STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157612	A. BUILDING B. WING	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN CHOICE HOME HEALTH CARE	131 RIDGE ROAD UNIT 1 SOUTH, MUNSTER, IN, 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: 11/10/2022, 11/14/2022 to 11/17/2022 Census: 87 Facility #: 011947 Quality Review Completed 12/01/2022	N0000		2022-11-29
N0470	Home health agency administration/management 410 IAC 17-12-1(m)	N0470	Steps taken to correct the deficiency: In-serviced all staffon agency policy and procedures on 1. “Bag technique”, 2. “Standard Precautions”and 3. “Bed Bath	2022-11-22

	Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review, and interview, the home health agency failed to ensure all employees followed standard / universal precautions and infection control practices, in 2 of 3 home visits conducted (#2, 3). The findings include: 1. Review of an agency policy received 11/17/2022, titled "STANDARD PRECAUTIONS", revised 4/2018, indicated agency staff shall adhere to standard precautions for infection control. The policy indicated any non-disposable equipment used in the provision of care shall be disinfected by the clinician. 2. Review of an agency policy received 11/17/2022, titled "BAG TECHNIQUE", revised 4/2018, indicated the clinician's bag should be placed on a clean surface (a surface that can be easily disinfected) in the patient's home. The policy indicated the clinician should		and Perineal Care". Joint visits made with 2 staff members toensure they are competent in these areas and skills checklist completed byclinical supervisor. Preventing the deficiency from recurring in the future: Jointvisits with 25% of staff in the next 4 weeks to ensure these policies andprocedures are being followed. Threshold100%. Once threshold is met annual skills checklist competency will becontinued during joint visits by the clinical supervisors. Responsible person: Admin/DON	

	wash their hands before entering the bag. The policy indicated after using equipment from the bag, the clinician should clean the equipment, clean their hands, then return the cleaned equipment to the bag. 3. Review of an undated agency procedure received 11/16/2022, titled "PROCEDURE #33: BED BATH / PERINEAL CARE", indicated the water used for the bath should be changed after washing the patient's feet, after washing genital area, and after washing anal area. The procedure indicated each area of the body should be washed, rinsed, and pat dry because soap left on the body can cause irritation and discomfort. 4. Observation of a home visit for patient #2 was conducted on 11/14/2022 at 9:24 AM. While giving patient #1 a bed bath, HHA (home health aide) #1 was observed using one basin of water and soap to wash the patient's entire body. HHA #1 failed to change the water or use clean water to rinse soap off of the patient. At 9:33 AM, HHA #1 was observed dropping a washcloth on the floor, picking			

	it up, rinsing it in the same used basin of water, and continuing with the bed bath. During an interview on 11/14/2022 at 4:37 PM, the administrator indicated when giving a bed bath, the HHA should have two basins for a bath, one for soapy water and one with clear water for rinsing. The administrator indicated the water should be changed at least twice during the bath, when moving to different parts of the body. When queried, the administrator indicated if only one basin was available, the HHA should change the water more frequently and indicated if a washcloth was dropped, the HHA should get a new one. When informed of the findings, the administrator indicated what the surveyor observed was not how the HHA's were instructed to give a bed bath. 5. Observation of a home visit for patient #3 was conducted on 11/14/2022 at 10:50 AM. After entering the home, PT (physical therapist) #1 was observed placing his bag on the couch without a barrier. PT #1 was observed removing a blood pressure cuff, stethoscope,			

	thermometer, and pulse oximeter from his bag, using them on the patient, and returning them (uncleaned) to 2 different zippered sections of his bag. During observation of the home visit, PT #1 failed to clean his hands before entering the bag, and failed to ensure only clean equipment was returned to the bag. During an interview on 11/14/2022 at 4:34 PM, the administrator indicated the inside of the bag was considered clean, and all hands and equipment that enter it should be clean. The administrator indicated the clinician should clean equipment used on the patient prior to returning it to the bag. The administrator indicated if a clinician's bag was placed on a couch, a barrier should be used. When informed of the findings, on 11/14/2022 at 4:34 PM, the clinical manager indicated the clinician may have a dirty part and a clean part of their bag. When informed PT #1 was observed not maintaining either part of the bag as clean, the clinical manager was silent.			

N0486	Q A and performance improvement 410 IAC 17-12-2(h) Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review and interview, the agency failed to coordinate its services with other providers serving the patient in 1 of 1 records reviewed receiving hemodialysis (#2). The findings include:	N0486	In-serviced all staff on agency policy and procedures on "CARESERVICE COORDINATION". Reviewed with staff how to document their effortsto show evidence of integration of all the services patient receives to ensure wecan identify all of the patient needs and all of the factors that could affect patients'safety and treatment effectiveness. Case conferenced with all the staff to ensure that all theirpatients receiving services from dialysis or wound clinics, or any otherfacility such as non-skilled care have documentation to show care coordination. 100% of all active clinical records reviewed to ensure compliance. Preventing the deficiency from recurring in the future: Audit50% of all active patients' charts receiving dialysis and other significantservices such as through wound care clinics, to ensure clinical notes showevidence that meets the requirements of "CARE SERVICE	2022-11-21

	Record review evidenced an agency policy, revised 4/2018, titled "CARE SERVICE COORDINATION", which indicated care coordination shall include the integration of all services received by the patient to ensure the identification of patient needs and factors that could affect patient safety and treatment effectiveness. The policy indicated written evidence of care coordination shall be maintained in the patient's clinical record. Clinical record review on 11/15/2022 for patient #2 evidenced a plan of care for certification period 9/10/2022 to 11/08/2022, which indicated the patient went to dialysis at entity #1 on Tuesdays, Thursdays, and Saturdays. The plan of care evidenced a summary which indicated the patient was compliant with going to dialysis. Review of all skilled nurse visit notes from 9/12/2022 to 10/31/2022 failed to evidence coordination of care with entity #1. Review of all coordination notes failed to evidence coordination of care with entity #1. Review of the		weeks.Target threshold 100%. Once threshold is met, will continue to audit 10% of allpatient records quarterly for this deficiency. Responsible person: Admin/DON	

	record (Kinnser) failed to evidence any coordination of care with entity #1. During an interview on 11/10/2022 at 10:17 AM, the administrator indicated care was coordinated with other entities via fax and then scanned into the patient's electronic medical record (Kinnser). During an interview on 11/17/2022 at 10:09 AM, when informed of the findings, the clinical manager stated, "We haven't gotten a lot from dialysis on [patient #2]. We know where [patient #2] goes. We get whatever they send us." By end of survey, no documentation was received to evidence care coordination had been attempted with entity #1.			
N0522	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:	N0522	Steps taken to correct the deficiency: In-serviced all staffon agency policy and procedure on “Care Planning Process” which includes theplan of care shall include but not be limited to; all equipment and supplies,all medications, specific services and treatments to be provided, actions to betaken to	2022-11-28

	Based on observation, record review and interview, the agency failed to follow a written medical plan of care in 1 of 3 records reviewed with a home visit (#3). The findings include: Review of an agency policy revised 4/2018, titled "CARE PLANNING PROCESS", indicated care decisions and services provided shall be dictated by the care plan. Review of an agency document received 11/17/2022, identified by the administrator as the Registered Nurse (RN) job description, indicated it was an essential function of the RN to follow the individualized plan of care for the patient. Clinical record review for patient #3 evidenced a plan of care for certification period 9/6/2022 to 11/4/2022, which indicated the nurse would assess the patient's weight log (a daily weight record maintained by the patient) at every visit. Clinical record review evidenced the nurse made weekly visits from		meet the patient goals as well as type, frequency, and duration ofthose actions. Reviewed with staff how to properly document to comply withthis requirement: *Ifa plan of care says to monitor weights weekly then weights should betranscribed in clinical record weekly, not just left in patients home folder. 100% of all active clinical records reviewed to ensure compliance. Preventing the deficiency from recurring in the future: Audit10% of all active patients charts to ensure clinical notes show evidence thatmeets the requirements of “Care Planning Process” for 4 weeks. Target threshold100%. Once threshold is met, will continue to audit 10% of all patient recordsquarterly for this deficiency. Responsible person: Admin/DON	

	9/6/2022 to 10/25/2022. Review of each of the nurse's visit notes failed to evidence assessment of the patient's weight log. During observation of a home visit of patient #3 on 11/14/2022 at 10:50 AM, review of the patient's weight log failed to evidence any entries after 9/29/2022. During an interview on 11/17/2022 at 10:25 AM, the clinical manager indicated the nurse should document tasks completed in the nurse's notes. The clinical manager indicated the nurse should assess the patient's weight log by looking at the paper record maintained by the patient in their home.			
N0524	Patient Care 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff.	N0524	Steps taken to correct the deficiency: In-serviced all staffon agency policy and procedure on “Care Planning Process” which includes theplan of care shall include but not be limited to: all equipment and supplies,all medications, specific services and treatments to be	2022-11-29

	(B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review, and interview, the agency failed to ensure the plan of care was complete in 3 of 7 records reviewed (#2, 4, 7). The findings include: 1. Record review evidenced an agency policy, revised 4/2018, titled "CARE PLANNING		provided, actions to betaken to meet the patient goals as well as type, frequency, and duration ofthose actions. Reviewed with staff how to properly document to comply withthis requirement: a. Include who will be doing the blood sugartesting and how often if based on the assessment it is planned that the caregiver is competent in managing blood sugar safely. b. Medications as needed should have clearinstructions to define what parameters would be applied to determine when touse it. c. Goals must be individualized to patient'sneeds based on the comprehensive assessment. A patient who has constant pain cannothave a goal of being completely pain free unless it is a reasonably achievable goal. 100% of all active clinical records reviewed to ensure compliance with the regulation. Preventing the deficiency from recurring in the future: Audit10% of all active patients	

	PROCESS", which indicated the plan of care shall include but not be limited to: all equipment and supplies, all medications, specific services and treatments to be provided, actions to be taken to meet the patient goals as well as type, frequency, and duration of those actions. 2. Clinical record review on 11/15/2022, for patient #2, evidenced a plan of care for certification period 9/10/2022 to 11/08/2022, which indicated the nurse was to assess the patient's diabetic status, including blood sugar monitoring. The plan of care failed to evidence who was checking the patient's blood sugar and at what frequency. During an interview on 11/17/2022 at 10:10 AM, the clinical manager indicated the plan of care failed to give clear instruction for how the nurse was to monitor the patient's blood sugar. Review of the plan of care evidenced an order for Medihoney (a wound / burn gel) to be applied to a surgical wound Monday, Wednesday,		show evidence thatmeets all the requirements of “Care Planning Process” for 4 weeks. Targetthreshold 100%. Once threshold is met, will continue to audit 10% of allpatient records quarterly for this deficiency. Responsible person: Admin/DON	

	of care failed to evidence the indication for use of the "as needed" medication. During an interview on 11/17/2022 at 10:07 AM, the clinical manager indicated the order should indicate why the Medihoney would be used, since it was to be used as needed. 3. Clinical record review for patient #4 on 11/15/2022, evidenced a start of care comprehensive assessment dated 10/17/2022. The assessment indicated the patient had constant pain that only improved slightly with medication, and interfered with activity or movement all of the time. Review of the plan of care for certification period 10/17/2022 to 12/15/2022, evidenced a subsection of goals and outcomes which stated, " ... Patient will remain pain free throughout episode....". During an interview on 11/17/2022 at 10:48 AM, the clinical manager indicated the goals in the plan of care should be individualized to the patient			

	comprehensive assessment. 4. Clinical record review for patient #7 on 11/15/2022, evidenced a plan of care for certification period 8/30/2022 to 10/28/2022, which indicated the nurse was to assess the patient's diabetic status, including blood sugar monitoring. The plan of care failed to evidence who was checking the patient's blood sugar and at what frequency. During an interview 11/17/2022 at 11:04 AM, the clinical manager indicated the plan of care failed to give clear instruction for how the nurse was to monitor the patient's blood sugar.			
N0527	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.	N0527	Steps taken to correct the deficiency: In-serviced all RNson agency policy and procedure" MONITORING PATIENT'S RESPONSE / REPORTING TOPHYSICIAN". Audit charts and case conferenced with RNs to ensure there is evidenceof proper documentation of on-going communication with the physicians. 100% of all active clinical	2022-11-29

	Based on record review and interview, the agency failed to promptly notify the physician to any changes that suggested a need to alter the plan of care in 1 of 1 records reviewed of a diabetic patient with a home visit (#2). The findings include: Record review evidenced an agency policy, revised 4/2018, titled "MONITORING PATIENT'S RESPONSE / REPORTING TO PHYSICIAN", which indicated clinicians shall maintain ongoing communication with the physician to ensure safe and appropriate care for the patient. The policy indicated all communication and attempted communication with the physician shall be documented in the clinical record. Review of an agency document received 11/17/2022, identified by the administrator as the Registered Nurse (RN) job description, evidenced the RN shall report changes and information necessary to modify and update the care plan. Clinical record review for patient #2 evidenced a nurse's note dated 10/6/2022. This note		records reviewed to ensure compliance. Preventing the deficiency from recurring in the future:Audit 10% of active charts for this compliance. Threshold 90%. Once thresholdis met, do quarterly audit of 10% of all clinical charts. Responsible person: Admin/DON	

	indicated the patient was not checking their blood sugar at least twice a day, as instructed. The note indicated the nurse left a message at physician #2's office. Review of all coordination notes and all nurse's visit notes from 10/6/2022 to 10/31/2022 failed to evidence any communication with the physician about the patient not monitoring their blood sugar. During an interview on 11/10/2022 at 10:29 AM, the administrator indicated if a patient was non-compliant, the clinician should notify the physician. During an interview on 11/17/2022 at 10:18 AM, the clinical manager indicated if a patient was non-complaint, the clinician should continue to educate the patient, and coordinate with the physician. When informed of the findings, the clinical manager indicated the nurse should have communicated with the physician and documented that communication in the nurse's notes. No further documentation was received.			

N0533	Nursing Plan of Care 410 IAC 17-13-2 Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. (b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan. Based on record review and interview, the nurse failed to ensure the home health aide care plan followed the activity orders prescribed by the	N0533	Steps taken to correct the deficiency: In-serviced RNs ontheir responsibilities related to delegating nursing duties to home health aidesand documenting correctly on the aide care plan and ensuring that aides are notonly following their care plan but also documenting correctly. Reviewed agencypolicy on “Home Health Aide Plan of Care’ with all clinical staff. 100% of all active clinical records reviewed to ensure compliance. Preventing the deficiency from recurring in the future:Audit 50% of all active clinical records receiving home health aide services toensure that the aide care plan and home health care plan matches for 4 weeks. Targetthreshold 100%. Once threshold is met, will continue to audit 10% of allpatient records quarterly for the deficiency. Responsible person:	2022-11-22

	reviewed receiving home health aide services (#5). The findings include: Review of an agency policy revised 4/2018, titled "HOME HEALTH AIDE PLAN OF CARE", indicated the home health aide plan of care shall be created by the Case Manager or other skilled professional in accordance with the comprehensive plan of care and physician orders. Clinical record review for patient #5 evidenced a plan of care for certification period 10/13/2022 to 12/11/2022, which indicated the patient was on complete bed rest. Review of the home health aide care plan for 10/13/2022 to 12/11/2022 had a subsection titled, "Activities Permitted", which indicated the patient could be transferred to a chair or wheelchair.		Admin/DON	

	During an interview on 11/17/2022 at 11:00 AM, the clinical manager indicated the patient was on complete bedrest, and the home health aide care plan needed to be changed.			
N0539	Scope of Services 410 IAC 17-14-1(a)(1) Rule 14 Sec. 1(a)(1) The registered nurse shall perform nursing duties in accordance with the Indiana Nurse Practice Act (IC 25-23). Based on record review and interview, the registered nurse failed to perform duties in accordance with the Indiana Nurse Practice Act in 1 of 3 records reviewed with a home visit (#3). The findings include: Review of the Indiana Nurse Practice Act (IC 25-23-1-1.1) indicated the registered nurse shall execute regimens delegated by a physician. Review of an agency policy revised 2018, titled, "IDENTIFICATION OF	N0539	Steps taken to correct the deficiency: In-serviced all RNson agency Policy and Procedure on "IDENTIFICATION OF MEDICATION FORADMINISTRATION", requiring RNs to review the written physician ordersprior to medication administration. Case conferences done with all RNs with activepatients receiving medications by RNs to ensure documentation is correct and upto date in the patients' clinical record. 100% of all active clinical records reviewed for this deficiency. Preventing the deficiency from recurring in the future: Audit50% of all active patients charts receiving medications to ensure clinicalnotes are prepared accurately, meeting the State and Federal requirements, for4 weeks.	2022-11-22

	ADMINISTRATION", indicated the nurse shall review the written physician orders prior to medication administration. Clinical record review for patient #3 evidenced a skilled nurse visit note dated 10/25/2022, which indicated the nurse gave the patient a Vitamin B12 injection. Clinical record review failed to evidence an order for the nurse to give the patient a Vitamin B12 injection. During an interview on 11/17/2022 at 10:30 AM, the clinical manager indicated if a nurse was to administer a medication in a patient's home, the nurse should get an order and document administration of the medication. When informed of the findings, the clinical manager indicated the physician sent the prescription to the pharmacy and the medication was already in the home when the nurse arrived. When queried, the clinical manager indicated the clinical record failed to evidence an order for the nurse to administer the injected medication.		Target threshold 100%. Once threshold is met, will continue to audit10% of all patient records quarterly for the deficiency. Responsible person: Admin/DON	

N0541	Scope of Services 410 IAC 17-14-1(a)(1)(B) Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview, the nurse failed to reevaluate the patient's nursing needs in 1 of 2 active records reviewed receiving wound care (#5). The findings include: Review of an agency document received 11/17/2022, identified by the administrator as the Registered Nurse (RN) job description, evidenced the nurse shall provide skilled interventions, based on patient assessment, with a focus on achieving patient goals. Review of an agency policy revised 4/2018, titled "MONITORING PATIENT'S RESPONSE / REPORTING TO PHYSICIAN", indicated during each home visit, the clinician shall monitor the patient's	N0541	Steps taken to correct the deficiency: In-serviced all RNson agency Policy and Procedure on "MONITORING PATIENT'S RESPONSE /REPORTING TO PHYSICIAN" related to monitoring and documenting wound statusand treatment. Case conferences done with all active wound patients nurses thatthey understand the requirement and ensure that they are documenting their actionsto show that they are regularly reevaluating their patients nursing needs inthe clinical record. 100% of all active clinical records reviewed to ensure compliance. Preventing the deficiency from recurring in the future: Audit10% of all active patients charts to ensure clinical notes are prepared accurately,meeting the State and Federal requirements, for 4 weeks. Target threshold 100%.Once threshold is met, will continue to audit 10% of all patient recordsquarterly for the	2022-11-28

	response to care treatments and progress to goals. Clinical record review for patient #5 evidenced a plan of care for certification period 10/13/2022 to 12/11/2022. The plan of care indicated the nurse shall perform the following wound care once a week: cleanse with saline, apply calcium alginate silver (a specialized dressing that absorbs drainage and promotes wound healing), and cover with sterile dry dressing. The plan of care indicated wound care may be discontinued when the wound healed. Clinical record review for patient #5 evidenced a recertification comprehensive assessment dated 10/10/2022, which indicated the patient had one wound, on the right side of the patient's trunk. The assessment indicated the wound was 2cm [centimeter] X 2cm X 1 cm, and had a moderate amount of serosanguinous (a watery drainage with red or pink hue) drainage. A skilled nurse visit note dated 10/17/2022, indicated the		deficiency. Responsible person: Admin/DON	

	wound was 2cm X 2cm X 1 cm, and had a moderate amount of serosanguinous drainage. A skilled nurse visit note dated 10/25/2022, indicated the wound was 2cm X 2cm X 1 cm, and had a moderate amount of serosanguinous drainage. A skilled nurse visit note dated 10/31/2022, indicated the wound was 2cm X 2cm X 1 cm, and had a moderate amount of serosanguinous drainage. This visit note failed to evidence wound care was performed and indicated wound care was discontinued. Clinical record review failed to evidence the wound was healed before the wound care was discontinued.			

	A skilled nurse visit note dated 11/7/2022, indicated the wound was still open with a moderate amount of serosanguinous drainage. Clinical record review failed to evidence the nurse addressed the patient's need for treatment of the open, draining wound. During an interview on 11/17/2022 at 10:54 AM, the clinical manager indicated patient #5's wound care was discontinued because the wound had healed. When informed of the findings, the clinical manager indicated the date on the order to discontinue wound care (10/31/2022) may not be correct. When informed the nurse's note dated 10/31/2022, also indicated wound care was discontinued, the clinical manager offered no further information.			
N0543	Scope of Services 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:	N0543	Steps taken to correct the deficiency: In-serviced all RNs onagency's policies and procedures (P/P) on "Ongoing Assessment" related to initiatingappropriate preventive and rehabilitative procedures. In-service included thatPeg	2022-11-28

	(D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on record review and interview, the nurse failed to initiate appropriate preventative and rehabilitative nursing procedures in 1 of 1 records reviewed with a feeding tube (#1). The findings include: Review of an agency policy titled "ONGOING ASSESSMENTS", revised 4/2018, indicated the clinician shall include skin integrity in their assessments. Review of an agency document received 11/17/2022, identified by the administrator as the registered nurse's job description, indicated the RN (registered nurse) shall provide nursing services utilizing a comprehensive base of nursing theory and nursing process, and communicate / document observations and assessments. Clinical record review for patient #1 evidenced a plan of care for certification period 9/8/2022 to 11/6/2022, which indicated the patient had a gastrostomy tube (a tube surgically placed		Tube site should be assessed regularly and documented in the clinical noteseven if the RN had determined before that the caregiver is competent inmanaging tube feeding safely. 100% of all active clinical records reviewed to ensure compliance. Preventing the deficiency from recurring in the future: Audit100% of all active patients charts to ensure clinical notes are prepared accurately,meeting the State and Federal requirements, for 4 weeks. Target threshold 100%.Once threshold is met, will continue to audit 10% of all patient recordsquarterly for this deficiency. Responsible person: Admin/DON	

	through the abdomen into the stomach, used for feeding). Review evidenced skilled nurse visit notes with the following dates which failed to evidenced an assessment of the gastrostomy tube site, including assessment of the skin surrounding the tube: 9/9/2022, 9/12/2022, 9/16/2022, 9/19/2022, 9/23/2022, 9/26/2022, 9/30/2022, 10/3/2022, 10/7/2022, 10/10/2022, 10/14/2022, 10/17/2022, 10/21/2022, 10/24/2022, 10/28/2022, and 10/31/2022. During an interview on 11/17/2022 at 9:57 AM, the clinical manager indicated the nurse should assess the gastrostomy tube site to monitor for infection or any complications. The clinical manager indicated the nurse should assess the site at each visit, and document it in the nurse's visit notes.			
N0544	Scope of Services 410 IAC 17-14-1(a)(1)(E)	N0544	Steps taken to correct the deficiency: In-serviced all RNs on agency	2022-11-28

	Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on record review and interview, the nurse failed to clearly document assessments, care provided, and physician communication in 2 of 3 records reviewed receiving wound care (#5, 7). The findings include: 1. Review of an agency document received 11/17/2022, identified by the administrator as the Registered Nurse (RN) job description, evidenced the nurse shall clearly document observations and assessments. 2. Review of an agency policy revised 4/2018, titled "MONITORING PATIENT'S RESPONSE / REPORTING TO PHYSICIAN" indicated all communication as well as attempted communication shall be documented in the clinical record. 3. Clinical record review for		policies andprocedures (P/P) related to preparing clinical notes; included in thein-service was agency's P/P related to a. wound assessment and documentation b. documenting notifying MD of any changesin plan of care (POC) c. documenting notifying MD of any services,disciplines checked off on referral order but not required for home health POC afteragency's evaluation and in corroboration with the home health POC MD. 100% of all active clinical records reviewed for the deficiency. Preventing the deficiency from recurring in the future: Audit 10% of all active patients charts to ensure clinicalnotes are prepared accurately, meeting the State and Federal requirements, for4 weeks. Target threshold 100%. Once threshold is met, will continue to audit10% of all patient records quarterly for this deficiency. Responsible person: Admin/DON	

	patient #5 evidenced a recertification comprehensive assessment dated 10/10/2022, which indicated the patient had one wound, which was on the right side of the patient's trunk. Clinical record review evidenced a skilled nurse visit note dated 10/17/2022. A subsection of this note titled "Skilled Intervention" stated, "Patient was instructed on leg wound's [sic] use direct pressure and elevation to control bleeding and swelling. When wrapping the wound, always use a sterile dressing or bandage...." A subsection of this note titled, "Wounds Addressed on this Visit" indicated the nurse assessed and performed care on one wound, on the right side of the patient's trunk.			

Clinical record review evidenced a skilled nurse visit note dated 10/25/2022. A subsection of this note titled "Skin" stated, " ... SN [skilled nurse] cleaned all wound areas...." A subsection of this note titled, "Wounds Addressed on this Visit" indicated the nurse assessed and performed care on one wound, on the right side of the patient's trunk.

During an interview on 11/17/2022 at 10:54 AM, the clinical manager indicated the patient had only one wound (on the trunk) on 10/17/2022 and 10/25/2022, and any conflicting documentation was done in error. The clinical manager indicated the nurse probably copied and pasted the documentation from another visit note.

4. Clinical record review for patient #7 evidenced a referral to home health from physician #3, dated 8/28/2022, which indicated the following services were medically necessary home health services for the patient: skilled nursing, physical therapy, occupational therapy, and home health aide. Clinical record review evidenced a referral to

home health from physician #4, dated 8/28/2022, which indicated the following services were medically necessary home health services for the patient: skilled nursing, physical therapy, occupational therapy, and home health aide.

Review of the plan of care for certification period 8/30/2022 to 10/28/2022 evidenced an order for skilled nursing services and for physical therapy to evaluate and treat. The plan of care failed to evidence occupational therapy and home health aide services. Review of all orders failed to evidence the discontinuation of occupational therapy and home health aide services. Review of all coordination notes and skilled nursing visit notes failed to evidence care coordination with the physician regarding services needed by the patient.

During an interview on 11/17/2022 at 11:10 AM, the clinical manager indicated the services provided were based on the clinician's assessment. The clinical manager stated, "We let them [physicians] know what we recommend". The clinical manager indicated the

	orders on the referral were not implemented because, "they always put everything on there". The clinical manager indicated the clinical record failed to evidence communication with the physician regarding services needed by the patient. When queried, the clinical manager stated, "I've never been asked for that before", and offered no further documentation.			

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
Shazia Aftab	Admin/DON	12/16/2022 5:43:03 PM