STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157711	A. BUILDING B. WING	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILITY HOME HEALTH LLC	4555 NORTHWESTERN ST STE 1A, INDIANAPOLIS, IN, 46077

(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 in conjunction with a State complaint survey of a Deemed Home Health provider. Survey dates: 1/24/23, 1/25/23, 1/26/23, 1/27/23, 1/30/23, 1/31/23, and 2/1/2023 Census (unduplicated, last 12 months): 82 Complaint # 95618 - Unsubstantiated Ability Home Health, LLC was found not to have been in compliance with 410 IAC 17 et seq., in regards to a State Re-licensure survey. QR by Area 3 on 2-14-2023	N0000	POC accepted on 3-8-2023 Deborah Franco, RN	2023-03-04

N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the agency failed to ensure there were clear lines of authority for the delegation of responsibility and failed to ensure these were clearly set forth in writing and readily identifiable, for 1 of 1 Home Health Agency surveyed. Findings include: 1. A review of an agency document dated 5/13/2019, titled 'GOVERNING BODY B-100,' stated, "POLICY The Governing Body shall assume full legal authority and responsibility for the agency's	N0440	The agency will outline the organization, services furnished,administrative control, and lines of authority for thedelegation of responsibility down to the patientcare level. Theseshall be clearly set forth in writing; and readily identifiable and inaccordance with Policy B-100 "Governing Body". Correction: The Governing Bodywill revise the Organizational Chart to clearly depict the lines of authority to include alternates and in accordance with information submitted to the State regarding these roles. FuturePrevention: The Governing Bodywill approve changes to the key roles. The Governing Body will update the Organizational chart accordingly.The Governing Body will then submit information to the State regarding the key roles. This information will be reviewed on a quarterly basis for accuracy andreflected in the Governing Body MeetingMinutes.	2023-02-24

	operation, the provision of all home health services ... and it's operational plans ... PURPOSE To ensure lines of authority are established. To ensure patients are provided with appropriate, quality services. SPECIAL INSTRUCTIONS The duties and responsibilities of the Governing Body shall include: 1. Appoint a qualified Administrator. Delegate to that individual the authority and responsibility for the provision of home care services in accordance with state and federal regulations, accreditation standards, and Agency mission ... 4. Define the corporate structure and indicate lines and indicate lines of authority ... " 2. A review of an agency document titled 'ORGANIZATION CHART 2023,' failed to indicate the Governing Body as head of the organization (not included on the chart). The head of the organization was listed as, "CEO [Administrative Staff 1]". Next in line was, "Administrator/DON (Director of Nursing)/Clinical Director [Administrative Staff 2]", followed by, "Clinical		Responsibility: Administrator/Governing Body	

	then indicated clinical and field staff were last in the reporting structure. The Organizational Chart failed to evidence the current and accurate Administrative and Management roles/positions and Alternates to these key roles/positions. The chart failed to evidence the inclusion of the Governing Body as having the fiscal, management, and operational authority and responsibility for the home health agency. The document failed to identify patients in the organizational chart. 3. On 1/31/23 at 2:50 PM, when queried as to who was the current Administrator, Administrative Staff 3 indicated that Administrative Staff 2 was the Administrator and the Executive Director. Administrative staff 3 verified the Governing Body was not identified in the agency's organizational chart.			
N0442	Home health agency administration/management	N0442	The agency’s governing body shall do the following: Appointa qualified administrator,adopt	2023-02-24

	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 Governing body failed to appoint an Administrator after the departure of the previous Administrator, for 1 of 1 Home Health agencies surveyed. Findings include: 1. A review of an agency document dated 5/13/2019, titled 'GOVERNING BODY B-100' stated, "POLICY The Governing Body shall assume full legal authority and responsibility for the agency's		and periodically review written bylaws or an acceptable equivalent, and oversee themanagement and fiscal affairs of the home health agency. Correction: The Governing Body shall formally appoint peopleto key roles, update the organizational chart accordingly and notify theaccrediting body of said changes following the completion of the first two steps. FuturePrevention: The Governing Bodywill approve changes to the key roles. The Governing Body will update the Organizational chart accordingly.The Governing Body will then submit information to the State regarding the key roles. This information will be reviewed on a quarterly basis for accuracy andreflected in the Governing Body MeetingMinutes. Responsibility: Administrator/Governing Body	

	operation, the provision of all home health services ... and it's operational plans ... PURPOSE To ensure lines of authority are established. To ensure patients are provided with appropriate, quality services. SPECIAL INSTRUCTIONS The duties and responsibilities of the Governing Body shall include: 1. Appoint a qualified Administrator. Delegate to that individual the authority and responsibility for the provision of home care services in accordance with state and federal regulations, accreditation standards, and Agency mission ... " 2. A review of Meeting Minutes from the agency documents dated 11/30/22 through 1/18/23, failed to evidence the Governing Body had appointed anyone to the position of agency Administrator when the previous Administrator left employment. 3. On 1/31/23 at 3:37 PM, during an interview with the current Administrator, when queried as to why the appointment of a new Administrator had not been addressed during the agency's			

	weekly Governing Body meetings, no answer was given.			
N0451	Home health agency administration/management 410 IAC 17-12-1(c)(8) Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence. Based on record review and interview, the agency failed to ensure it authorized in writing an alternate to act on the behalf of, and in the absence of the Administrator, in 1 of 1 Home Health agencies surveyed. Findings include: 1. A review of an agency document dated 4/15/19, titled 'ADMINISTRATOR BACKUP A-110,' stated, "POLICY When the administrator is not available, a designated qualified alternate will assume the	N0451	The agency's administrator, who may also be the supervisingphysician or registerednurse required by subsection (d), shall ensure that a qualified person is authorized in writing to actin the administrator's absence. Correction: The Governing Bodyshall formally appoint people to key roles, update the organizational chart accordingly and notify theaccrediting body of said changes following the completion of the first two steps. FuturePrevention: The Governing Bodywill approve changes to the key roles. The Governing Body will update the Organizational chart accordingly.The Governing Body will then submit information to the State regarding the key roles. This information will be reviewed on a quarterly basis for accuracy andreflected in the Governing Body MeetingMinutes. Responsibility:	2023-02-24

	responsibilities. If the Administrator leaves employment, the designated alternate will assume the responsibilities of the Administrator until a replacement is hired and oriented. The Administrator and designated backup will comply with accepted professional standards and principles that are applicable to professional home care practice. The Administrator or designated backup will be available at all times during regular business hours. PURPOSE To assure a qualified individual is designated to fulfill the responsibilities of the Administrator in the Administrator's absence. STATEMENT OF RESPONSIBILITY: In compliance with established policy, and in the event that the Administrator: [signed by a former Administrator] is not available, the designated, qualified backup: [signed by Administrative Staff 1] will assume the duties and responsibilities of the Administrator. (*Refer to the Administrator job description*). The Administrator and designated backup shall comply		Administrator/Governing Body	

	with accepted professional standards and principles that apply to professionals providing home care services. During hours of operation, the Administrator or designated backup shall be available at all times. The Administrator or designee will report, in writing, all changes in ownership or management to the Department of Health ..." 2. A review of an agency document 'ORGANIZATION CHART 2023,' failed to evidence the current and accurate Administrative and Management roles/positions, nor the Alternates to these key roles/positions. 3. On 1/31/23 at 3:37 PM, when Administrative Staff 1 indicated the agency did not have anything in writing to designate the appointment of a person to act in the absence of the administrator.			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for	N0458	The agency will employ personnel practices for employeesthat are supported bywritten policies. All employees caring for patients by the agency shall be subject	2023-03-03

	employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the agency failed to ensure job descriptions were signed by 1 of 7 employee records review. (Administrative Staff 1) Findings include: 1. During a record review of the personnel file for Administrative Staff 1 on 1/31/23 at 11 AM, the personnel file failed to evidence Administrative Staff 1 had received and signed for receipt of a job description for the position of Administrator. 2. During an interview with		to Indiana licensure,certification, or registration required to perform the respective service. Personnelrecords of employees who deliver home health services shall be keptcurrent and shall include documentation of orientation to the job, includingthe receipt of job description, qualifications for theposition, a copy of limited criminal history pursuantto IC 16-27-2, a copy of currentlicense, certification, or registration and annual performance evaluations. Correction: All employee fileswill be reviewed to ensure the file has a current signed job description. FuturePrevention: A check list willbe developed for all new hires to ensure that all needed information isincluded in the personnel file. Quarterly reviews of the personnel files will be conducted to include 25% of thecurrent staff to verify all files are complete. Responsibility: Human Resource Manager	

	1/31/23 at 11:30 AM, they stated they hadn't realized Administrative Staff 1 required a job description because Administrative Staff 1 was the owner. 3. During an interview with Administrative Staff 1, owner, on 1/31/23 at 3:44 PM, they stated they didn't know they had to sign for a job description.			
N0470	Home health agency administration/management 410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation and interview, the agency failed to ensure that infection control practices were implemented according to policy during the hands-on care of patients in 3 (Patients 3, 5 and 7) of 3 homecare visits observed. Findings include: 1. A review of an agency's	N0470	Theagency Policies and Procedures shall be written and implemented for thecontrol of communicable disease in compliance with applicable federal and state laws. Correction: All employees involved in “hands on care” of thepatient will be reeducated on infection control measures to include handhygiene, glove donning, glove doffing, and the cleaning of equipment. The staffwill be required to demonstrate the processes ofhand hygiene as well as the glove donning/doffing processes with proper stepsof hand hygiene. FuturePrevention: All staff will be required to demonstratehand hygiene,	2023-03-03

	undated policy, 'HANDWASHING/HAND HYGIENE D-330' revealed, "POLICY In an effort to reduce the risk for infection in patients and staff members, thorough hand washing/hand antisepsis is required of all employees...SPECIAL INSTRUCTIONS...3. Indications for hand washing and hand antisepsis: ...c. When there is prolonged or intense contact with the patient (bathing the patient). d. Between tasks on the same patient. ...g. After touching objects that are potentially contaminated...q. Decontaminate hands after contact with inanimate objects including equipment in the immediate vicinity of the patient..." 2. During a home visit on 1/26/23 at 10 AM, observed HHA (home health aide) 1 perform personal care to Patient #3. HHA 1 assisted the patient to the bathroom via wheelchair. HHA 1 performed hand hygiene and donned gloves. HHA 1 assisted Patient 3 to the shower chair and assisted with undressing. HHA 1 turned the water on, waiting for the water to warm up. HHA		equipmentcleaning techniques during their annual skills check to be conducted in February. Then all staff will be required to demonstratehand hygiene, glove donning/doffing and equipmentcleaning techniques monthly for three months after the initialretraining. Thenall staff will be required to demonstrate hand hygiene, glove donning/doffingand equipment cleaning on a quarterly basis for three quarters. Responsibility: Alternate Administrator	

	1 adjusted the shower head and began washing and rinsing the patient's hair. HHA 1 handed Patient #3 a washcloth to wash their face. HHA 1 used a clean washcloth to wash the patient's upper and lower body. When completed, HHA 1 assisted Patient #3 to stand, handed Patient #3 a clean washcloth to wash their peri area, then HHA 1 rinsed and dried the patient. HHA 1 applied lotion and massaged Patient #3 arms, legs, and back. HHA 1 doffed gloves and donned a clean pair of gloves. Assisted the patient with dressing, removed their gloves, and washed their hands. The home health aide failed to change gloves and perform hand hygiene at appropriate intervals during personal care. 3. During an interview on 1/26/23 at 3:35 PM with the administrator, they stated the HHA should have changed her gloves more often. 4. On 1/26/23 at 11:00 AM during a home observation for Patient 7, Staff 2 was preparing to assess the radial pulse of the patient's left wrist. Staff 2 pulled			

pocket and used the fingers of the right middle finger on the touchscreen, both hands were then holding the phone in order to pull up the timer function, the phone was then placed in the left hand, while the right hand went back into position on the left wrist of the patient.

The clinician failed to sanitize the device before use, and failed to use proper hand hygiene after touching the device and before touching patient with bare hands.

5. On 1/26/23 at 1:20 PM during a home observation for Patient 5, Nurse 1 was performing wound care to wounds on the left and right feet. After the right heel wound was measured, gloves were doffed and new gloves were donned. Hands were not sanitized in between. Later, after applying a heel cup to the right heel, the nurse doffed gloves into the trash and immediately donned new gloves, hands were not sanitized in between. The nurse then went to the kitchen to wash hands, returned and applied gloves to sanitize vital sign equipment. Returned the

	and doffed gloves. Hands were not sanitized after doffing gloves. The clinician failed to perform hand hygiene at appropriate intervals during patient care. 6. In an interview on1/26/23 at 3:45 PM with Administrative Staff 1 and Administrative Staff 2, when informed regrading infection control breaches during home observations, Administrative Staff 1 indicated that the agency does infection control education, "all the time".			
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.	N0486	Theagency shall coordinate its services with other health or social service providersserving the patient. Correction: All staff will bereeducated about the requirement to coordinate services with the physicians involved in the care of the patient. When callingoffices, within the visit note or in a coordination note, the staff will chart the time called, the person spoken with and the result ofthe call. Ifa voicemail is left,	2023-03-04

	Based on record review and interview, the agency failed to coordinate skilled nursing services with the attending physician in 1 (Patient 2) of 9 record reviews. Findings include: 1. A review of the agency's undated policy titled 'MEDICAL SUPERVISION C-645,' revealed, "POLICY Physicians will be informed...each parties' responsibilities in managing patient care...The patient's physician shall be responsible for providing signed orders, and for establishing and reviewing the patient's Plan of Care throughout the time the patient is receiving services. PURPOSE To assure the participation of physicians in the development and maintaining of the patient plan of care ... SPECIAL INSTRUCTIONS 1. Each physician will be notified ... responsibilities regarding managing home care patients upon referral, admission, and routinely thereafter. 2. A Physician Plan of Care is developed for each patient at the time of admission ... The physician orders shall outline the disciplines providing care		staff will be reeducated that they are responsible for following up with the physician. All care willbe through the physician's orders to include the education ofdiseases and disease management. Future Prevention: Through general QA, the QA team will review allroutine, Start of Care, Recertification, Resumption and Discharge visit notesto verify compliance with the services listed and existing orders for onequarter, followed by review of one(1) daily note weekly for each clinician for one quarter. New staff will have all notes reviewed throughQA for the first three (3) weeks of employment followed by the compliance checknoted above for all "experienced" staff. If services are being provided outsideexisting orders, the clinician will becontacted by agency supervisory staff with instructions, including and not limited tocontacting the physician for respective orders. Continued behavior outside ofexisting orders will result in progressive disciplinary action. Responsibility: Clinical Director/Alternate	

	and the type, frequency, and duration of services to be provided. a. The physician-signed Plan of Care will include: Description of patient needs. Patient's goals. Description of specific services to be provided. A list of actions to be taken for delivery of care including type, frequency, and duration of actions ... 4. Physician will be contacted when any of the following occurs ... D. Caregiver support or home environment changes. E. Any change in patient condition or agency services ... 13. Agency Responsibilities include...b. Confidential and accurate communication about patients...d. Periodic updates on patient condition/progress ... f. Support of Physician Plan of Care..." 2. A review of the agency's undated policy titled, 'COORDINATION OF PATIENT SERVICES C-360,' revealed, "POLICY All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively...The coordination of care will include...physicians .... PURPOSE... To establish effective interchange, reporting		Clinical Director	

	...To modify the plan to reflect needs or changes ... To identify needs to modify the plan of care...To provide the attending physician...To ensure continuity of care. SPECIAL INSTRUCTIONS ... 7. The primary care Nurse ... responsibility for updating/changing the Care Plan ... The physician will be contacted when his/her approval for that change is necessary..." A review of the clinical record of Patient 2, with the start of care date of 8/16/22, evidenced the clinical record contained a 'Home Health Certification and Plan of Care,' dated 8/24/22, for the certification period of 8/16/22 to 10/14/22, that revealed Patient 2 was to receive "SN (Skilled nursing) 2 times a week for 1 week, 3 times a week for 8 weeks to ... Perform wound vac (vacuum-assisted closure of a wound is a type of therapy to help wounds heal) dressing change using black foam kit, remove old dressing, cleanse area with NS (normal saline), apply skin prep to peri-wound, frame wound bed, pack with			

	foam, cover with vac dressing, apply suction, using at 125mmHg, change canister weekly or PRN ... Measure wound minimum of weekly ... " A review of Patient 2's Clinical note on 9/7/22 revealed, Former RN 14 documented, "Pt. discussed going on vacation, September 18, 2022 and would like to have wound resolved ... Will contact MD Wednesday for possible orders for her wound and vacation. A review of Patient 2 Clinical note on 9/12/22 revealed, Former RN 14 documented, "...Will contact MD as patient is vacationing Friday until the 26th and does not want to carry wound vac if possible. Patient would like a dressing in place of vac. [Family] taught how to change dressing if needed. A review of Patient 2 Clinical note on 9/14/22 revealed, Former RN 14 documented, "...Will contact MD as patient is vacationing Friday until the 26th and does not want to carry wound vac if possible. Patient would like a dressing place of vac. Doctor to contact RN at 3 pm with wound decision.			

	[Family] taught how to change dressing if needed. Demonstrates ability." A review of Patient 2 Clinical note on 9/16/22 revealed, Former RN 14 documented ... writer made sure client felt comfortable with still having wound vac on during vacation ... a book bag was given ... to keep wound vac machine in ... during their vacation..." The Clinical Record failed to evidence documentation of coordination of care or of any physician orders for teaching the family to change wound vac dressing, a change of frequency for wound care, and/or putting the Patient 2 on hold for services while on vacation. During a phone interview on 1/26/23 at 12:19 with RN 16 from Entity 15, Patient #2's physician' office, they stated they didn't find out the patient had gone on vacation, and the family was performing wound care until 10/10/22, when Former RN 14 had phoned to notify them.			
N0541	Scope of Services	N0541	The agency shall, except where	2023-03-03

	410 IAC 17-14-1(a)(1)(B) Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview, the agency failed to ensure the nurse regularly reevaluated a patient's nursing needs for 1 (Patient 9) of 9 patients whose clinical record was reviewed. Findings include: 1. A review of the clinical record for Patient 9, with a Start of Care date of 2/11/22, contained a document dated 10/8/22, 'Non-Skilled Assessment,' for the service period of 10/10/22 through 12/8/22. It contained a section titled 'Recent Hospitalization - Recent Hospitalization stays or Emergency room visits', this section was left blank. Page 3 contained a section titled 'Mouth Condition', this section was left blank. Page 4 contained a section titled		services are limited totherapy only, for purposesof practice in the home health setting, the registered nurse shall regularly reevaluate thepatient's nursing needs. Correction: Each nurse will bereeducated so that during recertification visits, the nurse will complete a head-to-toe assessment of the patientto determine the need for additional services. Included in the assessmentwill be the vital signs and general assessmentfindings. Future Prevention: Through the routine QA process, therecertifications will be reviewed for completeness and compliance with theprocess. At each visit all nurses will document: asking for new/changedmedications, any recent falls, any Emergency Room visits, any visits to aphysician for any reason even if for scheduled/routine checkup. Continued problems will be met withprogressive corrective action. Responsibility: Clinical Director/Alternate Clinical Director	

	'Meals/Nutrition' which stated, "Client needs assistance with:...", corresponding boxes were checked-off for the following: 'Cooking', 'Meal Preparation', 'Pureeing Food'. The box marked 'Feeding' was left unchecked. Page 5 contained a section titled 'Services to be provided', and a corresponding box titled 'Feed' was checked-off. Page 9 contained a narrative of the visit stating, "Pt is 18-year-old [sic male or female,] suffering neuromuscular disorder rendering him/her completely unable to provide for self-care, therefore is total care...Mother manages meds and all his/her care. Mother reports patient has R knee edema and has been following up with MD .... VS WNL [sic vital signs within normal limits] ... MOIST MUCUS MEMBRANES ... NO EDEMA NOTED ... The physician, patient/caregiver and nurse have collaborated, reviewed the expected outcomes, anticipated risks and benefits, and factors that could impact treatment for the development of the plan of care ..." 2. On 1/27/23 at 10:29 AM,			

	office, when queried regarding communications from the agency regarding Patient 9, stated their office had received only one call during September, October, and November of 2022. Stated this call was on 11/15/22 from the former Administrator seeking hospital records for a Date of Service of 9/14/22 and Other Nurse 5 indicated no records had been found to share at that time. Other Nurse 5 then stated Patient 9 had an Emergency Room visit on record for 9/29/22 related to, "inability to swallow, not wanting to eat, dental abscess, swelling, and pain." As stated further Patient 9 had been, "seen recently on 1/6/23 for an annual check-up and physical, no issues." 3. On 1/30/23 at 10:39 AM, in an interview with Administrative Staff 1, when queried as to why the Emergency Room visit for Patient 9 had not been documented in the clinical record, he/she indicated they did not know this had happened. 4. On 2/1/23 at 11:20 AM, in an interview with Administrative Staff 2, when queried as to how			

	a skilled nursing assessment is expected to be conducted, he/she indicated the assessment should include assessment of heart and lungs, vital signs, bowel sounds, visual inspection, checking for dependent edema, inspect their foley [sic if present], agreed essentially a head-to-toe assessment, with the focus of keeping the patient out of the hospital. When queried regarding a non-skilled assessment, indicated he/she would rather that vital signs be performed as currently, this may not be the practice, and indicated that currently there was just the use of checkboxes. When queried as to how a non-skilled Recertification assessment was conducted, he/she indicated the agency should be doing the same as a skilled assessment, indicated the current practice is to reconcile medications, inquire if there are any problems, he/she believed the nurses perform vital signs, but not necessarily a head-to-toe assessment. 5. On 2/1/23 at 12:07 PM, in an interview with Administrative Staff 1, when queried as to			

	Patient 9's physician after conducting the recertification assessment, indicated they left a message. 6. On 2/1/23 at 12:20 PM, in an interview with Administrative Staff 1, when queried as to the Non-Skilled Recertification reassessment he/she completed for Patient 9 on 10/8/22, and whether vital signs had been completed during this visit, he/she indicated the aide does the vital signs. When queried further as to whether he/she, himself/herself had performed vital signs on this visit replied, "we do, regardless." When asked where the vital signs were documented, he/she indicated they would be within the narrative. When informed the narrative read, "VS WNL" and there were no further details about the patient's vital signs, Administrative Staff 1 indicated if there were an issue with the patient's vital signs, the aide would inform of any change in Patient 9's vital signs. When queried as to discrepancies found in the assessment document, areas not completed, along with lack of documentation of an Emergency Room visit in the			

	previous 60-day care period, Administrative Staff 1 stated, "I need to do a better job of documenting."			
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 agency failed to ensure the registered nurse initiated revisions to the plan of care in 1 (Patient 2) of 9 clinical records reviewed. Findings include: 1. A review of the agency's undated policy titled, 'COORDINATION OF PATIENT SERVICES C-360,' revealed,	N0542	The agency shall, except where services are limited totherapy only, for purposesof practice in the home health setting, the registered nurse shall initiate the plan of care andnecessary revisions. Correction: All staff will bereeducated about the requirement to coordinate services with the physicians involved in the care of thepatient. Whencalling offices, a coordination note will be entered into theElectronic Medical Record and/or the visit note comments indicatingthe time called, the person spoken with and the result ofthe call. Ifa voicemail is left, staff will be reeducated that they are responsible for following up with the physician. All care willbe through the physician's orders to include the education	2023-03-03

	"POLICY All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively ... The coordination of care will include ... physicians ....PURPOSE ... To establish effective interchange, reporting ... To modify the plan to reflect needs or changes ... To identify needs to modify the plan of care... To provide the attending physician ... To ensure continuity of care. SPECIAL INSTRUCTIONS ... 7. The primary care Nurse ... responsibility for updating/changing the Care Plan ... The physician will be contacted when his/her approval for that change is necessary ..." 2. A review of the agency's undated policy, 'SKILLED NURSING SERVICES C-200' revealed, "POLICY Skilled nursing services will be provided ... accepted standards of medical and nursing practice will be considered. PURPOSE To abide by state/federal guidelines...SPECIAL INSTRUCTIONS 1. The registered nurse: ... b. Regularly reevaluates the		ofdiseases and disease processes. Future Prevention: Through general QA, the QA team will review allroutine, Start of Care, Recertification, Resumption and Discharge visit notes toidentify the compliance with the services listed andexisting orders for one quarter, followed by review of one (1) of each type ofnote weekly for each clinician for one quarter. New staff will have all daily notesthrough the QA daily for the first three (3) weeks of employment followed bythe compliance check noted above for all "experienced" staff. If services are being provided outsideexisting orders, the clinician will be contacted by supervisory staff withinstructions. Continued behavior outside of existing orders will result inprogressive disciplinary action. Responsibility: Clinical Director/Alternate Clinical Director	

	the necessary services. c. Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan ... e. Informs the physician and other personnel of changes in the patient condition and needs ..." 3. A review of the agency's undated policy, 'CLINICAL DOCUMENTATION C-680,' revealed, 'POLICY Agency will document each direct contact with the patient ... PURPOSE To ensure that there is an accurate record of the services provided, patient response and ongoing need for care. To document conformance with the Plan of Care, modifications to the plan, and interdisciplinary involvement. SPECIAL INSTRUCTIONS ... 3. Additional information that is pertinent to the patient's care or condition may be documented on the Communication Note in hard copy and/or electronic chart. 4. Telephone or other communication with patients, physicians ... will be documented in electronic patient chart ... 6. Services not provided and the reason for the missed visits will be documented and reported to			

the physician, an order will be requested if necessary ..."

4. A review of the clinical record of Patient 2, with the start of care date of 8/16/22, evidenced the clinical record contained a 'Home Health Certification and Plan of Care,' dated 8/24/22, for the certification period of 8/16/22 to 10/14/22, that revealed Patient 2 was to receive "SN (Skilled nursing) 2 times a week for 1 week, then 3 times a week for 8 weeks to ... Perform wound vac (vacuum-assisted closure of a wound is a type of therapy to help wounds heal) dressing change using black foam kit, remove old dressing, cleanse area with NS (normal saline), apply skin prep to peri-wound, frame wound bed, pack with foam, cover with vac dressing, apply suction, using at 125mmHg, change canister weekly or PRN (as needed)...Measure wound minimum of weekly... "

A review of Patient 2 Clinical Note for 9/7/22 revealed, Former RN 14 documented, "Pt. [sic patient] discussed going on vacation, 9/18/22, and would like to have wound resolved ...

Will contact MD Wednesday for possible orders for her wound and vacation."

A review of Patient 2 Clinical note for 9/12/22 revealed, Former RN 14 documented, "... Will contact MD as patient is vacationing Friday until the 26th and does not want to carry wound vac if possible. Patient would like a dressing in place of vac. [Family] taught how to change dressing if needed.'

A review of Patient 2 Clinical note for 9/14/22 revealed, Former RN 14 documented, "...Will contact MD as patient is vacationing Friday until the 26th and does not want to carry wound vac if possible. Patient would like a dressing place of vac. Doctor to contact RN at 3 pm with wound decision. [sic Family] taught how to change dressing if needed. Demonstrates ability."

A review of Patient 2 Clinical note for 9/16/22 revealed, Former RN 14 documented ... writer made sure client felt comfortable with still having wound vac on during vacation ... a book bag was given ... to

during their vacation ..."

The Clinical Record failed to evidence the plan of care was updated with physician orders for teaching the family to change Patient 2's wound vac dressing, orders for a change of frequency of care visits, and placing the patient on hold while on vacation.

5. During a phone interview on 1/26/23 at 12:19 with RN 16 from Entity 15, they stated they didn't find out the patient had gone on vacation, and the family had been performing wound care until 10/10/22 when Former RN 14 had phoned to inform them.

6. During a phone interview with on 1/26/23 at 2:31 PM with Former RN 14, stated that they expected the former administrator to obtain physician orders for teaching family wound vac dressing changes and to make necessary changes to the Plan of Care for change in visit frequencies, changes in supplies, and placing Patient 2's skilled nursing visits on hold while on vacation.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy Little	Alt Administrator/Alt Clinical Supervisor	2/24/2023 11:24:18 AM