DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 200889890A	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPOINTE HEALTHCARE	426 CENTER STREET, HOBART, IN, 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This survey was a re-licensure survey for a home health agency. Survey Dates: 10/25/2022 – 10/28/2022, 10/31/2022 Facility #: IN006663 Census: 12	N0000		2022-11-30
G0000	INITIAL COMMENTS This visit was a Federal Recertification and State Licensure survey of a home health agency. Survey Dates: 10/25/2022 – 10/28/2022, 10/31/2022 Facility ID: IN006663	G0000		2022-11-30

	Active Patients: 12 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Quality Review Completed 11/07/2022			
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Facility ID: IN006663 Survey dates: 10/24/2022 – 10/28/2022, 10/31/2022 At this Emergency Preparedness survey Homepointe Healthcare, was found to be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E0000		2022-11-30
N0543	Scope of Services	N0543	**1. How are you going to**	2022-11-30

410 IAC 17-14-1(a)(1)(D)

Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:

(D) Initiate appropriate preventive and rehabilitative nursing procedures.

Based on record review and interview, the registered nurse failed to initiate appropriate preventive nursing procedures in 1 of 1 clinical record review of a patient needing catheterization. (#3)

The findings include:

An agency procedure titled "Urinary Catheter Insertion," revised 3/2021, stated " ... Using the dominate hand cleanse meatus using a circular motion and move from the center to the outside ... insert catheter, advance until urine begins to flow out ... slowly remove single-use catheter after urine collection is complete...."

Clinical record review for patient #3, start of care 4/28/2008, evidenced an agency plan of care for certification periods 8/9/2022 -10/7/2022 and

correct thedeficiency?

· TheStraight/Intermittent Catheterization procedure was updated to include thefollowing instruction, "*If any deviationfrom this procedure is required a physician order must be obtained.*" **11/09/2022**

· Allstaff will be educated on the process of performing a straight catheterization.(See attached training and test; training will be completed on our HUB trainingplatform). **11/30/2022**

2. How are you going to prevent thedeficiency from recurring in the future, even if already corrected?

· HPHCwill perform audits on Nurse Flow Sheets, a minimum of 1 Flow Sheet per nursefor 100% of nurses will be audited **12/30/2022**

· HPHCwill audit >25% of Nurse Flow Sheet each quarter for of all nurseswho are providing straight catheter procedures **ongoing**.

3. Who is going to be responsible fornumbers 1 and 2 above: i.e., director,

	10/8/2022 – 12/6/2022. These documents evidenced an order to straight catheterize (also called intermittent catheter, which is a thin tube used to empty the bladder and then thrown away) the patient every 2-3 hours and as needed per patient request. Clinical record review evidenced agency documents titled “Homepointe Healthcare Nursing Flow Sheet,” which indicated on 10/5/2022, a straight catheter was placed at 9:45 AM, and at 1:30 PM, a straight catheter was removed and 800 ml (milliliters) of urine was documented, on 9/2/2022, the straight catheter was inserted at 12:55 PM, and removed at 1:50 PM, inserted again at 2:10 PM, and removed at 3:10 PM, the straight catheter was then inserted at 5:00 PM, and the nurse report off to the family and left the home, on 9/6/2022 the straight catheter was placed at 12:30 PM, and removed at 1:45 PM, on 9/8/2022 the narrative note indicated at 4:45 PM, there was no urine in the straight catheter, the nurse added 50 ml of water to gastrostomy and reported off to the family on 9/9/2022 the		**supervisor, etc.?** · 1.Clinical Care Managers · 2.Clinical Care Managers and/or Administrator **4. By what date are you going to havethe deficiency corrected?** · 11/30/2022	

	straight catheter was inserted at 11:30AM, and removed at 12:20 PM, the straight catheter was inserted again at 12:50 PM, and removed at 1:45 PM, on 9/14/2022 the straight catheter was inserted at 10:25 AM, and removed at 11:00 AM, inserted again at 12:00 PM, and removed at 12:45 PM, on 9/16/2022 the straight catheter was inserted at 10:00 AM, and removed at 11:00 AM, on 9/17/2022 the nurse documented when she arrived at 8:00 AM the patient had a straight catheter in place and she removed it, at 10:45 AM, a straight catheter was inserted and removed at 11:35 AM, at 1:40 PM, the straight catheter was inserted and removed it at 2:30 PM, on 9/19/2022 a straight catheter was inserted at 9:50 AM, and removed at 11:00AM, at 12:25 PM, inserted a straight catheter and removed the straight catheter at 1:30 PM, and at 5:00 PM, inserted a straight catheter and gave reported to family, on 9/22/2022, the straight catheter was placed at 12:30 PM, and removed at 1:30 PM, on 9/23/2022 the straight catheter was inserted at 9:15 AM, and removed at 10:00 AM, at 12:20 PM, a straight catheter was			

	inserted and removed at 1:00 PM, on 9/27/2022 at 9:30 AM, a straight catheter was inserted and removed at 11:15 PM, on 9/28/2022, the straight catheter was placed at 11:35 AM, and removed at 1:00 PM, and at 4:50 PM, another straight catheter was inserted and removed at 5:20 PM, on 9/30/2022 at 12:00 PM, a straight catheter was placed and the straight catheter was removed at 2:00 PM, on 10/3/2022 the straight catheter was placed at 2:30 PM, and was removed at 3:45 PM. These documents failed to evidence the nursing staff followed the procedure for straight catheterization usage on the patient. During an interview on 10/28/2022 at 3:20 PM, RN #4 indicated when doing a straight catheterization on a patient the catheter was inserted and removed as soon as the bladder was drained of urine. During an interview on 10/31/2022, at 10:25 AM, the clinical manager indicated when doing a straight catheterization, the catheter should be removed as soon as the bladder was			

	She indicated the patient may be requesting this, but it was not how it should be done.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review, and interview, the agency failed to ensure patients received the home health services which were written in an individualized plan of care that identified patient-specific measurable outcomes and goals in 4 of 6 clinical records reviewed. (#1, #3, #4, #6) The findings include: 1. Review of an agency policy titled "Client Plan of Care," revised 4/14/2020, stated, " ... Each client must receive the home health services that are written in the individualized Plan of Care...."	G0572	**1. How are you going to correct thedeficiency?** · Provideeducation to 100% of nurse's r/t the Plan of Care and its role with HomeHealthcare. **11/30/2022** · Educatenurses on verifying orders for treatment on the Plan of Care to ensurecompliance with providing physician ordered care. (See attached training andtest; training will be completed on our HUB training platform).**11/30/2022** **2. How are you going to prevent thedeficiency from recurring in the future, even if already corrected?** · **Phase 1:** HPHC will perform audits on Nurse FlowSheets, a minimum of 1 Nursing Flow Sheet per nurse for 100% of nurses. **12/30/2022** o Ifcare being provided is found to be outside of the physician ordered care thenurse will be contacted to discuss the findings and re-educated on the	2022-11-30

	2. Clinical record review for patient #1, start of care 12/15/2009, evidenced an agency plan of care for certification period 8/13/2022 – 10/11/2022. This plan of care evidenced orders to monitor the patient's blood pressure every morning. Clinical record review of agency documents titled "Homepointe HealthCare Nursing Flow Sheet" dated 8/13/2022, 9/4/2022, 9/11/2022, 9/18/2022, 10/2/2022, and 10/9/2022, failed to evidence the patient's blood pressure was taken as ordered on the plan of care. During an interview on 10/31/2022 at 11:39 AM, the clinical manager indicated the blood pressure should have been taken by the RN (Registered Nurse) as ordered in the plan of care. 3. Clinical record review for patient #3, start of care 12/15/2009, evidenced an agency plan of care for certification period 8/9/2022 – 10/7/2022. This plan of care evidenced orders for tracheostomy (a surgically created hole in the windpipe		Plan ofCare orders. · **Phase 2:** HPHC will perform routine Nurse FlowSheet audits on ≥10% of all nurses **ongoing**. **3. Who is going to be responsible fornumbers 1 and 2 above: i.e., director, supervisor, etc.?** · 1.Clinical Care Managers and Administrator · 2.Clinical Care Managers and Administrator **4. By what date are you going to havethe deficiency corrected?** · 11/30/2022	

	that provided an alternative airway) care twice a day. Clinical record review of agency documents titled "Homepointe HealthCare Nursing Flow Sheet" dated 8/15/2022 – 8/16/2022, 8/16/2022 - 8/17/2022, 8/17/2022 – 8/18/2022, 8/18/2022 – 8/19/2022, 8/19/2022 – 8/20/2022, 8/22/2022 – 8/23/2022, 8/29/2022 – 8/30/2022, 8/30/2022 – 8/31/2022, 8/31/2022 – 9/1/2022, 9/2/2022 – 9/3/2022, 9/4/2022 – 9/5/2022, 9/5/2022 – 9/6/2022, 9/6/2022 – 9/7/2022, 9/7/2022 – 9/8/2022, 9/8/2022 – 9/9/2022, 9/11/2022 – 9/12/2022, 9/12/2022 – 9/13/2022, 9/13/2022 – 9/14/2022, 9/14/2022 – 9/15/2022, 9/15/2022 – 9/16/2022, 9/16/2022 – 9/17/2022, 9/17/2022 – 9/18/2022, 9/19/2022 – 9/20/2022, 9/20/2022 –9/21/2022, 9/22/2022 – 9/23/2022, 9/23/2022 – 9/24/2022, 9/24/2022 – 9/25/2022, 9/27/2022 –9/28/2022, 9/28/2022 – 9/29/2022, 9/29/2022 – 9/30/2022, 9/30/2022 – 10/1/2022, 10/2/2022 –10/3/2022, 10/3/2022			

	–10/4/2022, 10/4/2022 – 10/5/2022, 10/5/2022 – 10/6/2022, and 10/6/2022 –10/7/2022, failed to evidence tracheostomy care was done twice per day as ordered on the plan of care. During an interview on 10/31/2022 at 10:15 AM, the clinical manager indicated if there was a nurse in the evening then the tracheostomy care should have been done by the nurse. 4. Clinical record review for patient #4, start of care 5/22/2018, evidenced an agency plan of care for certification period 8/18/2022 – 10/16/2022. This plan of care stated " … Home Heath Aide Discipline (HHA services currently on hold) To offer and provide assistance, as accepted, with ADL's [activities of daily living], may provide light housekeeping for health and safety, temperature to be taken per mom request or if patient is ill – to call Clinical Care Manager/Nurse if temperature is greater than 101 or less than 97…." Review of patient #4's clinical			

	record failed to evidence any home health aide visits. During an interview on 10/26/2022 at 10:03 AM, RN #2 indicated the family was very particular about who can come out to the home, and currently the agency does not have a home health aide. 5. Clinical record review for patient #6, start of care 4/8/2009, evidenced an agency plan of care for certification period 5/31/2022 – 7/29/2022. This plan of care indicated patient #6 was to have his blood pressure taken monthly. Review of the clinical record failed to evidence the patient's blood pressure was taken monthly. During an interview on 10/31/2022 at 10:27 AM, the clinical manager indicated the patient's blood pressure should have been taken as ordered. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi)	G0574	**1. How are you going to correct thedeficiency?** · CCMswere educated on the policy Client Plan of Care	2022-11-15

	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 plan of care was individualized and complete to include all indications and doses for medications in 3 of 5 active clinical records reviewed. (#1,		(C-580) **11/15/2022 (See Attached)** · CCMscontacted the PCPs of the clients who had identified deficiencies,clarification orders were sent to correct the Plan of Care. **11/15/2022** **2. How are you going to prevent thedeficiency from recurring in the future, even if already corrected?** · **Phase 1:** Audit 100% of clients Plan of Care toensure accuracy with special attention given to ensuring each medication hasindications. CCMs will work with PCPs for clarification orders on specific instructionfor use if indication is not present. **11/30/2022** o ClinicalCare Managers will work with direct care nurses to ensure all medications,(including PRN) on the Plan of Care are available in the home and currentlybeing used. § Ifit is discovered that the POC contains medication that are not currently in usethe CCM will coordinate care with the PCP to determine if an order todiscontinue should be	

	#2, #4) The findings include: 1. Review of an agency policy titled "Client Plan of Care," revised 4/14/2020, stated "The individualized Plan of Care must specify the care and services necessary to meet the client specific needs as identified on the comprehensive assessment ... The Plan of Care shall be completed in full to include: ... All medications and treatments...." 2. Clinical record review for patient #1, start of care 12/15/2009, evidenced an agency plan of care for certification period 8/13/2002 – 10/11/2022. This plan of care indicated the patent was taking the following medications: Magic bullet suppository (for constipation) 5 mg (1/2 suppository) to 10 mg (1 suppository) daily in the morning per mom's discretion, Desonate Cream (for itching) small amount topically three times a day until rash was resolved, expectorant syrup 200 mg - 400 mg four times a day as needed per mom's discretion depending on severity of		obtained. · **Phase 2:** Random audits will be performed on ≥25%of current client Plan of Care each quarter there after **Ongoing** · DuringSupervisory Visits CCMs will perform in-depth medication review with nurses,including but not limited to: o Ensuringall medications, including PRNs on the Plan of Care are available in the homeand are being used o Alltopical PRN medication include specific areas the medication is to be applied o AllPRN medications include the indication **3. Who is going to be responsible fornumbers 1 and 2 above: i.e., director, supervisor, etc.?** · 1. ClinicalCare Managers worked with PCP to update/clarify the POCs as indicated.Clarification orders sent. · 2. ClinicalCare Managers and Administrator will perform	

	symptoms. The plan of care failed to evidence indications and route for all medications. 3. Clinical record review for patient #2, start of care 10/18/2021, evidenced an agency plan of care for certification period 8/13/2002 – 10/11/2022. This plan of care indicated the patent was taking the following medications: bacitracin (for infection) small amount topically to gastrostomy [feeding tube inserted into the stomach] button site twice a day as needed until healed for redness or irritation per parent discretion, bacitracin quantity sufficient topically to reddened skin twice a day as needed until healed. The home health agency failed to ensure there were no duplicate medications on the plan of care. 4. Clinical record review for patient #4, start of care 5/22/2018, evidenced an agency plan of care for certification period 8/18/2022 – 10/16/2022. This plan of care stated, " … Cortisone 1% cream quality sufficient topical to affected area TID [three times a		Administratorand CCMs will conduct audits to ≥25% of all POCs each quarter atrandom to ensure continued compliance. **4. By what date are you going to havethe deficiency corrected?** · 11/30/2022	

	rash]....” This plan of care failed to indicate where to apply the cream. During an interview on 10/31/2022 at 10:02 AM, the clinical manager indicated the order was there for wherever the patient may need the cream. 410 IAC 17-13-(a)(1)(D)(ix)			
G0576	All orders recorded in plan of care 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review and interview, the home health agency failed to ensure all orders were recorded on the plan of care in 1 of 5 active clinical records reviewed. (#1) The findings include: Review of an agency policy titled “Physician Orders,” revised 3/4/2019 stated, “Medications, services, and treatments are administered only as ordered by a physician. The orders may be initiated via telephone, verbally,	G0576	**1. How are you going to correct thedeficiency?** · Reviewedand educated CCMs on the policy Physician Orders (C635) **11/15/2022** · Reviewedand educated CCMs on the policy Client Plan of Care (C-580) **11/15/2022** · TheCCMs contacted PCP for clarification orders, the POC was updated with theclarification, and nurses on the case were updated on the clarification order. **11/15/2022**. **2. How are you going to prevent thedeficiency from recurring in the future, even if already corrected?** · **Phase 1:** Audit 100% of	2022-11-15

	orders, including verbal orders, must be recorded in the plan of care....” Clinical record review for patient #1, start of care 12/15/2009, evidenced an agency document titled “Physician Order,” dated 8/15/2022, which stated “1. Discontinue Gas-X Drops (Simethicone 20 mg [milligram] /0.3mg) 75 mg1mL [milliliter] JT jejunostomy [feeding tube inserted through the abdomen into the small intestines] TID [three times daily] 2. Start Gas-X gel caps [capsule] (simethicone 125 mg/gel cap JT TID (dissolve in water before administering via JT)." Clinical record review evidenced a plan of care for certification period 8/13/2022 – 10/11/2022. This plan of care evidenced the following medication order: “Gas-X Drops (Simethicone 20 mg/0.3mg) 75 mg/ 1mL JT jejunostomy TID....” This plan of care failed to evidence the new medication orders were recorded on the plan of care. Clinical record review evidenced an agency plan of care for certification period 10/12/2022		client Plan of Cares toensure accuracy and make corrections when necessary. **11/30/2022** · **Phase 2:** Audits will be performed on ≥25%of all Plan of Cares each quarter thereafter. **Ongoing** **3. Who is going to be responsible fornumbers 1 and 2 above: i.e., director, supervisor, etc.?** · 1. ClinicalCare Managers and Administrator · 2.Clinical Care Managers and Administrator **4. By what date are you going to havethe deficiency corrected?** · 11/15/2022	

	evidenced the following medication orders: Dilantin [for seizures] 75 mg/3 mL once daily at 8 AM, Dilantin 100 mg/4ml twice a day at 3 PM, and 10 PM. The agency failed to ensure the plan of care was updated with the most current Dilantin orders. An agency document titled "Physician Order," dated 10/9/2022, stated "DC [discontinue] existing Dilantin order. Give Dilantin 100 mg/4ml at 8 AM, and 3 PM, and 125 mg/5ml at 10 PM, Recheck Dilantin level in 10 days." During an interview on 10/31/2022 at 11:42 AM, the clinical manager indicated orders are written on the physician order form and incorporated into the patient's clinical record and a copy was taken to the home. The plan of care would then be updated at the time of recertification.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or	G0580	**1. How are you going to correct thedeficiency?** · Educatenurses on physician driven care. (See attached training and test;	2022-11-30

	allowed practitioner. Based on record review and interview, the home health agency failed to administer treatments only as ordered by the physician in 1 of 5 active clinical records. (#2) The findings include: Review of an agency policy titled "Client Plan of Care," revised 4/14/2020, stated "All client care orders, including verbal/telephone orders. must be obtained by the physician...." Clinical record review for patient #2, start of care 10/18/2021, evidenced an agency document titled "Homepointe HealthCare Nursing Flow Sheet," dated 10/5/2022. This document indicated the patient had an open blister on the right heel and a band-aid was applied per parent request. Review of the patient's clinical record failed to evidence an order for treatment to the blister on the right heel. During an interview on 10/31/2022 at 10:05 AM, the clinical manager indicated the note should have been clearer, it was the parent that was applying the band-aid so an		training willbe completed on our HUB training platform). **11/30/2022** · Alterationin Skin Integrity Nursing Care Plan has been updated to include, "Notify PCP ofall new or worsening wounds, obtain orders for treatment" All nurses will beeducated on the change. **11/30/2022** **2. How are you going to prevent thedeficiency from recurring in the future, even if already corrected?** · **Phase 1:** A minimum of 1 Nursing Flow Sheet pernurse will be audited for compliance with physician orders **12/30/2022** · **Phase 2:** Random audits of Nursing Flow Sheets to≥25% of nurses per quarter. **3. Who is going to be responsible fornumbers 1 and 2 above: i.e., director, supervisor, etc.?** · 1.Administrator to create a training, 100% of nurses will complete the trainingby 11/30/2022 · 2.Clinical Care Manager,	

	order was not needed.		Clinical Supervisor and Administrator **4. By what date are you going to havethe deficiency corrected?** · 11/30/2022	
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 promptly alert the physician of changes in the patient's status in 4 of 5 active clinical records reviewed. (#1, #2, #3. #4) The findings Include: 1. Review of an agency policy titled "Skilled Nursing Services," revised 1/18/2011, stated, " ... The Registered Nurse: Informs the physician and other medical personnel of changes in the client's condition and needs...."	G0590	**1. How are you going to correct thedeficiency?** · Educatestaff are aware of the need to notify PCP of Change in Condition (See attachedtraining and test; training will be completed on our HUB training platform). **11/30/2022** **2. How are you going to prevent thedeficiency from recurring in the future, even if already corrected?** · Alterationin Skin Integrity Nursing Care Plan was updated to include the NursingIntervention, "Notify PCP of all new or worsening wounds, obtain orders fortreatment." **11/14/2022** · Performrandom audits of Nursing Flow Sheets of ≥25% of nurses per quarter. **Ongoing**	2022-11-30

	2. Clinical record review for patient #1, start of care 12/15/2009, evidenced an agency plan of care for certification period 8/13/2002 – 10/11/2022. This plan of care evidenced orders to monitor the patient's blood pressure every morning. Clinical record review evidenced agency documents titled "Homepointe HealthCare Nursing Flow Sheet" which indicated the patient's blood pressure was 140/102 (a normal blood pressure reading is 120/80) on 8/16/2022, 142/102 on 8/22/2022, 150/108 on 9/2/2022, 166/116 on 9/6/2022, 157/109 on 9/8/2022, 129/100 on 9/13/2022, 159/105 on 9/19/2022, 154/110 on 9/21/2022, 137/103 on 9/28/2022, and 135/100 on 9/29/2022. These documents failed to evidence the physician was notified of the elevated blood pressure. During an interview on 10/31/2022 at 11:41 PM, RN [registered nurse] #2 indicated the physician was aware of the patient's increased blood pressure and the staff was to recheck the blood pressure if it		**3. Who is going to be responsible fornumbers 1 and 2 above: i.e., director, supervisor, etc.?** · 1.Administrator create education, 100% of staff will complete education by **11/30/2022** · 2.Clinical Care Manager, Clinical Supervisor and Administrator **Ongoing** **4. By what date are you going to havethe deficiency corrected?** · 11/30/2022	

	was high. RN #2 indicated she should have added this to the patient's plan of care. 3. Clinical record review for patient #2, start of care 10/18/2021, evidenced agency documents titled "Homepointe HealthCare Nursing Flow Sheet," which indicated a rash to her upper arm on 9/1/2022, bruising noted to left side of the abdominal area and dragging her right foot on 9/16/2022, an abrasion 1 cm (centimeter) by 0.8 cm noted on 9/25/2022, right ankle open area 1 cm by 0.8 cm noted on 9/30/2022, abrasions to feet and an area noted on the left pinky toe on 10/3/2022. Review of these documents failed to evidence the physician was notified of the rash, bruising, and wounds. During an interview on 10/31/2022, at 10:20 AM, the clinical manager indicated the family thought the rash could have been from the pool float. She also indicated the patient's skin was very sensitive, so they do not call or notify the physician for tiny abrasions and bruises. 4. Clinical record review for			

patient #3, start of care 4/28/2008, evidenced agency documents titled “Homepointe HealthCare Nursing Flow Sheet,” which indicated on 9/14/2022, patient #3 had a creamy yellow discharge to his right eye, on 9/15/2022, the patient’s right eye was reddened, on 9/25/2022, the patient complained of belly spasms but refused medication because he didn’t like the way it made him feel, and on 9/29/2022, he complained of spasms again and refused medication. The document indicated the patient would speak with his doctor at his appointment in November. These documents failed to evidence the physician was notified of the eye drainage, redness and the stomach spasms.

During an interview on 10/31/2022 at 10:22 PM, the clinical manager indicated the patient was going to speak with his doctor, so they did not call the physician.

5. Clinical record review for patient #4, start of care 5/22/2018, evidenced agency

	HealthCare Nursing Flow Sheet," which indicated on 9/28/2022, the patient had a moist cough, on 9/30/2022, the patient had a cough and stridor (high pitched whistling sound when taking a breath), on 10/3/2022, the document indicated the patient had a nonproductive cough, and on 10/5/2022, the patient had a cough and rhonchi (abnormal breath sounds). These documents failed to evidence the physician was notified of the change in the patient's condition. During an interview on 10/31/2022 at 10:03 AM, the clinical manager indicated the physician should have been notified of the respiratory changes the patient was experiencing. 410 IAC 17-13-1(a)(2)			
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals	G0592	**1. How are you going to correct thedeficiency?** · TheCCM contacted the PCP for clarification orders, the POC was updated with thecorrection, nurses on the case were updated on the	2022-11-15

identified by the HHA and patient in the plan of care.

Based on observation, record review and interview, the home health agency failed to ensure the plan of care was revised to reflect the patient's current medications in 4 of 6 clinical records reviewed (#1, #2, #5, #6)

The findings include:

1. Review of an agency policy titled "Client Plan of Care," revised 4/14/2020, stated " … The Plan of Care will be updated as necessary, but no less than every 55 to 60 days…."

2. Clinical record review for patient #1 evidenced an agency document titled "Medication Profile," dated 10/2/2022, which indicated patient #1 was taking the medications: Sterapred (steroid) 30 mg [milligram] twice a day for five days as needed for respiratory distress per mom's discretion (start date 10/26/2020), Tobramycin (antibiotic) 0.3 mg eye solution instill one drop into affected eye four times a day for ten days as needed (start date 7/11/2017), Acetic Acid 2% solution (ear cleaner) to 5 drops

clarification order. **11/15/2022**.

· EducatedCCMs on policy Client Plan of Care (C-580) **11/15/2022**

2. How are you going to prevent thedeficiency from recurring in the future, even if already corrected?

· Audit100% of client Plan of Cares to ensure accuracy and receive new/clarificationorders from PCP when necessary. **12/29/2022**

· Followingthe initial review of 100% of all client Plan of Cares, audits will beperformed on ≥25% of all Plan of Cares each quarter there after. **Ongoing**

3. Who is going to be responsible fornumbers 1 and 2 above: i.e., director, supervisor, etc.?

· 1.Clinical Care Managers and Administrator

· 2.Clinical Care Managers and Administrator

4. By what date are you going to havethe deficiency

	day for 7 days for drainage, redness, or foul odor per mom's discretion (start date 11/1/2018), Neomycin-polymyxin (antibiotic) 4 drops into the affected ear twice a day for seven days as needed for signs and symptoms of infection per mom's discretion (start date 12/5/2018), Ofloxacin 0.3% drops (antibiotic) instill 5 drops into the affected ear twice a day for seven days as needed for symptoms of ear infection per mom's discretion (start date 6/1/2019). Tobi Inhalation solution (for infection) 300 mg/5ml nebulizer twice a day for ten days (start 7/10/22 and end 7/19/2022, Tobramycin (antibiotic) 0.3% eye solution instill one drop into affected eye four times a day for ten days (start 7/10/2022 and end 7/19/2002). Clinical record review for patient #1, start of care 12/15/2009, evidenced an agency plan of care for certification period 8/13/2002 – 10/11/2022. This plan of care indicated the patent was taking the following medications: Tobramycin 0.3 mg eye solution instill one drop		**corrected?** · 11/15/2022	

a day for ten days as needed, Tobi Inhalation solution 300 mg/5ml nebulizer twice a day for ten days (start 7/10/22 and end 7/19/2022), Tobramycin 0.3% eye solution instill one drop into affected eye four times a day for ten days (start 7/10/2022 and end 7/19/2002). The agency failed to revise the plan of care to reflect the patient's current medication usage.

3. Clinical record review for patient #2, start of care 10/18/2021, evidenced an agency plan of care for certification period 8/13/2002 – 10/11/2022. This plan of care indicated the patent was taking the following medications: Vicodin (narcotic pain reliever) 7.5 mg 325 mg one tablet every six hours as needed for moderate pain, Pulmicort (for breathing) 0.25 mg/1 vial via nebulizer twice a day as needed for wheezing, Flonase (for allergies) 100 mcg (micrograms) one spray in each nostril as needed for allergy symptoms. The agency failed to ensure the plan of care was revised to include the patient's current medication usage.

During a home visit on 10/27/2022, at 11:45 AM, medications were observed in the patient's home. Observation failed to evidence the patient had Vicodin, Flonase, and Pulmicort in the home.

Clinical record review evidenced an agency document titled "Medication Profile," dated 9/16/2022, which indicated an order for Tizanidine (muscle relaxer) 2 mg one tablet three times a day.

Clinical record review of the agency's plan of care for patient #2, for certification period 8/13/2022 – 10/11/2022, failed to evidence the order for Tizanidine.

During an interview on 10/27/2022 at 11:48 AM, RN [registered nurse] #4 indicated patient #2 had not used Vicodin, Pulmicort, or Flonase in a few years and the medications were not present in the home.

During an interview on 10/31/2022 at 10:43 AM, the clinical manager indicated orders are written on the physician order form and incorporated into the patient's

taken to the home. The order would be updated on the plan of care on the next recertification.

4. Clinical record review for patient #5, start of care 10/7/2021, evidenced an agency document titled "Physician Order." This document indicated the patient was to receive five to nine hours a day (skilled nursing services) for five to seven days a week.

Clinical record review evidenced an agency plan of care for certification period 10/7/2002 – 12/5/2022. This plan of care indicated patient #5 was to receive skilled nursing services seven to nine hours a day for six to seven days. The plan of care failed to evidence the revised hours and days for skilled nursing services.

During an interview on 10/31/2022 at 10:01 AM, the clinical manager indicated the order was updated in the patient's clinical record and the plan of care would be updated on the next recertification.

5. During an interview on 10/31/2022 at 10:54 AM, the clinical manager was queried

	about patient #6’s wound care to the back of the head. The clinical manager indicated the patient’s wound had healed but his mask would sometimes rub on the back of his head causing a new wound. Clinical record review for patient #6, start of care 4/8/2009, evidenced an agency plan of care for certification period 5/31/2022 – 7/29/2022. This plan of care evidenced an order to “Clean the area on the back of the head with betadine where the skin is broken/open/swollen. Apply PRN [as needed] Neosporin triple antibiotic ointment (quantity sufficient) topically to the area. Then apply dry dressing daily….” The agency failed to revise the plan of care when the patient's wound healed.			

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
Amanda L. Musser, RN	Administrator	11/16/2022 12:56:38 PM