STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157709	A. BUILDING B. WING	01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Indiana Home Healthcare Systems, Inc	7870 BROADWAY, SUITE G -SOUTH, MERRILLVILLE, IN, 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This survey was a re-licensure survey for a home health agency. Survey Dates: 1/5/2023, 1/6/2023, 1/9/2023, and 1/10/2023. Facility ID: 014461 Census: 11 Quality Review Completed 01/23/2023	N0000	N0000 This survey was a re-licensure survey for ahome health agency. 02/06/2023	2023-02-06
N0408	Licensure 410 IAC 17-10-1(d)	N0408	N0408 February 6, 2023, Director/Administrator will be responsiblefor notifying the state about staff changes within the agency and they will do	2023-02-06

	Rule 10 Sec. 1(d) Disclosure of ownership and management information must be made to the department at the time of the home health agency's initial request for licensure, for each survey, and at the time of any change in ownership or management. The disclosure must include the names and addresses of the following: (1) All persons having at least five percent (5%) ownership or controlling interest in the home health agency. (2) Each person who is: (A) an officer; (B) a director; (C) a managing agent; or (D) a managing employee; of the home health agency and evidence supporting the qualifications required by this article. (3) The corporation, association, or other company that is responsible for the management of the home health agency. (4) The chief executive officer and the chairman or equivalent position of the governing body of that corporation, association, or other legal entity responsible for the management of the home health agency. Based on record review and interview, the home health agency failed to disclose a change in positions of administrator, alternate administrator, and alternate clinical manager to the Indiana Department of Health at the time of the change.		sowithin 30 days of hire. The agency will notify the state of change in managing employees andgoverning body Hasmet to appoint a new administrator and alternate/clinical manager on 12/16/2022. The newadministrator took effect on 12/16/2022. The agency will follow the rules and regulations by maintaining meeting minutes, resending the 855 state forms for staff change notification, and maintaining a copy of meeting minutes in governing board folder. 02/06/2023	

The findings include:

Review of the Indiana Department of Health's pre-survey notes indicated person #4 was the administrator, and person #3 was the alternate administrator/alternate clinical manager.

Clinical record review evidenced an organizational chart obtained 1/6/2023, which indicated the administrator was administrator/clinical manager #1, and the alternate administrator and alternate clinical manager was registered nurse/alternate clinical manager/alternate administrator #2.

Employee record review on 1/9/2023, evidenced a personnel file for administrator/clinical manager #1, which included signed job descriptions dated 12/16/2022, for the positions of administrator and clinical manager.

Employee record review on 1/9/2023, evidenced a personnel file for alternate clinical manager/alternate administrator #2, which included signed job descriptions dated 12/16/2022, for the positions of administrator and clinical manager.

Record review failed to evidence any documentation or letters sent, which indicated the Indiana Department of Health was notified of the change in management.

During an interview on 1/5/2023, at 11:47 AM, administrator/clinical manager #1 indicated they took the position of administrator and clinical manager about 2 weeks prior and indicated the current alternate administrator and alternate clinical manager had taken their positions less than 1 month prior. Administrator #1 indicated the Indiana Department of Health had not

	yet for notification of the change in management.			
N0442	Home health agency administration/management 410 IAC 17-12-1(b) Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency. Based on record review and interview, the home health agency failed to ensure the governing body appointed an administrator. The findings include: Record review on 1/5/2023, evidenced an agency policy revised 10/2019, titled	N0442	N0442 Administratorwill be responsible for this task. Wewill audit governing body minute of the meeting monthly to ensure that we are 100% in compliance with appointing aqualified administrator, according to laws, and to ensure the managementoversee the fiscal affairs of the home health agency. We willperiodically review rules and regulations quarterly for the current administrator/alternate or monthly for the new administrator or alternate.	2023-02-06

	"... The Governing Body appoints a qualified Administrator or approves an Administrator selected by the corporation or another group and annually evaluates the Administrator's performance ...." Record review on 1/6/2023, failed to evidence any written appointment for administrator #1. During an interview on 1/6/2022, at 2:30 PM, administrator/clinical manager #1 indicated they were not sure if they had a written appointment of the administrator from the governing body but would try and get one to the surveyor. No further documentation was received by the end of the survey.			
N0462	Home health agency administration/management 410 IAC 17-12-1(h) Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical	N0462	N0462 Human Resources/Administrator will beresponsible for this task. We will in-service current employees about theimportance of having a physical examination with a physician's signature and submit the current physical examination no more than 180 days and ensure that new hireemployees have the current required physical examination from a physician stating employeeis free from communicable disease and we will continue to	2023-02-06

	examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on record review and interview, the home health agency failed to ensure all employees with direct patient contact had a physical examination no more than 180 days prior to patient contact in 1 of 6 employee records reviewed. (#1) The findings include: Record review on 1/10/2023, evidenced an agency policy revised 2/2022, titled "Personnel Records" which stated, "... The health record for applicable employees will include: ... Any other Agency required health requirements ...." Employee record review on 1/9/2023, evidenced a personnel file for alternate clinical manager/alternate administrator #2, start date 5/26/2022, and first patient contact on 6/13/2022, which failed to include a physical		audit 10 recordemployee charts quarterly to ensure compliance.	

	examination. During an interview on 1/10/2023, at 10:24 AM, administrator/clinical manager #1 indicated employees with direct patient contact were required to complete a physical prior to patient contact.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's	N0488	N0488 Administrator will be responsible for thistask. The home health agency will develop and implement a policy requiring anotice of discharge of service to the patient, the patient's legalrepresentative, or other individuals responsible for the patient's care at leastfifteen (15) calendar days before the services are stopped.	2023-02-06

	the patient of community resources to assist the patient following discharge. Based on record review and interview, the home health agency failed to develop and/or implement a policy requiring 15-day discharge notice to patients in 1 of 2 discharge clinical records reviewed. (#7) The findings include: Record review on 1/10/2023, evidenced an agency policy revised 2/2022, titled "Discharge Criteria and Planning" which stated, "... The patient is informed of discharge plan in a timely manner and acknowledges understanding reason ...." The policy failed to include 15-day notice of discharge.			

	Clinical record review for Patient #7 was completed on 1/10/2023, for certification period 9/28/2022 – 11/26/2022, discharged 11/17/2022. Record review evidenced a physical therapy visit note dated 11/7/2022, which indicated the patient was to be discharged the next week but failed to indicate if the patient was provided 15-day discharge notice prior or if the patient was aware of the discharge plan. Record review failed to evidence any additional documentation of discharge discussion. During an interview on 1/10/2022, at 11:18 AM, administrator/clinical manager #1 indicated the agency's policy was to provide 15-day discharge notice to the patients and indicated this should have been documented in the chart.			
N0520	Patient Care 410 IAC 17-13-1(a)	N0520	N0520 Director of Clinical Service will be responsiblefor this task. We will in-service all clinician staff with complying within 48hours regulations of providing care to assigned patients. We will audit 100% ofnew charts per Agency policy. We cannot accept the patient if we cannot provideservices as ordered by a	2023-02-06

	Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. Based on record review and interview, the home health agency failed to ensure patients were accepted for care on the reasonable expectation that the patients' health needs could be adequately met by the home health agency in the patients' place of residence in 3 of 6 active clinical records reviewed. (#1, 4, 5) The findings include: 1. Record review on 1/10/2023, evidenced an agency policy revised 2/2021, titled "Patient Admission Criteria" which stated, "... Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing and social needs can be met adequately by the Agency in the patient's place of residence ... Patients will be accepted for care only if Agency can meet a patient's identified needs ...." 2. Clinical record review for		physician. Wewill audit 10 records or 10% of the current sensor weekly for 5 weeks until the threshold is 95%. After the threshold is met, we will continue to audit the 10% recordquarterly to be in compliance.	

	1/10/2023, for certification period 1/2/2023 – 3/2/2023. Record review evidenced a start of care assessment dated 1/2/2023, which indicated the patient required an occupational therapy evaluation, and indicated occupational therapy was to see the patient 1 time per week for 1 week for this evaluation. Clinical record review failed to evidence the patient received any occupational therapy evaluation or services as ordered. During an interview on 1/10/2023, at 10:35 AM, administrator/clinical manager #1 indicated they had to send out an occupational therapist to see the patient since it was ordered. Administrator/clinical manager #1 did not know why the patient did not receive the occupational therapy visit. 3. Clinical record review for Patient #4 was completed on 1/10/2023. Record review			

	evidenced a plan of care for certification period 12/17/2022 – 2/14/2023, which indicated the patient was to receive home health aide visits for assistance with activities of daily living and personal care due to limitations on functional and physical status impeding self-care. This plan of care indicated the patient was to receive 2 skilled nursing visits per week. Clinical record review evidenced a home health aide plan of care dated 12/17/2022, which failed to indicate frequency of home health aide visits. Clinical record review evidenced one home health aide visit was completed on 1/5/2023, 20 days after start of care. Clinical record review indicated the patient did not receive any skilled nurse visits the week of 12/18/2022 and received 1 skilled nurse visit the weeks of 12/25/2022, and 1/1/2023.			

	During an interview on 1/10/2023, at 12:42 PM, administrator/clinical manager #1 indicated they were hoping for 2 home health aide visits per week and did not know why the patient did not receive a home health aide visit prior to 1/5/2023. Administrator/clinical manager #1 indicated maybe it was an issue with scheduling for the home health aide visits and indicated the agency should not have taken any patients if they could not meet their home health needs. Administrator/clinical manager #1 did not know why the patient did not receive the skilled nursing visits as ordered. 4. Clinical record review for Patient #5 was completed on 1/10/2023. Record review evidenced a plan of care for certification period 12/22/2022 – 2/19/2023, which indicated the patient was to receive 2 home health aide visits per week. Record review failed to evidence the patient received any home health aide visits. During an interview on			

	1/10/2023, at 12:56 PM, administrator/clinical manager #1 indicated they believed the patient or family refused a home health aide and the plan of care wasn't updated.			
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: Based on observation, record review, and interview, the home health agency failed to ensure medical care followed the written plan or care, and/or there was a medical plan of care established in 5 of 6 active clinical records reviewed. (#1, 2, 4, 5, 6) The findings include: 1. Record review on 1/10/2023, evidenced an agency policy revised 2/2022, titled "Plan of Care – CMS #485 and	N0522	N0522Director Clinical Services will be responsible for this task. We will be educatingclinical staff to follow a written medical plan of care established and periodicallyreviewed by the physician. We willalways in-service staff and audit 10% of patient records weekly for 5 weeks to target the 95% threshold. After the threshold ismet we will continue quarterly audits to ensure we are in compliance. Update: N0522Director Clinical Services will be responsible for this task. She will be educatingclinical staff to follow a written medical plan of care established and periodicallyreviewed by the physician. We willalways in-service staff and audit 100% of active clinical patient records weekly for 5weeks to target 100% threshold. After the threshold is met we will continuequarterly audits to ensure we are in compliance.	2023-02-06

	which stated, "... Each patient must receive an individualized written plan of care ... 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 ...." 2. Observation of a home visit for Patient #1 was conducted on 1/6/2023, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, the nurse completed vitals, educated the patient on diabetes (problem regulating blood sugars), heart failure, foot care, and diet. Clinical record review for Patient #1 was completed on 1/10/2023, certification period 1/2/2023 – 3/2/2023. Record review evidenced a start of care assessment was completed by the registered nurse on 1/2/2023, but failed to evidence a plan of care for Patient #1. During an interview on			

	administrator/clinical manager #1 indicated medical care should have followed the written plan of care for all patients. Administrator/clinical manager #1 did not know why no plan of care was completed for Patient #1, and indicated the plan of care should have been completed within 5 days from the start of care date. 3. Clinical record review for Patient #2 was completed on 1/10/2023. Record review evidenced a plan of care for certification period 12/13/2022 - 2/10/2023, signed by the nurse on 12/13/2022, which indicated the patient was to receive speech therapy 1 time per week for 1 week. The plan of care did not include any wound care orders or dressing orders. Clinical record review evidenced a speech therapy evaluation dated 12/27/2022, which indicated the patient did not receive speech therapy until 2 weeks after the start of care.			

	Clinical record review evidenced a skilled nurse visit note dated 12/28/2022, which indicated the patient had a new wound, and an Allevyn (foam dressing) was applied. During an interview on 1/10/2023, at 10:46 AM, administrator/clinical manager #1 indicated the therapy evaluations should have been completed within 3 days of the order. Administrator/clinical manager #1 did not know why speech therapy didn't see the patient for 2 weeks. At 11:13 AM, administrator/clinical manager #1 indicated the nurses should have completed wound care only as ordered on the plan of care, and the plan of care should have included wound care orders.			

	4. Clinical record review for Patient #4 was completed on 1/10/2022. Record review evidenced a plan of care for certification period 12/17/2022 – 2/14/2023, which did not include any wound care orders. Clinical record review evidenced a referral/history and physical dated 12/16/2022, which indicated the patient was to apply silver sulfadiazine twice daily to open wounds. Clinical record review evidenced a referral/history and physical dated 12/22/2022, which indicated the patient was to have left heel wound cleansed with alcohol, Santyl (wound treatment) applied, and covered with Allevyn (foam dressing). Clinical record review evidenced a skilled nurse visit note dated 12/27/2022, which indicated the nurse cleansed 4 wounds and applied dry dressings to all wounds.			

	During an interview on 1/10/2022, at 12:41 PM, administrator/clinical manager #1 indicated they did not know why the nurse did not apply santyl and Allevyn. Administrator/clinical manager #1 indicated the nurse should have called the physician to confirm orders and provided care as ordered on the plan of care. 5. Clinical record review for Patient #5 was completed on 1/10/2023. Record review evidenced a plan of care for certification period 12/22/2022 – 2/19/2023, which failed to include any wound care orders. Clinical record review evidenced skilled nurse visit notes dated 12/27/2022, which indicated the nurse cleansed a sacral wound with saline and applied an Allevyn dressing (foam wound dressing). During an interview on 1/10/2023, at 1:07 PM, administrator/clinical manager			

	#1 indicated the nurse should have provided wound care as ordered on the plan of care. Administrator/clinical manager #1 did not know why the nurse applied a foam dressing. 6. Clinical record review for Patient #6 was completed on 1/10/2023, for certification period 11/17/2022 – 1/15/2023. Record review evidenced a skilled nurse visit note dated 11/22/2022, which indicated the nurse administered a vitamin B12 injection on the patient. No orders were evidenced to administer a vitamin B12 injection. During an interview on 1/10/2023, at 1:28 PM, administrator/clinical manager #1 indicated the nurse should have administered medications as ordered on the plan of care.			
N0524	Patient Care 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical	N0524	N0524 Director of Clinical Services will beresponsible for this task. We will develop in consultation with the home healthagency staff. We will develop a medical plan of care to include all aspects andservices rendered, all diagnoses, types of services required, equipmentrequired, frequency and duration of visits, nutritional requirements, allmedication,	2023-02-06

	plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (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 observation, record review, and interview, the home health agency failed to ensure the plan of care included all services to be provided, all diagnoses, types of services required, equipment required, frequency and duration of visits,		and treatment. We will audit 10 records or 10% of the current sensor weeklyfor 5 weeks until the threshold is 95%. After the threshold is met, we will continue toaudit the 10% record quarterly to be in compliance. Update: N0524 Director of Clinical Services will beresponsible for this task. We will develop in consultation with the home healthagency staff. We will develop a medical plan of care to include all aspects andservices rendered, all diagnoses, types of services required, equipmentrequired, frequency and duration of visits, nutritional requirements, and allmedication and treatment. We will audit 100% of active clinical patient recordsof the current censor weekly for 5 weeks until the threshold is 100%. After the thresholdis met, we will continue to audit 100% of records quarterly to be in compliance.	

	medications and treatments, and/or any other appropriate items in 5 of 6 active clinical records reviewed. (#2, 3, 4, 5, 6) The findings include: 1. Record review on 1/10/2023, evidenced an agency policy revised 2/2022, titled "Plan of Care – CMS #485 Physician/Practitioner Orders" which stated, "... The individualized plan of care must include the following: ... All pertinent diagnoses ... The types of services, supplies and equipment required ... The frequency and duration of visits to be made ... Nutritional requirements ... All medications and treatments ... Patient-specific interventions and education ...." 2. Observation of a home visit for Patient #2 was conducted on 1/9/2023, at 11:00 AM, to observe a routine physical therapy visit. During the visit, the patient's medications were reviewed. The patient was taking the following medications which were not			

	included in the plan of care: furosemide (to pull water off body), lasanaprole (to decrease stomach acid), metoclopramide (to help with constipation and stomach upset), potassium chloride, and Remeron (to help with memory). The patient was taking levothyroxine (to help with underactive thyroid) 0.025 milligrams two tablets once daily. During the visit, the patient was observed to have a gastrostomy tube (tube inserted into the skin of the abdomen directly into the stomach), which was used for tube feedings. The following tube feeding was observed in the home: Fiber source, 6 cartons per day on a tube feeding pump, which ran from 4:00 PM – 8:00 PM daily, with 210 milliliters water flush 5 times per day, and 60 milliliters water flush with medications. A home folder was reviewed, which indicated the patient was allergic to penicillin (antibiotic) and sulfa (type of antibiotic) drugs. The following equipment was observed, which was not included in the plan of care: feeding pump, cardiac chair, heel elevation boots, turning wedge, suction cannister and tubing, electric wheelchair, and			

	manual wheelchair. Clinical record review for Patient #2 was completed on 1/10/2023. Record review evidenced a plan of care for certification period 12/13/2022 – 2/10/2023, which included the following medications the patient was not taking: famotidine (to decrease stomach acid), and levothyroxine (to help with underactive thyroid) 0.125 mg (milligrams) two tablets daily. The plan of care included the following medications as needed but failed to include an indication to take as needed: guaifenesin (for cough), acetaminophen (for pain or fever), and Zofran (for nausea). The plan of care indicated the patient was receiving enteral (through a gastrostomy tube) feedings but failed to include nutritional information such as type of tube feeding, quantity of tube feeding, frequency, or water flush information. The plan of care indicated the patient was to receive skilled nursing visits 1 time per week for 3 weeks but failed to include any interventions or education			

	for the skilled nurse to perform. The plan of care failed to include sulfa and penicillin allergies.			

	During an interview on 1/10/2022, at 10:45 AM, administrator/clinical manager #1 indicated the plans of care should have included all medications the patient was taking, and the medication name, dosage, frequency, route, and an indication for as needed medications. At 10:50 AM, administrator/clinical manager #1 indicated the plan of care should have included nursing interventions. At 10:55 AM, administrator/clinical manager #1 indicated the entire tube feeding order should have been included in the plan of care, including type of tube feed, if it was a bolus feed or pump feed, flush volume and frequency, and volume of feeding. Administrator/clinical manager #1 indicated the plan of cares should have included all allergies. Administrator/clinical manager #1 indicated all the equipment the patients' used should have been included in the plans of care. 3. Observation of a home visit for Patient #3 was conducted on 1/9/2023, at 11:00 AM, to			

	therapy visit. During the visit, a home health binder was reviewed, which indicated the patient had allergies to sulfa and penicillin (antibiotics). The patient's home medication list was reviewed, which indicated the patient was taking the following medications which were not included in the plan of care: Flonase (nasal spray), Loperamide (for diarrhea), melatonin (for sleep), and metoprolol (to lower heart rate and blood pressure). The medication list also included donezipil (for dementia) 23 milligrams 2 tabs daily. Clinical record review for Patient #3 was completed on 1/10/2023. Record review evidenced a plan of care for certification period 12/13/2022 – 2/10/2023, which indicated the patient had no allergies. The plan of care also included proctozone (for hemorrhoids) rectal cream as needed but failed to include an indication for use. The plan of care included donezipil 23 milligrams 1 tab daily.			

	Clinical record review evidenced a history and physical dated 12/12/2022, which indicated the patient was allergic to penicillin, sulfa, and Golytely (laxative). This document included the following diagnoses, which were not included in the plan of care: Alzheimer's dementia (disease affecting memory and cognition), Atrial fibrillation (irregular heartbeat), bradycardia (slow heart rate), chronic kidney disease, hypertension (high blood pressure), hyperlipidemia (high cholesterol), cardiac pacemaker, diabetes (problem regulating blood sugars), and ulcerative colitis (inflammatory disease of bowel). During an interview on 1/10/2023, at 11:10 AM, administrator/clinical manager #1 indicated the plans of care should have included all diagnoses from the history and physical documentation. 4. Clinical record review for Patient #4 was completed on 1/10/2023. Record review			

	certification period 12/17/2022 – 2/14/2023, which failed to include any wound care treatment orders. The plan of care indicated the patient was to receive home health aide services but failed to include the frequency of home health aide visits. Clinical record review evidenced a start of care assessment dated 12/17/2022, which indicated the patient had 3 pressure wounds with the top layer of skin missing, and 1 pressure wound with exposed muscle or bone. Clinical record review evidenced a referral/history and physical document dated 12/16/2022, which indicated the patient was to have silver sulfadiazine applied to open wounds two times daily.			

	Clinical record review evidenced a referral/history and physical dated 12/22/2022, which indicated the home health agency was to manage wound care. During an interview on 1/10/2023, at 12:40 PM, administrator/clinical manager #1 indicated the plan of care should have included wound care orders. Administrator/clinical manager #1 indicated the plan of care should have specified the frequency of home health aide visits. 5. Clinical record review for Patient #5 was completed on 1/10/2023. Record review evidenced a plan of care for certification period 12/22/2022 – 2/19/2023, which indicated the patient had a PICC line (peripherally inserted central catheter/an intravenous line, which can stay in place up to 8 weeks), and the dressing was to be changed by the nurse. The plan of care failed to indicate how frequently the PICC line			

	and what the PICC line was to be flushed with or the quantity of the flush. The plan of care failed to include dressing change supplies. The plan of care failed to include any orders for occupational therapy including frequency or duration of visits. Clinical record review evidenced a wound care order dated 12/8/2022, which indicated the patient used a waffle mattress and heel elevating boots, which were not included in the plan of care. The wound care order indicated the patient was to receive the following sacral (area at base of spine) wound care, which was not included on the plan of care: cleanse wound with normal saline, apply no sting barrier spray to peri wound skin, apply Aquacell AG to wound bed, secure with foam adhesive, change every 3 days and as needed for soilage. Clinical record review evidenced a referral/history and physical dated 12/14/2022, which included the following diagnoses, which were not			

	included on the plan of care: hypertension (high blood pressure), hyperlipidemia (high cholesterol), and diabetes (problem regulating blood sugars). Clinical record review evidenced an order dated 12/14/2022, which indicated the patient was to have weekly blood work drawn by the home health agency, which was not included on the plan of care. Clinical record review evidenced a start of care assessment dated 12/22/2022, which indicated the patient had pressure wound, but failed to include any wound orders. Clinical record review evidenced an occupational therapy evaluation dated 12/30/2022, which failed to be completed and failed to indicate frequency or duration of occupational therapy visits. Clinical record review indicated			

	the patient received 1 occupational therapy visit per week for the weeks of 12/25/2022, 1/1/2023, and 1/8/2023, but no orders were evidenced. During an interview on 1/10/2023, at 1:01 PM, administrator/clinical manager #1 indicated the entire PICC line order including the frequency of dressing changes, dressing change kit, type of flush and quantity of flush should have been included on the plan of care. Administrator/clinical manager #1 indicated the patient was using a waffle mattress and heel boots, and they should have been included on the plan of care. Administrator/clinical manager #1 indicated the plan of care should have included the ordered wound care. Administrator/clinical manager #1 indicated all the diagnoses should have been included on the plan of care from the history and physical. Administrator/clinical manager #1 indicated the blood draw order should have been included in the plan of care.			

	Administrator/clinical manager #1 indicated they did not know what the occupational orders were, or how frequently they were supposed to visit the patient. 6. Clinical record review for Patient #6 was completed on 1/10/2023. Record review evidenced a plan of care for certification period 11/17/2022 – 1/5/2023, which indicate skilled nursing, occupational therapy, and physical therapy were to see the patient, but failed to include a frequency or duration of visits. During an interview on 1/10/2023, at 1:15 PM, administrator/clinical manager #1 indicated the plan of care should have indicated how frequently and for how long physical therapy, occupational therapy, and skilled nursing were to visit.			
N0532	Patient Care 410 IAC 17-13-1(d)	N0532	N0532Director of Clinical Services will be responsible for this task. We willin-service clinical staff to promptly notify a patient's physician or otherappropriate licensed professional staff and legal representative, if any, ofany significant physical or mental	2023-02-06

	Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact. Based on record review and interview, the home health agency failed to ensure agency staff promptly notified patients' physicians of any mental or physical changes observed or reported in 1 of 6 active clinical records reviewed. (#2) The findings include: Record review on 1/10/2023, evidenced an agency policy revised 2/2021, titled "Coordination of Patient Care" which stated, "... The Agency must: ... Assure communication with all physicians/practitioners involved in the plan of care ... staff provides the physician/practitioner with patient information on an ongoing basis regarding: ...		changes observed or reported by the patient.In the case of a medical emergency, the home health agency must know in advancewhich emergency system to contact. We will audit 10 records or 10% of the currentsensor weekly for 5 weeks until the threshold is 95%. After the threshold is met, wewill continue to audit the 10% record quarterly to be in compliance. Update: N0532Director of Clinical Services will be responsible for this task. We willin-service clinical staff to promptly notify a patient's physician or otherappropriate licensed professional staff and legal representative, if any, ofany significant physical or mental changes observed or reported by the patient.In the case of a medical emergency, the home health agency must know in advancewhich emergency system to contact. We will audit 100% of active clinical patientrecords of the current sensor weekly for 5 weeks until the threshold is 100%. After the threshold is met, we will continue to audit 100% of records quarterly to be in compliance.	

	in condition ….” Clinical record review for Patient #2 was completed on 1/10/2023, for certification period 12/13/2022 – 2/10/2023. Record review evidenced a skilled nurse visit note dated 12/28/2022, which indicated the patient had a new wound to their left buttocks but failed to indicate the physician was notified of new wound or orders requested for wound care. During an interview on 1/10/2023, at 11:11 AM, administrator/clinical manager #1 indicated the physician should have been notified of any new wounds.			
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.	N0541	N0541Director of Clinical Services will be responsible for this task. We will in-service and educate staff on theneed of re-evaluating patients on all aspects of physician-order care throughoutthe certification process, resumption of care, and proper documentation of care.We will continue to in-service staff, perform the quality assessment, and then wewill audit 10 records or 10% of the current sensor weekly for 5 weeks until the threshold is 95%. After the threshold is met, we will continue to audit the 10% recordquarterly to be in compliance.	2023-02-06

	Based on observation, record review, and interview, the home health agency failed to ensure registered nurses regularly re-evaluated patients' nursing needs in 5 of 6 active clinical records reviewed. (#2, 3, 4, 5, 6) The findings include: 1. Record review on 1/10/2023, evidenced an agency policy revised 2/2022, titled "Job Description Registered Nurse" which stated, "... regularly reevaluates the patient's nursing needs ...." 2. Observation of a home visit for Patient #2 was conducted on 1/9/2023, at 11:00 AM, to observe a routine physical therapy visit. During the visit, the patient was observed to be non-verbal, bedbound, and had a gastrostomy tube (tube inserted into abdominal skin through to the stomach), used for feedings. Clinical record review for Patient #2 was completed on 1/10/2023, for certification		Update: N0541Director of Clinical Services will be responsible for this task. We will in-service and educate staff on theneed of re-evaluating patients on all aspects of physician-order care throughoutthe certification process, resumption of care, and proper documentation of care.We will continue to in-service staff, perform the quality assessment, and then wewill audit 100% of active clinical patient records of the current censor weekly for5 weeks until the threshold is 100%. After the threshold is met, we will continue toaudit 100% of records quarterly to be in compliance.	

	period 12/13/2022 – 2/10/2023. Record review evidenced a start of care assessment dated 12/13/2022, which failed to include a gastrostomy tube assessment including site appearance, residual, or dressing status. This document indicated the patient had a stage 1 pressure ulcer (area of redness which does not turn white when pressure is applied), which was unable to be assessed because the patient refused. Clinical record review evidenced a skilled nursing visit note dated 12/20/2022, which failed to include an assessment of the gastrostomy tube site, dressing, or residual. This document failed to include an evaluation of the wound, which was noted, but not assessed on 12/13/2022. Clinical record review evidenced a skilled nursing visit note dated 12/28/2022, which failed to evaluate patient's gastrostomy site, dressing, or residual.			

Clinical record review evidenced a skilled nursing visit note dated 1/3/2023, which failed to evaluate patient's gastrostomy tube site, dressing, or residual amount.

During an interview on 1/10/2023, at 11:06 AM, administrator/clinical manager #1 indicated the nurses should have included on every visit note, a gastrostomy site assessment, including skin condition, if there was a dressing in place, and if there was any residual. Administrator/clinical manager #1 indicated wounds should have been documented and assessed every visit.

3. Clinical record review for Patient #3 was completed on 1/10/2023, for certification period 12/13/2022 – 2/10/2023. Record review evidenced a start of care assessment dated 12/13/2022, which failed to evaluate the following body systems: sensory, nutritional,

	document indicated the patient had diabetes (problem regulating blood sugar), but failed to assess patient's blood sugar level, or include a diabetic assessment. During an interview on 1/10/2023, at 11:27 AM, administrator/clinical manager #1 indicated the start of care assessment should have included an assessment of sensory, nutritional, cardiac and diabetic systems. Administrator/clinical manager #1 indicated the nurse should have assessed the patient's blood glucose level. 4. Clinical record review for Patient #4 was completed on 1/10/2022, for certification period 12/17/2022 – 2/14/2023. Record review evidenced a start of care assessment dated 12/17/2022, which indicated the patient had 4 wounds, but failed to indicate location, size, measurements, drainage, odor, or other characteristics.			

	Clinical record review evidenced a skilled nurse visit note dated 12/27/2022, which indicated the patient had 4 wounds, but failed to include measurements, or any other assessment of wounds. During an interview on 1/10/2023, at 12:41 PM, administrator/clinical manager #1 indicated the nurse should have assessed all aspects of the wound on every visit, including measurements, appearance, odor, and drainage. 5. Clinical record review for Patient #5 was completed on 1/10/2023. Record review evidenced a plan of care for certification period 12/22/2022 – 2/19/2023, which indicated the patient had a PICC line (peripherally inserted central catheter/a large intravenous line to administer medications or fluids which can stay in place for several weeks/months). Clinical record review evidenced			

	12/22/2022, which failed to include an assessment of the PICC line, including location, number and status of lumens, site status, or dressing change date. The start of care assessment indicated the patient had 1 pressure wound, but failed to include location, measurements, or assessment of the wound. Clinical record review evidenced a skilled nurse visit note dated 12/27/2022, which failed to include wound measurements. Clinical record review evidenced a skilled nurse visit note dated 1/3/2023, which failed to include any assessment of patient's wound, including measurements, drainage, site appearance, or odor. During an interview on 1/10/2023, at 1:06 PM, administrator/clinical manager #1 indicated the nurse should have assessed the PICC line site, location, number of lumens,			

	during every visit. Administrator/clinical manager #1 indicated wounds should have been measured and assessed every nurse visit. 6. Clinical record review for Patient #6 was completed on 1/10/2023, for certification period 11/17/2022 – 1/15/2023. Record review evidenced recertification assessment dated 11/16/2022, which failed to include any assessment of cardiac, psychosocial, or pain assessment. This document indicated the patient had diabetes (problem regulating blood sugars), but failed to include any assessment of patient's diabetes. During an interview on 1/10/2023, at 1:15 PM, administrator/clinical manager #1 indicated the nurse should have assessed the patient's cardiac, psychosocial, pain status, and diabetes status during the recertification assessment.			

N0542	Scope of Services 410 IAC 17-14-1(a)(1)(C) Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on record review and interview, the home health agency failed to ensure the registered nurse initiated the plan of care and/or necessary revisions in 2 of 6 active clinical records reviewed. (#1, 5) The findings include: 1. Record review on 1/10/2023, evidenced an agency policy revised 2/2022, titled "Job Description Registered Nurse" which stated, "... Initiates the plan of care and necessary revisions ...." 2. Clinical record review for Patient #1 was completed on 1/10/2023, for certification period 1/2/2023 – 3/2/2023. Record review evidenced a start	N0542	N0542Director of Clinical Services will be responsible for this task. SN willinitiate the plan of care and make necessary revisions as needed throughout thecertification period. MD should be notified of changes as well as orderswritten. We will in-service staff on proper documentation and prompt communicationto the Doctor about any revisions of ordered care. We will continue toin-service staff, perform the quality assessment, and then we will audit 10 recordsor 10% of the current sensor weekly for 5 weeks until the threshold is 95%. After the threshold is met, we will continue to audit the 10% record quarterly to be in compliance. Update: N0542Director of Clinical Services will be responsible for this task. SN willinitiate the plan of care and make necessary revisions as needed throughout thecertification period. MD should be notified of changes as well as orderswritten. We will in-service staff on proper documentation and prompt communicationto the Doctor about any revisions of ordered care. We will continue toin-service staff, perform the quality assessment, and then we will audit 100% ofactive clinical patient records of the current sensor weekly for 5 weeks until the threshold is 100%. After the threshold is met, we will continue to audit 100% of records quarterly to be in compliance.	2023-02-06

on 1/2/2022, by the registered nurse, but failed to evidence the registered nurse had initiated a plan of care. Record review failed to evidence a current plan of care.

During an interview on 1/10/2023, at 10:30 AM, administrator/clinical manager #1 indicated the plan of care for Patient #1 should have been completed by the nurse within 5 days.

3. Clinical record review for Patient #5 was completed on 1/10/2023. Record review evidenced a plan of care for certification period 12/22/2022 – 2/19/2023, which indicated the patient was to receive 2 home health aide visits per week. Record review failed to evidence the patient received any home health aide visits.

During an interview on 1/10/2023, at 12:56 PM, administrator/clinical manager #1 indicated they thought the family had refused a home

	health aide, and the plan of care should have been revised.			
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: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on record review and interview, the home health agency failed to ensure registered nurses implemented appropriate preventative and rehabilitative nursing procedures in 1 of 6 active clinical records reviewed. (#1) The findings include: Record review on 1/10/2023, evidenced an agency policy revised 2/2022, titled "Job Description Registered Nurse" which stated, "... Initiates appropriate preventative and rehabilitative nursing procedures ...."	N0543	N0543Director of Clinical Services will be responsible for this task. SN willinitiate appropriate preventive and rehabilitative nursing procedures forpurposes in the home health setting. We will in-service staff withindividualized care with the appropriate diagnosis. We will continue toin-service staff, perform the quality assessment, and then we will audit 10 recordsor 10% of the current sensor weekly for 5 weeks until the threshold is 95%. After the threshold is met, we will continue to audit the 10% record quarterly to be in compliance. Update: N0543Director of Clinical Services will be responsible for this task. SN willinitiate appropriate preventive and rehabilitative nursing procedures forpurposes in the home health setting. We will in-service staff withindividualized care with the appropriate diagnosis. We will continue toin-service staff, perform the quality assessment, and then we will audit 100% ofactive clinical patient records of the current censor weekly for 5 weeks until the threshold is 100%. After the threshold is met, we will continue to audit 100% of records quarterly to be in compliance.	2023-02-06

	Clinical record review for Patient #1 was completed on 1/10/2023, for certification period 1/2/2023 – 3/2/2023. Record review evidenced a start of care assessment dated 1/2/2023, which indicated the patient had a diagnosis of diabetes (problem regulating blood sugars) with polyneuropathy (nerve pain and numbness caused by diabetes). The registered nurse failed to initiate monitoring of blood glucose measurements based on the patient's diabetes. The start of care failed to include any glucose measurements. The start of care indicated the patients blood pressure goal was less than 160/90. Clinical record review evidenced a referral/history and physical dated and signed by the nurse practitioner on 12/27/2022, which indicated the patient's blood pressure goal was less than 140/90. During an interview on 1/10/2023, at 10:33 AM, administrator/clinical manager			

	have been checking the patient's blood glucose measurement every visit. Administrator/clinical manager #1 indicated the blood pressure parameters were generic, and the nurse was responsible for updating them specifically for each patient's goal.			
N0544	Scope of Services 410 IAC 17-14-1(a)(1)(E) 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 observation, record review, and interview, the home health agency failed to ensure registered nurses accurately prepared clinical notes in 5 of 6 active clinical records reviewed. (#1, 2, 3, 4, 5) The findings include: 1. Record review on 1/10/2023, evidenced an agency policy revised 2/2022, titled "Job Description Registered Nurse"	N0544	N0544Director of Clinical Services will be responsible for this task. SN shallprepare and complete clinical and progress notes for each patient visit andsummaries of care conferences. The SOC and subsequent visits must be accurateand complete including diagnosis and treatments. We will in-service staff with individualizedcare with the appropriate diagnosis. We will continue to in-service staff,perform the quality assessment, and then we will audit 10 records or 10% of the currentsensor weekly for 5 weeks until the threshold is 95%. After the threshold is met, wewill continue to audit the 10% record quarterly to be in compliance. Update: N0544Director of Clinical Services will be responsible for this task. SN shallprepare and complete clinical and progress notes for each patient visit andsummaries of care conferences. The SOC and subsequent visits must be accurateand complete including diagnosis and treatments. We will in-service staff with individualizedcare with the appropriate diagnosis. We will continue to in-service staff,perform the quality assessment, and then we will audit 100% of active clinical patientrecords of the current sensor weekly for 5 weeks until the threshold is 100%. After the threshold is met, we will continue to audit 100% of records quarterly to be in compliance.	2023-02-06

clinical and progress notes for each patient visit and summaries of care conferences ...."

2. Observation of a home visit for Patient #1 was conducted on 1/6/2023, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was observed resting comfortable in sitting position. No respiratory distress or dyspnea (shortness of breath) was observed. The patient was observed to be living with 2 family members who were present at time of home visit. The family members indicated they assisted with meal preparation and ambulation.

Clinical record review for Patient #1 was completed on 1/10/2023, for certification period 1/2/2023 – 3/2/2023. Record review evidenced a start of care assessment completed by the registered nurse on 1/2/2023, which indicated the date of referral was 1/2/2023. This document indicated the patient lived alone around the

	the patient had no respiratory problems, and in the next section indicated the patient had dyspnea with minimal exertion, such as talking or performing activities of daily living. Clinical record review evidenced a referral order from an assisted living facility which indicated the referral date was 12/28/2022. During an interview on 1/10/2023, at 10:33 AM, administrator/clinical manager #1 indicated they were unsure of why there were discrepancies in the start of care assessment, because they had not seen this patient. Administrator/clinical manager #1 indicated the start of care assessment should have indicated the patient lived with family members, and the referral date was 12/28/2022. 3. Observation of a home visit for Patient #2 was conducted on 1/9/2023, at 11:00 AM, to observe a routine physical			

	therapy visit. During the visit, the patient was observed to be alert, but non-verbal, and moaned in pain, but was unable to specify location, rating, or severity of pain. The patient had a gastrostomy tube (tube inserted through the skin of the abdomen directly into the stomach), through which they were receiving nutrition. Clinical record review for Patient #2 was completed on 1/10/2023, for certification period 12/13/2022 – 2/10/2023. Record review evidenced a start of care assessment dated 12/13/2022, which indicated the patient had a stage 1 pressure wound reported by family, but in a section titled "Potential Risk for Infection Assessment" it indicated the patient did not have any wounds or nutritional concerns. This document indicated the patient did not have any impairment which limited their ability to voice pain or discomfort, but also indicated the patient was aphasic (difficulty speaking). The start of care assessment indicated the patient received Fibersource tube feeding, 3			

	cartons every 8 hours, or 9 cartons per day, or 2160 milliliters per day of tube feeding. Clinical record review evidenced a skilled nursing visit note dated 12/20/2022, which indicated the patient received 2 cans three times per day, or 6 cans per day of unspecified tube feeding. This note indicated the patient received bolus feedings (feeding given all at one time, versus a pump, which infuses a regular amount of tube feeding over several hours). During an interview on 1/9/2023, at 11:00 AM, person #1 (caregiver) indicated the patient received Fibersource tube feeding, 5 cartons per day, or 1200 milliliters, from 4:00 PM – 8:00 PM on a tube feeding pump. Person #1 indicated each carton was 240 milliliters, and the patient received 1200 milliliters of tube feeding per day. During an interview on			

	1/10/2023, at 10:50 AM, administrator/clinical manager #1 indicated the start of care assessment was not accurate. Administrator/clinical manager #1 indicated the start of care assessment was not accurate because some areas they were not able to accurately assess. At 10:57 AM, administrator/clinical manager #1 indicated the start of care assessment and nurse visit note should have indicated the correct dosage, type, frequency, and route of tube feeding. 4. Clinical record review for Patient #3 was completed on 1/10/2023, for certification period 12/13/2022 – 2/10/2023. Record review evidenced a history and physical dated 12/12/2022, which indicated the patient had a diagnosis of diabetes (trouble regulating blood sugar). Clinical record review evidenced a start of care assessment dated 12/13/2022, which included a diagnosis of diabetes, but in a section titled co-morbidities			

	indicated the patient did not have diabetes. During an interview on 1/10/2023, at 11:23 AM, administrator/clinical manager #1 indicated the start of care assessment was inaccurate. 5. Clinical record review for Patient #4 was completed on 1/10/2023, for certification period 12/17/2022 – 2/14/2023. Record review evidenced a start of care assessment dated 12/17/2022, which indicated the patient was not discharged from an inpatient facility within the last 14 days. Clinical record review evidenced a referral order dated 12/16/2022, which indicated the patient was discharged from the hospital on 12/16/2022.			

	During an interview on 1/10/2023, at 12:50 PM, administrator/clinical manager #1 indicated the start of care assessment was not accurate. 6. Clinical record review for Patient #5 was completed on 1/10/2023. Record review evidenced a plan of care for certification period 12/22/2022 – 2/19/2023, which indicated the patient had bladder incontinence. The plan of care indicated the patient had a PICC line (peripherally inserted central catheter/a large intravenous line to administer medications or fluids which can stay in place for several weeks/months). The plan of care indicated the patient was to receive Cefazolin (antibiotic) through the PICC line every 12 hours. Clinical record review evidenced a start of care assessment dated 12/22/2022, which indicated the patient had no abnormal bladder control. The start of care assessment indicated the integumentary section that patient had no skin issues, but			

	in another section indicated the patient had 1 pressure wound. The start of care assessment indicated the patient had no injectable medications and indicated the patient did not have intravenous access. During an interview on 1/10/2023, at 1:01 PM, administrator/clinical manager #1 indicated the start of care assessment was inaccurate.			
N0545	Scope of Services 410 IAC 17-14-1(a)(1)(F) Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on record review and interview, the home health agency failed to ensure registered nurses coordinated services in 2 of 6 active clinical records reviewed. (#4, 6) The findings include: 1. Record review on 1/10/2023,	N0545	N0545Director of Clinical Services will be responsible for this task. SN is tocoordinate services upon admission of new patients. They are responsible tocommunicate concerning aspects of care and services to be provided. All ordersand procedures ordered by a physician should be documented and communicatedwith the physician and staff. We will in-service staff with individualized carewith the appropriate diagnosis. We will continue to in-service staff, perform the quality assessment, and then we will audit 10 records or 10% of the current sensor weeklyfor 5 weeks until the threshold is 95%. After the threshold is met, we will continue toaudit the 10% record quarterly to be in compliance. Update: N0545Director of Clinical Services will be responsible for this task. SN is tocoordinate services upon admission of new patients. They are responsible tocommunicate concerning aspects of care and services to be provided. All ordersand procedures ordered by a physician should be documented and communicatedwith the physician and staff. We will in-service staff with individualized carewith	2023-02-06

	evidenced an agency policy revised 2/2022, titled "Job Description Registered Nurse" which stated, "...Coordinates services ...." 2. Clinical record review for Patient #4 was completed on 1/10/2023. Record review evidenced a plan of care for certification period 12/17/2022 – 2/14/2023, which did not include any wound care orders. Clinical record review evidenced a referral order dated 12/16/2022, which indicated the patient was to apply silver sulfadiazine to all wounds two times daily. Clinical record review evidenced a physician order dated 12/22/2022, which indicated the home health agency was to manage all wounds, and apply santyl (wound ointment), and Allevyn (foam dressing) to left heel and right ankle wounds daily.		the appropriate diagnosis. We will continue to in-service staff, perform the quality assessment, and then we will audit 100% of active clinical patient recordsof the current censor weekly for 5 weeks until the threshold is 100%. After the thresholdis met, we will continue to audit 100% of records quarterly to be in compliance.	

	Clinical record review evidenced a skilled nurse visit note dated 12/27/2022, which indicated the nurse applied dry dressings to 4 wounds. This visit note indicated the patient had wounds to right heel, left ankle, right buttocks, and sacrum. Clinical record review evidenced a physician order dated 12/28/2022, which indicated the nurse was to cleanse sacral wounds with saline, apply aquacel (wound dressing), and cover with Allevyn, and change every 3 days. This order indicated the nurse was to cleanse left heel wound with alcohol and cover with Allevyn. Clinical record review failed to evidence any care coordination clarifying the conflicting wound treatment orders. No wound orders were evidenced for a right heel wound or left ankle wound. During an interview on 1/10/2023, at 12:40 PM,			

	#1 indicated they did not know what wound care was supposed to be applied or where exactly the wounds were located. Administrator/clinical manager #1 indicated the nurse should have coordinated care with the physician to clarify the wound treatment orders. 3. Clinical record review for Patient #6 was completed on 1/10/2023, for certification period 11/17/2022 – 1/15/2023. Record review evidenced a skilled nurse visit note dated 12/19/2022, which indicated orders were received for a urine sample to be drawn to check for infection. This note indicated the urine sample was drawn during the visit, and dropped off at a lab on 12/19/2022. Clinical record review evidenced a fax report received 12/22/2022, which indicated the patient had an antibiotic resistant urinary tract infection (a bladder infection, which does not get better with regular antibiotics).			

	Clinical record review evidenced a fax report sent on 12/22/2022 to physician #2, which included a copy of the urine culture results. Clinical record review failed to evidence the home health agency had received any antibiotic orders from physician #2, or any acknowledgement that physician #2 had been made aware of the patient's urinary tract infection. No orders for antibiotics were evidenced. During an interview on 1/10/2023, at 1:27 PM, administrator/clinical manager #1 indicated the patient was probably started on antibiotics, but was not sure, and did not see an order. Administrator/clinical manager #1 called the nurse to verify if any antibiotic orders were received, and no antibiotic orders were evidenced.			
N0546	Scope of Services	N0546	N0546Director of Clinical Services will be responsible for this task. SN will informthe	2023-02-06

	410 IAC 17-14-1(a)(1)(G) Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on record review and interview, the home health agency failed to ensure registered nurses informed the physician of changes in the patient's condition or needs in 2 of 6 active clinical records reviewed. (#1, 4) The findings include: 1. Record review on 1/10/2023, evidenced an agency policy revised 2/2021, titled "Coordination of Patient Care" which stated, "... The agency must: ... Assure communication with all physicians/practitioners involved in the plan of care ...." 2. Clinical record review for		physician and other appropriate medical personnel of changes in the patient'scondition and needs, counsel the patient and family in meeting nursing and relatedneeds, participate in in-service programs, and supervise and teach othernursing personnel. We will in-service staff with individualized care with the appropriatediagnosis. We will continue to in-service staff, perform the quality assessment, andthen we will audit 10 records or 10% of the current sensor weekly for 5 weeks until the threshold is 95%. After the threshold is met, we will continue to audit the 10% recordquarterly to be in compliance. Update: N0546Director of Clinical Services will be responsible for this task. SN will informthe physician and other appropriate medical personnel of changes in the patient'scondition and needs, counsel the patient and family in meeting nursing and relatedneeds, participate in in-service programs, and supervise and teach othernursing personnel. We will in-service staff with individualized care with the appropriatediagnosis. We will continue to in-service staff, perform the quality assessment, andthen we will audit 100% of active clinical patient records of the current sensor weeklyfor 5 weeks until the threshold is 100%. After the threshold is met, we will continueto audit 100% of records quarterly to be in compliance.	

	Patient #2 was completed on 1/10/2023, for certification period 12/13/2022 – 2/10/2023. Record review evidenced a start of care assessment dated 12/13/2022, which indicated the patient had a stage 1 pressure wound but refused nurse assessment, so the nurse was unable to assess the wound. Record review failed to evidence the physician was notified of patient's wound status, refusal of skin assessment, or orders were received for wound care. During an interview on 1/10/2023, at 10:48 AM, administrator/clinical manager #1 indicated the physician should have been notified of the patient's wound and refusal of skin assessment.			

	3. Clinical record review for Patient #4 was completed on 1/10/2023, for certification period 12/17/2022 – 2/14/2023. Record review evidenced a start of care assessment dated 12/17/2022, which indicated the patient had no swelling to lower extremities. Clinical record review evidenced a skilled nurse visit note dated 12/27/2022, which indicated the patient now had 3+ pitting edema (swelling which causes a 5-6 millimeter depression in the skin which rebounds in 60 seconds) to right lower extremity. Record review failed to evidence the physician was notified of increase in swelling and change in condition. During an interview on 1/10/2023, at 12:53 PM, administrator/clinical manager #1 indicated the physician should have been notified of the change in status.			
N0565	Scope of Services	N0565	N0565Director of Clinical Services will be responsible for this task. The appropriatetherapist will help develop the plan of care and revise it as necessary. Anychanges	2023-02-06

	410 IAC 17-14-1(c)(4) Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary); Based on record review and interview, the home health agency failed to ensure therapists helped develop the plans of care and revised them as necessary in 1 of 6 active clinical records reviewed. (#2) The findings include: Clinical record review for Patient #2 was completed on 1/10/2023. Record review evidenced a plan of care for certification period 12/13/2022 – 2/10/2023, which indicated the patient was receiving enteral nutrition (feeding through a feeding tube). Clinical record review evidenced a speech therapy visit dated 12/27/2022, which indicated the patient could have pureed feedings for pleasure as requested. Record review failed		should be communicated with family members and physicians. We willeducate appropriate staff on all changes that should be communicated and documentedas necessary. We will in-service staff with individualized care with the appropriatediagnosis. We will continue to in-service staff, perform the quality assessment, andthen we will audit 10 records or 10% of the current censor weekly for 5 weeks until the threshold is 95%. After the threshold is met, we will continue to audit the 10% recordquarterly to be in compliance. Update: N0565Director of Clinical Services will be responsible for this task. The appropriatetherapist will help develop the plan of care and revise as necessary. Anychanges should be communicated with family members and physicians. We willeducate appropriate staff on all changes that should be communicated and documentedas necessary. We will in-service staff with individualized care with the appropriatediagnosis. We will continue to in-service staff, perform the quality assessment, andthen we will audit 100% of active clinical patient records of the current censor weeklyfor 5 weeks until the threshold is 100%. After the threshold is met, we will continueto audit 100% of records quarterly to be in compliance.	

	to evidence the plan of care was updated or revised to reflect new diet orders. During an interview on 1/10/2023, at 11:11 AM, administrator/clinical manager #1 indicated they should have confirmed the order with the physician and then added it to the plan of care.			
N0567	Scope of Services 410 IAC 17-14-1(c)(6) Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel; Based on observation, record review, and interview, the home health agency failed to ensure physical therapists advised and consulted with the patient's family and other home health agency personnel in 1 of 3 home visits completed. (#2) The findings include: Record review on 1/10/2023, evidenced an undated agency	N0567	N0567Director of Clinical Services will be responsible for this task. The therapistshall advise and consult with the family and other home health agency personnelconcerning treatments and medication prior to care being given. In-service concerningpatients being pre-medicated with pain medication before completing therapy visits.We will in-service staff with individualized care with the appropriate diagnosis.We will continue to in-service staff, perform the quality assessment, and then wewill audit 10 records or 10% of the current sensor weekly for 5 weeks until the threshold is 95%. After the threshold is met, we will continue to audit the 10% recordquarterly to be in compliance. Update: N0567Director of Clinical Services will be responsible for this task. The therapistshall advise and consult with the family and other home health agency personnelconcerning treatments and medication prior to care being given. In-service concerningpatients being pre-medicated with pain medication before completing therapy visits.We will in-service staff with individualized care with the appropriate diagnosis.We will continue to in-service staff, perform the quality assessment, and then wewill audit 100% of	2023-02-06

	policy titled "Job Description Registered Physical Therapist" which stated, "... Participates with all other home care personnel in patient care planning ... Consults with physicians regarding change in treatment ...." Observation of a home visit for Patient #2 was conducted on 1/9/2023, at 11:00 AM, to observe a routine physical therapy visit. During the visit, the patient was observed to be alert, but non-verbal, and bedbound. The patient was unable to move the entire right side of their body and left lower leg. The physical therapist was observed performing range of motion exercises, during which the patient was moaning loudly and grimacing, and grabbing their right arm to prevent the range of motion exercises. The patient's family was not home, during the visit. Clinical record review for Patient #2 was completed on 1/10/2023. Record review evidenced a plan of care for		active clinical patient records of the current censor weekly for5 weeks until the threshold is 100%. After the threshold is met, we will continue toaudit 100% of records quarterly to be in compliance.	

	– 2/10/2023, which indicated the patient had an order for acetaminophen (for pain) as needed. Record review failed to evidence any documentation regarding medicating the patient prior to physical therapy visits or communication with the physician about patient's pain level. Record review failed to evidence any communication with the patient's family regarding need for pain medication prior to therapy. During an interview on 1/10/2023, at 10:54 AM, administrator/clinical manager #1 indicated the therapist should have communicated with the patient's family to pre-medicate with pain medication before completing therapy visits or contacted the physician if additional pain medication was required.			
N0608	Clinical Records 410 IAC 17-15-1(a)(1-6) Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient	N0608	N0608Director of Clinical Services will be responsible for this task. All medicalrecords should contain a complete medical plan of care showing all aspects ofcare, medication, and procedures. We will in-service staff with individualizedcare with the appropriate diagnosis. We will continue to in-service staff,perform the quality assessment, and then we will audit 10 records or 10% of the currentsensor weekly for 5 weeks until the threshold is 95%. After the threshold is met,	2023-02-06

	as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the home health agency failed to ensure patients' clinical records contained a medical plan of care in 1 of 6 active clinical records reviewed. (#1) The findings include: Record review on 1/10/2023, evidenced an agency policy revised 2/2022, titled “Medical Record Content” which stated, “... Each medical record will contain the following: ... Current medication profile ... Identification of problems, interventions and goals [care		wewill continue to audit the 10% record quarterly to be in compliance. Update: N0608Director of Clinical Services will be responsible for this task. All medicalrecords should contain a complete medical plan of care showing all aspects ofcare, medication, and procedures. We will in-service staff with individualizedcare with the appropriate diagnosis. We will continue to in-service staff,perform the quality assessment, and then we will audit 10 records or 10% of the currentsensor weekly for 5 weeks until the threshold is 100%. After the threshold is met, wewill continue to audit the 10% record quarterly to be in compliance.	

	and updates to the plan of care … Actions/interventions/procedures … Goals in the patient's plan of care and the patient's progress toward achieving goals ….” Clinical record review for Patient #1 was completed on 1/10/2023, for certification period 1/2/2023 – 3/2/2023. Record review failed to evidence a medication profile or plan of care. During an interview on 1/10/2023, at 10:30 AM, administrator/clinical manager #1 indicated they did not know why Patient #1 did not have a plan of care. Administrator/clinical manager #1 indicated every patient should have a plan of care within 5 days of start of care.			
N9999	Final Observations	N9999	N9999Director of Clinical Services will be responsible for this task. The HomeHealth Agency shall randomly test at least 50% of the employees who have directpatient care and that are not licensed at least annually. We will develop andimplement a policy concerning drug testing of employees and will continue toreview the policy and ensure it remains in	2023-02-06

			compliance.	
	Review of Indiana Code 16-27-2.5 stated "... Section 2.(b) A home health agency shall randomly test: (1) at least fifty percent (50 %) of the home health agency's employees who: (A) have direct contact with patients; and (B) are not licensed by a board or commission under IC 25; at least annually; or (2) when the home health agency has reasonable suspicion that an employee is engaged in the illegal use of a controlled substance...." Based on record review and interview, the home health agency failed to develop and implement a drug testing policy which required them to perform random, annual drug tests on at least 50% of unlicensed employees with direct patient contact in 2 of 2 home health aides employed by the agency. (#7, 8) The findings include:			

Record review on 1/10/2023, failed to evidence an agency policy regarding drug testing.

Employee record review on 1/9/2023, evidenced a personnel file for home health aide #7, start date 4/19/2021, and first patient contact on 4/19/2021, which failed to include any drug screens.

Employee record review on 1/9/2023, evidenced a personnel file for home health aide #8, start date 8/1/2022, and first patient contact on 8/12/2022, which failed to include any drug screens.

During an interview on 1/9/2023, at 2:51 PM, office manager #4 indicated they were not sure if drug testing home health aides was done randomly or scheduled yearly.

correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Delsie McHugh	Administrator	2/3/2023 5:10:02 PM