STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157689	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HOME CARE	51099 BITTERSWEET ROAD, SUITE E , GRANGER, Indiana, 46530

(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 for a home health agency. Facility ID: 13874 Current Census: 63 Skilled unduplicated census for the last 12 months: 110 Survey Dates: 4/20/2023, 4/21/2023, 4/24/2023, and 4/25/2023. QR Completed.	N0000		
N0486	Q A and performance improvement CFR(s): 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. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure services were coordinated with other providers seeing the patient in 1 of 3 home visits observed. (Patient #2) The findings include: Record review evidenced an agency policy revised 2018, titled "Coordination of Patient Services" which stated, "... Policy: ... All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support he objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current Care Plans; and written and verbal interaction ...." Observation of a home visit for Patient #2 was conducted on 4/21/2023, at 10:30 AM, to observe a routine physical therapy visit. During the visit, the	N0486		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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N0486	Continued from page 1 patient indicated they had trouble finding rides for dialysis some days. Physical therapist #5 was observed telling Patient #2 that they would speak to a social worker at the home health agency to provide the patient assistance with getting rides to dialysis (blood filtration). Clinical record review for Patient #2 was completed on 4/24/2023, for certification period 3/10/2023 - 5/8/2023. Record review failed to evidence any care coordination regarding a social work consult or patient's need for transportation to dialysis. During an interview on 4/24/2023, at 1:46 PM, Clinical Manager #1 indicated they had not heard anything from the physical therapist about the patient needing rides to dialysis. Clinical Manager #1 did not know about the patient's transportation needs.	N0486		
N0520	Patient Care CFR(s): 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure patients were accepted for care upon the expectation the patient's needs could be met in their place of residence in 1 of 3 home visits conducted. (Patient #2) The findings include: Record review evidenced an agency policy revised in 2018, titled "Admission Policy" which stated, "... Patients are accepted for treatment in the home on the basis of reasonable criteria and under the expectation that the patient's medical, nursing, and social needs can be met adequately by Agency in the patient's place of residence ...." Observation of a home visit for Patient #2 was conducted on 4/21/2023, at 10:30 AM, to observe a routine physical therapy visit. During the visit, the patient was observed to be alert and oriented, and chair-bound. The patient indicated they got out of bed in the morning with assistance from their spouse and the use of a slide board. The patient was observed to have bilateral below the knee amputations, and	N0520		

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N0520	Continued from page 2 bilateral prosthetic legs in use. The patient was unable to stand except with a maximum assist from the physical therapist for a few seconds at a time. The patient indicated they did not have any assistance with showering at this time, and indicated their spouse worked full time. Clinical record review for Patient #2 was completed on 4/24/2023, for certification period 3/10/2023 - 5/8/2023. Record review evidenced a start of care assessment dated 3/10/2023, which indicated the patient was dependent in transfers, and required assistance from another person for bathing, dressing, grooming, and toileting. Record review evidenced a plan of care for certification period 3/10/2023 - 5/8/2023, which indicated the patient was receiving physical therapy, skilled nursing, and occupational therapy services. Record review failed to evidence the patient was offered a home health aide for assistance with grooming, dressing, bathing, or toileting. During an interview on 4/24/2023, at 3:10 PM, Clinical Manager #1 indicated the patient should have been offered home health aide services for assistance with bathing, grooming, and toileting, and was not sure why these services weren't offered.	N0520		
N0522	Patient Care CFR(s): 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure patient care followed the written plan of care in 4 of 5 active clinical records reviewed. (Patient #1, 2, 3, 4) The findings include: 1. Record review evidenced an agency policy revised in 2018, titled "Plan of Care" which stated, "... The Plan of Care will delineate specific services and assessments to be delivered based on the evaluation and will include amount, frequency, duration, and expected outcomes for the patient ... Physician orders are needed to provide care requiring the administration of	N0522		

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N0522	Continued from page 3 medication, treatments, on-going assessments, or other activities governed by state law ...." 2. Clinical record review for Patient #1 was completed on 4/25/2023. Record review evidenced a plan of care for certification period 4/3/2023 - 6/1/2023, which indicated the skilled nurse was to visit twice weekly to perform the following wound care to a left lower leg wound and a mid back wound every visit: cleanse with normal saline and gauze, pat dry, and apply optifoam (foam dressing). The plan of care indicated the skilled nurse was to assess the patient's integumentary status every visit. Record review evidenced a skilled nurse visit note dated 4/17/2023, which failed to evidence wound care was performed on the left lower leg and mid back wounds.This visit note failed to include an integumentary assessment of the left lower leg and mid back wounds as ordered on the plan of care. During an interview on 4/24/2023, at 1:32 PM, Clinical Manager #1 indicated wound care should have been provided as ordered on the plan of care. Clinical Manager #1 indicated the nurse should have assessed and documented the status of the patient's lower leg and mid back wounds as ordered on the plan of care every visit. 3. Observation of a home visit for Patient #2 was conducted on 4/21/2023, at 10:30 AM, to observe a routine physical therapy visit. During the visit, the patient was observed to have a right chest permacath (dialysis access). Clinical record review for Patient #2 was completed on 4/25/2023, for certification period 3/10/2023 - 5/8/2023. Record review evidenced a start of care assessment which indicated the patient had a right chest permacath for dialysis, and indicated the site was clean, dry, and intact. Record review evidenced a plan of care for certification period 3/10/2023 - 5/8/2023, which indicated the nurse was to perform a skilled assessment of integumentary status every visit. The plan of care indicated the patient had diabetes (problem regulating blood sugars), was taking insulin (medication to lower blood sugar) and glipizide (medication to lower blood sugars), and the blood sugar goal was to be within 50 - 350. The plan of care indicated the nurse was assess the patient's blood glucose every visit, and notify the physician if the blood sugar level was outside of parameters.	N0522		

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N0522	Continued from page 4 Record review evidenced skilled nurse visit notes dated, 3/13/2023, 3/17/2023, 3/20/2023, 4/7/2023, 4/12/2023, and 4/19/2023, which all failed to include an assessment of the patient's permacath site. Record review evidenced skilled nurse visit notes dated, 3/20/2023, and 4/7/2023, which failed to include blood glucose readings as ordered on the plan of care. During an interview on 4/24/2023, at 2:45 PM, Clinical Manager #1 indicated the nurses should have been assessing the patient's permacath site every visit. Clinical Manager #1 indicated the nurses should have documented and assessed the patient's blood sugar level every visit. 4. Observation of a home visit for Patient #3 was conducted on 4/21/2023, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, the nurse failed to complete a medication reconciliation of the patient's medications. Clinical record review for Patient #3 was completed on 4/25/2023. Record review evidenced a plan of care for certification period 4/12/2023 - 6/10/2023, which indicated the skilled nurse was to visit twice weekly and complete medication management, reconciliation, and review. During an interview on 4/24/2023, at 2:55 PM, Clinical Manager #1 indicated the nurse should have reviewed and reconciled the patient's medications every visit as ordered on the plan of care. 5. Clinical record review for Patient #4 was completed on 4/25/2023. Record review evidenced a plan of care for certification period 3/27/2023 - 5/25/2023, which indicated the clinician was to notify the physician of pain greater than 5/10. Record review evidenced skilled nurse visit notes dated 3/30/2023, 4/5/2023, 4/12/2023, and 4/19/2023, which all indicated the patient's pain was 6/10, and failed to include physician notification of pain outside of parameters as ordered on the plan of care. Record review evidenced physical therapy visit notes dated 3/28/2023, and 4/4/2023, which all indicated the patient's pain level was 8/10, and failed to include physician notification of pain outside of parameters as ordered on the plan of care. Record review evidenced a physical therapy visit note	N0522		

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N0522	Continued from page 5 dated 4/11/2023, which indicated the patient's pain level was 7/10, but failed to include physician notification of pain outside of parameters as ordered on the plan of care. During an interview on 4/25/2023, at 11:05 AM, Clinical Manager #1 indicated the physician should have been notified of pain greater than 5/10 as ordered.	N0522		
N0524	Patient Care CFR(s): 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	N0524		

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N0524	Continued from page 6 Based on observation, record review, and interview, the home health agency failed to ensure the plan of care included all required elements in 4 of 5 active clinical records reviewed. (Patient #1, 2, 3, 4) The findings include: 1. Record review evidenced an agency policy revised in 2018, titled "Plan of Care" which stated, "... The Plan of Care shall be completed in full to include: ... Principle diagnoses and other pertinent diagnoses ... Medications: dose/frequency/route ... Equipment and supply needs ... Caregiver needs ... Diet and nutritional requirements ... Safety measures to protect against injury ... Patient specific interventions and education ... Treatments/orders ...." 2. Observation of a home visit for Patient #1 was completed on 4/21/2023, at 9:30 AM, to observe a routine home health aide visit. During the visit, a urinal was observed to be in use by the patient. During the visit, the patient indicated the nurses at Entity #1 (assisted living facility) provided them with their medications. Clinical record review for Patient #1 was completed on 4/25/2023, for certification period 4/3/2023 - 6/1/2023. Record review evidenced a start of care assessment dated and signed by Registered Nurse #4 on 4/3/2023. The start of care assessment indicated the patient had pain rated at a level of 8/10 when getting out of bed, which frequently interfered with day to day activities. The start of care document indicated the patient was taking 2 medications for pain, and the pain goal was 2 - 3/10. The start of care assessment indicated the patient was not diabetic (problem regulating blood sugars). Record review evidenced a plan of care for certification period 4/3/2023 - 6/1/2023, which was signed by Registered Nurse #4, and which included but was not limited to diagnoses of chronic pain and lower back pain. The plan of care failed to include pain parameters. The plan of care included parameters for blood glucose measurements, and did not include a diagnosis of diabetes. Record review evidenced a medication list obtained on 4/21/2023, from Entity #1 (assisted living facility), which indicated the patient was taking the following medications: Amantadine (medication for Parkinson's disease), Hydrocodone-Acetaminophen (pain medication), Psyllium (probiotic), Ongentys (medication for	N0524		

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N0524	Continued from page 7 Parkinson's disease), Melatonin (for sleep), Magnesium Oxide (supplement), Escitalopram Oxalate (for depression) 10 milligrams daily, and Apixaban (blood thinner) 5 milligrams twice daily. Record review evidenced a plan of care for certification period 4/3/2023 - 6/1/2023, which failed to include a urinal. The plan of care included but was not limited to the following medications: Apixaban 5 milligrams once daily and Escitalopram Oxalate 5 milligrams once daily. The plan of care failed to include the following medications the patient was taking: Amantadine, Hydrocodone-Acetaminophen, Psyllium, Ongentys, Melatonin, and Magnesium Oxide. During an interview on 4/24/2023, at 12:33 PM, Clinical Manager #1 indicated the plan of care should have included all equipment being used by the patient. At 12:41 PM, Clinical Manager #1 indicated they did not know why the plan of care didn't include all the medications Entity #1 (assisted living facility) was giving the patient. At 12:45 PM, Clinical Manager #1 indicated the nurse may have not reviewed the medications with the assisted living facility, and only reviewed the discharge paperwork. Clinical Manager #1 indicated the plan of care should have included all the medications the patient was taking. At 1:07 PM, Clinical Manager #1 indicated if pain was well controlled, it would just be monitored, and not require pain parameters. Clinical Manager #1 indicated if the pain was not controlled, the nurse should have implemented pain parameters. At 1:10 PM, Clinical Manager #1 indicated they did not know why Patient #1 had blood glucose parameters on the plan of care. 3. Observation of a home visit for Patient #2 was conducted on 4/21/2023, at 10:30 AM, to observe a routine physical therapy visit. During the visit, the patient was observed to have a right chest permacatheter (catheter inserted for blood filtration). Clinical record review for Patient #2 was completed on 4/25/2023. Record review evidenced a plan of care for certification period 3/10/2023 - 5/8/2023, which included an order for gentamycin cream topically once daily, but failed to include a location of application. The plan of care failed to include any assessment or care instructions regarding the permacatheter. Record review evidenced a history and physical dated 3/1/2023, which indicated the patient was to apply gentamycin cream daily to a peritoneal dialysis catheter (tube inserted through the skin of the stomach into the peritoneum to filter blood) site.	N0524		

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N0524	Continued from page 8 Record review evidenced a skilled nurse visit note dated 4/7/2023, which indicated the patient was to apply a skin barrier ointment, which was not included on the plan of care. Record review evidenced a physical therapy visit note dated 4/17/2023, which indicated the patient was utilizing a stump shrinker, which was not included on the plan of care. Record review evidenced a skilled nurse visit note dated 4/19/2023, which indicated the patient was instructed to take Imodium (medication for diarrhea), which was not included on the plan of care. During an interview on 4/21/2023, at 10:45 AM, Patient #2 indicated they had the peritoneal dialysis catheter removed between 1 and 2 months prior. During an interview on 4/24/2023, at 1:36 PM, Clinical Manager #1 indicated the plan of care should have included a location of application for any topical medications. Clinical Manager #2 indicated they were unsure if the patient still had the peritoneal dialysis catheter in, or if they were applying gentamycin cream still. At 1:46 PM, Clinical Manager #1 indicated the plan of care should have had instructions for care of the permacatheter. At 2:45 PM, Clinical Manager #1 indicated the skin barrier should have been included in the plan of care. Clinical Manager #1 indicated the Imodium should have been included in the plan of care. Clinical Manager #1 indicated the stump shrinker should have been included in the plan of care. 4.Observation of a home visit for Patient #3 was conducted on 4/21/2023, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, a reacher/grabber was noted to be in use by the patient. During the visit, the patient's medications were reviewed with the patient. During an interview at 1:15 PM, Patient #3 indicated they were not taking calcium, vitamin D, or pepcid (antacid). Patient #3 indicated at 1:15 PM they were taking Torsemide (diuretic), and miralax (laxative) every other day. Clinical record review for Patient #4 was completed on 4/25/2023, for certification period 4/12/2023 - 6/10/2023. Record review evidenced a referral order from Entity #3 (wound clinic), dated 4/11/2023, which indicated the patient was to apply Sensicare (wound ointment) around a wound. Record review evidenced a plan of care for	N0524		

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N0524	Continued from page 9 certification period 4/12/2023 - 6/10/2023, which failed to include the order for Sensicare and the reacher/grabber. The plan of care indicated the patient was taking calcium, vitamin D, and pepcid. The plan of care failed to include the order for Torsemide. The plan of care indicated the patient was taking miralax daily. During an interview on 4/24/2023, at 2:55 PM, Clinical Manager #1 indicated the Sensicare and reacher/grabber should have been included on the plan of care. At 2:56 PM, Clinical Manager #1 indicated the plan of care should have included all medications the patient was taking, with the correct frequencies. 5. Clinical record review for Patient #4 was completed on 4/25/2023, for certification period 3/27/2023 - 5/25/2023. Record review evidenced a recertification assessment dated 3/23/2023, which indicated the patient was drinking Boost nutritional supplements daily. Record review evidenced a plan of care for certification period 3/27/2023 - 5/25/2023, which failed to include the Boost nutritional supplements. During an interview on 4/25/2023, at 11:00 AM, the Administrator indicated the Boost supplements should have been included in the plan of care.	N0524		
N0527	Patient Care CFR(s): 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the physician was promptly notified of any changes which indicated the plan of care needed to be altered in 1 of 3 home visits conducted. (Patient #3) The findings include: Record review evidenced an agency policy revised 2018, titled "Coordination of Patient Services" which stated, "... The physician will be contacted when his/her approval for that change is necessary and to alert physician to changes in patient condition ...."	N0527		

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N0527	Continued from page 10 Record review evidenced an agency policy revised in 2018, titled "Plan of Care" which stated, "... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care ...." Observation of a home visit for Patient #3 was conducted on 4/21/2023, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, a right buttock wound was observed, which did not have any dressing on it upon nurse and surveyor arrival to home. During an interview on 4/21/2023, at 1:05 PM, Patient #3 indicated the dressing usually came off the night before the nurse was scheduled to come and change the dressing, so they just applied Medi-honey, and left the wound open to air since they were unable to complete wound care themselves. Clinical record review for Patient #3 was completed on 4/25/2023. Record review evidenced a plan of care for certification period 4/12/2023 - 6/10/2023, which indicated the patient was to receive skilled nursing twice weekly for 9 weeks, for wound care to a right buttock pressure ulcer as follows: cleanse with normal saline and pat dry with gauze, apply Medi-honey, may apply Calmoseptine cream peri wound, cover with foam dressing, and instruct patient to perform wound care if dressing becomes soiled or disrupted. Record review evidenced a skilled nurse visit note dated 4/19/2023, which indicated the patient's dressing were coming off the night before they needed to be changed, so the patient was just applying Medi-honey. Record review failed to evidence the physician was notified of the dressings coming off the night before, and patient inability to apply foam dressing, and the need to alter the plan of care. During an interview on 4/24/2023, at 3:00 PM, Clinical Manager #1 indicated the physician should have been notified of the dressings coming off prematurely, and the need to alter the plan of care.	N0527		
N0529	Patient Care CFR(s): 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician;	N0529		

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MICHIANA HOME CARE	51099 BITTERSWEET ROAD, SUITE E , GRANGER, Indiana, 46530

(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
N0529	Continued from page 11 (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure written summaries were sent to the physician every 2 months for 2 of 2 clinical records reviewed with recertification assessments. (Patient #4, 5) The findings include: 1. Record review evidenced an agency policy revised in 2018, titled "Plan of Care" which stated, "... The individualized Plan of Care shall be reviewed and revised by the physician who is responsible for the home health Plan of Care and the agency as frequently as the patient's conditions or needs requires, but no less frequently than once every 60 days, beginning with the start-of-care date ...." 2. Clinical record review for Patient #4 was completed on 4/25/2023, for certification period 3/27/2023 - 5/25/2023. Record review evidenced a recertification assessment dated 3/23/2203, which included a written summary of care provided, and services required by the patient, but this document failed to be sent to the physician. Record review evidenced a plan of care for certification period 3/27/2023 - 5/25/2023, which was signed by the physician, but failed to include a written summary of care provided to the patient and care required. Record review failed to evidence a 60 day summary, or other written summary sent to the physician. During an interview on 4/25/2023, at 11:06 AM, Clinical Manager #2 indicated the agency had written summary reports included as part of the comprehensive recertification assessments, but did not send these assessments to the physician. Clinical Manager #2 indicated the plans of care did not include summary reports.	N0529		

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N0529	Continued from page 12 3. Clinical record review for Patient #5 was completed on 4/25/2023, for certification period 3/10/2023 - 5/8/2023. Record review evidenced a recertification assessment dated 3/8/2023, which included a written summary of care. Record review failed to evidence the recertification assessment was sent to the physician. Record review evidenced a plan of care for certification period 3/10/2023 - 5/8/2023, which was signed by the physician, but failed to include a written summary of care. Record review failed to evidence a 60 day summary, or other written summary sent to the physician. During an interview on 4/25/2023, at 11:12 AM, Clinical Manager #1 indicated there was no written summary sent to the physician.	N0529		
N0532	Patient Care CFR(s): 410 IAC 17-13-1(d) Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the physician was notified of any reported changes in patient status in 2 of 2 clinical records reviewed with changes in patient status. (Patient #1, 2) The findings include: 1. Record review evidenced an agency policy revised in 2018, titled "Coordination of Patient Services" which stated, "... The physician will be contacted when his/her approval for that change is necessary and to alert physician to changes in patient condition ...." 2. Clinical record review for Patient #1 was completed on 4/25/2023, for certification period 4/3/2023 - 6/1/2023. Record review evidenced a start of care assessment dated 4/3/2023, which indicated the patient had clear yellow urine output. Record review evidenced a skilled nurse visit note	N0532		

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N0532	Continued from page 13 dated 4/10/2023, which indicated the patient was having hematuria (bloody urine). This visit note indicated the physician was notified of the bloody urine, and a urine sample was drawn to test for infection. Record review evidenced a skilled nurse visit note dated 4/13/2023, which indicated the urine sample was negative for infection, but the patient was still having hematuria, but failed to include any physician notification of the continued bloody urine. Record review evidenced skilled nurse visit notes dated 4/17/2023, and 4/20/2023, which indicated the patient was still having hematuria, but failed to include physician notification of the continued bloody urine. During an interview on 4/24/2023, at 1:24 PM, Clinical Manager #1 indicated the physician should have been notified of the continued hematuria. 3. Clinical record review for Patient #2 was completed on 4/25/2023. Record review evidenced a plan of care for certification period 3/10/2023 - 5/8/2023, which indicated the patient had a diagnosis of diabetes (trouble regulating blood sugars) and fasting blood sugar measurements were to be between 50 and 150, and random blood sugar measurements were to be between 150 and 350. The plan of care indicated the patient was taking insulin (to lower blood sugar) 4 times daily and glipizide (to lower blood sugars) daily. Record review evidenced a skilled nurse visit note dated 3/13/2023, which indicated the patient reported their blood sugar had been dropping, and they had not been taking their glipizide due to the low blood sugars. This document indicated the patient had fallen on 3/10/2023, due to a low blood sugar. Record review failed to evidence the skilled nurse contacted the physician regarding the change in blood sugars, fall, or medications. During an interview on 4/24/2023, at 2:25 PM, Clinical Manager #1 indicated the clinician should have notified the physician of the change in patient status.	N0532		
N0542	Scope of Services CFR(s): 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:	N0542		

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N0542	Continued from page 14 (C) Initiate the plan of care and necessary revisions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the registered nurses implemented necessary revisions to the plan of care in 2 of 3 home visits conducted. (Patient #1, 2) The findings include: 1. Record review evidenced an agency policy revised in 2018, titled "Plan of Care" which stated, "... The individualized Plan of Care shall be reviewed and revised by the physician who is responsible for the home health Plan of Care and the agency as frequently as the patient's condition or needs requires ....." 2. Record review evidenced an agency policy revised in 2022, titled "Position: Registered Nurse" which stated, "... Essential Functions/Areas of Accountability: ... Makes necessary revisions as needed to the Plan of Care ...." 3. Clinical record review for Patient #1 was completed on 4/25/2023. Record review evidenced a plan of care for certification period 4/3/2023 - 6/1/2023, which included the following goal: Patient will achieve pain level less than 4. The plan of care indicated the patient was taking tylenol extra strength for pain. The plan of care indicated the skilled nurse was to assess the patient's pain level and effectiveness of pain medication every visit, and instruct on nonpharmacologic pain relief measures every visit. The plan of care failed to include any pain parameters. Record review evidenced a start of care assessment dated 4/3/2023, which indicated the patient's pain level was 8/10, and pain interfered frequently with patient's daily activities. Record review evidenced skilled nurse visit notes for the following dates: 4/6/2023, 4/10/2023, 4/13/2023, 4/17/2023, and 4/20/2023; which all indicated the patient was experiencing pain during movement at an 8/10. Record review failed to evidence the registered nurses re-evaluated or revised the patient's pain goal, progress towards pain goal, or the current pain treatment regimen and its effectiveness. During an interview on 4/24/2023, at 1:20 PM, Clinical Manager #1 indicated the nurses should have evaluated	N0542		

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N0542	Continued from page 15 when the patient was taking pain medication and the pain medication's effectiveness if the patient was having continued pain at 8/10. At 1:40 PM, Clinical Manager #1 indicated the nurses should have re-evaluated the patient's pain goal, and updated the plan of care if the goal wasn't being met. 4. Clinical record review for Patient #2 was completed on 4/25/2023. Record review evidenced a plan of care for certification period 3/10/2023 - 5/8/2023, which indicated the patient was to receive skilled nursing twice weekly for 4 weeks, and once weekly for 4 weeks for wound care and education related to wound care and skin integrity. The plan of care indicated the patient was to receive physical therapy twice weekly for 6 weeks for gait training, transfer training, strengthening, and balance exercises. The plan of care indicated the patient was to receive occupational therapy once weekly for 4 weeks for education on safe transfers and strengthening exercises. The plan of care failed to include any interventions or education regarding fall prevention. Record review evidenced a start of care assessment dated 3/10/2023, which indicated the patient was at a high risk for falls. Record review evidenced a skilled nurse visit note dated 3/13/2023, which indicated the patient fell on 3/10/2023, due to low blood sugars, and the patient was not taking their glipizide (to lower blood sugars) due to low blood sugars. Record review failed to evidence revision of the plan of care. Record review evidenced a skilled nurse visit note dated 3/17/2023, which indicated the patient fell while leaning forward from wheelchair. Record review failed to evidence revision of the plan of care. Record review evidenced a skilled nurse visit note dated 3/20/2023, which indicated the patient was found on the floor upon the nurses arrival. Record review failed to evidence the plan of care was revised to address the frequent falls. Record review evidenced a skilled nurse visit note date 4/12/2023, which indicated the patient fell on 4/10/2023. Record review failed to evidence any revisions to the plan of care to address the patient's frequent falls. During an interview on 4/24/2023, at 2:45 PM, Clinical Manager #1 indicated the nurses should have assessed the patient's reasons for falling, and addressed all	N0542		

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N0542	Continued from page 16 the issues on the plan of care. Clinical Manager #1 indicated the patient's falls should have been resolved by a multi-disciplinary approach with the physician and updates to the care plan.	N0542		
N0544	Scope of Services CFR(s): 410 IAC 17-14-1(a)(1)(E) Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure nurses prepared accurate and appropriate clinical notes in 4 of 5 active clinical records reviewed. (Patient #1, 2, 3, 4) The findings include: 1. Record review evidenced an agency policy revised 2022, titled "Position: Registered Nurse" which stated, "... Prepares clinical and progress notes ... Documents legibly and according to Agency documentation guidelines and standards ...." 2. Record review evidenced an agency policy revised 2018, titled "Comprehensive Patient Assessment" which stated, "... The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: ... Head to toe assessment ...." 3. Observation of a home visit for Patient #1 was conducted on 4/21/2023, at 9:30 AM, to observe a routine home health aide visit. During the visit, the patient was observed receiving a shower, and did not have any contractures or shortening of muscles. The patient was observed standing and pivoting into the shower chair, and all extremities had full range of motion. The patient was observed to be alert and oriented, and verbalized understanding of surveyors questions and home health aide's instructions. The patient was not observed to be aphasic. Clinical record review for Patient #1 was completed on 4/25/2023, for certification period 4/2/2023 - 6/1/2023. Record review evidenced a start of care assessment dated 4/3/2023, and signed by Registered	N0544		

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N0544	Continued from page 17 Nurse #4, which indicated the patient had contractures (shortening of muscles), and was aphasic. The start of care assessment failed to include documentation of heart sounds. During an interview on 4/24/2023, at 1:00 PM, Clinical Manager #1 indicated they were not sure why the registered nurse documented the patient had contractures if they did not. At 1:00 PM, Clinical Manager #1 indicated the patient could have been aphasic. Clinical Manager #1 did not know why the registered nurse documented the patient was aphasic if they were not. At 1:15 PM, Clinical Manager #1 indicated heart sounds should have been assessed and documented on the start of care assessment. 4. Observation of a home visit for Patient #2 was conducted on 4/21/2023, at 10:30 AM, to observe a routine physical therapy visit. During the visit, the patient was observed to be alone in the home. The patient indicated during the visit, that they lived with their spouse, who worked, and would be left alone, when their spouse was working. Clinical record review for Patient #2 was completed on 4/25/2023, for certification period 3/10/2023 - 5/8/2023. Record review evidenced a start of care assessment dated and signed by Registered Nurse #4 on 3/10/2023,, which indicated the patient lived with someone who was available around the clock. The start of care assessment indicated the patient had a distal and a proximal sacral wound (area at top of buttocks) which required wound care. Record review evidenced a skilled nurse visit note dated 3/20/2023, which included 4 wound total: 2 distal sacral and 2 proximal sacral wounds. During an interview on 4/24/2023, at 2:09 PM, Clinical Manager #1 indicated the start of care assessment was documented inaccurately. At 2:44 PM, Clinical Manager #1 indicated the wound documentation on 3/20/2023, was not accurate, and the patient did not have 4 wounds. 5. Observation of a home visit for Patient #3 was conducted on 4/21/2023, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was observed to live alone. The patient indicated they lived alone also. Clinical record review for Patient #3 was completed on 4/25/2023, for certification period 4/12/2023 - 6/10/2023. Record review evidenced a start of care assessment dated and signed by the registered nurse on	N0544		

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N0544	Continued from page 18 4/12/2023, which indicated the patient lived with someone in the home. During an interview on 4/24/2023, at 3:06 PM, Clinical Manager #1 indicated the start of care assessment was inaccurate. 6. Clinical record review for Patient #4 was completed on 4/25/2023, for certification period 3/27/2023 - 5/25/2023. Record review evidenced a recertification assessment dated 3/23/2023, which indicated the patient was dysphagic (inability to swallow normally), but was on a regular diet. During an interview on 4/25/2023, at 10:58 AM, Clinical Manager #1 indicated the patient was not dysphasic since they were on a regular diet, and were not sure why the recertification assessment indicated the patient was dysphasic.	N0544		
N0545	Scope of Services CFR(s): 410 IAC 17-14-1(a)(1)(F) Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review, and interview, the home health agency failed to ensure registered nurses coordinated patient care in 2 of 3 home visits conducted. (Patient #1, 2) The findings include: 1. Record review evidenced an agency policy revised 2022, titled "Position: Registered Nurse" which stated, "... Essential functions/areas of accountability: ... coordinates with other services ...." 2. Record review evidenced an agency policy revised 2018, titled "Coordination of Patient Services" which stated, "... Policy: ... All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support he objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current Care Plans; and written and verbal interaction ...."	N0545		

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N0545	Continued from page 19 3. Clinical record review for Patient #1 was completed on 4/25/2023, for certification period 4/3/2023 - 6/1/2023. Record review evidenced a medication list obtained on 4/21/2023, from Entity #1 (assisted living facility), which indicated the patient was taking the following medications: Amantadine (medication for Parkinson's disease), Hydrocodone-Acetaminophen (pain medication), Psyllium (probiotic), Ongentys (medication for Parkinson's disease), Melatonin (for sleep), Magnesium Oxide (supplement), Escitalopram Oxalate (for depression) 10 milligrams daily, and Apixaban (blood thinner) 5 milligrams twice daily. Record review evidenced a plan of care for certification period 4/3/2023 - 6/1/2023, dated and signed by the registered nurse, which included but was not limited to the following medications: Apixaban 5 milligrams once daily and Escitalopram Oxalate 5 milligrams once daily. The plan of care failed to include the following medications the patient was taking: Amantadine, Hydrocodone-Acetaminophen, Psyllium, Ongentys, Melatonin, and Magnesium Oxide. During an interview on 4/24/2023, at 12:41 PM, Clinical Manager #1 indicated they did not know why the plan of care didn't include all the medications Entity #1 (assisted living facility) was giving the patient. At 12:45 PM, Clinical Manager #1 indicated the nurse may have not reviewed the medications with the assisted living facility, and only reviewed the discharge paperwork. At 12:54 PM, Clinical Manager #1 indicated the nurses should have been coordinating care with Entity #1 (assisted living facility) by giving the assisted living facility oral report after visits, and filling out log books at the assisted living facility. Clinical Manager #1 indicated the medications should have been coordinated with the assisted living facility. 4. Clinical record review for Patient #2 was completed on 4/24/2023, for certification period 3/10/2023 - 5/8/2023. Record review evidenced a start of care assessment dated and signed by the registered nurse on 3/10/2023, which indicated the patient received dialysis (blood filtration), but failed to include any additional information for care coordination such as location of dialysis facility, nephrologist, or dialysis communications. Record review evidenced a plan of care for certification period 3/10/2023 - 5/8/2023, which was dated and signed by the registered nurse on 3/10/2023, which failed to include any information regarding the	N0545		

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N0545	Continued from page 20 patient's nephrologist, dialysis center, or days of dialysis. Record review failed to evidence any documented care coordination between the home health agency and the dialysis clinic or the nephrologist. Record review failed to evidence any documentation of the patient's nephrologist or dialysis orders. During an interview on 4/21/2023, at 10:45 AM, Patient #2 indicated they received dialysis on Tuesdays, Thursdays, and Saturdays. Patient #2 indicated Person #2 (physician) was their nephrologist. During an interview on 4/24/2023, at 1:47 PM, Clinical Manager #1 indicated the start of care assessment sometimes included information on the nephrologist and the dialysis center. Clinical Manager #1 indicated the clinical record should have included the dialysis center and days the patient went to dialysis. During an interview on 4/24/2023, at 2:18 PM, Clinical Manager #2 indicated care is coordinated with dialysis clinics by finding out the time the patient goes to dialysis, and they request a medication list. Clinical Manager #2 indicated the agency sometimes received monthly documentation from the nephrologist, but not all the time.	N0545		