STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157634	A. BUILDING B. WING	05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Home Health Care Services Inc	2711 W LINCOLN HIGHWAY, 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
G0000	INITIAL COMMENTS This survey was a 2nd Post Condition Revisit Survey of a home health agency. Survey Dates:05/18/2023-05/23/2023 Facility ID: 012486 Census: 30 12 month unduplicated skilled patients census: 83 9 standards were corrected, 2 new standards are cited, 14 standards were recited, one Condition of Participation 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care was corrected. This deficiency report reflect State Findings cited in accordance with 410 IAC 17.	G0000	G0000 Sunrise Home Health Care Service is submitting the followingPlan of Correction in response to the 2567 issued by ISDH and/or CMS as it isrequired to do by applicable state and federal regulations. The submission ofthis Plan of Correction is not intended as an admission, does not constitute anadmission by and should not be construed as an admission by Sunrise Home HealthCare Service that the findings and allegations contained herein are accurateand true representations of the quality of care and services provided topatients of the Agency. Sunrise Home Health Care Service desires this Plan ofCorrection to be considered our Allegation of Compliance.”	

G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Deficiency corrected 04/21/2023 corrected 04/21/2023	G0570	Deficiency corrected 4/21/23	2023-05-23
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a	G0572	G0572 Director of Nursing willin-service clinicians on requirement to do a complete assessment, ensureinterventions on plan of care reflect assessed needs and visit documentationreflects interventions/teaching and is accurate. If during visit	2023-06-22

	patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to provide services as ordered in the plan of care in 4 of 6 clinical records reviewed. (Patient #2, #3, #5, #6) The findings include: X. Review of the plan of care for Patient #3, certification period 3/14/2023 to 5/12/2023, indicated the patient was to receive 2 physical therapy visits per week. Clinical record review evidenced only one physical therapy visit took place on the week of 4/30/2023 to 5/6/2023. A missed visit was documented on 5/3/2023. During an interview on 5/22/2023 at 11:01 AM, PT (physical therapist) 1 indicated if a visit is missed, the therapist should try to re-schedule it or get another PT or PTA (physical therapy assistant) to cover it. #. Clinical record review for patient #2, on 05/19/2023, evidenced an agency document		assessment adiscrepancy is noted (from what is on plan of care) clinician is to discusswith patient and notify MD. 6/20/23 Director of Nursing willaudit all current patient charts to ensure assessments are complete and have appropriateinterventions as based on assessments. Any patient whose plan of care doesn'treflect appropriate interventions based on assessment an MD order will beobtained to revise plan of care. 06/22/23 Director of Nursing/designee willaudit all assessments and plans of care submitted weekly to ensure assessmentis complete and interventions on plan of care reflect the assessed need. Allvisit notes submitted weekly will be reviewed to ensure they reflectinterventions on plan of care. If there are discrepancies noted there is to bedocumentation MD was notified. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) Director of Nursing willin-service clinicians that if a visit is missed there is to be	

	Certification and Plan of Care," for certification period 04/29/2023-06/27/2023 which indicated physical therapy visits 2 times per week for 8 weeks. Review of an agency document dated 05/04/2023, titled, "Missed Visit Form (PT [physical therapy] Visit)," indicated the patient/caregiver refused the visit. Review failed to evidence an attempt to reschedule to visit was completed. Review of an agency document dated 05/11/2023, titled, "Missed Visit Form (PT Visit)," indicated the patient cancelled the physical therapy visit and was rescheduled for 05/15/2023. Review failed to evidence the physical therapy visit was completed on 05/15/2023. During an interview on 05/22/2023, at 4:00 PM, the administrator indicated clinicians should attempt to reschedule missed visits and the reschedule patient did not have the rescheduled visit completed. 1. Review of an agency policy revised 05/2023, titled "Plan of Care" stated, "... Home care		documentationclinician tried to reschedule the visit for later in week. 6/20/23 Director of Nursing/designeewill review all missed visit reports submitted weekly to ensure there isdocumentation agency attempted to reschedule visit for later in week. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) The Administrator will be responsible for monitoringthese corrective actions to ensure that this deficiency is correct	

	services are furnished under the supervision and direction of the client's physician/allowed non-physician practitioner ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided...." 2. Clinical record review on 5/18/2023, for Patient #5, evidenced agency documents titled "PT [physical therapy] Re-Evaluation" dated 4/4/2023 and 4/25/2023, which failed to evidence the PT assessed the patient's ability to climb stairs. Review indicated the PT treatment plan included, but was not limited to, transfer training and balance training. Review failed to evidence the PT interventions included stair training. Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/1/2023-6/29/2023, which indicated the skilled nurse was to assess all body systems. Review indicated the patient used a shoulder immobilizer to the right arm due to right pain from arthritis causing limited			

	patient used oxygen at 2 liters per minute. Review indicated the skilled nurse was to educate the patient and caregiver on bleeding precautions. Review of agency nursing visit notes completed by the licensed practical nurse and dated 5/2/2023 and 5/9/2023, failed to include the assessment of the right arm, the use of the right arm immobilizer, and the education of the patient/caregiver on bleeding precautions. Review of document dated 5/2/2023, indicated the patient's oxygen was delivered at a rate of 3 liters per minute and failed to evidence the oxygen amount was provided per the plan of care. Review of agency physical therapy assistant (PTA) visit notes indicated PTA #2 completed stair training with the patient on documents dated 4/25/2023, 5/1/2023, 5/2/2023, 5/9/2023, and 5/11/2023. Review of documents dated 5/1/2023, 5/2/2023, 5/9/2023, and 5/11/2023, failed to evidence the PTA completed transfer and balance training as directed in the plan of care.			

	Review failed to evidence the PTA provided services as directed in the plan of care. During an interview on 5/19/2023, at 11:28 AM, the administrator indicated the oxygen should be delivered per the plan of care or the physician should be contacted to clarify the order. At 11:37 AM, the administrator indicated the skilled nursing visits did not include an assessment of the musculoskeletal system to include the use of the right arm immobilizer. The administrator indicated the circulation, movement, sensation, pulse, and skin should be assessed to the right arm. At 11:50 AM, the administrator indicated the skilled nurse was to do all education interventions at every visit unless the patient cognitively understood the education. At 12:28 PM, the administrator indicated the PTA should not be performing stair training if it was not assessed by the PT and included in the plan of care. During an interview on 5/19/2023, at 10:39 AM, PT #1 indicated the PT plan of care			

	indicated the PTA was not supposed to do stair training for the patient and the PT did not evaluate the patient for stair training. During an interview on 5/22/2023, at 10:50 AM, PT #1 indicated the interventions provided by the PT and the PTA were documented in the narrative section of the document. 3. Clinical record review on 5/19/2023, for Patient #6, evidenced an agency document titled "PT Evaluation" completed by PT #1 and dated 4/17/2023, indicated the PT interventions included transfer training. Review of agency documents titled "PT Visit" dated 5/3/2023, 5/8/2023, and 5/15/2023, failed to evidence transfer training was performed. 4. During an interview on 5/19/2023, at 10:39 AM, PT #1 indicated the PT plan of care was the PT evaluation. 5. During an interview on 5/22/2023, at 10:00 AM, PT #1 indicated the therapists do not have time to do all the interventions in the plan of care			

	at every visit. At 10:50 AM, PT #1 indicated the interventions provided by the PT and the PTA were documented in the narrative section of the document.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge;	G0574	G0574 Director of Nursing will in-service clinicians onrequirement for plan of care to be individualized to patient to includepatient-specific interventions and measurable outcomes and goals, completemedication orders, and all pertinent diagnoses. There must be MD orders forinterventions implemented. 6/20/23	2023-06-20

	(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure the plan of care was individualized to include patient-specific interventions and measurable outcomes and goals, complete medication orders, and all pertinent diagnoses in 3 of 4 clinical records reviewed with physical therapy services. (Patient #2, #3, #4, #5, #6) The findings include: X. Review of the plan of care for Patient #3, certification period 3/14/2023 to 5/12/2023, evidenced a primary diagnosis of Hypertension (a condition in which the blood vessels have persistently raised pressure). Review of the plan of care failed to evidence interventions or goals related to hypertension.		Director of Nursing will audit all current patient plans ofcare to ensure they are individualized to each patient and includepatient-specific interventions and measurable outcomes and goals, completemedication orders, and all pertinent diagnoses.Clinician will contact MD for anorder to revise plan of care for any patient whose plan of care doesn't havethe required information. Director of Nursing/designee will audit all plans of caresubmitted weekly to ensure they are individualized to patient to includepatient-specific interventions and measurable outcomes and goals, completemedication orders, and all pertinent diagnoses. There must be MD orders forinterventions implemented. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to	

	The plan of care failed to evidence interventions corresponding to the skilled nurse goals of the patient remaining cooperative with care and participating in activities in the group home. During an interview on 5/22/2023 at 3:15 PM, the administrator indicated the plan of care failed to evidence specific nursing interventions and goals related to hypertension as well as interventions corresponding to the nursing goals listed. X. Review of the plan of care for Patient #4, certification period 3/14/2023 to 5/12/2023, indicated the patient was taking Ipratropium-Albuterol (a medication that helps make breathing easier), but failed to evidence the route for how the patient took the medication. Review of skilled nurse visit notes dated 4/21/2023, 4/27/2023, and 5/5/2023 evidenced the patient complained of right shoulder pain. Review of physical therapy visit notes dated 4/21/2023, 4/25/2023, 5/2/2023, 5/4/2023, and		corrected and will notrecur.	

	5/9/2023 evidenced the patient complained of right shoulder pain. Review of the plan of care failed to evidence pain as a patient problem. During an interview on 5/22/2023 at 10:45 AM, the administrator indicated pain was a problem for Patient #4, and the plan of care should include nursing interventions for pain. # Record review of an agency policy dated 04/2023, titled, "Therapy Services," indicated physician orders will be obtain for the kind, type and intensity of therapy services, after the assessment, the therapist will communicate specific treatments and modalities to be used. The therapist will participate in implementing the physician's plan of care and evaluating client progress. #. Clinical record review for patient #2 on 05/19/2023, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 04/29/2023-06/27/2023, which indicated the patient diagnosis included hypertension,			

	hyponatremia, shortness of breath, urinary tract infection, diarrhea, elevated white blood cell count, dermatophytosis, cellulitis, anemia, obesity, hypothyroidism and low back pain. Review indicated the patient was taking the medication Xarelto (blood thinner). Review failed to evidence a diagnosis on the plan of care for the use of Xarelto. During an interview on 05/22/2023, at 2:45 PM, the administrator indicated the diagnosis on the plan of care are based on encounter notes from the physician and the plan of care should include a diagnosis for the Xarelto. During an interview on 05/23/2023, at 9:45 AM, the administrator indicated he/she had spoke to the patient's primary physician and the diagnosis for the Xarelto use was for the patient's history of blood clots to the lung and legs. Review failed to evidence the patient had a physical therapy plan of care.			

	Review evidenced patient had a physical therapy visit on 04/21/2023, 04/27/2023, 04/28/2023, 05/02/2023, 05/16/2023, 05/17/2023, and 05/18/2023. Review evidenced agency documents titled, "PT Visit," dated 04/21/2023, 05/10/2023, 05/17/2023, and 05/18/2023 which indicated physical therapy included range of motion, bed mobility training, transfer and gait training, and balance training with theraband resistance. Review evidenced an agency document dated 04/28/2023, titled "PT [physical therapy] Re-Evaluation" which failed to evidence the patient's home exercise program plan. During an interview on 05/19/2023, at 11:48 AM, the administrator indicated the physical therapy plan of care included the physical therapy evaluation, nursing plan of care and physician orders. During an interview on 05/22/2023, at 3:16 PM, physical therapist 4 indicated the physical therapy			

patient's home exercise program. Physical therapist 4 texted on 05/24/2023, that the physical therapy plan of care was added to the patient's chart.

1. Review of an agency policy revised 05/2023, titled "Plan of Care" stated, "... An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services ... The Plan of Care shall be completed in full to include: ... Patient-specific interventions ... measurable outcomes and goals ... Patient specific goals must be individualized to the patient based on the patient's medical diagnosis or diagnoses ... The individualized Plan of Care must specify the care and services necessary to meet patient specific needs as identified in the comprehensive assessment..."

2. Clinical record review on 5/18/2023, for Patient #5, evidenced agency documents

	Re-Evaluation" dated 4/4/2023 and 4/25/2023, which indicated the patient was at a high risk of falls and had a history of falls. Review indicated PT was to perform therapeutic exercises and failed to evidence to which extremities therapeutic exercises were to be performed. Review indicated the patient required minimum assistance for sit to stand transfers, bed to wheelchair transfers, toilet transfers, tub/shower transfers, and car transfers. Review failed to evidence the plan of care included what transfers were to be included in the transfer training. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 5/1/2023-6/29/2023, indicated the patient's primary diagnosis was sarcoidosis (an inflammatory disease primarily affecting the lungs and lymph nodes). Review failed to evidence the plan of care was individualized to include goals related to the primary diagnosis. Review indicated the patient used oxygen at 2 liters per minute. Review failed to			

	included goals related to the patient's oxygen use and respiratory status. Review indicated the agency was to provide home health aide services 1 time a week and failed to evidence the plan of care included goals related to the home health aide services. Review failed to include goals related to the patient's high risk and history of falls. During an interview on 5/19/2023, at 11:20 AM, the administrator indicated the same concern related to goals for the primary diagnosis was mentioned at the last survey and goals were interchangeable and should be based on comprehensive assessment. The administrator indicated the plan of care did not include goals related to the oxygen use. The administrator indicated a goal related to home health aide services was that personal care would be completed. At 12:21 PM, the administrator indicated the plan of care should include goals related to the patient's high risk of falls. During an interview on 5/19/2023, at 10:08 AM, PTA #2 indicated he/she provided			

	therapy services to the patient and had not done tub/shower transfers with the patient, sometimes did toilet transfer training, and one time did car transfer training. PTA #2 indicated the interventions provided to the patient at each visit were based on what the PTA felt the patient needed that visit. During an interview on 5/19/2023, at 10:39 AM, PT #1 indicated the PT plan of care was the PT evaluation and upper extremities should not be performed. 3. Clinical record review on 5/19/2023, for Patient #6, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/17/2023-6/15/2023, which indicated the patient's primary diagnosis was diabetes (a chronic condition which affects the way the body processes blood sugar). Review indicated the patient had neuropathy (damage to the nerves often caused by diabetes) with numbness in her hands and feet. Review indicated the			

	were not limited to, the patient was to improve circulation in extremities. Review failed to evidence the goal was measurable. During an interview on 5/22/2023, at 10:40 AM, the administrator indicated the goal should be measured by checking circulation and edema (swelling). Review of an agency document titled "PT Evaluation" completed by PT #1 and dated 4/17/2023, indicated the goals included, but were not limited to, strengthening lower extremities. Review indicated the PT interventions included therapeutic exercises and failed to evidence to which extremities therapeutic exercises were to be performed. Review indicated the patient required minimal assistance with sit-to-stand transfers, stand-to-sit transfers, bed-to-wheelchair transfers, wheelchair-to-bed transfers, toilet transfers, tub/shower transfers, and car transfers. Review indicated the PT goals included, but were not limited to, patient will demonstrate safe transfers. Review failed to evidence the interventions			

included what transfer training was to be performed. Review indicated the goals included, but were not limited to, improved standing balance. Review indicated the PT interventions included balance training but failed to specify what type of balance training was to be performed.

Review of agency documents titled "PT Visit" dated 5/3/2023 and 5/15/2023, indicated sitting balance training was performed but failed to evidence standing balance was performed as identified as a PT goal.

During an interview on 5/22/2023, at 10:10 AM, the administrator read the scope of practice for physical therapists and indicated transfer training was within the scope of the PT to make the determination on what the patient needed.

During an interview on 5/22/2023, at 10:50 AM, PT #1 indicated the plan of care is based on the patient-specific assessment. PT #1 indicated the PT can make the determination to change what interventions are performed with the patient as the patient improves.

	4. During an interview on 5/22/2023, at 10:00 AM, PT #1 indicated therapeutic exercises need to be specified in the plan of care.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the agency failed to ensure services and treatments were administered only as ordered by a physician in 1 of 2 clinical record reviews with physical therapy assistant (PTA) services. (Patient #6) The findings include: Review of an agency policy revised 09/2019, titled "Physician Orders" stated, "... All medications, treatments and services provided to clients must be ordered by a	G0580	G0580 Director of Nursing will in-service clinicians that servicesand treatments are to be administered as ordered by MD. There must bedocumentationclinician contacted provider to obtain an order. 6/22/23 Director of Nursing will audit all visit notes submittedweekly to ensure documented services and treatments are being provided asordered. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring	2023-06-22

	physician…." Clinical record review on 5/18/2023, for Patient #6, evidenced an agency document titled "Plan of Care Addendum" dated 3/24/2023, which indicated the patient was to wear a right shoulder immobilizer during waking hours and to remove for ambulation. Review of an agency document titled "PTA Visit" completed by PTA #2 and dated 5/9/2023, indicated the PTA completed upper extremity exercises using pulleys the patient had in the home. Review of an agency document titled "Plan of Care Addendum" signed by the clinical manager and dated 5/9/2023, indicated the physical therapist instructed the use of pulleys to aid in increasing range of motion to both shoulders and decreasing pain. Review indicated the patient's physician on the plan of care addendum was Person #1 (nurse practitioner). Review failed to evidence documentation of the communication with the		thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	was received for the use of pulleys. Review indicated Person #2 (physician) signed the document on 5/11/2023. During an interview on 5/19/2023, at 10:08 AM, PTA #2 indicated she did not receive an order from the physician or directions from the PT for the pulley exercises. PTA #2 indicated he/she initiated the pulley exercises for upper extremity exercises because the patient had the pulleys in the home. PTA #2 indicated the patient did wear an immobilizer to the right arm for pain to the shoulder. During an interview on 5/19/2023, at 10:39 AM, physical therapist (PT) #1 indicated the patient did wear an immobilizer to the right arm due to severe pain in the right shoulder and he/she was the supervising PT. PT #1 indicated he/she was unaware of pulley exercises completed by the PTA. During an interview on 5/19/2023, at 12:35 PM, the administrator indicated he wrote the plan of care addendum when he saw the note from the PTA related to			

	the use of the pulleys and then sent the order to the physician. The administrator indicated he did not contact the physician for the order but sent the plan of care addendum document to the physician to communicate the use of the pulleys to the physician. 17-13-1(a)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to notify the physician of changes in the patient's status in 2 of 2 clinical records reviewed with physical therapy assistant (PTA) or licensed professional nurse (LPN) services. (Patient #4, #5) The findings include: X. Review of a LPN (licensed practical nurse) visit note dated 5/5/2023 evidenced Patient #4	G0590	G0590 Director of Nursing will in-service clinicians onrequirement to promptly alert the relevant physician(s) or allowedpractitioner(s) to any changes in the patient's condition or needs that suggestthat outcomes are not being achieved and/or that the plan of care should bealtered. 6/22/23 Director of Nursing/designee will audit all visit notessubmitted weekly to ensure if there is documentation indicating a change inpatient condition or anything that suggests outcomes are not being achievedand/or the plan of care should be altered there is	2023-06-22

	complained of not had a bowel movement in 3 or 4 days. Clinical record review failed to evidence physician notification of the patient's complaint. During an interview on 5/23/2023 at 10:18 AM, the administrator indicated the nurse should have notified the physician of the patient's complaint and documented the communication in the visit note. Review of an undated agency policy on 5/23/2023, titled "Medical Supervision" stated, "... Physician will be contacted when any of the following occurs: ... Any change in client condition ...." Clinical record review on 5/18/2023, for Patient #5, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/1/2023-6/29/2023, which indicated the patient used a shoulder immobilizer to the right arm due to right pain from arthritis causing limited mobility. Review of an agency document titled "PT [physical therapy] Re-Evaluation" completed by		documentation MD wasnotified. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	the PT and dated 4/25/2023, indicated the patient had pain to the right shoulder was assessed to be 3 on a scale on a scale of 1-10. Review of agency documents titled "PTA Visit" completed by PTA #2, indicated the patient's pain to the right shoulder was assessed to be 5 on a scale of 0-10 on 5/1/2023, 6 on a scale of 0-10 on 5/2/2023, 6 on a scale of 0-10 on 5/9/2023, and 7 on a scale of 0-10 on 5/11/2023. Review failed to evidence the physician was notified of the increased pain to the right shoulder. During an interview on 5/19/2023, at 12:43 PM, the administrator indicated he could not find any documentation the physician had been notified of the increased pain.			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination	G0606	G0606 Director of Nursing will in-service clinicians they are tointegrate services to assure the identification of patient needs and factorsthat could affect patient safety and	2023-06-22

	of care provided by all disciplines. Based on record review and interview, the agency failed to integrate services to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care between the physical therapy assistant (PTA) and physical therapist (PT) and nursing staff in 2 of 5 clinical records reviewed with PT services. (#2, #6) The findings include: Review of an undated agency policy on 5/23/2023, titled "Coordination of Client Services" stated, "... Involvement of the care team must be apparent in the record ... How and when communication happens must be documented ... The agency will identify a communication system to assure that all disciplines and departments are informed of changes to plan and/or need for modifications...." Clinical record review on 5/18/2023, for Patient #6, evidenced an agency document titled "Plan of Care Addendum" dated 3/24/2023, which indicated the patient was to		treatment effectiveness and thecoordination of care between disciplines and MD.6/22/23 Director of Nursing will in-service clinicians onrequirement to follow plan of care and to notify supervising RN/therapistand/or MD of any change in patient condition.6/22/23 Director of Nursing/designee will audit all visit notessubmitted weekly to ensure care documented follows plan of care and if there isdocumentation of a change in patient condition there is documentation thesupervising RN/therapist and /or MD was notified. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) Physical therapist will conduct a weekly meeting (in personor via phone) with physical therapy assistant to discuss patient plan of careand any concerns. After 4 weeks thismeeting will be done monthly and anytime there are concerns with patient or achange in plan of care. (On-going)	

	wear a right shoulder immobilizer during waking hours and to remove for ambulation. Review of an agency document titled "PTA Visit" completed by the PTA and dated 5/9/2023, indicated the PTA completed upper extremity exercises using pulleys the patient had in the home. During an interview on 5/19/2023, at 10:08 AM, PTA #2 indicated she did not receive an order from the physician or directions from the PT for the pulley exercises. PTA #2 indicated he/she initiated the pulley exercises for upper extremity exercises because the patient had the pulleys in the home. When queried why the pulleys would be used when a physician order for the immobilizer to be used during waking hours and removed for ambulation, PTA #2 stated, "The immobilizer order says that?" During an interview on 5/19/2023, at 10:39 AM, PT #1 indicated he/she was the supervising PT, was unaware of pulley exercises completed by the PTA, and was not informed		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	by the PTA of pulley exercises initiated with the patient. During an interview on 5/19/2023, at 12:38 PM, the administrator indicated the PTA should communicate changes to the PT. 1. Record review of an undated agency policy received on 05/23/2023, titled, "Medical Supervision," indicated the agency responsibilities include promptly reporting a change in the client condition. 2. Record review of an undated agency policy received on 05/23/2023, titled, "Coordination of Client Services," indicated the coordination of care is provided by all disciplines and included communication with physicians. The policy indicated the purpose is to coordinate care delivery to meet individual client needs and to provide the attending physician with an ongoing assessment of the client and identify the client's response to services provided. 3. Record review of an agency policy dated 02/2023, titled,			

	"Contract Personnel," indicated contract personnel shall report any significant changes in a client's condition or response to treatment or therapy immediately to the Director of Clinical Services or Nursing Supervisor and the client's physician. 4. Clinical record review on 05/19/2023, for patient #2 evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 04/29/2023-06/27/2023, which indicated patient had a history of falls (2 or more falls, or any falls with an injury, in the past 12 months). Review evidenced agency documents dated 05/10/2023, 05/17/2023, and 05/18/2023, titled, "PT [physical therapy] Visit," which indicated patient complained of slight dizziness after getting up from the chair and that the dizziness subsided after a while. Review failed to evidence the physical therapist notified the agency or clinical manager of the patient's complaints of dizziness.			

	During an interview on 05/22/2023, at 3:16 PM, physical therapist 4 indicated the patient would complain of dizziness after getting out of the shower and the therapist indicated he did not report the dizziness to the agency or clinical manager because the dizziness subsided during the visit. During an interview on 05/22/2023, at 3:25 PM, the administrator indicated the agency and physician should be notified of patient complaints of dizziness during physical therapy.			
G0652	Activities lead to an immediate correction 484.65(c)(1)(iii) (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Based on record review and interview, the home health agency failed to ensure the performance improvement activities led to an immediate correction of any identified problems that directly or potentially threaten the health and safety of patients.	G0652	G0652 Administrator will in-service Director of Nursing onrequirement for agency to implement an immediate corrective action plan for anyarea monitored for QAPI that has a reported incident. 6/9/23 Administrator/Director of Nursing will ensure that areasmonitored as part of QAPI that have reported incidents the agency implements	2023-06-09

	Findings include: Record review evidenced an undated agency policy received on 05/23/2023, titled, "Quality Assessment and Performance Improvement (QAPI)" which indicated the purpose of the QAPI was to use performance improvement activities to track adverse client events, analyze their causes and implement preventive actions and to measure agency success and ensure that improvements are sustained. The policy indicated the scope of the QAPI program will be capable of showing measurable improvement in indicators that will improve health outcomes, client safety, and quality of care and the agency will identify, measure, analyze, and track quality indicators that include client adverse events, and other relevant data to assess processes of care, services, and operations. Review of incident reports indicated 4 patient falls in March 2023. Review of incident reports indicated 4 patient infection		animmediate corrective action plan for those issues. (On-going) Administrator/Director of Nursing will in-service clinicianson any corrective action plan(s) that are to be implemented as a result of theQAPI program. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	since 03/23/2023. Review of hospitalizations indicated 8 patient transfers since 01/2023. Review failed to evidence the QAPI activities led to an immediate correction of identified problems that directly threaten the health and safety of patients. During an interview on 05/22/2023, at 11:18 AM, the administrator indicated the agency was only tracking falls and infections and did not implement an immediate correction for the identified problems. 410 IAC 17-12-2(a)			
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations.	G0658	G0658 Administrator will ensure agency's QAPI program documentsthe reason for conducting the performance improvement project and themeasurable progress achieved on these projects. (On-going) Administrator will in-service Director of Nursing	2023-06-09

	(2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview the home health agency failed to document the quality improvement project reason for conducting the project and the measurable progress achieved on these projects. Findings include: Record review evidenced an undated agency policy received on 05/23/2023, titled, "Quality Assessment and Performance Improvement (QAPI)," which indicated the performance improvement project must document the quality improvement projects taken, the reasons for conducting these projects and the measurable progress achieved on these projects. Review of agency's QAPI binder on 05/21/2023, failed to evidence the reason the performance improvement project was conducted, and the measurable progress achieved on these projects. During an interview on 05/22/2023, at 11:18 AM, the		onrequirement for QAPI program to indicate the reason for conducting theperformance improvement project and the measurable progress achieved on theseprojects. 6/9/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	administrator indicated the reason for the performance improvement project was not documented and did not have correction rate for measurable goals documented.			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review and interview, the home health agency failed to ensure all staff followed standard precautions, to prevent the transmission of infections and communicable disease in 1 of 1 home visits. (Patient #1) Findings include: Record review of an undated agency policy received on 05/23/2023, titled, "Infection Prevention/Control," indicated equipment used for client care was to be properly cleaned. Record review of an undated agency document received on	G0682	G0682 Director of Nursing will in-service all clinicians onstandard precautions to include proper cleaning of equipment. 6/20/23 Director of Nursing will ensure all clinicians receivetraining annually and anytime there is an issue on standard precautions.(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2023-06-20

	"Competency Evaluation Supply Bag Technique," indicated performance criteria included, but was not limited to, equipment cleansed prior to returning to bag. During an observation of a home visit for patient #1 on 05/19/2023, from 1:15 PM-1:40 PM, home health aide #1 used a wrist blood pressure machine to take the patient's blood pressure and returned the blood pressure machine to the supply bag without cleaning. During an interview on 05/22/2023, at 11:30 AM, the administrator indicated home health aide #1 should have cleansed the equipment prior to returning to the supply bag. 410 IAC 17-12-1(m)			
G0686	Infection control education 484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). Based on record review and interview, the agency failed to provide infection control education	G0686	G0686 Director of Nursing will audit all current employee files.Any employee who doesn't have documentation of infection control training inpast 12 months will receive infection control education. This will includeeducation on hand hygiene. This education is to be	2023-06-20

	to staff for 1 of 3 active physical therapists (PT) employed by the agency. (PT #3) The findings include: Review of an undated agency document on 5/23/2023, titled "Infection Control Education/Training" stated, "... For each twelve (12) months of employment, all employees and contractors who have contact with the clients in the clients' residence shall complete in-service training about infection control practices to be used in the home ... Training records will include dates, contents of the training sessions ...." Review of in-service records on 5/18/2023, failed to evidence PT #3 received in-service training for infection prevention and control in the last 12 months. During an interview on 5/18/2023, at 12:14 PM, the alternate administrator indicated training was provided by staff reading the policy attached to the sign-in sheet. Review of an untitled agency document on 5/18/2023,		documented in employee file.6/20/23 Director of Nursing will ensure all clinicians receiveinfection control education annually and anytime there is a concern. Thiseducation will be documented in employee file. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	identified as the in-service record for Infection Control by the administrator, had an attached policy to the in-service sign-in sheet titled "Infection Control Plan". Review of the policy indicated the plan would include staff education to infection prevention to include hand hygiene. Review failed to evidence the in-service included material regarding hand hygiene. During an interview on 5/18/2023, at 12:14 PM, the alternate administrator indicated there was additional training to include infection control that clinical staff took on a computer program, and the alternate administrator indicated there was no infection control training through the computer program for PT #3, because she overlooked assigning the training to PT #3.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the physical therapist	G0716	G0716 Director of Nursing will in-service clinicians onrequirement to ensure their documentation is accurate and complete. Thisincludes date of visit, safety precautions and MD	2023-06-20

	(PT) failed to prepare clinical notes accurately in 1 of 3 clinical records reviewed with a PT. (Patient #5) The findings include: Review of an undated agency policy on 5/23/2023, titled "Skilled Professional Services" stated, "... Skilled professionals must assume responsibility for, but not be restricted to the following: ... Preparing clinical notes...." Clinical record review on 5/18/2023, for Patient #5, of an agency document titled "Home Health Certification and Plan of Care" for certification period 3/2/2023-4/30/2023, indicated the patient used oxygen at 2 liters per minute. Review evidenced an agency document titled "PT Re-Evaluation" completed by PT #1 and dated 4/25/2023, which failed to evidence the PT prepared the document accurately to include oxygen precautions in the assessment of safety precautions. Review indicated the patient had a physician appointment next		appointments. 6/20/23 Director of Nursing/designee will audit all documentationsubmitted weekly to ensure it is complete and accurate. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

week related to increased shoulder pain.

Review evidenced an agency document titled "Time Log Work Sheet" signed by the patient and PT #1 and dated 4/28/2023, which indicated the PT re-evaluation was completed on 4/28/2023 and not 4/25/2023. Review failed to evidence the PT prepared the clinical note accurately for the date of the PT re-evaluation.

During an interview on 5/19/2023, at 12:21 PM, the alternate administrator indicated the date the visit was completed should be the date entered on the visit note and indicated the PT must have made a mistake on the document since the time log was signed by the patient for a visit completed on 4/28/2023.

During an interview on 5/19/2023, at 12:28 PM, the administrator indicated oxygen precautions should have been included in the re-evaluation document by the PT in the assessment of the patient's safety precautions.

During an interview on 5/22/2023, at 10:50 AM, PT #1

	indicated the documentation on 4/25/2023 regarding a physician appointment the following week was a carry-over from a previous note and was not accurate. 410 IAC 17-14-1(c)(5)			
G0728	Rehab services supervised by PT, OT 484.75(c)(2) Rehabilitative therapy services are provided under the supervision of an occupational therapist or physical therapist that meets the requirements of §484.115(f) or (h), respectively. Based on record review and interview, the physical therapist (PT) failed to provide supervision of the physical therapy assistant in 1 of 2 clinical records reviewed with PTA services. (Patient #5) The findings include: Review of an undated agency policy on 5/23/2023, titled "Clinical Supervision" stated, "... On-site supervision of clients receiving services will be performed by a Registered Nurse/Therapist to direct,	G0728	G0728 Director of Nursing will in-service therapists they are toreview visit notes for physical therapy assistants as part of their supervisionto ensure they are following plan of care. 6/22/23 Director of Nursing will audit all visit notes submitted weeklyto ensure plan of care is being followed. If a therapy plan of care isn't beingfollowed supervising therapist will be notified and therapist will speak withphysical therapy assistant to discuss plan of care and requirement to followplan of care. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) Director of Nursing will	2023-06-22

	implementation of the Plan of Care and the delivery of services ...." Clinical record review on 5/18/2023, for Patient #5, evidenced agency documents titled "PT Re-Evaluation" dated 4/4/2023 and 4/25/2023, which failed to evidence the PT assessed the patient's ability to climb stairs. Review indicated the PT treatment plan included, but was not limited to, transfer training and balance training. Review failed to evidence the PT interventions included stair training. Review of agency PTA visit notes indicated PTA #2 completed stair training with the patient on documents dated 4/25/2023, 5/1/2023, 5/2/2023, 5/9/2023, and 5/11/2023. Review of documents dated 5/1/2023, 5/2/2023, 5/9/2023, and 5/11/2023, failed to evidence the PTA completed transfer and balance training as directed in the plan of care. Review of agency documents titled "PTA Visit" completed by PTA #2 and dated 5/9/2023 and 5/11/2023, indicated the PTA completed upper extremity		in-services physical therapiststhey are to supervise therapy assistants and document those visits. 6/20/23 Director of Nursing will audit all therapy supervisory notessubmitted weekly to ensure they are timely and complete. Once 100% is achieved10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	exercises using pulleys the patient had in the home. Review failed to evidence the PT provided supervision of the PTA regarding the failure to provide services as directed in the plan of care. During an interview on 5/19/2023, at 10:39 AM, PT #1 indicated the PT plan of care was the PT evaluation. PT #1 indicated the PTA was not supposed to do stair training for the patient and the PT did not evaluate the patient for stair training. PT #1 indicated he/she was the supervising PT for the patient, and he/she should review notes and then talk to the PTA if the plan of care was not followed. During an interview on 5/19/2023, at 12:45 PM, the alternate administrator indicated the PT should review the PTA notes and then re-educate the PTA if the plan of care was not followed. Requested information regarding the most recent PTA supervisory visit and no additional documentation or information was provided.			

	410 IAC 17-14-1(b)(1)			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the agency failed to provide the home health aides with complete, patient-specific written patient care instructions to be performed by the home health aides in 1 of 3 clinical records reviewed with home health aide services. (Patient #5) The findings include: Review of an agency policy revised 8/23/19, titled "Home Health Aide Care Plan" stated, "... A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse...."	G0798	G0798 Director of Nursing will in-service clinicians they areensure aide plans of care complete to include any precautions specific topatient, frequency of tasks to be performed. 6/22/23 Director of Nursing will audit all current aide plans ofcare to ensure they are complete and accurate. Any one that isn't will berevised accordingly. 6/22/23 Director of Nursing/designee will audit all aide plans ofcare submitted weekly to ensure they are complete and accurate. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2023-06-22

	Clinical record review on 5/18/2023, for Patient #5, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/1/2023-6/29/2023, which indicated the patient used oxygen at 2 liters per minute. Review of an agency document titled "Aide Care Plan" dated 5/1/2023, failed to evidence oxygen precautions were included in written instructions for the home health aide. Review indicated the registered nurse instructed the home health aide to complete foot care and oral care as needed and failed to provide directions for at what times the home health aide was to provide foot care and oral care.			

	During an interview on 5/19/2023, at 11:27 AM, the administrator indicated the home health aide should be aware of the patient's oxygen precautions. At 11:28 AM, the administrator indicated the directions to be included in the home health aide care plan were subject to interpretive guidelines and not black and white. 410 IAC 17-13-2(a)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on observation, record review, and interview, the home health aide failed to provide services as instructed by the registered nurse and included in the aide care plan in 2 of 4 records reviewed receiving home health aide services. (Patient #1, #4)	G0800	G0800 Director of Nursing will in-service aides they are followaide plan of care and only provide tasks listed. 6/22/23 Director of Nursing/designee will audit all aide notessubmitted weekly by comparing notes to aide plan of care to ensure plan is beingfollowed. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to	2023-06-22

	Findings include: Review of the aide care plan for Patient #4 for certification period 3/14/2023 to 5/12/2023 evidenced the aide was to perform the following tasks at every visit: light housekeeping, make bed, shampoo hair, assist in transfer, clean dentures, clean nails, and assist in ambulation. Review of home health aide notes dated 4/27/2023 and 5/11/2023 failed to evidence the aide did light housekeeping. Review of notes dated 4/14/2023, 4/24/2023, 4/27/2023, 5/2/2023, 5/5/2023, 5/9/2023 and 5/11/2023 failed to evidence the aide made the bed. Review of notes dated 4/14/2023, 4/17/2023, 4/21/2023, 4/24/2023, 4/27/2023, 5/2/2023, 5/5/2023, 5/9/2023 and 5/11/2023 failed to evidence the aide shampooed the patient's hair, assisted to transfer, cleaned dentures, cleaned nails, and assisted to ambulate. During an interview on 5/23/2023 at 10:36 PM, the administrator indicated the aide should complete tasks as assigned on the aide care plan. Record review evidenced an		corrected and will notrecur.	

	undated agency policy received on 05/23/2023, titled, "Home Health Aide Services," which stated, "... Home Health Aide Services may include: ... Obtaining client temperature, pulse, and respirations ... The nurse or therapist assesses the need for personal care services and includes the services in the physician plan of care (orders). A specific care plan is developed documenting the Aide services to be provided. The Aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising Nurse/therapist ... All services provided by the Home Health Aide shall be documented in the clinical record...." Clinical record for patient #1 evidenced an agency document titled, "Aide Care Plan," for certification period 05/12/2023-07/10/2023, indicated home health aide to provide vitals signs including pulse, respiration, and temperature every visit. During an observation of a home visit for patient #1 on 05/19/2023, from 1:15 PM-1:40			

	PM, home health aide 1 performed a blood pressure with a wrist blood pressure machine. Home health aide 1 indicated the blood pressure was 148/75. Review failed to evidence the aide care plan included blood pressure. During an interview on 05/22/2023, at 12:14 PM, the administrator indicated the home health aide should only complete the vitals signs as directed on the aide care plan. During an interview on 05/22/2023, at 2:34 PM, the administrator indicated home health aide 1 indicated a blood pressure was performed.			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the administrator failed to be responsible for all day-to-day operations of the agency in 1 of 4 records reviewed receiving home	G0948	G0948 Governing Body will meet to discuss with Administrator whatAdministrator's responsibilities are which include being aware of issues withdocumentation and plans of care not being followed. 6/9/23	2023-06-09

	health aide services (Patient #4). The findings include: Review of an undated agency policy titled "CLINICAL SUPERVISION" indicated the nursing supervisor will be responsible for the quality of care provided and supervision of all staff providing services, coordination of the day-to-day operation of the agency, and review client services to assure the delegation of tasks / assignments are appropriate. Review of the aide care plan for Patient #4 for certification period 3/14/2023 to 5/12/2023 evidenced the aide was to perform the following tasks at every visit: light housekeeping, make bed, shampoo hair, assist in transfer, clean dentures, clean nails, and assist in ambulation. Review of home health aide visit notes dated 4/27/2023 and 5/11/2023 failed to evidence the aide did light housekeeping. Review of notes dated 4/14/2023, 4/24/2023, 4/27/2023, 5/2/2023, 5/5/2023, 5/9/2023 and 5/11/2023 failed to evidence the aide made the bed. Review of notes dated 4/14/2023, 4/17/2023, 4/21/2023, 4/24/2023,		Administrator will meet with Director of Nursing weekly toreview issues noted during implementation of plan or correction or found duringaudits. This will be done weekly for one month. After that this meeting willoccur monthly and more often if needed. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	4/27/2023, 5/2/2023, 5/5/2023, 5/9/2023 and 5/11/2023 failed to evidence the aide shampooed the patient's hair, assisted to transfer, cleaned dentures, cleaned nails, and assisted to ambulate. Review of the home health aide visit notes dated 4/14/2023, 4/17/2023, 4/21/2023, 4/24/2023, 5/2/2023, and 5/9/2023 evidenced the patient's temperature was 98.1, respiratory rate was 20, and pulse was 80. Aide visit notes dated 4/27/2023, 5/5/2023, and 5/11/2023 evidenced the patient's temperature was 98, respiratory rate was 20, and pulse was 80. During an interview on 5/23/2023 at 10:36 PM, the administrator (who also functioned as clinical manager) indicated he was not aware the aide had not been providing care as instructed in the aide care plan. The administrator indicated he did not know why all of the vital signs were the same, and he had not reviewed the documentation himself to address the findings with the aide.			

	410 IAC 17-12-1(c)(1)			
G0960	Make patient and personnel assignments, 484.105(c)(1) Making patient and personnel assignments, Based on record review and interview, the clinical manager failed to provide clinical oversight of personnel assignments in 1 of 2 visit schedules for a home health aide (HHA). (HHA #1) The findings include: Review of an undated agency policy on 5/23/2023, titled "Clinical Manager" stated, "... The oversight provided by the clinical manager(s) includes: ... Making client and personnel assignments ...." Review of an agency document titled "Schedule for [HHA #1] for the week of 5/15/2023-5/19/2023, indicated the HHA was scheduled to provide a visit to Patient #7 on	G0960	G0960 Director of Nursing will in-service clinicians they are tonotify Director of Nursing/designee if they need to change the scheduled visitdate for a patient. 6/22/23 Director of Nursing will review all visit notes submittedweekly and compare to visit schedules to ensure they reflect when visits wereactually made. This will be done for a month. After a month 10% of visitschedules will be reviewed by comparing date on visit note to schedule toensure they match. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2023-06-22

	Review of the clinical record indicated HHA #1 completed visits on 5/16/2023 and 5/18/2023. Review indicated HHA #1 was scheduled to provide a visit to Patient #8 on 5/18/2023, and review of the clinical record indicated HHA #1 completed a visit on 5/19/2023. Review failed to evidence communication with the agency from HHA #1 regarding the change in the patient schedules. During an interview on 5/22/2023, at 11:29 AM, the clinical manager called HHA #1 on the phone who informed the clinical manager that Patient #7 had a funeral to attend on 5/15/2023 which changed the visits for that week. The clinical manager indicated HHA #1 informed the clinical manager that Patient #8 requested her visits be on Fridays instead of Thursdays as the reason why the visit was changed from what was scheduled. The administrator indicated staff should call the office to inform administrative staff of changes to their scheduled visits. The administrator indicated he was not aware of changes in the visit schedule for HHA #1.			

	410 IAC 17-14-1(a)(1)(K)			
N0000	Initial Comments This visit was a relicensure survey of a home health agency. This visit took place from 05/18/2023-05/23/2023 Facility ID: 012486 Census: 30	N0000	N000 Sunrise Home Health Care Service is submitting the followingPlan of Correction in response to the 2567 issued by ISDH and/or CMS as it isrequired to do by applicable state and federal regulations. The submission ofthis Plan of Correction is not intended as an admission, does not constitute anadmission by and should not be construed as an admission by Sunrise Home HealthCare Service that the findings and allegations contained herein are accurateand true representations of the quality of care and services provided topatients of the Agency. Sunrise Home Health Care Service desires this Plan ofCorrection to be considered our Allegation of Compliance.”	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Dodson	Administrator	6/9/2023 10:21:48 AM