STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157552	A. BUILDING B. WING	05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HEALTH SERVICES LLC	2825 E 96TH ST, INDIANAPOLIS, IN, 46240

(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 visit was for the investigation of a Federal and State complaint/intake of a Deemed Medicare Home Health provider. Survey Dates: 05-01-2023, 05-03-2024, 05-04-2023, and 05-05-2023. Complaint # 97779; with deficiencies cited. Joy Health Services LLC was found to be out of compliance with Condition of Participation 42 CFR 484.75, Skilled Professional Services, in relation to the complaint allegations. QR by Area 3 from 5-17 through 5-22-2023	G0000	*POC accepted on 7-14-2023* *Deborah Franco, RN*	

G0478	Investigate complaints made by patient 484.50(e)(1)(i) (i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics: Based on record review and interview, the agency failed to investigate a complaint and concerns expressed to the agency for 1 of 5 patients (Patient #3.) Findings Include: 1. On 05-04-2023 at 03:15 PM, the Director of Nursing (DON) provided a 10-23-2010, Joy Health Services LLC policy titled, "Complaint/Grievance Process". The policy indicated but was not limited to, "...The Assistant Director of Nursing or designated person... gather facts, and interview all persons involved and complete the complaint form..." 2. On 05-01-2023 at 12:15 PM, the DON provided the Complaint log for Joy Health Services LLC. The complaint log failed to evidence that the agency investigated Entity M's concerns expressed during the	G0478	Providedinservice regarding the documentation 5/23 Ina visit note. Reviewed the procedure,& Theinformation that should be shared in EachCase Conference, & all issues should be Addressed& documented upon recognizing Anissue exists, such as lack of safety equipment, Lackof equipment for care, etc. & the necessary Documentationwhen an issue is discovered & Whoseresponsibility it is to follow thru on this Andwhat coordination of care is necessary when Anissue such as this arises & documentation Neededwhen addressing such an issue Providedinservice regarding the use, proper Assessment,administration of feeding/medication Checks to be done prior toadministering the treatment, needed documentation of same & Reviewedthe process for changing the G-Tube & Documentationneeded Providedinservice on coordination of care - Whois responsible for same, documentation Needed, Inserviced infection control, tracheostomy Care,	2023-05-25

	case conference on 04-13-2023. A complaint form was not evidenced in 4 of 4 survey days. 3. On 05-03-2023 at 01:00 PM, during the clinical record review of Patient #3, the documents titled "Visit Note (SN) (Pediatric) Clinical Note" and dated 04-14-2023, 04-15-2023, and 04-16-2023 by Licensed Practical Nurse (LPN #2) failed to evidence the agency addressed the concerns from Entity M. The document indicated but was not limited to, "... Pediatric Assessment... Emergency Equipment Check (blank)... Care Plan / MD Orders Checked (blank)... Medication Reconciled (blank)... AmbuBag / Extra Trach on site (blank)... Last date DME Equipment Check: (blank)... Pediatric Nutrition:... Bag Change: No... Comments: mix with duo cal... Pediatric Respiratory:... Ambu bag readily available: No... Caregiver able to change? (blank)... How often changed? (blank)... Date Last Changed: Unknown... Pathway: Pediatric G-J/G-Tube... Narrative-Progress Toward Goal... weight done reported in doctor's office...". The clinical record failed to evidence that the concerns of Person I from		documentation needed, andeach clinician was competencied on both of these procedures at this Inservice Reference #6 – Agency has no recordor notice Of any mtg. during the week of04/24-04/28/23. Agency did have a conferencecall later with The referring agency regardingone of the Patients of the medical recordsthe surveyor Asked to have for herreview. An agreement was Reached Implemented a QI project toaudit all 05/25/23 Gastrostomy patients and thecomplaint Log for any issue that may havebeen Overlooked or not entered intothe log. Will continue until we haveattained 100% Compliance and then will bemonitored For 3 months to ensure it ismaintained. DON is responsible for all thecorrections.	

	Entity M were addressed. 4. On 05-03-2023 at 4:00 PM, the DON provided a case conference document from Patient #3's chart with the date 04-13-2023. The document evidenced a conversation between the agency and Person I, a nurse supervisor from Entity M, an agency contracted through Entity C (an organization that ensures the safety of individuals younger than the age of 18) that provided resources for youths and their families. The document indicated but was not limited to, "... equipment to update; will follow up with supply company/MD... medication profile and regime, water flush regime, weight scale, need for pt (sic Physical Therapy), ot (sic Occupational Therapy), st (Speech Therapy) [need for orthotics, braze due to foot drop/contracture] ...". 5. During an interview on 05-03-2023 at 02:58 PM with the DON, the DON clarified the Gastrostomy was to be verified before administration of medication and feeding and documented in the visit notes.			

	tubing for the feeding for the Gastrostomy was to be changed every day, and if the caregivers change the bags, it would be documented by the nurse that they verified the bag was changed. When queried regarding whether a patient may need therapy services, the DON expressed that the nurses would perform an assessment, call the office to inform them of the potential need, and request a verbal order from the physician to start therapy. When queried regarding the verification of medications, the DON clarified the nurses were to check for duplicates, interactions, adverse reactions, expiration dates, and educate the patient and/or caregiver about the medications every visit. When queried regarding Tracheostomy care, the DON indicated tracheostomy change would be based on the physician's order, ensure the change was completed according to the agency policy, and if the caregiver performed the care, the nurses are to check			

	the site and document that the caregiver performed the care. 6. During an interview on 05-03-2023 at 10:56 AM with Person G, a nurse with Entity M; Person G evidenced the nurses were to have a meeting with the agency the week of 04-24-2023 through 04-28-2023, but the agency did not attend the meeting and the agency had not responded since their 04-13-2023 case conference. 7. During an interview on 05-03-2023 at 04:20 PM, when queried, regarding whether another agency had a concern/complaint about a patient, the DON indicated they would go to the home and investigate to find a resolution. The DON evidenced they would also call the physician's office if it was needed, but that did not occur in this instance.			
G0484	Document complaint and resolution 484.50(e)(1)(ii)	G0484	Agencyhas implemented a new procedure to ensure all complaints are reported, investigated, resolved and documented on the"Complaint Form"and in the "Complaint Log	2023-05-23

	(ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview, the agency failed to document the existence and resolution of a complaint for 1 of 5 patients (Patient #3.) Findings Include: On 05-04-2023 at 03:15 PM, the Director of Nursing (DON) provided a 10-23-2010, Joy Health Services LLC policy titled, "Complaint/Grievance Process." The policy indicated but was not limited to, "...1. The Assistant Director of Nursing or designated person... gather facts, and interview all persons involved and complete the complaint form... 2. may determine what actions are to be taken... 6... notified of the resolution of the complaint verbally and/or in writing by the Director of Nursing or the designated person, within (15) working days of the complaint..." On 05-01-2023 at 12:15 PM, the DON provided the Complaint log for Joy Health Services LLC. The complaint log failed to evidence that the agency		Book" Inservice held to advise staff of thenew process and a copy given to all staff 05/23/23 The DON will review thecomplaint logs and forms each day with nursing administration and the ADON willinvestigate all complaints and determine a resolution and report same toAdministrator & DON	

	ncy that provided resources to ıths and their families) concerns ressed during the case ıference on 04-13-2023. A nplaint form and resolution of complaint were not evidenced of 4 survey days regarding ient #3. On 05-03-2023 at 4:00 PM, the DON provided a case conference document from Patient #3's chart with the date 04-13-2023. The document evidenced a conversation between the agency and Person I, a nurse supervisor from Entity M, an agency contracted through Entity C (an organization that ensures the safety of individuals younger than the age of 18) that provided resources for youths and their families. The document indicated but was not limited to, "... equipment to update; will follow up with supply company/MD... medication profile and regime, water flush regime, weight scale, need for pt (sic Physical Therapy), ot (sic Occupational Therapy), st (Speech Therapy) [need for orthotics, braze due to foot drop/contracture]...". The agency failed to evidence this complaint in the complaint log			

	l include a resolution. During an interview on 05-03-2023 at 10:56 AM with Person G, a nurse with Entity M; Person G indicated the nurses were to have a meeting with Joy Health agency the week of 04-24-2023 through 04-28-2023, but Joy Health did not attend the meeting and had not responded to Entity M since their 04-13-2023 case conference. During an interview on 05-03-2023 at 04:20 PM, when queried regarding what Joy Health expected should happen if another agency had a concern about a shared patient, the DON indicated they would go to the home and investigate to find a resolution. The DON indicated Joy Health would also call the physician's office if it was needed, but had not done so in this instance.) IAC 17-12-3(C)(2)			
G0486	Protect patient during investigation 484.50(e)(1)(iii) (iii) Take action to prevent further potential	G0486	Anew process has been developed & implemented regardingcomplaints The DON & ADON were	2023-05-25

	violations, including retaliation, while the complaint is being investigated. Based on record review and interview, the agency failed to protect a patient by having failed to document the existence and resolution of concerns expressed to the agency for 1 (Patient #3) of 5 patients whose clinical record was reviewed. Findings Include: On 05-04-2023 at 03:15 PM, the Director of Nursing (DON) provided a 10-23-2010, Joy Health Services LLC policy titled, "Complaint/Grievance Process". The policy indicated but was not limited to, "...1. The Assistant Director of Nursing or designated person... gather facts, and interview all persons involved and complete the complaint form... 2. may determine what actions are to be taken... 6... notified of the resolution of the complaint verbally and/or in writing by the Director of Nursing or the designated person, within (15) working days of the complaint...". On 05-01-2023 at 12:15 PM, the DON provided the Complaint log for Joy Health Services LLC.		Investigatea complaint, ensure all parties involved Arereviewed & their actions, as well as the person Makingthe complaint. The person making the complaint will be interviewed in person. The ADON willmaintain a record of the investigation and report To the DON and Administrator with his/her Resolution 05/16/23 DONresponsible Inserviceheld for all staff regarding documentation Neededwhen making a home visit. Stressed Completeassessment, treatments given & results, Inquiry& documentation for patient's receiving Enterealfeedings regarding weight, skin turgor, Adverse physical signs orsymptoms, who should be notified and all is to be documented. Inservice held to reviewinfection control, tracheostomy care, and attendees were re-competencied duringthe inservice. Documentation is a constant auditprocess by the Nursing Administrationpersonnel as well	

	: complaint log failed to dence that the agency estigated Entity M's (an agency t provided resources for youths l their families) concerns ressed during the case iference on 04-13-2023. A nplaint form was not evidenced of 4 survey days. On 05-03-2023 at 01:00 PM, during the clinical record review of Patient #3, the documents titled "Visit Note (SN (sic Skilled Nurisng)) (Pediatric) Clinical Note" and dated 04-14-2023, 04-15-2023, and 04-16-2023 by Licensed Practical Nurse (LPN #2) failed to evidence the agency addressed the concerns from Entity M. The document indicated but was not limited to, "... Pediatric Assessment:... Emergency Equipment Check (blank)... Care Plan / MD Orders Checked (blank)... Medication Reconciled (blank)... AmbuBag / Extra Trach (sic an opening in the neck that brought oxygen to the lungs) on site (blank)... Last date DME Equipment Check: (blank)... Pediatric Nutrition:... Bag Change: No... Comments: mix with duo cal... Pediatric Respiratory:... Ambu bag readily available: No... Caregiver able to change?		as the Quality Assurance Committee. The complaint issue was added to the QAaudits as well as a review of Infection control &tracheostomy care. Will continue until 100% compliance 05/25/23. DON is responsible.	

	ınk)... How often changed? ınk)... Date Last Changed: ‹nown... Pathway: Pediatric /G-Tube (sic Gastrostomy, a e in the abdomen that brought rients to the stomach)... ·rative-Progress Toward Goal... ght done reported in doctor's ce...". The clinical record failed evidence that the concerns of son I from Entity M were dressed. During an interview on 03-2023 at 02:58 PM with the N, the DON clarified the ;trostomy was to be verified ore administration of dication and feeding and :umented in the visit notes. The N indicated the bag and tubing the feeding for the Gastrostomy ; to be changed every day, and atient 3's caregivers changed bags, it would need to be :umented by the nurse that they ified the bag was changed. On 05-03-2023 at 4:00 PM, the DON provided a case conference document from Patient #3's chart with the date 04-13-2023. The document evidenced a conversation between the agency and Person I, a nurse supervisor from Entity M, an agency contracted through Entity C (an organization that ensures the			

	ety of individuals younger than age of 18) that provided ources for youths and their ilies. The document indicated was not limited to, "... uipment to update; will follow up n supply company/MD... dication profile and regime, er flush regime, weight scale, d for pt (sic Physical Therapy), sic Occupational Therapy), st Speech Therapy) [need for notics, braze due to foot p/contracture]...". The clinical ord failed to evidence any ow-up conversations with Entity egarding the complaint. During an interview on 05-03-2023 at 02:58 PM with the DON, the DON clarified the Gastrostomy was to be verified before administration of medication and feeding and documented in the visit notes. The DON indicated the bag and tubing for the feeding for the Gastrostomy was to be changed every day, and if the caregivers change the bags, it would need to be documented by the nurse that they verified the bag was changed. When queried regarding if a patient may need therapy services, the DON expressed the			

	nurses would perform an assessment and the nurses would call the office to inform them of the potential need and would request a verbal order from the physician to start therapy. When queried regarding the verification of medications, the DON clarified the nurses were to check for duplicates, interactions, adverse reactions, expiration dates, and educate the patient and/or caregiver about the medications every visit. When queried regarding Tracheostomy care, the DON indicated tracheostomy change would be based on the physician's order, ensure the change was completed according to the agency policy, and if the caregiver performed the care, the nurses are to check the site and document that the caregiver performed the care. During an interview on 05-03-2023 at 04:20 PM, when queried, regarding whether another agency had a concern about a patient, the DON indicated they would go to the home and investigate to find a			

	olution. For Patient #3, the DON icated this agency had not tected the rights of Patient #3 having failed to take action en notified by another agency t shared care for Patient #3 of ıcerns related to quality of care. DON evidenced they would o call the physician's office if it ; needed.			
G0602	Communication with all physicians 484.60(d)(1) Assure communication with all physicians or allowed practitioners involved in the plan of care. Based on record review and interview, the agency failed to communicate a change in condition to the physician for 1 of 2 (Patient #1) active patient records reviewed with weight checks ordered in the plan of care. Findings Include: On 05-03-2023 at 04:20 PM, the Director of Nursing (DON) provided a policy titled, "Physician Order Policy" that was dated 10-23-2010. The policy indicated but was not	G0602	Held inservice with field staff to review the process andwhen we are to advise the patient's physician ofa situation. Staff was instructed thatthe physician signsthe Plan of Care and is in charge of the patient. Therefore,they are to be advised of anything unusualwith their patient, and this is to be acted upon, Documented in the EMR, and the resolution. 05/23/23 Thisissue is already an audit project of the QA Committee. Will continue until 100% compliance Isreached DONis responsible	2023-05-23

	nsed personnel contact the nt's physician: ... b. When there changes in the client's ıdition ..." On 05-03-2023 at 02:40 PM, the clinical record review of Patient #1 was conducted. The record evidenced a plan of care with a start of care of 09-11-2019, and a certification period of 04-23-2023 to 06-21-2023. The plan of care orders included, but were not limited to, "... Pediatric SN (sic Skilled Nurse)/ADL Extended Visit Note Pathway... Skilled nurse to monitor client's appetite and report any changes in nutritional status ..." On 05-03-2023 at 02:40 PM, the clinical record of Patient #1 evidenced a verbal order that indicated the patient's weight was to be checked every 1-2 weeks. ı review of visit notes evidenced all were signed by LPN #1 and: On 03-07-2023, "... Pediatric Vital Signs ... lb (pounds): 39... oz (ounces): 0... Kg (Kilograms): 17.69..." On 03-14-2023, "... Pediatric Vital signs ... lb: 39... oz: 0... Kg:			

	17.69…" On 03-21-2023, "… Pediatric Vital signs … lb: 39… oz: 2.0… Kg: 17.75…" On 03-28-2023, "… Pediatric Vital signs … lb: 39… oz: 0.5… Kg: 17.70…" On 04-04-2023, "… Pediatric Vital signs … lb: 39… oz: 0.9… Kg: 17.72…" On 04-11-2023, "… Pediatric Vital signs … lb: 40… oz: 13… Kg: 18.50…" On 04-18-2023, "… Pediatric Vital signs … lb: 42… oz: 16… Kg: 19.50…" On 04-25-2023, "… Pediatric Vital signs … lb: 36… oz: 6.0… Kg: 16.50… The clinical record of Patient #1 failed to evidence a communication note made by LPN #1 notifying the Case Manager, RN #1, of the weight change noted from the weight checks for Patient #1 on 04-18-2023 to 04-25-2023. On 05-03-2023 at 04:05 PM, the Case Conference Binder was reviewed. The Case Conference			

	:ussion between LPN #1 and RN about Patient #1's weight :reasing by 6 lbs in a week proximately 14% of Patient #1's dy weight.) On 05-05-2023 at 10:25 AM, the documents from Entity F, Patient #1's physician's (Person N) office, were reviewed. The documents failed to evidence the agency contacted Person N about Patient #1's decrease in weight. During an interview with the Director of Nursing (DON) on 05-04-2023 at 10:32 AM, they indicated Patient #1 had their weights checked at their residence and the nurse did the weights every Tuesday. During a phone interview with LPN #1 on 05-04-2023 at 11:49 AM, the LPN indicated they checked the weight every Tuesday, 1 time a week. LPN #1 stated, "The weight for (sic Patient #1) on 05-02-2023 was 36.8 lbs. I do not call the physician." When queried regarding if they had contacted the nurse every week regarding the weights LPN #1 stated, "I put the weight in my notes			

	;istered Nurse) can see it." During a phone interview with RN #1 on 05-04-2023 at 12:05 PM, the RN confirmed they were Patient #1's case manager. RN #1 indicated they saw the patient for recertification every 2 months and would monitor weights and compare to previous weights at that time. The RN indicated they completed supervisory visits of the LPN 1 time a month. RN #1 stated, "I told the LPN to let me know if there are any issues, or let the physician or office know." During an interview with the DON on 05-05-2023 at 10:33 AM, the DON confirmed the plans of care and physician notes were the only documents Entity F provided them. There was no evidence the physician, Person N, was notified of Patient #1's loss of 14% of their body weight in one (1) week.) IAC 17-14-1(a)(1)(G)			
G0606	Integrate all services	G0606	Staffinvolved in this tag were	2023-05-23

	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 of care provided by all disciplines. Based on record review and interview, the agency failed to communicate patient needs between disciplines for 1 of 2 (Patient #1) active patient records reviewed with weight checks in their plan of care. Findings Include: On 05-05-2023 at 09:00 AM, the Office Manager provided the job description/policy titled "Staff Nurse / Licensed Practical Nurse (LPN)" with a date of 09-04-2012. The policy indicated but was not limited to, "... 4. Observes patient and reports to the physician/RN (sic Registered Nurse) any changes of the patient's condition and reactions to treatment... 6. Reports daily to the Case Manager or Clinical Supervisor on services rendered, problems concerning patient's needs, and how they can be resolved..." On 05-05-2023 at 10:28 AM, an		counseled on 5/4/23and 5/23/23 theirjob description was reviewed with them, andthe disciplinary form placed in their personnel file. Reporting to another team members & physician was stressed to each of them. Held mandatory inservice for all clinical staff regardingcoordination of care, documentation ofsame with active exercise in inservice each Participantcompleted. 05/23/23 Continueto audit medical records entries to ensurecompliance. Continues to be a QA/QI Projectuntil 100% compliance. 20% of allrecords willbe audited each month and reported to the QAcommittee. DON is responsible.	

	job description/policy titled aff Nurse/RN (sic Registered rse)". The policy indicated but s not limited to, "... 5. Observes ient and reports to the physician changes of the patient's dition and reactions to atment... 7. Reports daily to the e Manager or Clinical pervisor on services rendered, blems concerning patient's eds, and how they can be olved. 8. Involves other ciplines when the need arises..." On 05-03-2023 at 02:40 PM, the clinical record review of Patient #1 was conducted. The record evidenced a plan of care with a start of care of 09-11-2019 and a certification period of 04-23-2023 to 06-21-2023. The plan of care indicated but was not limited to, "... Pediatric SN (Skilled Nurse)/ADL Extended Visit Note Pathway... Skilled nurse to monitor client's appetite and report any changes in nutritional status..." On 05-03-2023 at 02:40 PM, the clinical record of Patient #1 evidenced a verbal order that indicated the patient's weight was to be checked every 1-2 weeks.			

	On 05-03-2023 at 02:40 PM, the clinical record of Patient #1 evidenced documents titled "Visit Note (SN) (Pediatric) Clinical Note." The documents evidenced Patient #1's weight was checked 1 time a week, on Tuesdays. A review of visit notes evidenced all were signed by LPN #1 and: 03-07-2023, "... Pediatric Vital Signs ... lb (pounds): 39... oz (ounces): 0... Kg (Kilograms): 17.69..." On 03-14-2023, "... Pediatric Vital signs ... lb: 39... oz: 0... Kg: 17.69..." On 03-21-2023, "... Pediatric Vital signs ... lb: 39... oz: 2.0... Kg: 17.75..." On 03-28-2023, "... Pediatric Vital signs ... lb: 39... oz: 0.5... Kg: 17.70..." On 04-04-2023, "... Pediatric Vital signs ... lb: 39... oz: 0.9... Kg: 17.72..." On 04-11-2023, "... Pediatric Vital signs ... lb: 40... oz: 13... Kg: 18.50..." On 04-18-2023, "... Pediatric			

	19.50…" On 04-25-2023, "… Pediatric Vital signs … lb: 36… oz: 6.0… Kg: 16.50… On 05-03-2023 at 04:05 PM, the Case Conference Binder was reviewed. The Case Conference Binder failed to evidence a discussion between LPN #1 and RN #1 about Patient #1's weight decreasing by 6 lbs in a week. During an interview with the Director of Nursing (DON) on 05-04-2023 at 10:32 AM, they indicated Patient #1 had their weights checked at their residence and the nurse did the weights every Tuesday.			

	During a phone interview with LPN #1 on 05-04-2023 at 11:49 AM, the LPN indicated they checked the weight every Tuesday, 1 time a week. LPN #1 stated, "The weight for (sic Patient #1) on 05-02-2023 was 36.8 lbs. I do not call the physician." When queried regarding if they had contacted the nurse every week regarding the weights LPN #1 stated, "I put the weight in my notes every week, so the nurse (sic Registered Nurse) can see it." During a phone interview with RN #1 on 05-04-2023 at 12:05 PM, the RN confirmed they were Patient #1's case manager. RN #1 indicated they saw the patient for recertification every 2 months and would monitor weights and compare to previous weights at that time. The RN indicated they completed supervisory visits of the LPN 1 time a month. RN #1 stated, "I told the LPN to let me know if there are any issues, or let the physician or office know.") IAC 17-12-2(g)			
G0700	Skilled professional services	G0700	Mandatory inservice for all	2023-05-23

	484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician or allowed practitioner and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. Based on record review and interview, the agency failed to communicate patients' health across all disciplines (G0706), perform all services outlined in the plan of care (G0710), communicate concerns to the physician (G0718), and ensure a Registered Nurse (RN) was supervising the care the Licensed Practical nurses provided (G0726). The cumulative effects of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of 42 CFR 484.75, Skilled Professional Services. Findings Include:		clinical staff regarding coordination ofcare with all disciplines both in-Housepersonnel as well as any professional Involvedoutside of the Agency. 05/23/23 All staff involved werecounseled and disciplinary 5/4/23 and 5/23/23 formcompleted and placed in their personnel file. Continueto audit medical records entries to ensure Compliance. Will continue to be a QA/QI project Until100% compliance is attained. 20% of all records Willbe reviewed each month & reported to the QA committee. DONis responsible	

	*			
G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on record review and interview, the agency failed to coordinate patient care by having failed to communicate patient needs between the agency's licensed practical nurse (LPN 1) and the supervising case manager registered nurse (RN 1) for 1 of 2 (Patient #1) active patient records reviewed with weight checks in the plan of care. Findings Include: On 05-05-2023 at 09:00 AM, the Office Manager provided the job description/policy titled "Staff Nurse / Licensed Practical Nurse (LPN,)" with a date of 09-04-2012. The policy indicated but was not limited to, "... 4. Observes patient and reports to the physician/RN (sic Registered Nurse) any changes of the patient's condition and reactions to treatment... 6.	G0706	Education of the ADON reviewing the conduction of the Case Conference, the contentand documentation ofthe conference. Included in the CaseConference should be a coordination ofcare component. 05/11/23 Clinical staff involved wereeach counseled on 5/4/23 and 5/23/23 Disciplinaryform placed in their personnel file Mandatoryinservice for all clinical staff reminding themof their responsibility for the Case Conference, Followingthe Plan of Care & Coordination of Care Procedures were reviewed withstaff. 05/25/23 Toensure compliance with the above, staff not in Attendancefor Case Conference will be disciplined, Auditswill continue to be conducted as a QA/QI Projectuntil 100% compliance is attained and 20%of active records will be reviewed.	2023-05-25

	nager or Clinical Supervisor on vices rendered, problems ıcerning patient's needs, and v they can be resolved..." On 05-05-2023 at 10:28 AM, an Office Staff employee provided the job description/policy titled "Staff Nurse/RN (sic Registered Nurse)". The policy indicated, but was not limited to, "... 5. Observes patient and reports to the physician any changes of the patient's condition and reactions to treatment... 7. Reports daily to the Case Manager or Clinical Supervisor on services rendered, problems concerning patient's needs, and how they can be resolved. 8. Involves other disciplines when the need arises..."		DONis responsible	

On 05-03-2023 at 02:40 PM, the clinical record review of Patient #1 was conducted. The record evidenced a plan of care with a start of care of 09-11-2019 and a certification period of 04-23-2023 to 06-21-2023. The plan of care indicated but was not limited to, "... Pediatric SN (Skilled Nurse)/ADL Extended Visit Note Pathway ... Skilled nurse to monitor client's appetite and report any changes in nutritional status ..."

On 05-03-2023 at 02:40 PM, the clinical record of Patient #1 evidenced a verbal order that indicated the patient's weight was to be checked every 1-2 weeks.

On 05-03-2023 at 02:40 PM, the clinical record of Patient #1 evidenced documents titled "Visit Note (SN) (Pediatric) Clinical Note." The documents evidenced Patient #1's weight was checked 1 time a week, on Tuesdays.

eview of Visit Note document completed by LPN #1 evidenced:

03-07-2023, signed by LPN #1, "... Pediatric Vital Signs... lb (pounds): 39... oz (ounces): 0...

	(Kilograms): 17.69..." 03-14-2023, signed by LPN #1, "... Pediatric Vital signs... lb: 39... oz: 0... Kg: 17.69..." 03-21-2023, signed by LPN #1, "... Pediatric Vital signs... lb: 39... oz: 2.0... Kg: 17.75..." 03-28-2023, signed by LPN #1, "... Pediatric Vital signs... lb: 39... oz: 0.5... Kg: 17.70..." 04-04-2023, signed by LPN #1, "... Pediatric Vital signs... lb: 39... oz: 0.9... Kg: 17.72..." 04-11-2023, signed by LPN #1, "... Pediatric Vital signs... lb: 40... oz: 13... Kg: 18.50..." 04-18-2023, signed by LPN #1, "... Pediatric Vital signs... lb: 42... oz: 16... Kg: 19.50..." 04-25-2023, signed by LPN #1, "... Pediatric Vital signs... lb: 36... oz: 6.0... Kg: 16.50..." The clinical record of Patient #1 failed to evidence a communication note made by LPN #1 notifying the Case Manager, RN #1, of the weight change noted from the weight checks for Patient #1 on 04-18-2023 to 04-25-2023 (14% of body weight for a pediatric			

	ient.) On 05-03-2023 at 04:05 PM, the Case Conference Binder was reviewed. The Case Conference Binder failed to evidence a discussion between LPN #1 and RN #1 about Patient #1's weight having decreaded by 6 lbs in a week. During an interview with the Director of Nursing (DON) on 05-04-2023 at 10:32 AM, they indicated Patient #1 had their weights checked at their residence and the nurse did the weights every Tuesday. During a phone interview with LPN #1 on 05-04-2023 at 11:49 AM, the LPN indicated they checked the weight every Tuesday, 1 time a week. LPN #1 stated, "The weight for (sic Patient #1) on 05-02-2023 was 36.8 lbs. I do not call the physician." When queried regarding if they had contacted the nurse every week regarding the weights LPN #1 stated, "I put the weight in my notes every week, so the nurse (sic Registered Nurse) can see it." During a phone interview with RN #1 on 05-04-2023 at 12:05 PM, the RN confirmed they			

	·e Patient #1's case manager. RN indicated they saw the patient recertification every 2 months l would monitor weights and npare to previous weights then. RN indicated they completed ervisory visits of the LPN 1 time onth. RN #1 stated, "I told the J to let me know if there are any ıes, or let the physician or office ow.") IAC 17-12-2(g)			
G0710	Provide services in the plan of care 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; Based on record review and interview, the agency failed to ensure all tasks on the plan of care were completed each care visit for 4 of 4 active clinical records reviewed. (Patient #1, 2, 3, 5) Findings Include: On 05-05-2023 at 09:00 AM, the Director of Nursing (DON) provided a policy titled, "Charting," and was dated	G0710	Mandatory inservice held for all clinical staff re: Procedurefor completing and responsibilities for ThePlan of Care were reviewed and each participant Wasgiven a copy for reference 05/23/23 Demonstrations of the procedurefor trach, G-tube care & infection control was presented & each staff Member returned thedemonstration and was Competencied. Discussed the responsibility for DMEequipment & their responsibility for checking this with each visit tomaintain what patient needs. 05/23/23 20%of medical records will be audited each month	2023-05-23

	icated but was not limited to, "... cedure... 6... staff and erdisciplinary team members cument all findings, servations, skills or tasks formed, interventions, outcomes l/or client response to care..." On 05-03-2023 at 04:20 PM, the Director of Nursing provided a policy titled, "Gastrostomy (sic a tube in the abdomen that brought nutrients to the stomach) Tube Care" and was dated 04-02-2003. The policy indicated but was not limited to, "... Procedure... 5. Gently cleanse peristomal area with soap and water using a spiral motion beginning at the stoma site and working outward... 9. Verify tube placement by either withdrawing gastric content or by injecting 20ml of air into the tube while simultaneously listening over the left upper quadrant with a stethoscope..." On 05-03-2023 at 02:40 PM, the clinical record for Patient #1 was reviewed. The clinical record evidenced a plan of care (POC) with a start of care (SOC) date of 09-11-2019 and a certification period of		Untilcompliance of 100% is met. This willalso be Partof the documentation project (on-going) of the QAcommittee. Reported to QA committee each Month Allclinical staff involved in this report were Counseled,disciplinary report placed in their Personnelfile and the ADON was appointed Tomonitor these individuals entries for the next three Months& counsel them regarding inappropriate Entriesor lack thereof. DON& ADON are responsible jointly.	

	n of care indicated but was not ited to, "... Monitor equipment proper functioning..." On 05-03-2023 at 02:40 PM, the clinical record for Patient #1 was reviewed. The clinical record evidenced documents titled, "Visit Note (SN (sic Skilled Nursing)) (Pediatric) Clinical Note." The documents dated 04-11, 04-12, 04-13, 04-14, 04-15, 04-16, 04-17, 04-18, 04-19, 04-24, 04-25, and 04-26-2023, failed to evidence a date for when the Durable Medical Equipment (DME) was last checked. On 05-04-2023 at 11:30 AM, the clinical record of Patient #2 was reviewed. The clinical record evidenced a POC with a SOC date of 01-21-2016 and a certification period of 04-14-2023 to 06-12-2023. The plan of care orders included, but were not limited to, "...SN to monitor equipment for proper functioning..." On 05-04-2023 at 11:30 AM, the clinical record for Patient #2 was reviewed. The clinical record evidenced documents titled, "Visit Note (SN (sic Skilled Nursing)) (Pediatric) Clinical			

	te." The documents dated 04-01, 02, 04-03, 04-04, 04-05, 04-07, 08, 04-09, 04-10, 04-11, 04-12, 14, and 04-15-2023 failed to dence a date for when the DME ; last checked. On 05-03-2023 at 01:00 PM, the clinical record for Patient #3 was reviewed. The clinical record evidenced a POC with a SOC date of 03-09-2023 and a certification period of 03-09-2023 to 05-07-2023. The plan of care indicated but was not limited to, "... Nurse verified patient's G-J/G-Tube (sic A feeding tube that goes in the stomach) placement before all feedings throughout certification period... Change #4.0 Pediatric Shiley trach (sic an opening in the neck to allow air to the lungs) weekly and as needed via (sic by) SN or caregiver... Emergency equipment... keep within reach at all times... Monitor equipment function and report equipment repair needs to DME provider..." On 05-03-2023 at 01:00 PM, the clinical record for Patient #3 was reviewed. The clinical record evidenced documents titled, "Visit Note (SN (sic Skilled			

	rsing)) (Pediatric) Clinical Note." documents dated 04-12, 04-13, 14, 04-15, 04-17, 04-19, 04-20, 22, 04-23, 04-24, 04-26, 04-27, l 04-29-2023 failed to evidence: The gastrostomy tube's placement was verified before the feeding was restarted. The feeding tube had been changed as evidenced by, "...Nutrition... Bag Change: No...". DME and emergency equipment were monitored as evidenced by, "... Pediatric Assessment... Emergency Equipment Check: (blank)... Ambubag / Extra Trach on site: (blank)... Last date DME Equipment Check: (blank)...".de. The date of the last tracheostomy (an opening in the neck that brought oxygen to the lungs) changed as evidenced by the note indicating, "...Tracheostomy... Ambu bag readily available: No... How often changed: (blank)... Date Last Changed: Unknown...". On 05-03-2023 at 01:00 PM, the clinical record for Patient #3 was reviewed. The clinical			

	ed, "Visit Note (SN (sic Skilled rsing)) (Pediatric) Clinical Note." e documents dated 04-21-2023 l 04-28-2023 failed to evidence: The gastrostomy tube's placement was verified before the feeding was restarted. The feeding tube bag was changed as evidenced by, "...Nutrition... Bag Change: No...". DME and emergency equipment were monitored as evidenced by, "... Pediatric Assessment... Emergency Equipment Check: (blank)... Ambubag / Extra Trach on site: (blank)... Last date DME Equipment Check: (blank)...". The gastrostomy was cleaned with soap and water according to the plan of care orders. The date of the last tracheostomy changed as evidenced by the note indicating, "...Tracheostomy... Ambu bag readily available: No... How often changed: (blank)... Date Last Changed: Unknown... Pathway: Pediatric Tracheostomy... asepsis tech used to change trach..."			

	The clinical record for Patient #3 evidenced documents titled, "Visit Note (SN (sic Skilled Nursing)) (Pediatric) Clinical Note." The documents dated 04-17-2023 and 04-24-2023 failed to evidence: The gastrostomy tube's placement was verified before the feeding was restarted. The gastrostomy was cleaned with soap and water as ordered on the plan of care. The clinical record for Patient #3 evidenced documents titled, "Visit Note (SN (sic Skilled Nursing)) (Pediatric) Clinical Note." The document dated 04-16-2023 failed to evidence: The gastrostomy tube's placement was verified before the feeding was restarted. The feeding tube bag was changed as evidenced by, "...Nutrition... Bag Change: No...". DME and emergency equipment were monitored as evidenced by, "... Pediatric Assessment... Emergency Equipment Check: (blank)...			

	ınk)... Last date DME Equipment ɛck: (blank)...". The gastrostomy was cleaned with soap and water according to the plan of care orders. The date of the last tracheostomy changed as evidenced by the note indicating, "...Tracheostomy... Ambu bag readily available: No... How often changed: (blank)... Date Last Changed: Unknown...". The tracheostomy was cleaned during the visit according to the plan of care orders. On 05-04-2023 at 01:00 PM, the clinical record for Patient #5 was reviewed. The clinical record evidenced a POC with a SOC date of 02-24-2023, and a certification period of 03-16-2023 to 05-14-2023. The POC included orders "... SN to Nurse will clean the G-J site daily and prn (sic as needed) with soap and water. Pat site dry. SN to Nurse will verify placement before feedings... SN to monitor equipment for proper functioning..." The clinical record evidenced			

	:uments titled, "Visit Note (SN Skilled Nursing)) (Pediatric) ıical Note." The document dated 19 (RN #3), 03-20 (RN #3), 21 (RN #3), 03-22 (RN #3), 23 (RN #3), 03-26 (RN #3), 27 (RN #3), 03-28 (RN #3), 29 (RN #3), 04-02 (RN #3), 03 (RN #3), 04-04 (RN #3), 05 (RN #3), 04-09 (RN #3), 11-2023 (RN #3) failed to ɗence: The gastrostomy tube's placement was verified before the feeding was restarted. The feeding tube bag was changed. DME and emergency equipment were monitored as evidenced by, "... Pediatric Assessment... Emergency Equipment Check: (blank)... Ambubag / Extra Trach on site: (blank)... Last date DME Equipment Check: (blank)...". The gastrostomy site was cleaned with soap and water according to the plan of care. The clinical record evidenced documents titled, "Visit Note (SN (sic Skilled Nursing)) (Pediatric) Clinical Note." The			

	24 (RN #2), 03-28 (RN #2), 30 (RN #2), 03-31 (RN #2), 04 (RN #2), 04-06 (RN #3), 07 (RN #2), 04-10 (RN #3), 11 (RN #2), 04-13 (RN #2), 14 (RN #2), 04-18 (RN #2), 20 (RN #2), 04-21 (RN #2), 25 (RN #2), 04-27 (RN #2), 28-2023 (RN #2) failed to dence: The feeding tube bag was changed. DME and emergency equipment were monitored as evidenced by, "... Pediatric Assessment... Emergency Equipment Check: (blank)... Ambubag / Extra Trach on site: (blank)... Last date DME Equipment Check: (blank)..." The gastrostomy site was cleaned with soap and water according to the plan of care order. The clinical record evidenced documents titled, "Visit Note (SN (sic Skilled Nursing)) (Pediatric) Clinical Note." The document dated 03-30-2023 (RN #3) failed to evidence:			

	The gastrostomy tube's placement was verified before the feeding was restarted. DME and emergency equipment were monitored as evidenced by, "... Pediatric Assessment... Emergency Equipment Check: (blank)... Ambubag / Extra Trach on site: (blank)... Last date DME Equipment Check: (blank)...". The agency failed to provide all ordered care in the plan of care and failed to implement the agency's policies and procedures. During an interview with the DON on 05-03-2023 at 02:58 PM, the DON confirmed the nurses are to verify the G-J tube placement and document it before administering medication and feedings. The DON indicated the feed tubing was changed to be changed every day, if the caregivers of a patient changed the bag, the nurses were to ask if the task was completed and document it. At 2:59 PM, the DON confirmed the nurses were to change the tracheostomy according to the physician's			

	·e to ask the caregivers of ients if they had performed the ‹ and document it. The nurses ·e to check the tracheostomy to ure it was intact. The DON ıfirmed the nurses were to check equipment every visit and ure the equipment was ctioning appropriately.) IAC 17-14-1(a)(1)(H) and (2)(F)			
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and interview, the agency failed to communicate a change in condition to the physician for 1 of 2 (Patient #1) active patient records reviewed with weight checks in their plan of care. Findings Include: On 05-03-2023 at 04:20 PM, the Director of Nursing (DON) provided a policy titled, “Physician Order Policy” that was dated 10-23-2010. The	G0718	Mandatory inservice was held for all clinical staff to review the staff nurseresponsibilities regarding communication with patient's physician. Stressed that with any “Change InCondition” the nurse is to advise the patient’s physician ofthe change, obtain any orders the physician determinesis necessary and to document the Order(s)and the conversation. 05/23/23 Willcontinue to audit 20% of medical records asa part of the QA/QI projects, report to the QAcommittee monthly until 100% compliance Isattained. ADONwill monitor entries of staff involved for thenext three months or until staff member is 100%compliant with this	2023-05-23

	ited to, "... Professional licensed sonnel contact the client's ysician:... b. When there are nges in the client's condition...". On 05-03-2023 at 02:40 PM, the clinical record review of Patient #1 was conducted. The record evidenced a plan of care with a start of care of 09-11-2019 and a certification period of 04-23-2023 to 06-21-2023. The plan of care indicated but was not limited to, "... Pediatric SN (Skilled Nurse)/ADL Extended Visit Note Pathway... Skilled nurse to monitor client's appetite and report any changes in nutritional status...". On 05-03-2023 at 02:40 PM, the clinical record of Patient #1 evidenced a verbal order that indicated the patient's weight was to be checked every 1-2 weeks. On 05-03-2023 at 02:40 PM, the clinical record of Patient #1 evidenced documents titled "Visit Note (SN) (Pediatric) Clinical Note." The documents evidenced Patient #1's weight was checked 1 time a week, on Tuesdays.		process. DON& ADON are responsible.	

	review of visit notes evidenced all were signed by LPN #1 and: 03-07-2023, "... Pediatric Vital Signs ... lb (pounds): 39... oz (ounces): 0... Kg (Kilograms): 17.69..." On 03-14-2023, "... Pediatric Vital signs ... lb: 39... oz: 0... Kg: 17.69..." On 03-21-2023, "... Pediatric Vital signs ... lb: 39... oz: 2.0... Kg: 17.75..." On 03-28-2023, "... Pediatric Vital signs ... lb: 39... oz: 0.5... Kg: 17.70..." On 04-04-2023, "... Pediatric Vital signs ... lb: 39... oz: 0.9... Kg: 17.72..." On 04-11-2023, "... Pediatric Vital signs ... lb: 40... oz: 13... Kg: 18.50..." On 04-18-2023, "... Pediatric Vital signs ... lb: 42... oz: 16... Kg: 19.50..." On 04-25-2023, "... Pediatric Vital signs ... lb: 36... oz: 6.0... Kg: 16.50..." The clinical record of Patient #1 failed to evidence a communication note made by			

	J #1 notifying the Case nager, RN #1, of the weight nge noted from the weight cks for Patient #1 on 18-2023 to 04-25-2023. On 05-03-2023 at 04:05 PM, the Case Conference Binder was reviewed. The Case Conference Binder failed to evidence a discussion between LPN #1 and RN #1 about Patient #1's weight decreasing by 6 lbs in one (1) week. On 05-05-2023 at 10:25 AM, the documents from Entity F, Patient #1's physician's (Person N) office, were reviewed. The documents failed to evidence the agency contacted Person N about Patient #1's decrease in weight if 14% or 6 pounds in one (1) week. During an interview with the Director of Nursing (DON) on 05-04-2023 at 10:32 AM, they indicated Patient #1 had their weights checked at their residence and the nurse did the weights every Tuesday. During a phone interview with LPN #1 on 05-04-2023 at 11:49 AM, the LPN indicated they checked the weight every			

:ed, "The weight for (sic Patient on 05-02-2023 was 36.8 lbs. I not call the physician." When :ried regarding if they had ıtacted the nurse every week arding the weights LPN #1 :ed, "I put the weight in my es every week, so the nurse (sic ;istered Nurse) can see it."

During a phone interview with RN #1 on 05-04-2023 at 12:05 PM, the RN confirmed they were Patient #1's case manager. RN #1 indicated they saw the patient for recertification every 2 months and would monitor weights and compare to previous weights then. The RN indicated they completed supervisory visits of the LPN 1 time a month. RN #1 stated, "I told the LPN to let me know if there are any issues, or let the physician or office know."

During an interview with the DON on 05-05-2023 at 10:33 AM, the DON confirmed the plans of care and physician notes were the only documents Entity F provided them. There was no evidence the physician, Person N, was notified of Patient #1 weight loss.

) IAC 17-14-1(a)(1)(2)(G)

G0726	Nursing services supervised by RN 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). Based on record review and interview, the agency failed to ensure a Registered Nurse (RN) supervised a Licensed Practical Nurse (LPN) to ensure the LPN performed care according to the plan of care (POC) in 1 of 2 patients (Patient #1) with weight checks in their care plans. Findings Include: On 05-05-2023 at 09:00 AM, the Office Manager provided the job description/policy titled "Staff Nurse / Licensed Practical Nurse (LPN)" with a date of 09-04-2012. The police indicated but was not limited to, "... 4. Observes patient and reports to the physician/RN (sic Registered Nurse) any changes of the patient's condition and reactions to treatment... 6. Reports daily to the Case Manager or Clinical Supervisor on services rendered, problems	G0726	Mandatory inservice was held and the Case Managerjob description was reviewed and Presenterspecifically pointed out to the Case Managersthat they are responsible for ensuring thestaff is following the Plan of Care, providing Coordinationof Care and for communications withall parties of the team in Agency & outside Agency includingthe patient's physician. They were reminded of what they should be observing at home visit, a supervisory visit& the documentation needed as well as what they need to report to nursingadministration. 05/23/23 CaseManager involved in this report was Counseledregarding the supervisory visits of an LPNwith regard to when it should occur, what she/he Isto observe, what her responsibilities with the LPN areupon completion of the supervisory visits and the Documentationneeded 06/01/23 ADON will ensure the minutes ofthe Case Conferences are followed through regarding The	2023-06-01

	v they can be resolved…". On 05-05-2023 at 10:28 AM, an Office Staff employee provided the job description/policy titled "Staff Nurse/RN (sic Registered Nurse)". The policy indicated but was not limited to, "… 5. Observes patient and reports to the physician any changes of the patient's condition and reactions to treatment… 7. Reports daily to the Case Manager or Clinical Supervisor on services rendered, problems concerning patient's needs, and how they can be resolved. 8. Involves other disciplines when the need arises…". On 05-03-2023 at 04:20 PM, the Director of Nursing (DON) provided a policy titled, "Physician Order Policy" that was dated 10-23-2010. The policy indicated but was not limited to, "… Professional licensed personnel contact the client's physician:… b. When there are changes in the client's condition…". On 05-03-2023 at 02:40 PM, the clinical record review of Patient #1 was conducted. The		supervision by the CaseManagers and the Documentation is in therecord. This will continue Until 100% compliance. A new process for supervisionof the Case Managers has been activated for nursingadministration. The DONand ADON will make a supervisory visit each Month to ensure the CaseManagers are performing Their duties and will work withthe Case Manager if he/she is not performing all duties as should be. Counseling forms will becompleted as needed and Placed in each CM"s personnelfile. 06/01/23 DON& ADON are responsible	

n a start of care of 09-11-2019
l a certification period of
23-2023 to 06-21-2023. The
n of care indicated but was not
ited to, "... Pediatric SN (Skilled
se)/ADL Extended Visit Note
hway... Skilled nurse to monitor
nt's appetite and report any
nges in nutritional status...".

On 05-03-2023 at 02:40 PM, the clinical record of Patient #1 evidenced a verbal order that indicated the patient's weight was to be checked every 1-2 weeks.

On 05-03-2023 at 02:40 PM, the clinical record of Patient #1 evidenced documents titled "Visit Note (SN) (Pediatric) Clinical Note." The documents evidenced Patient #1's weight was checked 1 time a week, on Tuesdays.

eview of visit notes evidenced all were signed by LPN #1 and:

03-07-2023, "... Pediatric Vital Signs ... lb (pounds): 39... oz (ounces): 0... Kg (Kilograms): 17.69..."

On 03-14-2023, "... Pediatric Vital signs ... lb: 39... oz: 0... Kg: 17.69..."

On 03-21-2023, "... Pediatric Vital signs ... lb: 39... oz: 2.0... Kg: 17.75..."

On 03-28-2023, "... Pediatric Vital signs ... lb: 39... oz: 0.5... Kg: 17.70..."

On 04-04-2023, "... Pediatric Vital signs ... lb: 39... oz: 0.9... Kg: 17.72..."

On 04-11-2023, "... Pediatric Vital signs ... lb: 40... oz: 13... Kg: 18.50..."

On 04-18-2023, "... Pediatric Vital signs ... lb: 42... oz: 16... Kg: 19.50..."

On 04-25-2023, "... Pediatric Vital signs ... lb: 36... oz: 6.0... Kg: 16.50..."

The clinical record of Patient #1 failed to evidence a communication note made by LPN #1 notifying the Case Manager, RN #1, of the weight change noted from the weight checks for Patient #1 on 04-18-2023 to 04-25-2023.

On 05-03-2023 at 04:05 PM, the Case Conference Binder was reviewed. The Case Conference Binder failed to evidence a

cussion between LPN #1 and RN about Patient #1's weight creasing by 6 lbs in a week.

On 05-05-2023 at 10:25 AM, the documents from Entity F, Patient #1's physician's (Person N) office, were reviewed. The documents failed to evidence the agency contacted Person N about Patient #1's decrease in weight.

During an interview with the Director of Nursing (DON) on 05-04-2023 at 10:32 AM, they indicated Patient #1 had their weights checked at their residence and the nurse did the weights every Tuesday.

During a phone interview with LPN #1 on 05-04-2023 at 11:49 AM, the LPN indicated they checked the weight every Tuesday, 1 time a week. LPN #1 stated, "The weight for (sic Patient #1) on 05-02-2023 was 36.8 lbs. I do not call the physician." When queried regarding if they had contacted the nurse every week regarding the weights LPN #1 stated, "I put the weight in my notes every week, so the nurse (sic Registered Nurse) can see it."

During a phone interview with

	#1 on 05-04-2023 at 12:05 PM, RN confirmed they were Patient s case manager. RN #1 indicated y saw the patient for ertification every 2 months and uld monitor weights and npare to previous weights then. RN indicated they completed ervisory visits of the LPN 1 time onth. RN #1 stated, "I told the to let me know if there are any ies, or let the physician or office w." During an interview with the DON on 05-05-2023 at 10:33 AM, the DON confirmed the plans of care and physician notes were the only documents Entity F provided them. There was no evidence the physician, Person N, was notified of the Patient #1's weight loss. IAC 17-14-1(a)(1)(J)			