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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANEW HOME HEALTH	3830 E SOUTHPORT ROAD, SUITE 700, INDIANAPOLIS, IN, 46237

(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 Agency. Survey Dates: 12-6, 12-7, and 12-8-22 Census: 215 Unduplicated Skilled Admissions: 1450 QR Completed 12/12/2022 A4	N0000		2023-01-08

N0486

All staff will be trained and educated on care communication and agency requirements of documentation and completion of care communication.

During the intake process, any other agencies involved in the patient's care will be added under patient contacts.

During admission, the Start of Care clinician will review and inquire about additional services the patient is receiving.

Upon admission to the agency, the start of care clinician will make a phone call to any other agencies listed who are providing care to the patient at the

			completion of the start of care visit and document the contact with the agency in the start of care summary. Any change in condition or care related concerns will be telephoned to the other agencies at the time of the change by the observing home health clinician and documented in the visit summary at the time of the visit. Upon recertification, rehospitalization, or resumption of care, the clinician completing the visit/documentation will telephone other agencies to update on patients plan of care and document in visit summary for that visit.	

Upon discharge from discipline or agency, the discharging clinician will call other agencies and give notification of discharge and document in the visit summary.

The clinical director or designee will be responsible for educating all staff on the requirements of care coordination with additional agencies involved in home health patients plan of care.

The clinical director or designee will monitor 100% of new Start of Care charts to ensure any additional services are listed in the contacts for the patients and that care communication is documented in the visit summaries for start of care, resumption of care, recertification, significant change of condition, transfer, and discharge for 30 days. If 100% compliance is reached, the clinical director or designee will complete 50% of new Start of Care charts for 30 days. If 100% compliance

reached, the clinical director or designee will complete 20% of new Start of Care charts for 30 days. If 100% compliance reached, ongoing monitoring will be done through QAPI activities.

Each period of noncompliance will result in an additional 30 days of review at the compliance threshold.

Results will be monitored by

Completion Date

			01/08/2023		
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 observation, record review, and interview, the agency failed to coordinate care delivery with dialysis treatment	N0486	POC		2023-01-08

	facilities, Home Health Agencies, and Patient Service Agencies to meet the patient's needs in 5 of 5 patients receiving care from outside agencies. (Patient #9, 10, 11, 12, and 18) Findings include: 1. On 12-08-202 at 10:35 AM, an Anew Home Health policy titled "Coordination of Services With Other Providers," with a reviewed date of April 2020, was provided by the Governing Body, Additional Staff #1. The policy indicated but was not limited to, "Purpose: To ensure the coordination of services provided by the organization and by other service providers…A. Organization personnel's understanding of each organization's responsibility in providing care….6. Ongoing communication regarding issues and concerns with the organizations or individuals providing care will be the responsibility of Anew Home Health management team…." 2. A review of the clinical record for Patient #11, with the start of		N0486 All staff will be trained and educated on care communication and agency requirements of documentation and completion of care communication. During the intake process, any other agencies involved in the patient's care will be added under patient contacts.	

care date of 10-27-2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for the initial certification period of 10-27-2022 to 12-25-2022, indicated but was not limited to the diagnoses of other fracture of the sacrum, multiple fractures of the pelvis, unspecified fracture of the left acetabulum, fracture of unspecified neck of left femur, fall on the same level slipping, stenosis of other vascular prosthetic devices, hypertensive heart disease and chronic kidney disease, heart failure, type 2 diabetes, and end-stage renal disease. The plan of care failed to evidence any coordination of care with Entity #1.

A review of agency documents titled "Communication Notes" dated 10-27-2022 to the current date failed to evidence any coordination of care with Entity #1, the dialysis facility that Patient #11 received treatment.

A review of a document titled "Hemodialysis Transfer Form" was received on 12-06-2022, at

During admission, the Start of Care clinician will review and inquire about additional services the patient is receiving.

Upon admission to the agency, the start of care clinician will make a phone call to any other agencies listed who are providing care to the patient at the completion of the start of care visit and document the contact with the agency in the start of care summary.

Any change in condition or care related concerns will be telephoned to the other agencies at the time of the change by the observing home health clinician and documented in the visit summary at the time of the visit.

Upon recertification, rehospitalization, or resumption of care, the

2:08 PM, from the Medical Social Worker, Person #3, from Entity #2, the dialysis treatment center where Patient #11 received treatment. The hemodialysis transfer form indicated that Patient #11 had a left upper arm fistula and received treatment three times a week every Monday, Wednesday, and Friday.

During an interview on 12-06-2022, at 12:34, the family member of Patient #11, Person #1, confirmed Patient #11 was receiving treatment at Entity #2, the dialysis center, every Monday, Wednesday, and Friday.

During an interview on 12-06-2022, at 12:52 PM, the Administrator, RN #1, when queried regarding coordination of care notes with Entity #2, the dialysis clinic where Patient #1 received treatment, stated, "We are not seeing them for renal. We are seeing them for a fracture."

clinician completing the visit/documentation will telephone other agencies to update on patients plan of care and document in visit summary for that visit.

Upon discharge from discipline or agency, the discharging clinician will call other agencies and give notification of discharge and document in the visit summary.

The clinical director or designee will be responsible for educating all staff on the requirements of care coordination with additional agencies involved in home health patients plan of care.

The clinical director or designee will monitor 100% of new Start of Care charts to ensure any additional services are listed in the contacts for the patients and that care communication is documented in the visit summaries for start of care,

	3. During a home visit at Patient #12's residence on 12-08-2022, at 8:50 AM, observed the Speech Therapist (ST), ST #1, and the Clinical Manager, RN #2, provide skilled care to Patient #12. The patient's family member informed the team that they would return in a few minutes and that the caregiver was there with the patient. A review of the clinical record for Patient #12, with the start of care date of 11-08-2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for the initial certification period of 11-08-2022 to 01-06-2023, indicated but was not limited to the diagnoses of hypertensive heart disease, other cardiomyopathies, retention of urine, encounter for fitting adjustment of urinary device, vascular dementia, and depression. The plan of care failed to evidence any coordination of care with Entity #6, the Personal Care Agency, that Patient #12 received services.		resumption of care, recertification, significant change of condition, transfer, and discharge for 30 days. If 100% compliance is reached, the clinical director or designee will complete 50% of new Start of Care charts for 30 days. If 100% compliance reached, the clinical director or designee will complete 20% of new Start of Care charts for 30 days. If 100% compliance reached, ongoing monitoring will be done through QAPI activities. Each period of noncompliance will result in an additional 30 days of review at the compliance threshold. Results will be monitored by	

A review of agency documents titled "Communication Notes" dated 11-08-2022, to the current date, failed to evidence any coordination of care with Entity #6. The Personal Care Agency, that Patient #12 received personal care support services.

During an interview on 12-08-2022, at 8:50 AM, when queried, the caregiver, Person #5, about their job indicated they worked for Entity 6, a Personal Care Agency, and they were a PSA (Personal Support Assistant). Person #5 further confirmed they worked there Monday through Friday from 8:30 AM to 11:30 AM, and provided care for Patient #12 for the past six weeks.

During an interview on 12-08-2022, at 10:00 AM, the Governing Body Member, Additional Staff #1, when queried regarding documentation to show evidence of their coordination of care, confirmed the agency

	failed to coordinate care, and they should have, as it is part of their agency philosophy. 4. During the entrance conference on 12-06-2022, at 9:25 AM, the Administrator, RN#1, the Clinical Manager, RN #2, and Governing Body Member, Additional Staff #1, confirmed that the Case manager coordinates the care of the patients. The coordination of care would be seen in the agency documents titled "Communication Notes." 5. During a daily conference on 12-07-2022, at 3:10 PM, these findings were reviewed with the Governing Body, Additional Staff #1, and the Clinical Manager, RN #2. At that time, they had no further documentation to provide.			

6. During a home visit at Patient #9's residence on 12-7-22 at 11:30 AM, Licensed Practical nurse (LPN), LPN #1, was observed providing skilled care to Patient #9. Other Employee #17 from Entity #15 was present during the visit.

A review of agency documents titled "Communication Notes" dated 6-6-2022 to the current date failed to evidence any coordination of care with Entity #15, the dialysis facility that Patient #9 received treatment. Dated 12-1-2022, the "Communication Notes" provided by the agency on 12-8-2022, indicated the agency contacted Entity #15 and confirmed Patient #9's Medicaid is covering the patient, not Medicare. As evidenced by Patient #9's "Plan of Care" and "Communication Notes," this is the only communication between the agency and Entity #15.

7. A review of the clinical record for Patient # 9 on 12-6-2022, with the start of care date of 12-2-2022, evidenced an agency document titled, "Home Health Certification and Plan of Care" for the initial

certification period 12-2-2022 to 1-30-2023. The document indicated but was not limited to the diagnoses of type two diabetes mellitus with diabetic chronic kidney disease, end stage renal disease, dependence on renal dialysis, long term (current) use of insulin, contracture right hand, primary osteoarthritis right shoulder, atherosclerosis heart disease of native coronary artery without angina pectoralis, atrial fibrillation, epilepsy, and constipation, and obstructive sleep syndrome. There is no evidence of coordination of care between the agency and Entity #12.

Patient #9 goes to dialysis Monday, Wednesday, and Friday. Patient #9's hemodialysis schedule is typed on the documents "Plan of Care" and "Communication Notes." There is no evidence of coordination of care between agency and Entity #12.

8. During an interview with Other Employee #16 with Entity #15 on 12-8-2022 at 10:15 AM. Other Employee #16 was queried regarding coordination

Employee #16 indicated, the agency did not reach out to Entity #15 regarding the care of Patient #9.

9. On 12-8-2022 at 9:45 AM an attempt to interview Entity #12 three times, with no success.

10. During an interview with Staff #1 of governing body on 12-8-2022 at 9:35 AM, Staff #1 confirmed no coordination of care with Entity #12.

11. During a home visit at Patient #10's residence on 12-7-2022 at 8:30 AM, observed LPN #2 provide skilled nurse care to Patient #10. Other Employee #9 was observed providing non-skilled services for Patient #10. Other Employee #9 stated she was providing services through Entity #8.

12. A review of the clinical record for Patient #10, with a start of care date of 6-2-2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for the certification period 9-30-2022 to 11-28-2022. The record indicated but was not

obstructive and reflux uropathy, urinary tract infection, paroxysmal atrial fibrillation, essential (primary) hypertension, chronic obstructive pulmonary disease, benign prostatic hyperplasia with lower urinary tract symptoms, acute kidney failure, pain in right shoulder. The plan of care failed to evidence any coordination of care with Entity #8.

13. A review of the clinical record for Patient #10 did not indicate on the contact list the facility in which the patient was receiving Home Health Aide services. The record reported caregiver is Other Employee #9.

14. During an interview on 12-8-2022 at 10:41 AM Other Employee #10 was queried regarding coordination of care between the agency and Entity #8. Other Employee #10 indicated they coordinate care and communicate through Entity #11. The agency does not coordinate directly with Entity #8.

15. A review of clinical record

care date of 9-29-2022, evidenced an agency document titled “Home Health Care Certification and Plan of Care” for the initial certification period of 9-29-2022 to 11-27-2022. The record indicated but was not limited to the diagnosis of hyp chronic kidney disease with stage 5 chronic kidney disease or ESRD, pressure ulcer of sacral region stage 2, essential (primary) hypertension, other chronic pain, hyperkalemia, and headache. The plan of care failed to evidence coordination of care with Entity #13.

A review of agency documents titled “Communication Notes” dated 9-29-2022 to the current date indicates Patient #18, has dialysis Monday, Wednesday, and Friday. There is no evidence of the coordination of care with Entity #13, the dialysis center for Patient #18.

16. During an interview with Other Employee #14 of Entity #13 on 12-8-2022 at 9:40 AM. Other Employee #14 confirmed there was no coordination of care with the agency.

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
Amy Barker	Administrator	12/16/2022 10:28:08 AM