STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200913590A	A. BUILDING B. WING	11/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER HOMECARE SERVICES LLC	614 EAST 53RD STREET, ANDERSON, IN, 46013

(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 POC accepted on 1-20-2023 *Deborah Franco, RN* This visit was for a State complaint survey of a HHA Provider. Survey Dates: November 17, 18, 21, 22, 23, 28, and 29, 2022 Complaint: IN0094194 - substantiated. State deficiencies were cited. Unrelated deficiencies were cited. Census: 910 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR: Area 2 12/12/22	N0000	Effective immediately the Agency will complete all future Home Health Aid Competency Evaluations and/or training under contract with an area agency that is licensed to perform such duties from 11/29/22 to 11/28/24. This will be implemented and followed by the Director of Nursing with support from Human Resources to identify the annual deadline for all current home health aide Competency Evaluations.	2022-12-28

G0000	INITIAL COMMENTS This visit was for a Federal and State complaint survey of a HHA Provider. Survey Dates: November 17, 18, 21, 22, 23, 28, and 29, 2022 Complaint: IN0094194 - substantiated. Federal and State deficiencies were cited. Unrelated deficiencies were cited. During this Federal Complaint Survey, Hoosier Homecare Services LLC was found to be out of compliance with Conditions of Participation 484.60 Care planning, coordination of services, and quality of care. Based on the Condition-level deficiencies during the November 29, 2022 survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on November 29, 2022. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training, skills	G0000	Effective immediately theAgency will complete all future Home Health Aid CompetencyEvaluations and/or training under contract with anarea agency that is licensed to perform such duties from 11/29/22 to11/28/24. This will be implemented and followed by the Director ofNursing with support from Human Resources to identify the annualdeadline for all current home health aide Competency Evaluations.	2022-12-28

	competency evaluation programs for a period of two years beginning November 29, 2022 and continuing through November 28, 2024. Census: 910 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. QR: Area 2 12/12/22			
G0452	Transfer and discharge 484.50(d) Standard: Transfer and discharge. The patient and representative (if any), have a right to be informed of the HHA's policies for transfer and discharge. The HHA may only transfer or discharge the patient from the HHA if: Based on record review and interview, the home health agency failed to verify the patient was currently hospitalized prior to discharging the patient for hospitalization for 1 of 2 records reviewed of a patient discharged for hospitalization (Patient #6).	G0452	In the event, that apatient is discharged from the home health agency, due to an expiringHome Health Certification, the Agency will confirm the inpatientstatus by phoning the patient, caregiver or hospital, and theconfirmed status will be documented in the physician discharge order,to include the source of the information. The patient/caregiver willalso be phoned on the date of discharge from Agency and the phonecall will be documented in the patient record by the author of theDischarging Order or by the Office Staff making the call, ifdifferent. The	2022-12-06

	Findings included: An agency policy #C-500 "Patient Discharge Process" indicated but was not limited to "... To avoid charges of 'abandonment' at the time of discharge agency documentation will include the following: ... d. Documentation of all communication with the patient, including the rationale for discharge, will be kept in the patient file ... Discharge Criteria: 1. Criteria for discharge may include, but are not limited to the following: ... i. The patient is hospitalized and the hospitalization period ... exceeds the current home care episode of care ...." Review of the clinical record of Patient #6 included a plan of care for the recertification period 08/08/2022-10/06/2022. The record included a physician order, dated 10/03/2022 and signed by the Administrator, which indicated the patient's home health services were placed on hold due to the patient being hospitalized for COVID-19. The record included a second physician order, dated 10/06/2022 and signed by the		Administrator, Alternate Administrator, or Director ofNursing will ensure compliance with this documentation prior to finalapproval of the Discharge Order to ensure 100% compliance. All staff were trained onimplementation of this process and agency policy related to "PatientDischarge Process" on 12/06/22 by the Administrator. This agency will attain 100% compliance through these measures.	

	the patient was discharged from the home health agency "effective this date as home health certification expires while patient remains inpatient. Patient/caregiver were involved in the development and/or aware of the updates to the plan of care." The record included hospitalization records for Patient #6 which indicated the patient was admitted to a local hospital on 10/02/2022 and was discharged on 10/05/2022. An interview was conducted on 11/23/2022 at 12:54 PM with Patient #6's caregiver. During the interview, the caregiver confirmed the agency had not called the caregiver or patient on 10/06/2022 to verify the patient was still admitted to the hospital nor had the agency notified the patient or caregiver that the patient was discharged from the agency. An interview was conducted on 11/28/2022 at Office Staff Member #1 and the Administrator. During the interview, Office Staff Member #1 reported they spoke with Patient #6's family member on			

	10/04/2022 and the family member had indicated Patient #6 would be in the hospital for the remainder of the week. The office staff member stated they notified the caregiver to call the office when the patient was discharged from the hospital. The Administrator confirmed the agency did not confirm the patient was still admitted to the hospital when the patient was discharged on 10/06/2022.			
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with:	N0464	The Agency has sent the Director of Nursing for certification to allow her to administer tuberculin skin tests using Mantoux Method to employees of the Agency on 12/20/22. The Director of Nursing will be responsible for ensuring her certification remains active. The Administrator will be responsible for reviewing the TB Basic Validation card issued on or before 12/28/22. The Director of Nursing will be responsible for opening, dating, and initialing all Tubersol solution bottles and will be responsible for properly discarding the Tubersol solution after 30 days of opening. The Director of Nursing will be	2022-12-28

	(A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on observation and interview, the home health agency failed to ensure the proper handling of tuberculin or tuberculosis skin testing of agency staff, potentially affecting all staff and patients.		responsible for verifying the date of the solution is within 30 days of opening prior to administration of the TB skin test for each employee tested. The Director of Nursing will track and order Tubersol solution when indicated to ensure it is available when needed. In the absence of the Director of Nursing, the agency will utilize a local Occupational Health Center to administer the TB tests. The agency will attain 100% compliance with these measures.	

	Findings include: On 11/18/22 at 9:01 AM, observed an open tuberculin vial for Mantoux testing in the medication refrigerator; the vial did not indicate the open date nor expiration date, nor the initials of the person who opened. During an interview on 11/22/22, beginning at 04:13 PM, the Administrator nor the Alternate Administrator could relay the length of time a vial of tuberculin solution can remain in use, after opening. They indicated the human resource staff handled the tuberculosis testing and was gone for the day. During an interview on 11/23/22 at 11:38 AM, the Human Resources staff indicated the tuberculin should be discarded 30 days after opening and should be dated and initialed and confirmed the vial in the refrigerator was not dated nor initialed until that same morning.			
G0512	Standard: Initial assessment visit.	G0512	The Initial AssessmentVisit will be completed within 48 hours	2022-12-06

	484.55(a) Standard: Initial assessment visit. Based on record review and interview, the home health agency failed to follow their own policy and failed to complete an initial assessment within 48 hours for 2 of 8 active patient records reviewed (Patient #3,10.) Findings include: 1. Undated policy C-140 titled "Patient Admission Process" indicated but not limited to "... Each patient referred to the agency shall be evaluated by a Registered Nurse/ Therapist to determine the immediate care and support needs of the patient... The initial assessment will be completed within forty-eight (48) hours of referral or within forty-eight (48) hours of the patient's return home..." 2. Record review for Patient #3 indicated the home health agency received a referral by fax on 09/08/2022 for physical therapy, occupational therapy, nursing services, and home health aide services with a discharge date from a facility of 09/09/2022. The record included an initial assessment completed on 09/13/2022		of patient's return to homeor within 48 hours of the referral, when the patient is already athome, unless specified by a Physician's order, and documented inthe patient record that the delay was requested specifically by thepatient and/or caregiver. When the delay in the Initial Assessment isby patient/caregiver request, the entry of the date the Agency wascontacted, and by whom the request was made, will be entered into thepatient record by the person receiving the request and dated andsigned by receiving office personnel or clinician. Staff training forthis requirement and review of the agency's policy titled "PatientAdmission Process" was completed on 12/06/22 by the Administratorand will be the responsibility of the Administrator, AlternateAdministrator, or Director of Nursing to confirm appropriatedocumentation. When Start of Care Oasis and Admission order are reviewed by either the D.O.N., Administrator or Alternate Administrator a review will be made regarding the referral date and the Start of Care date	

	which indicated "... delay in care per pt request..." The record failed to evidence a conversation with the patient or family indicating a request to delay the initial assessment. 3. Record review for Patient #10 indicated a referral on 02/10/2022 for skilled nursing for catheter care. The record included a faxed request for order dated 02/15/2022 for patient to be admitted for skilled nursing. The initial assessment was completed on 02/16/2022 with verbal order for frequency and treatment faxed to the physician that day. The record failed to evidence a conversation with the patient or a representative indicating a request to delay the initial assessment. 4. During an interview on 11/21/2022 at 11:45AM, Patient #3's daughter indicated she did not request a delay in the start of care for Patient #3. 5. During an interview on 11/29/2022 beginning at 11:30AM, the administrators deferred the question of who specifically requested a delay in		to ensure compliance with the above protocol. Employees identified as not following this protocol will be re-trained by the D.O.N., Administrator or Alternate Administrator.	

	#3 to their office assistant who indicated it was Patient #3's daughter who requested it but was unable to provide documentation of same. The administrators also deferred the question of who specifically requested a delay in the initial assessment for Patient #10 to their office assistant who indicated the delay was due to the referring agency sending the patient's information to the incorrect fax number but could not provide any documentation of same. The administrator indicated it was possibly an issue with prior authorization due to the patient's insurance. The human resources director checked and indicated Patient #10 did not require prior authorization at the time of their admission.			
N0518	Patient Rights 410 IAC 17-12-3(e) Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as	N0518	The Alternate Administrator trained all staff on 12/06/22 on the importance of ensuring the admission folders contain the most current components. All clinicians were instructed to return any admission packets in his/her possession so that the correct components could be updated including listing the current Clinical Manager. Copies	2022-12-06

	long as the information is furnished before care is provided. Based on observation, record review, and interview, the home health agency failed to distribute current written information regarding advanced directives, before care was provided, for 3 of 5 patients with home visits and home folders available in the home at the time of the visit. [Patients 3, 4, and 5]. Findings include: 5. During a home visit with Patient #5 on 11/18/2022 at 10:15 AM, the patient's home folder failed to include current written information regarding advanced directives. Findings included: 1. Review of an undated documented titled "Patient Rights and Responsibilities" included but not limited to "... you have the right to be informed and receive written notification in advance, concerning the agency's policies on advanced directives including a description of applicable state law..." 2. Review of the agency's		of the most current information page related to listing the Agency contact information, Administrator, Alternate Administrator, and Clinical Manager was printed and given to all clinicians to take to all current patients to ensure the most up-to-date version is available and agency is in 100% compliance. The content of the Admission Folder will be reviewed at least annually by the QAPI/Governing Body to verify content and updated immediately when there are changes to these positions: Administrator, Alternate Administrator, and Director of Nursing to ensure 100% compliance for all current and future patients.	

admission packet included a document from the Indiana State Department of Health titled "Advanced Directives: Your Right to Decide," revised July 1, 2013.

3. During a home visit with Patient #3 on 11/18/2022 at 11:04AM, the patient's home folder failed to include current written information regarding advanced directives.

4. During a home visit with Patient #4 on 11/18/2022 at 01:13PM, the patient's home folder failed to include current written information regarding advanced directives.

6. During an interview on 11/17/2022 at 10:25AM, the Director of Nursing (DON) confirmed the admission packet they provided at 9:55AM the same day was the current version of the admission packet being given to patients.

7. During an interview on 11/22/2022 at 04:13PM, the administrator indicated patient's were informed of their rights regarding advanced directives at admission, and the alternate administrator indicated patient's

	regarding advanced directives via the admission packet. When asked how the agency ensures the information regarding advanced directives provided to the patients was up-to-date, the administrator indicated the patient folders were reviewed at minimum annually, and the alternate administrator indicated the patient folders were reviewed every 60 days.			
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 observation, record review, and interview the home health agency failed to follow their own policy and failed to include all medications on the medication list, failed to include frequency of medications, and failed to include indications for PRN (as needed) medications for 4 of 8 active patient records reviewed (Patient #1,5,8,10.) 2. Review of the clinical record for Patient #1 included a	G0536	A Review of All CurrentMedications: Staff training was completed by the Director of Nursingfor all clinicians conducting medication entries on 12/06/22.Training during this session included review of agency policy on“Medication Profile” and education on medication entry intopatient’s record, as well as, entry of “PRN” or “as needed”medications with the listing of the indication for these medications.Clinicians were also educated on the importance of entering the useof oxygen on the medication profile. The components of the medicationprofile were reviewed to include dose, frequency, and route.	2022-12-19

	medication profile completed as part of the recertification comprehensive assessment process by Physical Therapist (PT) #3 on 11/12/2022. The medication list included orders for as-needed medications: fleet enema (medication given rectally to treat constipation), Miralax (given to treat constipation), Bisacodyl (given to treat constipation), and Refresh Tears Opthalmic (eye drops given to treat dry or itchy eyes). The medication list failed to evidence indications for administration for the as-needed medications. 3. Review of the clinical record for Patient #5 included a medication profile completed as part of the recertification comprehensive assessment process by Physical Therapist #2. The medication list included an order for Triamcinolone Acetonide (a steroid cream used to treat a variety of skin conditions) with the directions "apply to affected area." The medication list failed to evidence clear directions on the specific location the patient was to apply the medication. 4. Review of the clinical record		Allclinicians are required to interview the patient or caregiver at eachvisit to identify medication changes or new medications. Thisinterview is a required component of each visit and will be monitoredfor compliance by the Administrator, Alternate Administrator, andDirector of Nursing. It will be the responsibility of the Director ofNursing to conduct reviews of each medication profile submitted toensure 100% compliance that each medication has been identified and has the appropriate indication and frequency. Theclinician will notify the Director of Nursing of any medicationchange entered for a patient and any identified interactions. Verification of this oversight will be evidenced by the Director ofNurse's initials/date on the medication profile. For patients thatare that are admitted forcare by this Agency on or after 12/19/22, the admitting clinicianwill be required to obtain a copy of the medication profile from the provider in order to accurately reconcile themedication profile and treatment orders. The admitting clinician/case	

	for Patient #8 included a medication profiled completed as part of the recertification comprehensive assessment completed on 11/04/2022 by Registered Nurse (RN) #2. The medication list included orders for as needed medication Tylenol (over-the-counter medication given to treat pain and/or fever), but failed to evidence an indication(s) for administration for the Tylenol. 5. During an interview conducted on 11/22/2022 beginning at 4:13 PM, when queried if the medication list should included an indication for administration for as needed medications, the Administrator and Alternate Administrator were unable to provide an answer. Findings include: 1. Policy C-700 titled "Medication Profile" included but not limited to "... The Medication Profile shall document... the route and frequency of administration... The Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and		manager will also physically identify patient's medications during the visit to identify all patient medications including prescription, over-the-counter, herbal, etc. There will be an assignedoffice personnel to verify the inclusion of the medication profile inthe submission of admission paperwork. The Alternate Administratorwill be responsible for contacting the assisted living facilities ofall current patients to obtain medication profiles if not present inpatient's medical record. The Director of Nursing will beresponsible for assigning the obtained medication profiles to thepatient's Case Manager for reconciliation, as well as physical, direct observation of a patient's medications. The Director of Nursing will make random visits quarterly to current patients to verify 100% compliance and will report findings to the QAPI for fiscal year 2023.	

	change or discontinuation in medication... During therapy only cases, a Registered Nurse will review and sign/ initial medication profile and any changes to medication profile..." 4. Review of the clinical record for Patient #10, SOC 06/15/2022, included a medication profile, completed as part of the assessment process and initialed by the current DON (director of nursing.) The medication list included but not limited to "...Zims Max-Freeze External 3.7% [an over-the-counter topical pain relief medication]1 Take as directed... Senna S Oral 8 6-50 MG [used to treat constipation] 1 Tab(s) Take as directed... metformin HCl [used to treat Type 2 diabetes] Oral 1000 MG 1 Tab(s) Take as directed..." The medication profile failed to include the frequency for each of these medications. 5. During an interview on 11/28/2022 at 12:41PM, the DON indicated those were her initials on Patient #10's medication list and the medication list should have specific instructions for			

	administration. When asked if the phrase "take as directed" was appropriate for a patient's medication list, the DON indicated "it could definitely be more specific."			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review, and interview, the home health agency failed to ensure the patient received all services as written in the plan of care (See G572); failed to evidence a single plan of care and failed to include all medications and treatments in the plan of care (See G574); failed to coordinate care to meet the	G0570	Care planning,coordination of services, and quality of care: All Clinicians were trained on 12/06/22 on the agency policy "Plan of Care". Clinicians were instructed on the process of writing and completing physician orders to update a patient's plan of care. Staff training was completed on 12/06/22 with clinicians to educate on the importance of following all prescribed physician orders and to contact the patient's physician to update the plan of care when the patient requests a change to the ordered interventions to ensure 100% compliance. The clinicians were educated to review the discipline specific interventions to ensure there is an individualized patient plan of care. The Director of Nursing will be responsible for reviewing all submitted nursing and home health aide documentation for 100% compliance and accuracy in care planning, coordination	2022-12-06

	patient's needs (See G608); and failed to provide the name and contact information for the current clinical manager (See G622). Findings include: The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate care and services which could result in the agency not providing quality health care, thus being out of compliance with Condition of Participation 42 CFR 484.60 Condition of participation: Care planning, coordination of services, and quality of care. 410 IAC 17-13-1(a)		of services, and quality of care. The Administrator will be responsible for reviewing clinical documents submitted by Occupational Therapy and Speech Therapy for 100% compliance and accuracy in care planning, coordination of services, and quality of care. The Alternate Administrator will be responsible for reviewing 100% compliance and accuracy in all submitted Physical Therapy documentation for accuracy in care planning, coordination of services, and quality of care. Upon 100% compliance, all future records with inaccuracies will be returned for the clinician to review and correct and trends identified will be submitted to the QAPI for program improvement processes. The Administrator was responsible for adding a "template" to the Home Health Certification/Plan of Care to identify appropriate medical records (Physical, Occupational and Speech Therapy Evaluations) as "Addendums to the Physician's Plan of Care". The Home Health Certification/Plan of Care and Addendums (PT, OT, and ST	

			Evaluations) will continue to be sent to the physician for review, approval and signature to ensure 100% compliance. Staff training was completed by the Administrator on 12/06/22 and included education on the need for an individualized plan of care with the appropriate title to identify Addendums to the Home Health Certification/Plan of Care. The Administrator, Alternate Administrator, and Director of Nursing will be responsible for reviewing each patient's plan of care to ensure that Addendums to the Plan of Care are identified as such to ensure 100% compliance. The Agency's medical software company was also contacted and a Work Order Request Ticket was established to identify processes to incorporate these Addendums into the Home Health Certification/Plan of Care. The Alternate Administrator trained all staff on 12/06/22 on the importance of ensuring the admission folders contain the most current components. All clinicians were instructed to return any admission packets in his/her possession so that the correct components could be	

			updated including listing the current Clinical Manager. Copies of the most current information page related to listing the Agency contact information, Administrator, Alternate Administrator, and Clinical Manager was printed and given to all clinicians to take to all current patients to ensure the most up-to-date version is available and agency is in 100% compliance. The content of the Admission Folder will be reviewed at least annually by the QAPI/Governing Body to verify content and updated immediately when there are changes to these positions: Administrator, Alternate Administrator, and Director of Nursing to ensure 100% compliance for all current and future patients.	
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	G0572	All Clinicians weretrained on 12/06/22 on the agency policy "Plan of Care".Clinicians were instructed on the process of writing and completingphysician orders to update a patient's plan of care. Staff trainingwas completed on 12/06/22 with clinicians to educate on theimportance of following all prescribed	2022-12-06

	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 ensure the patient received all treatments as written in the plan of care for 1 of 2 home visit observations of a Registered Nurse (RN) (Patient #8). Findings included: An agency policy #C-580 titled "Plan of Care" indicated but was not limited to "Policy: Home care services are furnished under the supervision and direction of the patient's physician …." An agency job description for the role "Registered Nurse" indicated but was not limited to "… Essential Functions/Areas of Accountability … c … Follows an individualized Plan of Care … d. Provides skilled interventions …." Review of the clinical record for Patient #8 included a plan of care for the recertification period 11/04/2022 – 01/02/2023 and included orders		physician orders and tocontact the patient's physician to update the plan of care when thepatient requests a change to the ordered interventions to ensure 100% compliance. Theclinicians were educated to review the discipline specificinterventions to ensure there is an individualized patient plan ofcare. The Director of Nursing will be responsible for reviewing allsubmitted nursing and home health aide documentation for 100% compliance and accuracy incare planning, coordination of services, and quality of care. TheAdministrator will be responsible for reviewing clinical documentssubmitted by Occupational Therapy and Speech Therapy for 100% compliance and accuracy incare planning, coordination of services, and quality of care. TheAlternate Administrator will be responsible for reviewing 100% compliance and accuracy inall submitted Physical Therapy documentation for accuracy in careplanning, coordination of services, and quality of care. Upon 100% compliance, all future recordswith inaccuracies will be returned for the clinician to review andcorrect and trends	

	for skilled nursing 2 visits per week for 8 weeks and 1 visit per week for 1 week. The plan of care indicated nursing interventions included but were not limited to "... SN [Skilled Nurse] to perform finger stick for fasting blood sugar/random blood sugar during visit if it has not been done ...." During a home visit with Patient #8 and Registered Nurse (RN) #2 on 11/21/22 at 11:34 AM the nurse failed to check the patient's blood sugar. RN #2 was interviewed at 12:22 PM and confirmed they had completed the visit and did not check the patient's blood sugar. The nurse asked Patient #8 if they checked their blood sugar, and the patient indicated they did not routinely check their blood sugar. 410 IAC 17-13-1(a)		identified will be submitted to the QAPI forprogram improvement processes.	
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	G0574	The Administrator wasresponsible for adding a "template" to the Home HealthCertification/Plan of Care to identify appropriate medical records(Physical, Occupational and Speech Therapy Evaluations) as "Addendumsto	2022-12-19

	cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the home health agency failed to follow their own policy and failed to provide a single Plan of Care containing all medications and treatments for 5 of 8 active patient records reviewed (Patient #1,2,3,4,5.) 2. Review of the clinical record for Patient #1 included a plan of care for the recertification period 09/13/2022 -		the Physician's Plan of Care". The Home HealthCertification/Plan of Care and Addendums (PT, OT, and ST Evaluations) will continue to be sent tothe physician for review, approval and signature to ensure 100% compliance. Staff training wascompleted by the Administrator on 12/06/22 and included education onthe need for an individualized plan of care with the appropriatetitle to identify Addendums to the Home Health Certification/Plan ofCare. The Administrator, Alternate Administrator, and Director ofNursing will be responsible for reviewing each patient's plan ofcare to ensure that Addendums to the Plan of Care are identified assuch to ensure 100% compliance. The Agency's medical software company was also contacted anda Work Order Request Ticket was established to identify processes toincorporate these Addendums into the Home Health Certification/Planof Care. The Alternate Administrator trained all staff on 12/06/22 on the importance of ensuring the admission folders contain the most current components. All	

	11/11/2022 which indicated the patient was to receive physical therapy and home health aide services. The plan of care failed to evidence specific procedures and modalities for therapy services. 6. Review of the clinical record for Patient #5 included a plan of care for the recertification period 10/21/2022 - 12/19/2022 which indicated the patient was to receive skilled nursing and physical therapy services. The plan of care failed to evidence specific procedures and modalities for therapy services. Findings include: 1. Policy C-580 titled "Plan of Care" indicated "... The Plan of Care shall be completed in full to include... Type, frequency, and duration of all visits/ services... If a service is not scheduled to begin until a subsequent week then the order should read, "blank services to evaluate and treat effective the week of... Specific procedures and modalities for therapy services... Medications, treatments, and procedures... *All of the above items must*		clinicians were instructed to return any admission packets in his/her possession so that the correct components could be updated including listing the current Clinical Manager. Copies of the most current information page related to listing the Agency contact information, Administrator, Alternate Administrator, and Clinical Manager was printed and given to all clinicians to take to all current patients to ensure the most up-to-date version is available and agency is in 100% compliance. The content of the Admission Folder will be reviewed at least annually by the QAPI/Governing Body to verify content and updated immediately when there are changes to these positions: Administrator, Alternate Administrator, and Director of Nursing to ensure 100% compliance for all current and future patients. A Review of All Current Medications: Staff training was completed by the Director of Nursing for all clinicians conducting medication entries on 12/06/22. Training during this session included review of agency policy on "Medication	

	always be addressed on the Plan of Care... The plan of care is developed as required by agency/state guidelines..." 3. Review of the clinical record for Patient #2, SOC (start of care) 11/11/2022, failed to evidence a POC (Plan of Care) which included specific procedures and modalities for therapy services. 4. Review of the clinical record for Patient #3, SOC 09/13/2022, included a POC (Plan of Care) for the certification period from 11/12/2022 to 01/10/2023. The POC failed to include the indications for the PRN medication acetaminophen oral 500 mg and failed to include specific procedures and modalities for therapy services. 5. Review of the clinical record for Patient #4, SOC 10/26/2022, included a POC for certification period 10/26/2022 to 12/24/2022. The POC failed to include indications for four (4) PRN medications, Valtrex (a drug used to treat herpes virus infections), Ipratropium-Albuterol Inhalation (a drug used to treat to prevent bronchospasm),		Profile" and education on medication entry into patient's record, as well as, entry of "PRN" or "as needed" medications with the listing of the indication for these medications. Clinicians were also educated on the importance of entering the use of oxygen on the medication profile. The components of the medication profile were reviewed to include dose, frequency, and route. All clinicians are required to interview the patient or caregiver at each visit to identify medication changes or new medications. This interview is a required component of each visit and will be monitored for compliance by the Administrator, Alternate Administrator, and Director of Nursing. It will be the responsibility of the Director of Nursing to conduct reviews of each medication profile submitted to ensure 100% compliance that each medication has been identified and has the appropriate indication and frequency. The clinician will notify the Director of Nursing of any medication change entered for a patient and any identified interactions.	

	Diclofenac Sodium External (a drug used to treat pain and inflammation), and Clobetasol Propionate External (a drug used to treat a variety of skin conditions such as eczema or psoriasis). The POC also failed to include the frequency or location to apply Nystatin External (a drug used to treat fungal skin infections) and failed to include O2 (oxygen) 2L per nasal cannula during sleep. During a home visit with Patient #4 on 11/18/2022 beginning at 01:13PM, observed Patient #4 confirmed to nurse the patient is using O2 2L at night. 7. During an interview on 11/22/2022 at 04:13PM, the alternate administrator indicated route, dosage, name, and frequency should be included for each medication. 8. During an interview on 11/23/2022 at 3:45PM, the alternate administrator confirmed orders for oxygen were not on Patient #4's POC. 9.During an interview on 11/29/2022 at 11:30AM, when asked which document was considered the POC, the administrator indicated if PT		Verification of this oversight will be evidenced by the Director of Nurse's initials/date on the medication profile. For patients that are that are admitted for care by this Agency on or after 12/19/22, the admitting clinician will be required to obtain a copy of the medication profile from the provider in order to accurately reconcile the medication profile and treatment orders. The admitting clinician/case manager will also physically identify patient's medications during the visit to identify all patient medications including prescription, over-the-counter, herbal, etc. There will be an assigned office personnel to verify the inclusion of the medication profile in the submission of admission paperwork. The Alternate Administrator will be responsible for contacting the assisted living facilities of all current patients to obtain medication profiles if not present in patient's medical record. The Director of Nursing will be responsible for assigning the obtained medication profiles to the patient's Case Manager for reconciliation, as well as physical, direct	

	(physical therapist) did the initial assessment the 485 (POC) would be PT orders and aide orders also but if a nurse does the initial assessment then PT and OT (occupational therapist) do their assessments separately and become part of the POC as an addendum. When asked where on the Physical Therapy Assessment or Occupational Therapy Assessment it indicated it was an addendum to the POC, the administration was unable to show.		observation of a patient's medications. The Director of Nursing will make random visits quarterly to current patients to verify 100% compliance and will report findings to the QAPI for fiscal year 2023.	
G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on observation, record review, and interview, the agency failed to ensure coordination of care to meet the patient's needs for 2 of 8 active patient records reviewed (Patient #2 and 8). 3. Review of the clinical record for Patient #8 included a plan of care for the recertification period 09/05/2022 – 11/03/2022 and included orders for skilled nursing, 3 visits per	G0608	On 12/05/22 the Directorof Nursing identified all patients that go to a wound center and theday of the week of the appointments. The Director of Nursing will beresponsible for ongoing tracking of these patients to ensure agency attains 100% compliance through these measures. The Director ofNursing will contact the wound center for new orders if the agencyhas not received the orders the day following the patient'sscheduled appointment. All patients, or his/her caregiver, that areseen at wound centers were educated to contact the agency	2022-12-05

	week for 8 weeks and 2 visits per week for 1 week. The plan of care indicated the skilled nurse was to perform wound care to Patient #8's right plantar (bottom of the foot) diabetic wound and right lateral foot diabetic wound. The wound care was ordered to be performed at each visit and included "... cleanse with [normal saline], apply Prisma [type of wound dressing], cover with Hydrofera Blue [type of wound dressing], apply ABD [pad, type of wound dressing], apply Kerlix [gauze wrap]. Change three times a week ...." The record included a clinic visit note from Patient #8's physician, dated 10/26/2022, which indicated Apligraf (a skin substitute wound dressing) was applied to Patient #8's wounds. The note indicated the patient's wound dressing change frequency was decreased to once a week by the home health agency and once by the wound clinic. The wound dressing orders also indicated the home health agency was to "keep Mepitel layer [wound dressing] in place as Apligraf is under the Mepitel."		to notifyof any missed appointments. All clinicians have been trained to educate all future patients/caregivers to contact agency to notify of missed wound center appointments. The Director of Nursing or the CaseManager be responsible to contact the wound center regarding missed appointmentsto seek new orders if indicated.	

	The record included a physician order dated 11/02/2022 which indicated the physician approved to continue Patient #8's home health orders and the patient was to receive skilled nursing, 2 visits per week for 8 weeks and 1 visit per week for 1 week. The order indicated the skilled nurse was to perform wound care to both wounds once a week. The wound dressing care included keeping the Apligraf and Mepitel in place, cleansing the wound and surrounding area with normal saline, apply Hydrofera Blue, cover with ABD pad, and wrap with Kerlix. The record included a physician order, dated 11/07/2022, which indicated Patient #8's home health services were to be put on hold due to the patient being hospitalized. A second physician order, dated 11/10/2022 and signed by RN #2, indicated the patient's home health services were to resume that same day for 1 visit per week for 1 week then 2 visits per week for 7 weeks. Patient #8's wound care to both wounds included "cleanse with normal and pat dry, apply			

	with Hydrofera Blue dressing and wrap with Kerlix and secure with tape," to be completed at each skilled nurse visit. During a home visit with Patient #8 and Registered Nurse (RN) #2 on 11/21/22 at 11:34 AM, the patient's right foot wounds were observed. No Apligraf nor Mepitel dressings were observed. RN #2 was interviewed during the home visit and confirmed they obtained the 11/10/2022 physician order to resume care and the wound change orders from Patient #8's physician. The nurse reported Patient #8 had their Apligraf and Mepitel dressing removed while hospitalized, was to return to the wound clinic on 11/16/2022 to have the Apligraf and Mepitel placed on again, after which the wound clinic would send the home health agency new wound clinic orders. RN #2 also reported Patient #8 had missed the 11/16/2022 visit and the agency had continued the current wound care orders. A follow up interview was conducted with RN #2 on 11/22/2022 at 4:42 PM. During			

	reported when they obtained the 11/10/2022 order for Patient #8's wound care, the office nurse had stated the home health agency was to change the dressing on 11/10/2022 and 11/14/2022, then the home health agency would receive new wound care orders on 11/16/2022. A second follow up interview was conducted with RN #2 on 11/28/2022 at 3:50 PM. During the interview, the nurse confirmed they had spoken with the Clinical Manager after obtaining Patient #8's physician orders on 11/10/2022 and had reported the wound clinic was to send new wound care orders to the home health agency after the patient's appointment on 11/10/2022. The record included a skilled nurse visit note dated 11/17/2022 by LPN #2. The visit note indicated no Apligraf or Mepitel was observed in either of Patient #8's wounds and the nurse performed wound care according to the order dated 11/10/2022. An interview was conducted on			

	LPN #2. During the interview, the nurse confirmed Patient #8 did report they missed the wound clinic visit on 11/16/2022 however the nurse did not report this to the Clinical Supervisor as the patient's family member had already rescheduled the visit. The nurse stated they were not aware the patient's wound care orders were to change after the wound care visit on 11/16/2022. The record indicated Patient #8's wound care was performed twice by the home health agency during the week of 11/13/2022 – 11/19/2022, which was one dressing change less per week than when the patient previously had the same dressing orders. The home health agency failed to ensure effective communication between all staff members and failed to ensure the frequency of wound care dressing change twice per week was to continue one additional week after the patient missed their wound care visit on 11/16/2022. Findings include: 1. Policy C-360 titled			

	Services" indicated "... Purpose... to ensure appropriate, quality care is being provided to patients... to establish effective interchange reporting, and coordination of patient care does occur... to ensure continuity of care... After the initial assessment, the admitting Registered Nurse/ Therapist shall discuss the findings of the initial visit with the Clinical Manager to ensure... coordination with other agencies and institutions, if the need arises..." 2. During a home visit with Patient #2 on 11/17/2022, a copy of the patient's medication record was received from the patient's ALF (assisted living facility.) The medication record indicated but not limited to no blood pressures or lab draws to the left upper extremity due to a history of left breast mastectomy and TED hose (stockings used to prevent blood clots in the legs) to be applied in the morning and removed in the evening. Record review for Patient #2, SOC (start of care) 11/11/2022, failed to evidence the above			

	addressed by the agency. 4. During an interview on 11/23/2022 at 03:45PM, the Administrator confirmed the nurse assessing a patient at an ALF should review the ALF's medication record. Neither the Administrator nor the Alternate Administrator could show mention of TED hose or the restriction on blood pressures to the left arm in Patient #2's record.			
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager. Based on observation, record review, and interview, the home health agency failed to ensure all patients were provided with the name of the Clinical Manager for 3 of 5 patients who had patient folders in the home during home visit observations (Patient #3,5,8.) 3. During a home visit with Patient #5 on 11/18/2022 at 10:15 AM, review of the patient home folder failed to evidence the name of the current Clinical Manager.	G0622	The AlternateAdministrator trained all staff on 12/06/22 on the importance ofensuring the admission folders contain the most current components.All clinicians were instructed to return any admission packets inhis/her possession so that the correct components could be updatedincluding listing the current Clinical Manager. Copies of the mostcurrent information page related to listing the Agency contactinformation, Administrator, Alternate Administrator, and ClinicalManager was printed and given to all clinicians to take to allcurrent patients to ensure the most up-to-date version is available and agency	2022-12-06

	4. During a home visit with Patient #8 on 11/21/2022 at 11:34 AM, review of the patient home folder failed to evidence the name of the current Clinical Manager. Findings include: 1. An untitled document from the admission packet provided to the surveyors failed to evidence the name of the Clinical Manager. 2. During a home visit with Patient #3 on 11/18/2022 at 11:04AM, review of the patient folder failed to evidence the name of the Clinical Manager. 5. During an interview on 11/17/2022 at 10:25AM, the Clinical Manager confirmed the admission packet provided was the most current version being distributed to patients.		is in 100% compliance.The content of the Admission Folder will be reviewed at leastannually by the QAPI/Governing Body to verify content and updatedimmediately when there are changes to these positions: Administrator,Alternate Administrator, and Director of Nursing to ensure 100% compliance for all current and future patients.	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard	G0682	All nursing staff will be trained onthe following and will be competency checked by the Director ofNursing by 12/20/22: Infection Control, Supply Bag Technique,Pressure Ulcer Dressing Change, Wound	2022-12-20

	precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the home health agency failed to ensure all staff followed infection prevention and standard precaution policies and procedures for 4 of 7 home visit observations (Patient #3, 4, 5, 7). Findings included: 1. Agency policy #G-160 titled "Pressure Ulcer Dressing Change," dated 4/2008, indicated but was not limited to "... Procedure ... 4. Put on gloves and remove old dressing and discard ... 6. Apply new pair of gloves. 7. Measure wound perimeter with disposable device ... 10. Cleanse the wound bed ...." 2. An agency competency evaluation for "Supply Bag Technique" indicated but was not limited to "... Hands washed before entering bag. Equipment cleaned prior to returning to bag ... Hands washed prior to re-entry after possible contamination ...." 5. During a home visit with Patient #5 and Physical		Measuring, and Hand Washing.Any nurse that has failed to complete the training and provencompetency will be prohibited from treating patients until these arecompleted. The Director of Nursing will be responsible forcompleting and tracking this training to ensure 100% compliance. All staff will be trained andcompetency checked by the Director of Nursing on the following:Infection Control, Bag Technique, and Hand Washing. The Director ofNursing will be responsible for completing and tracking this trainingfor all current and future clinical staff. All staff will be checked for competency annually on the following: Infection Control, Supply Bag Technique, and Hand Washing by his/her supervisor and record of the competency will be kept in the employee's records. All nursing staff will competency evaluated annually regarding Pressure Ulcer Dressing Change and Wound Measuring by the Director of Nursing and record of this training will be kept as part of the employees medical records. Human Resources will be responsible to ensuring the	

	Therapist (PT) #3 on 11/18/2022 at 10:15 AM, the PT was observed failing to perform hand hygiene prior to entering their supply bag. 6. During a home visit with Patient #8 and Registered Nurse (RN) #2 on 11/21/22 at 11:34 AM, the nurse was observed assessing and performing wound care to the patient's two wounds on their right foot. After removing the old dressings, cleaning each wound with saline soaked gauze, and performing a glove change with hand hygiene, RN #2 measured the length and width of both wounds using the same disposable measuring tape. The nurse then applied new dressings to each wound, rotating back and forth between each wound when applying the different layers of dressing (Mepitel, Hydroferra blue, ABD pad, then wrapped with Kerlix and tape). The nurse failed to use a new, clean measuring tape for each wound and failed to perform hand hygiene and change gloves when going between the two wounds while applying new dressings. 3. During a home visit with		scheduling and completion of this training. The Agency will attain 100% with the described measures.	

	Patient #3 on 11/18/2022 at 11:04AM, PTA (Physical Therapy Assistant) #1 failed to perform hand hygiene after touching the front of his face mask and before touching the patient two times and failed to perform hand hygiene after touching his face mask and before touching his tablet one time. After wiping used equipment, PTA #1 failed to allow the items to dry before placing them into his bag. 4. During a home visit with Patient #4 on 11/18/2022 at 01:13PM, LPN (Licensed Practical Nurse) #1 wiped her used equipment and failed to allow the items to dry before placing them into her bag. 5. During an interview on 11/22/2022 at 04:13PM, the Alternate Administrator indicated the agency process for disinfecting equipment was to clean and allow to dry on a barrier before putting back into the bag. The Alternate Administrator also confirmed staff, if they touched their face mask, should perform hand hygiene before touching the patient or equipment. 410 IAC 17-12-1(m)			

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 observation, record review, and interview, the home health aide (HHA) failed to perform all tasks ordered on the aide care plan for 1 of 1 home visit observations with a home health aide (Patient #1). Findings included: An agency job description for the position Home Health Aide, revised 10/2017, indicated home health aide "essential functions" included but were not limited to "... Follows the assignment sheet/service plan ...." Review of the clinical record of Patient #1 included an aide care plan created and signed by	G0800	All clinicians will betrained by the Alternate Administrator by 12/20/22 on the "HomeHealth Care Plan" Policy and Procedure related to tasks identifiedas PRN or "as needed". Each clinician was instructed to discussthe Home Health Care Plan thoroughly with the patient and caregiverto educate on the provision of aide services identified as "PRN"or as needed. This training will include the responsibility of thehome health aide to interview the patient/caregiver at each visit todetermine the need or request of the patient/caregiver for completionof PRN or "as needed" tasks by the home health aide. The HomeHealth Aide Care Plans will include the prompt "As Directed byPatient and/or Caregiver" next to each PRN or "as needed" task.The 100% of all Home Health Aide Visit Note will be reviewed by the Director ofNursing to confirm that these tasks were identified as "completedor declined" to ensure compliance. The Alternate Administrator willbe responsible for ensuring 100% of all existing Home Health Aide Care Planswill be	2022-12-20

	11/12/2022. The aide care plan included the tasks "... Change Linen ... Light Housekeeping ... Make Bed" to be done "PRN" (as needed). A home visit observation was conducted on 11/17/2022 at 12:22 PM with Patient #1 and Home Health Aide #1. During the visit, HHA #1 failed to perform or ask the patient if the following tasks were to be done "Change Linen ... Light Housekeeping ... Make Bed ...." During an interview conducted on 11/22/2022 beginning at 4:13 PM, the Administrator and Alternate Administrator confirmed the home health aide should ask the patient if PRN task(s) are/were to be done during the visit.		updated by the patient's Case Manager, per agency policy,to reflect this requirement. These measures will be ongoing as Agency procedure to ensure this deficiency does not recur. The Agency will attain 100% compliance through these measures.	
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.	G1024	All staff will be trainedon 12/20/22 by the Alternate Administrator on the following Policy andProcedures: "Authentication Policy" and "Documentation ofChanges to Medical Records". All changes to medical records will beelectronically signed, authenticated and dated by the clinicalauthor. In the event, that	2022-12-20

	Based on record review and interview, the home health agency failed to follow their own policy and failed to ensure appropriate authentication of patient records for 2 of 8 active patient records reviewed (Patient #3,10.) 17-15-1(a)(7) Findings include: 1. A policy titled "Authentication Policy" indicated "… Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry…" 2. Policy C-873 titled "Documentation of Changes to the Medical Record" indicated "…Any changes or revisions of information documented in the patient record documented in the patient record must follow accepted legal requirements… If it is necessary to make an addition to a previous entry, this must be done using an addendum to the record… The clinician who completes the assessment form is responsible for making changes (corrections, revisions, or additions, to the document…		changes or entries are made following aclinician's departure from agency employment, there will be aseparate "Communication" entry that will identify the change orentry made, the clinician making the change, and the date of thechange or entry. The Administrator, Alternate Administrator, orDirector of Nursing are responsible for ensuring 100% compliance and willbe the only individuals authorized for oversight of these type ofentries. 100% of all discharged patients will be audited by assigned office staff as an ongoing measure to ensure 100% compliance. The Initial Assessment Visit will be completed within 48 hours of patient's return to home or within 48 hours of the referral, when the patient is already at home, unless specified by a Physician's order, and documented in the patient record that the delay was requested specifically by the patient and/or caregiver. When the delay in the Initial Assessment is by patient/caregiver request, the entry of the date the Agency was contacted, and by whom	

	designee may enter changes based on the review of the assessment. These changes must be documented in the record identifying the reason for the changes and the communication of those changes to the authoring clinician. These changes must also be initialed and dated…" 3. Review of Patient #3's clinical record, SOC (start of care) 09/13/2022, included an order signed by the DON (director of nursing) and dated 09/13/2022 which indicated but not limited to "… Delay in SOC per patient/ family request…" and an order signed by RN (Registered Nurse) #2 and dated 10/20/2022 which indicated "… decrease HHA [home health aide] 1xWK3 [1 time per week for 3 weeks] per patient request…] During a home visit with Patient #3 on 11/18/2022 at 11:04AM, Patient #3's wife, when asked if they requested a decrease in home health aide visits, she answered no but that she understands the aide must see multiple patients per day and that it was okay because their daughter comes to shower and		the request was made, will be entered into the patient record by the person receiving the request and dated and signed by receiving office personnel or clinician. Staff training for this requirement and review of the agency's policy titled "Patient Admission Process" was completed on 12/06/22 by the Administrator and will be the responsibility of the Administrator, Alternate Administrator, or Director of Nursing to confirm appropriate documentation. When Start of Care Oasis and Admission order are reviewed by either the D.O.N., Administrator or Alternate Administrator a review will be made regarding the referral date and the Start of Care date to ensure compliance with the above protocol. Employees identified as not following this protocol will be re-trained by the D.O.N., Administrator or Alternate Administrator.	

shave Patient #3 on the weekend.

During an interview on 11/21/2022 at 11:45AM, Patient #3's daughter indicated that she did not request a delay in SOC nor did she request a reduction in HHA service frequency. The patient's daughter also denied she or her parents requested any decreases in services and indicated more frequent HHA services would be helpful for her parents. When asked about several missed HHA visits, she indicated missed aide visits were probably from the family canceling scheduled visits due to Patient #3's doctor visits.

4. Review of Patient #10's record, SOC 06/15/2022, included a comprehensive assessment authored by RN #3 and initially signed on 07/28/2022 at 07:40PM per the work log for the assessment. The work log also indicated the DON (Director of Nursing) reopened and signed the assessment on 10/05/2022 at 03:43PM. The assessment appears in the EMR (electronic medical record) as if the DON performed the assessment as there is no mention of the

original author on the OASIS assessment.

The clinical record included a POC with a SOC of 06/15/2022 for certification period 06/15/2022 to 08/13/2022 signed by RN #3 and dated 06/15/2022, faxed to the physician 08/05/2022, and signed and dated by the physician 08/05/2022. The record also included an order to admit for skilled nursing 1 time every other week signed by RN #3 and dated 06/15/2022 and signed and dated by the physician on 08/03/2022 and included an order for discharge due to insurance change, effective 06/14/2022, signed by RN #3 and dated 06/14/2022, faxed to the physician on 08/01/2022, and signed and dated by the physician 08/01/2022.

The closed clinical record for Patient #10 included a Plan of Care with a SOC of 02/16/2022 for certification period 06/16/2022 to 08/14/2022 and signed by RN #3 and dated 06/16/2022, faxed to the physician on 07/05/2022, and signed by the physician on 07/05/2022. The record also

included an order for Patient #10 to be re-certified for skilled nursing 1 time every other week signed by RN #3 and dated 06/15/2022 and signed and dated by the physician on 06/17/2022. The Case Conference note for Patient #3 dated 06/15/2022 indicated a SOC of 02/16/2022 with a recommendation for recertification; the note failed to indicate a need for discharge and readmission. An insurance eligibility and verification form indicated the patient's insurance was checked on 07/28/2022 and the insurance had terminated 05/31/2022.

5. During an interview on 11/28/2022 at 12:41PM, when asked who completed the comprehensive assessment for Patient #10, the DON looked at the record and indicated she did. When asked why the admission paperwork for that day was signed by RN #3, the DON looked at the work log and noted RN #3 had completed the assessment but it had to be corrected and signed by the DON for a billing issue after RN #3 had left the agency.

6. During an interview on 11/29/2022 at 11:30AM, when asked how the agency should handle an assessment that needs to be re-signed after the nurse who completed the assessment has left the agency, the administrator indicated he would have to check the regs (regulations) but someone with equal credentials could sign if the the employee was no longer available and that the work log showed who has opened and signed it. When asked how someone without access to the work log would know the DON did not complete the assessment she signed, the administrator could not provide an answer.

During the same interview, when asked who specifically requested a delay in the initial assessment for Patient #3, the office assistant indicated it was Patient #3's daughter who requested it but was unable to provide documentation of same. When asked who specifically requested a decrease in frequency of home health aide (HHA) visits, the office assistant indicated the patient requested the change in front of his spouse and HHA #1 and indicated Patient #3 had missed several Friday visits in a row. When questioned who specifically requested a delay in the initial assessment for Patient #10, the office assistant indicated the delay was due to the referring agency sending

	the patient's information to the incorrect fax number but could not provide any documentation of same. The administrator indicated it was possibly an issue with prior authorization due to the patient's insurance. The human resources director checked and indicated Patient #10 did not require prior authorization at the time of their admission.			

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
Christopher E Daggy	Administrator	1/13/2023 12:51:25 PM