023, at 2:48 PM, the clinical manager indicated there was no documentation the physician was notified of the diastolic blood pressure and indicated the physical therapist should have notified the case manager who should have notified the physician. 6. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the physician needed to be contacted if either the systolic (the pressure against the arteries when the heart contracts and represented by the top number of a blood pressure reading) or the diastolic (the pressure against the arteries when the heart is at rest and represented by the bottom number of a blood pressure reading) blood pressure was less than 60. Review indicated the primary diagnosis was hypoosmolality (a			

	condition where levels of electrolytes, nutrients, and proteins in the blood are lower than normal) and hyponatremia (a condition where sodium level in the blood is lower than normal). Review failed to evidence the plan of care included interventions and goals related to the primary diagnosis. Review indicated the patient's diet was a heart healthy diet. Review of the plan of care indicated the patient's homebound status included oxygen dependency. Review indicated the skilled nurse was to assess the patient's pain. During an interview on 2/14/2023, at 3:10 PM, the administrator indicated it was impossible for the systolic blood pressure to be that low. At 3:38 PM, the administrator indicated the patient was not on oxygen and indicated the oxygen dependence for homebound status was part of standard verbiage in the template for the plan of care in the electronic medical record. During an interview on 2/14/2023, at 3:10 PM, the intake coordinator indicated the			

	parameter was incorrect and indicated the plan of care was not individualized. During an interview on 2/14/2023, at 3:11 PM, the clinical manager indicated interventions should include the assessment of sodium intake, intake and output, edema, and skin turgor as related to the patient's primary diagnosis. The clinical manager indicated there were not individualized goals related to the primary diagnosis but there should be. At 3:36 PM, the clinical manager indicated a heart healthy diet included low sodium and low fat. When queried why the plan of care included a low sodium diet for a patient with a primary diagnosis of abnormal low sodium levels, the clinical manager indicated the diet order was carried over from a previous plan of care but should have been changed on the current plan of care. Review of agency documents titled "Recertification" dated 12/30/2022 and "Skilled Nurse Visit" dated 1/18/2023, 1/26/2023, and 2/8/2023, indicated the patient had edema (swelling) to the lower extremities. Review failed to			

	evidence the plan of care was individualized to include interventions related to the assessment of edema. During an interview on 2/14/2023, at 3:37 PM, the clinical manager indicated individualized interventions that should have been included in the plan of care was to educate the patient on elevating the legs. Review of agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/25/2023, and 2/8/2023, indicated the patient had pain less often than daily and failed to indicate the assessment of pain at the time of the visit as directed in the plan of care. 7. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the physician needed to be contacted if the systolic blood pressure was less than 60. Review indicated the skilled nurse was to assess the patient's pain.			

	During an interview on 2/15/2023, at 2:23 PM, the clinical manager indicated the plan of care was not individualized with an accurate systolic blood pressure parameter. Review of agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/25/2023, and 2/8/2023, indicated the patient had pain less often than daily and failed to indicate if the patient had any pain at the time of the visit as directed in the plan of care. 8. During an interview on 2/15/2023, the clinical manager indicated pain should be assessed at every skilled nursing visit to include location, intensity, and frequency.			
N0524	Patient Care 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses.	N0524	The NurseConsultant in serviced the HHA Staff about, - PatientCare - Typesof Services - Typesof Equipment's required. - Prognosis.	2023-03-14

	(C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview, the home health agency failed to ensure the individualized plan of care included all pertinent diagnoses; medical supplies, and equipment required; all medications, reasons for use, and treatments; and safety measures to protect against injury in 4 of 6 clinical records reviewed. (Patient #1, #2, #5, #6) Findings include: 1. Record review of an undated		- MentalStatus. - Frequencyand duration of visits **ACTIONCOMPLETED** - Staffis educated. - 100%charts are audited. **FUTUREPLAN** - TheDON will supervise each clinical manager to make sure a comprehensive Plan ofCare is established for every patient. The Director ofNursing will be responsible to make sure this deficiency is corrected and willnot recur.	

	02/15/2023, titled, "Physician's Plan of Treatment/Change Orders," stated, "The physician's 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 limited to: ... Diagnosis primary and secondary ... safety precautions ... Medications ... Medical supplies and equipment ... Orders for treatments ...." 2. Clinical record review on 02/10/2023, for patient #1, start of care 01/11/2023, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 01/11/2023-03/11/2023 indicated patient was taking Eliquis (medication to thin the blood) and Ozempic (medication to lower the blood sugar) given by injection. The plan of care failed to evidence safety precautions related to bleeding precautions and failed to evidence sharps (needles)			

	medication. During an interview on 02/14/2023, at 12:44 PM, the clinical manager indicated a patient on a blood thinning medication and taking an injectable medication should have bleeding precautions and sharps safety on the plan of care. Review of the agency Plan of Care for certification period 01/11/2023-03/11/2023, indicated patient was exhibiting taxing effort to leave home due to dementia (loss of memory). Review of the Plan of Care indicated failed to evidence a diagnosis of dementia. During an interview on 02/15/2023, at 1:43 PM, the clinical manager indicated the patient does not have a diagnosis of dementia. Review of an agency document titled, PT [physical therapy] Plan of Care," for certification period 01/11/2023-03/11/2023 indicated patient used walker for mobility. The agency's plan of care of			

	walker under DME (durable medical equipment) and Supplies. During an interview on 02/14/2023, at 11:37 AM, LPN (licensed practical nurse) #2 indicated the patient ambulated with a walker. During an interview on 02/15/2023, at 1:43 PM, the clinical manager indicated the patient's use of the walker should be included on the plan of care. 3. Clinical record review on 02/10/2023, for patient #2, start of care10/14/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 02/11/2023-04/11/2023, indicated patient was taking medication Eliquis. The plan of care failed to evidence bleeding safety precautions. During an interview on 02/14/2023, at 12:44 PM, the clinical manager indicated a patient taking Eliquis should have bleeding safety precautions on the plan of care. 4. Clinical record review on			

	care 11/3/2022, evidenced agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/25/2023, and 2/8/2023. Review indicated the patient was using laxative (a medication used to treat constipation) and/or enemas (a medication used to treat constipation). Review indicated the nurse educated the patient on the use of pain medication and indicated the patient used a walker. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023 failed to evidence the plan of care included laxatives, enemas, and pain medication in the patient's list of medications. Review failed to evidence the plan of care included the walker in the list of DME. During an interview on 2/14/2023, at 3:54 PM, the clinical manager indicated any laxative, enema, and pain medication the patient was using should have been included in the plan of care. The clinical manager indicated she observed the patient using the			

	walker to go to the bathroom and all DME should be included in the plan of care. 5. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient's medication included, but was not limited to, acetaminophen (a medication used to treat pain and/or fever) as needed, Ventolin (an inhaled medication used to treat shortness of breath) as needed, Combivent (an inhaled medication used to treat shortness of breath) as needed, and Ipratropium/Albuterol (an inhaled medication used to treat shortness of breath) as needed. Review failed to evidence the plan of care included the indications for the medications to be used as needed. Review indicated the patient's homebound status included being chair bound. During an interview on 2/15/2023, at 2:26 PM, the clinical manager indicated the			

	reasons for use for the medications to be used as needed. Review of an agency document titled "Recertification" and identified as the comprehensive assessment dated 12/30/2022, the patient was assessed to be ambulatory with assistive device. Review indicated the patient used a sleep apnea (a condition where breathing stops and restarts while sleeping) machine. Review failed to evidence the type of sleep apnea machine and directions for use in the plan of care. During an interview on 2/15/2023, at 2:28 PM, the clinical manager indicated the patient could use the walker if needed and indicated the plan of care should be corrected. The clinical manager indicated the patient had a CPAP machine which was supposed to be worn at night.			
N0527	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1.(a)(2) The health care	N0527	**The NurseConsultant in serviced the HHA Staff about,** o **How to follow plan of care** o **How to follow physician's**	2023-03-23

	professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on record review and interview, the home health agency failed to alert the physician of any changes in the patients condition or needs that suggest outcomes were not being achieved or that the plan of care should be altered in 3 of 6 clinical records reviewed. (Patient #2, #4, #6) Findings include: 1. Record review evidenced an undated agency policy received on 02/15/2023, titled, "Physician's Plan of Treatment/Change Orders," stated, "The physician's plan of treatment [Medicare's Plan of Care] is an individualized plan for care and treatment … The physician shall be notified immediately of any changes in the client's condition which indicate changes to the plan of treatment …." 2. Clinical record review on 02/10/2023, for patient #2, start of care 10/14/2022, evidenced an agency document titled,		**orders.** o **How to inform the physician for anychange in patient's condition.** o **How to update Medication Profile** o **How to check interactions ofdifferent medications and drugs.** **ACTIONCOMPLETED** o **100% Active Patient's Plan of Care arereviewed.** o **Staff is educated.** o **RNs will supervise LPNs to make sureany significant change to be notified to physician.** o **New RNs are hired.** **FUTUREPLAN** o **The DON will supervise 100% nursingvisits.** o **Plan of Care will be followed.** o **Physician will be notified for anychange in condition or medication.** **The Director of Nursing will be responsible**	

	"Home Health Certification and Plan of Care," for certification period 12/13/2022-02/10/2023, indicated the foley catheter (tube inserted into bladder to drain urine) to be changed every 30 days. Review of an agency document dated 01/24/2023, titled, "Skilled Nurse Visit," indicated patient had foley catheter last catheter change was 11/30/2022. Review failed to evidence the physician was notified the foley catheter was not changed every 30 days per the plan of care order. During an interview on 02/13/2023, at 11:43 PM, LPN (licensed practical nurse) #1 indicated they foley catheter was not changed at end of December due to daughter did not want patient's foley catheter changed during week of Christmas. LPN #1 indicated daughter spoke to Doctor's office A, and office A was going to send clinician to change the foley catheter due to patient had pain during last foley catheter change. LPN #1		**to make sure thatthis deficiency is corrected and will not recur.**	

Doctor A's office to discuss. LPN #1 indicated the home health agency spoke to Doctor A's office and informed LPN #1 to change the foley catheter.

During an interview on 02/14/2023, at 12:55 PM, the clinical manager indicated the physician should have been notified if the plan of care order for foley catheter change every 30 days was not performed.

Review of an agency document dated 01/30/2023, time in 12:30 PM, indicated LPN #1 changed the patient's foley catheter during visit on 01/30/2023.

Review of an agency document dated 01/31/2023, titled, "Communication Note," indicated patient #2 called on 01/30/2023, at 7:30 PM, to inform the office and nurse that the urine bag had a tea cup amount of urine in it. The document indicated LPN #1 was notified to call patient and MD (medical doctor) notified by the office manager.

Review failed to evidence the patient's call to the office were addressed. Review failed to evidence LPN #1 documented, addressed, or assessed the

patient's call.

During an interview on 02/14/2023, LPN #1 indicated she was not notified of patient's call regarding tea cup amount of urine in the urine bag on 01/30/2023 as she did not take after hours call. LPN #1 indicated the foley catheter was changed on 01/30/2023 during skilled nurse visit.

During an interview on 02/15/2023, at 1:46 PM, the administrator indicated the nurse saw patient on 01/31/2023 to address the patient's 01/30/2023 call.

Review of documentation failed to evidence documentation of a Skilled Nurse Visit on 01/31/2023. The administrator indicated the Skilled Note Visit from 01/30/2023 was dated wrong and left the room and returned with a Skilled Note Visit dated 01/31/2023. The Skilled Nurse Visit was the same as the 01/30/2023 Skilled Note Visit which indicated the foley catheter was changed on 01/30/2023. The 01/31/2023 Skilled Note Visit was signed by LPN #1 on 01/30/2023.

During an interview on

	02/15/2023, at 1:50 PM, the clinical manager indicated the plan of care should be followed by the LPN and the patient should have been evaluated for the patient call and documentation of the follow up completed. During an interview on 02/15/2023, at 1:56 PM, the clinical manager indicated the office manager's communication note which indicated MD notified should not have been documented by the office manager. 3. Clinical record review on 2/14/2023, for Patient #4, start of care 1/26/2023, evidenced an agency document titled "Medication Profile" for episode period 1/26/2023 – 3/26/2023. Review indicated the patient's medications included, but were not limited to, Entresto (a medication used to treat heart failure) and potassium chloride (a mineral supplement). Review failed to evidence the document was signed by a registered nurse (RN). Review of an agency document titled "Drug-Drug Interactions"			

	major drug interaction between potassium chloride and Entresto which could cause kidney failure, muscle paralysis, irregular heart rhythm, and cardiac arrest. Review failed to evidence the agency notified the physician of the major drug interaction. During an interview on 2/15/2023, at 2:40 PM, the clinical manager indicated the agency should notify the physician of medication interactions. The clinical manager indicated there was no record the medication interactions were noted by the RN and sent to the physician. 4. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the patient's diagnosis included, but were not limited to, sleep apnea (a condition where breathing stops and restarts while sleeping) and used a sleep apnea machine (a machine that treats sleep apnea by assisting breathing by			

	tube and into a mask worn on the face while sleeping). Review of agency documents titled "Skilled Nurse Visit" completed by LPN #1 and dated 1/18/2023 and 1/26/2023, indicated the patient reported using the sleep apnea machine "all of the time" and indicated oxygen saturation (the measurement of oxygen in the blood) dropped without the sleep apnea mask on the patient's face. Review of document dated 2/8/2023, indicated the patient used the sleep apnea machine most of the time and oxygen saturation dropped without the sleep apnea mask in place. Review failed to evidence the LPN notified the physician of the patient's use of the sleep apnea machine when not asleep and of decreased oxygen saturation levels. During an interview on 2/15/2023, at 2:28 PM, the clinical manager indicated the sleep apnea machine should be worn while the patient sleeps. At 2:40 PM, the clinical manager indicated the LPN should have notified the physician of the patient's use when not sleeping			

	and of the decreased oxygen saturation levels.			
N0541	Scope of Services 410 IAC 17-14-1(a)(1)(B) Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview, the home health agency failed to review all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy in 4 of 6 clinical records reviewed. (Patient #2, #4, #5, #6) Findings include: 1. Record review of an agency policy dated August 2011, titled, "Medication Profile," stated, "... Patient receiving medications administered by the	N0541	**The NurseConsultant in serviced the HHA Staff about,** o **Scope of Services** o **Drug Therapy.** o **Adverse effects of drugs andmedication.** o **Patient Safety.** **<u>ACTIONCOMPLETED</u>** o **Clinical staff is educated.** o **A tab in EMR is added for drugsreaction and adverse effects.** o **100% Active patient's medication profiles are rechecked and reviewed withphysician.** **<u>FUTUREPLAN</u>** - **EMR is being used for potential adverse effects and drug reactions, includingsignificant side effects, significant drug interactions, duplicate drug**	2023-03-23

	organization will have a current, accurate medication profile in the clinical record. Medication profiles will be updated for each change to reflect current medications, new, and/or discontinued medications. Upon admission to the organization, the admitting clinician will initiate a medication profile to document the current medication regimen. A drug regimen review will be performed at the time of admission, when updates to the comprehensive assessments are performed, when care is resumed after a patient has been placed on hold, and with the addition of a new medication. The review will identify drug/food interactions, potential adverse effects and drug reactions, ineffective drug therapy, duplicative drug therapy, and noncompliance with drug therapy ...." 2. Clinical record review on 02/10/2023, of patient #2, start of care 10/14/2022, evidenced an agency document titled, "OASIS (outcome and assessment information set) D-1 Recertification," for certification period 02/11/2023-04/11/2023, indicated medication review		**therapy,and noncompliance with drug therapy.** - **The Director of Nursing will be responsible to make sure that thisdeficiency is corrected and will not recur.**	

	was completed and assessed for drug interactions. The comprehensive assessment evidenced a blank box for physician contacted regarding medication review. Review of an agency document dated 02/10/2023, titled, "Drug-Drug Interactions," indicated major drug interactions between sucralfate (medication for stomach ulcers) and cholecalciferol (vitamin D) , amlodipine (blood pressure medication) and simvastatin (cholesterol lowering medication), simvastatin and dronedarone (medication of irregular heart rhythms), and aspirin (pain reliever) and apixaban (blood thinning medication). Review of a web based source on 02/13/2023, https:drugs.com/drug-interactions.html, evidenced the following 3 major medication interactions between medications on patient #2's medication list: Aspirin and apixaban may increase risk of bleeding, simvastatin and amlodipine may increase liver damage and may cause rare condition that breaks down the skeletal muscles and causes			

	kidney damage, simvastatin and dronedarone may increase liver damage and may cause rare condition that breaks down the skeletal muscles and causes kidney damage. Review failed to evidence the physician was notified of the patient's major drug interactions. During an interview on 02/15/2023, at 1:48 PM, the clinical manager indicated there is no documentation the physician was informed of the major drug interactions. The clinical manager indicated the physician should be notified of major drug interactions and going forward would notify physician of major drug interactions. 3. Clinical record review on 2/14/2023, for Patient #4, start of care 1/26/2023, evidenced an agency document titled "Medication Profile" for episode period 1/26/2023 – 3/26/2023. Review indicated the patient's medications included, but were not limited to, Entresto (a medication used to treat heart failure), potassium chloride (a			

	metoprolol (a medication used to treat high blood pressure), amlodipine (a medication used to treat high blood pressure and/or heart disease), furosemide (a medication used to rid the body of excess fluid), digoxin (a medication used to treat heart failure and/or abnormal heart rhythms), aspirin (a medication used to reduce pain/fever/inflammation), and atorvastatin (a medication used to lower cholesterol). Review failed to evidence the document was signed by a registered nurse (RN). Review of an agency document titled "Drug-Drug Interactions" dated 2/14/2023, indicated a major drug interaction between potassium chloride and Entresto which could cause kidney failure, muscle paralysis, irregular heart rhythm, and cardiac arrest. Review indicated moderate interactions to include, but not limited to, metoprolol and amlodipine, potentially causing heart failure, severe low blood pressure, and chest pain; furosemide and metoprolol, potentially causing low blood pressure, slowed			

	sugar control; furosemide and digoxin, potentially causing abnormal heart rhythms; aspirin and digoxin, potentially causing digoxin toxicity; metoprolol and digoxin, potentially causing lowered heart rate; and digoxin and atorvastatin, potentially causing an increase in digoxin levels. Review failed to evidence the registered nurse reviewed the medications for potential drug interactions. Review of the initial comprehensive assessment electronically signed by the RN and dated 1/26/2023, indicated the RN reconciled the medications and found no issues. During an interview on 2/15/2023, at 2:40 PM, the clinical manager indicated there was no record the registered nurse was aware of drug interactions. 4. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Recertification" and identified as the comprehensive assessment, signed by the RN and dated 12/30/2022.			

	Review evidenced an agency document titled "Medication Profile", which was last signed by the clinical manager on 12/1/2022. Review failed to evidence the RN reviewed the medications for potential drug interactions and adverse side effects at the time of the comprehensive assessment. 5. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Recertification" and identified as the comprehensive assessment, signed by the RN and dated 12/30/2022. Review evidenced an agency document titled "Medication Profile", which was last signed by the clinical manager on 12/1/2022. Review failed to evidence the RN reviewed the medications for potential drug interactions and adverse side effects at the time of the comprehensive assessment. 6. During an interview on 2/14/2023, at 3:44 PM, the clinical manager indicated medications should be reviewed at every recertification assessment.			

N0549	Scope of Services 410 IAC 17-14-1(a)(1)(J) Rule 14 Sec. 1(a) (1)(J) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (J) Direct the activities of the licensed practical nurse. Based on record review and interview, the home health agency failed to ensure the registered nurse (RN) supervised the nursing services in 3 of 6 clinical records reviewed with services provided by a licensed practical nurse (LPN). (Patient #2, #5, #6) Findings include: 1. Record review of an undated agency job description received on 02/15/2023, titled, "Licensed Graduate Practical Nurse," stated, "The licensed graduate practical nurse provides nursing care and teaching to clients and families. She also functions as an assistant to the physician and registered professional nurse, and is supervised by the RN ... Responsibilities: Participates in the planning and coordination of total client care	N0549	The NurseConsultant in serviced the HHA Staff about. - Scopeof Services. - LPN'sSupervision **ACTIONCOMPLETED** - LPNsand RNs are educated. - NewRNs are hired. - 100%Charts are audited. **FUTUREPLAN** - Administratorwill make sure the competent RNs are hired and they are supervising LPNs. TheAdministrator will be responsible to make sure this deficiency is corrected andwill not recur.	2023-03-14

	the physician's plan of treatment ...." 2. Clinical record review on 02/10/2023, for patient #2, start of care 10/14/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/13/2022-02/10/2023, which indicated foley catheter (tube placed into bladder to drain urine) to be changed every 30 days. Review evidenced LPN (licensed practical nurse) visits on 01/11/2023 and 01/24/2023. Review of an agency document dated 01/18/2023, titled, "LVN (licensed vocational nurse) Supervisory Visit," indicated the alternate clinical manager completed a supervisory visit for LPN #1. The supervisory visit indicated LPN #1 followed the patient's plan of care for completion of tasks assigned. Review of an agency document dated 01/24/2023, titled, "Skilled Nurse Visit," indicated the foley catheter was last changed on 11/30/2022. Review failed to evidence the RN provided supervision to			

	ensure the LPN followed the plan of care. On 02/13/2023, at 12:54 PM, administrative staff #4 was contacted with no return call. During an interview on 02/15/2023, at 1:45 PM, the administrator indicated the alternate clinical manager didn't like to use the electronic medical records and didn't review the electronic medical records to supervise LPN's documentation. 3. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced agency documents titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the skilled nurse was to assess the patient's pain.			

	Review of agency documents titled "Skilled Nurse Visit" completed by licensed practical nurse (LPN) #1 and dated 1/18/2023, 1/25/2023, and 2/8/2023, indicated the patient had pain less often than daily and failed to indicate if the patient had any pain at the time of the visit as directed in the plan of care. Review of an agency document titled "LVN [licensed vocational nurse, also knows as a LPN] Supervisory Visit" electronically signed by the alternate clinical manager and dated 1/26/2023, indicated LPN #1 followed the plan of care and implemented care as directed. Review failed to evidence the registered nurse (RN) provided supervision of the LPN to ensure the LPN was following the plan of care. 4. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced agency documents titled "Home Health Certification and Plan of Care" for certification period 1/2/2023-3/2/2023, which indicated the skilled nurse was to assess the patient's pain. Review of agency documents			

titled "Skilled Nurse Visit" completed by LPN #1 and dated 1/18/2023, 1/25/2023, and 2/8/2023, indicated the patient had pain that does not interfere with activity or movement. Review failed to indicate the LPN assessed the pain to include the location and intensity of the pain as directed in the plan of care.

Review of an agency document titled "LVN Supervisory Visit" electronically signed by the alternate clinical manager and dated 1/26/2023, indicated LPN #1 followed the plan of care and implemented care as directed. Review failed to evidence the RN provided supervision of the LPN to ensure the LPN was following the plan of care.

5. During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated she does not know who the alternate clinical manager is and has not had any communication with her.

6. During an interview on 2/14/2023, at 4:01 PM, the clinical manger indicated the RN should not document the

	when care is not provided as directed. The clinical manager indicated the RN should educate the LPN to the services to be provided per the plan of care. The clinical manager indicated she cannot say when the alternate clinical manger last communicated with LPN #1 and indicated the alternate clinical manager has not returned multiple phone calls.			
N0554	Scope of Services 410 IAC 17-14-1(a)(2)(B) Rule 14 Sec. 1(a) (2) (B) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (B) Prepare clinical notes. Based on record review and interview, the licensed practical nurse (LPN) failed to prepare notes accurately in 3 of 6 clinical records reviewed. (Patient #1, #5, #6) The findings include: 1. Review of an agency policy revised August 2011, titled "Clinical Record Review" stated, "... Clinical records will be reviewed ... to assure that	N0554	The NurseConsultant in serviced the HHA Staff about, - Scopeof Services. - LPNsand RNs are educated. - NewRNs are hired. - 100%Charts are audited. **ACTIONCOMPLETED** - LPNsand RNs are educated. - NewRNs are hired. - 100%Charts are audited. - **100% clinical notes of LPNs are audited.** - **New competent RNs**	2023-03-17

	documentation entered is reliable, timely, valid, and accurate…." 2. Clinical record review on 2/9/2023, for Patient #5, start of care 11/3/2022, evidenced an agency document titled "Skilled Nurse Visit" dated 1/18/2023, and completed by licensed practical nurse (LPN) #1, indicated LPN #1 provided discharge notice to the patient due to noncompliance and indicated the physician was aware of plans to discharge. Review of an agency document titled "Physician Order" dated 2/1/2023, and electronically signed by the office manager, indicated the patient was being discharged due to noncompliance. During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated she was informed by the office manager the week prior that the patient was discharged due to noncompliance. LPN #1 indicated she was then notified this week to conduct a nurse visit and the patient would be discharged next week. LPN #1		**are hired.** - **LPNs are educated.** - **RN will supervise LPN to make sure POC is followed.** - **DON will supervise and monitor Case Managers.** - **The Director of Nursing will be responsible to make sure that thisdeficiency is corrected and will not recur.** **<u>FUTUREPLAN</u>** - RN,Case Manager will supervise the LPN. - DONwill supervise the case managers. The Directorof Nursing will be responsible to make sure this deficiency is corrected andwill not recur.	

	discharge notice as documented on the visit note on 1/18/2023 because she was not aware then the patient was discharging. LPN #1 indicated she added the discharge notice to the visit note on 1/18/2023 when she was informed by the office manager last week the patient was discharged since the note for the visit on 1/18/2023 had yet to be completed. LPN #1 indicated she did not contact the physician regarding the plans for discharge because she assumed the office had notified the physician since the office is who told her the patient was discharged last week. During an interview on 2/14/2023, at 3:58 PM, the intake coordinator indicated visit notes should be dated and signed at the time of the visit and should be documented accurately. During an interview at the entrance conference on 2/9/2023, at 10:39 AM, the administrator indicated any corrections or amendments to a clinical document should be documented as an amendment.			

	Review evidenced agency documents titled "Skilled Nurse Visit" dated 1/18/2023, 1/25/2023, and 2/8/2023, and electronically signed by LPN #1. Review indicated the patient homebound status included oxygen dependence. During an interview on 2/14/2023, at 3:38 PM, the administrator indicated the patient was not on oxygen and indicated the oxygen dependence for homebound status was part of standard verbiage in the template for the plan of care in the electronic medical record which was pulled over into the skilled nursing visit note. 3. Clinical record review on 2/10/2023, for Patient #6, start of care 11/3/2022, evidenced an agency document titled "Skilled Nurse Visit" dated 1/18/2023, and completed by LPN #1, indicated LPN #1 provided discharge notice to the patient due to noncompliance and indicated the physician was aware of plans to discharge. Review of an agency document titled "Physician Order" dated			

	signed by the office manager, indicated the patient was being discharged due to noncompliance.			

	During an interview on 2/10/2023, at 3:15 PM, LPN #1 indicated she was informed by the office manager the week prior that the patient was discharged due to noncompliance. LPN #1 indicated she was then notified this week to conduct a nurse visit and the patient would be discharged next week. LPN #1 indicated she did not provide discharge notice as documented on the visit note on 1/18/2023 because she was not aware then the patient was discharging. LPN #1 indicated she added the discharge notice to the visit note on 1/18/2023 when she was informed by the office manager last week the patient was discharged since the note for the visit on 1/18/2023 had yet to be completed. LPN #1 indicated she did not contact the physician regarding the plans for discharge because she assumed the office had notified the physician since the office is who told her the patient was discharged last week. 4. Clinical record review on 02/10/2023, for patient #1, start of care 01/11/2023, evidenced			

	"Home Health Certification and Plan of Care," for certification period 01/11/2023-03/11/2023, indicated patient is on Eliquis (blood thinning medication). Review of agency documents dated 01/19/2023, 01/24/2023, 01/31/2023, 02/08/2023, titled, "Skilled Nurse Visit," signed by LPN #2, indicated the patient was on Eliquis and the patient/caregiver self-monitored PT/INR (blood test for monitoring medication Coumadin (blood thinning medication). Review failed to evidence the PT/INR blood test was monitored by the patient/caregiver or the PT/INR blood test was indicated on the plan of care. During an interview on 12/14/2023, at 12:50 PM, the administrator indicated a patient on Eliquis does not require PT/INR blood tests and should not be on the skilled nurse visit notes that patient performs PT/INR blood tests. 5. During an interview on 2/14/2023, at 3:58 PM, the intake coordinator indicated visit notes should be dated and			

	signed at the time of the visit and should be documented accurately. 6. During an interview at the entrance conference on 2/9/2023, at 10:39 AM, the administrator indicated any corrections or amendments to a clinical document should be documented as an amendment.			
N0614	Clinical Records 410 IAC 17-15-1(c) Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service. Based on observation, record review, and interview, the agency failed to safeguard clinical records against loss and unauthorized use.	N0614	HHA is usingElectronic Medical Record since 2015. All new and7 years old records are in the EMR. ThoseRecords in the Record Room are more than 7 years old. - **Record Room is locked.** - **More than 7 years old charts will be shredded to safe the patient'sinformation.** Administratorwill be responsible to make sure that this deficiency is corrected and will notrecur.	2023-03-17

	The findings include: Review of an agency policy revised August 2011, titled "Used and Disclosure of PHI [protected health information]" stated, "... Patient information and clinical record documents will not be left in open ...." During an observation on 2/15/2023, at 12:40 PM and again at 2:30 PM, a door labeled "Records Room" was observed open with clinical records unsecured on a desk and on top of boxes as well as clinical records in envelopes and boxes sitting on shelves in the room. The room was observed to be left unattended. During an interview on 3:37 PM, the clinical manager indicated the record room should be locked at all times and indicated she forgot to close the door and lock it after retrieving medical supplies prior to her home visit earlier in the morning.			
N9999	Final Observations	N9999	POC is being submitted.	2023-03-15

	These findings were corrected on 11/3/2022.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
AFZAL J MALIK	Administrator	4/6/2023 3:53:08 PM