STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157683	A. BUILDING B. WING	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUNOVA HOME CARE LLC	6910 NORTH MAIN STREET, SUITE 23A, GRANGER, IN, 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: 013602 Current Census: 101 Skilled unduplicated census for the last 12 months: 826 Survey Dates: 5/16/2023, 5/17/2023, 5/18/2023, 5/19/2023, 5/22/2023, 5/23/2023, 5/24/2023, and 5/25/2023. Quality Review Completed 06/09/2023	N0000		

N0408	Licensure 410 IAC 17-10-1(d) Rule 10 Sec. 1(d) Disclosure of ownership and management information must be made to the department at the time of the home health agency's initial request for licensure, for each survey, and at the time of any change in ownership or management. The disclosure must include the names and addresses of the following: (1) All persons having at least five percent (5%) ownership or controlling interest in the home health agency. (2) Each person who is: (A) an officer; (B) a director; (C) a managing agent; or (D) a managing employee; of the home health agency and evidence supporting the qualifications required by this article. (3) The corporation, association, or other company that is responsible for the management of the home health agency. (4) The chief executive officer and the chairman or equivalent position of the governing body of that corporation, association, or other legal entity responsible for the management of the home health agency. Based on record review and interview, the home health agency failed to inform the	N0408	Agency had listed Clinical Manager #1 with the IDOH as an Alternate. Administrator faxed the STAFF UPDATE form to IDOH to note staff change on 06/13/2023. Administrator will be responsible for ensuring updating of staff change is occurring timely with IDOH.	2023-06-13

	(IDOH) when a change in the agency's management occurred. The findings include: Record review evidenced an organizational chart obtained on 5/17/2023, which indicated Clinical Manager #1 was the Clinical Manager. Review of pre-survey notes from the State of Indiana, on 5/16/2023, indicated Person #3 (previous Clinical Manager) was on file as the Clinical Manager. Employee record review on 5/17/2023, evidenced Clinical Manager #1 started the job of Clinical Manager on 4/26/2023. Record review failed to evidence the home health agency disclosed to the State of Indiana, the name and address of Clinical Manager #1 when they began their role as Clinical Manager. During an interview on 5/16/2023, at 12:51 PM, the Administrator indicated Clinical Manager #1 was the Clinical Manager, but they had not submitted the change of			

	Indiana yet.			
N0451	Home health agency administration/management 410 IAC 17-12-1(c)(8) Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence. Based on record review and interview, the Administrator failed to ensure that a qualified person was authorized in writing to act in the Administrator's absence. The findings include: Review of all employee personnel files was conducted 5/17/2023, with the Administrator. This review failed to evidence a personnel record for an Alternate Administrator. Review of an organizational chart on 5/17/2023, failed to evidence a current Alternate Administrator.	N0451	The GB assigned an Alternate Administrator who is the current Clinical Manager on 05/19/2023. GB will ensure an Alternate Administrator is assigned to agency if there is a change in staff and reported to IDOH in a timely fashion. Faxed with an updated Staff Change Form on 6/15/23. Governing Body (GB) will be responsible for assigning any Alternate Administrator in future.	2023-06-15

	During an interview on 5/16/2023, at 12:51 PM, the Administrator indicated the Clinical Manager would take the position of the Alternate Administrator in the future but had not yet done so. The Administrator indicated there was no current Alternate Administrator.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable	N0488	All field staff were educated on 05/25/2023, 06/07/2023 and on 06/12/2023 regarding agency Discharge Policy that agency needed to provide a notice of discharge of service to the patient, patient's legal representative, or other individual responsible for the patient's care, at least fifteen (15) calendar days before the services were stopped and/or scheduled to be stopped. Agency to continue with monthly education to all clinicians on Discharge Policy to ensure they continue to meet the requirement. Administrator to ensure monthly education is being sent to all clinicians on Discharge Policy.	2023-06-12

regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.

Based on observation, record review, and interview, the home health agency failed to ensure it provided a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care, at least fifteen (15) calendar days before the services were stopped and/or scheduled to be stopped for 1 of 6 discharged clinical records reviewed; and 1 of 1 active clinical records reviewed with a home visit for the purpose to discharge services.

The findings include:

1. Record review evidenced an

	titled "Transfer and Discharge Policy" which stated, "... Agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen calendar days before the services are stopped ...." 2. Observation of a home visit for Patient #8 was conducted on 5/18/2023, at 12:00 PM, to observe a discharge physical therapy visit. During the visit, a document titled "Notice of Medicare Non-Coverage" was observed in the patient's home folder, and was signed on 5/15/2023 (3 days prior to discharge), notifying patient they would be discharged on 5/19/2023. Clinical record review for Patient #8 was completed on 5/23/2023, for certification period 5/4/2023 - 7/2/2023, and discharge date 5/18/2023. Record review failed to evidence discharge notice was provided to the patient prior to 5/15/2023. During an interview on			

	5/23/2023, at 12:45 PM, the Administrator indicated the agency provided most patients with 2 days discharge notice if they were discharging due to goals being met. The Administrator indicated this discharge notice would be documented in the notes, or on the "Notice of Medicare Non-Coverage" form. 3. Clinical record review for Patient #18 was completed on 5/24/2023, for certification period 4/13/2023 - 6/11/2023, and discharge date 5/10/2023. Record review evidenced a resumption of care assessment conducted on 5/3/2023, which indicated the patient was made aware of discharge plan for 5/10/2023 (7 days prior to discharge). During an interview on 5/24/2023, at 2:53 PM, the Administrator indicated the patient did not receive 15 day discharge notice.			
N0505	Patient Rights 410 IAC 17-12-3(b)(2)(D)(ii)	N0505	Agency educated all clinicians on 05/25/2023 and then in-serviced with all admitting disciplines on the licensure requirement of patient participating in the development of the plan of care prior to the provision of care	2023-06-12

	Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment. Based on observation, record review, and interview, the home health agency failed to ensure the patient participated in the development of the plan of care prior to the provision of care and/or any changes to the plan of care, in 5 of 7 clinical records reviewed with a home visit (Patient #1, #2, #5, #7, #9). The findings include:		and/or any changes made to the plan of care on 6/07/23. Effective week of 06/12/2023 Administrator or DCS to make in person supervisory visits 1x/wk every 2 weeks to patient's home on all admitting Clinicians to ensure compliance with the requirement for the next 30 days. Administrator responsible for ensuring 100% compliance.	

	4. Record review for Patient #1 occurred on 5/25/2023. Record review evidenced a plan of care for certification period 4/27/2023 - 6/25/2023 (start of care date 4/27/2023). The document was an incomplete "draft", and was effective 29 days prior to the record review. During an interview on 5/25/2023 at 11:15 AM, the Administrator indicated the plan of care was incomplete, and the patient didn't have a copy. 5. A home visit occurred on 5/19/2023 at 11:40 AM with Patient #2 and Registered Nurse (RN) #1. Review of the Patient's home folder failed to evidence a plan of care, and the Patient indicated she didn't know when the next nursing visit was. Record review for Patient #2 was completed on 5/25/2023, which evidenced an updated plan of care for certification period 5/07/2023 - 7/05/2023 (start of care date 11/08/2022). The document was an incomplete "draft", and was effective 13 days prior to the home visit observed on 5/19/2023.			

During an interview on 5/25/2023 at 11:36 AM, the Administrator indicated there was a summary form to be included in the home folder, but it didn't include all treatments/orders for care.

6. A home visit occurred on 5/19/2023 at 1:00 PM with Patient #5. Review of the Patient's home folder failed to evidence a plan of care.

Record review for Patient #5 was completed on 5/25/2023, which evidenced an updated plan of care for certification period 5/05/2023 - 7/03/2023 (start of care date 5/05/2023). The document was an incomplete "draft", and was effective 14 days prior to the home visit observed on 5/19/2023.

During an interview on 5/25/2023 at 12:15 PM, the Administrator indicated the plan of care was incomplete, and confirmed the patient didn't receive a copy of the plan of care because it wasn't done yet.

1. Record review evidenced an undated agency policy revised 5/24/2023, titled "Patient Rights

	stated, "... Participate in, be informed about, with respect to: ... the care to be furnished ... establishing and revising the plan of care ...." 2. Observation of a home visit for Patient #7 was conducted on 5/18/2023, at 10:40 AM, to observe a routine physical therapy visit. During the visit, a home folder was reviewed, which failed to include a plan of care, or include all treatments/interventions to be performed. During an interview on 5/23/2023, at 11:13 AM, the Clinical Manager indicated they verbally reviewed the plan of care during the start of care assessment but didn't provide patients with a written plan of care. The Clinical Manager indicated the home folder should have included a paper with all the interventions and treatments on it, to inform the patient of the care to be provided. 3. Observation of a home visit for Patient #9 was conducted on 5/18/2023, at 2:00 PM, to observe a routine skilled nurse visit. During the visit, a home			

	folder was reviewed, which failed to include a plan of care, or include all treatments/interventions to be performed.			
N0520	Patient Care 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. Based on observation, record review, and interview, the home health agency failed to ensure patients were only accepted for care if the agency could meet the patient's needs, for 4 of 12 active clinical records reviewed (Patient #2, 4, 7, 12). The findings include: * Record review evidenced an undated agency policy obtained 5/24/2023, titled "Transfer and Discharge Policy", which evidenced a patient discharge/transfer may occur "for cause", if the patient's behavior was uncooperative to	N0520	On 06-07-2023 Agency in-serviced all admitting clinicians on licensure requirement on patients being 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 and the patient's place of residence. Effective 06-12-2023 DCS to ensure communication with the admitting physician is being performed to ensure agency is able to adequately meet the health needs of patients. DCS to ensure admitting physician is being notified of all disciplines appropriate to meet patients needs. All admitting home health orders are being reviewed by DCS to ensure compliance with the licensure requirement. Effective 06-12-2023 DCS to ensure 100% compliance with communication with physicians patients are only being accepted for care if they agency is able to meet the patients health needs.	2023-06-12

	was seriously impaired. 4. A home visit occurred on 5/19/2023 at 11:40 AM with Patient #2 and Registered Nurse (RN) #1. Prior to entering the patient's home, RN #1 indicated the patient was very non-compliant with keeping the lower leg elevated to reduce swelling, worsening of wounds and decrease the copious drainage from the wounds, and the wounds were just getting worse because of it. RN #1 performed wound care to the patient's right lower leg/foot, which revealed a copious amount of drainage on the old dressings, and the bottom of the patient's foot was white (dead skin from exposure to moisture for to long). RN #1 indicated nursing visits were made twice weekly, but only once per week if the patient went to the wound clinic; and that's the frequency ordered by the wound clinic. Record review for Patient #2 was completed on 5/25/2023, which evidenced a recertification of services order dated 5/05/2023, for certification period 5/07/2023 - 7/05/2023 (start of care date			

	11/08/2022). The document indicated the patient was continually non-compliant with teaching for offloading (relieving pressure or not bearing weight) and wound care, skilled nursing visits were ordered twice weekly, but only once weekly if the patient went to the wound clinic. During an interview on 5/16/2023 at 12:41 PM, the Clinical Manager indicated she would notify the physician for non-compliance issues, make sure it was documented in the chart, and provide patient education. The Clinical Manager failed to indicate a patient may be discharged if their needs could not be met. During an interview on 5/25/2023 at 11:36 AM, the Clinical Manager indicated the patient had a history of non-compliance, and the wound continually worsened. The Clinical Manager indicated there wasn't a request for an increase in nursing visit frequency made to the physician during the recertification visit, the patient would probably benefit from weekly wound clinic			

	appointments as well, but she had transportation issues. The Administrator indicated she wasn't sure about the procedure to discharge a patient from services for non-compliance with treatment/orders. 5. Record review for Patient #4 was completed on 5/25/2023, which evidenced a 1. Record review evidenced an undated agency policy obtained 5/24/2023, titled "Referral/Admission Policy" which stated, "... Before accepting a client for services, the agency ensures that it can meet the client's medical, nursing, rehabilitative, and psychosocial needs in the client' place in the residence ... The assigned RN/therapist will complete the initial start of care evaluation within 48 hours of the agency obtaining referral admitting orders once the referral has been processed, or date of physician order ...." 2. Clinical record review for Patient #7 was completed on 5/24/2023, for certification period 4/26/2023 - 6/24/2023. Record review evidenced a			

	referral order dated 4/14/2023, which indicated the patient discharged home on 4/14/2023, from a skilled nursing facility, and was being referred for home health services including skilled nursing and physical therapy. Record review evidenced a communication note dated 4/17/2023, which indicated the patient requested to have initial visit after 4/20/2023. Record review evidenced a communication note dated 4/24/2023, which indicated the patient was expecting the nurse to do the initial visit on 4/21/2023, but nobody came out to see them. Record review indicated the patient received an initial skilled nurse visit on 4/26/2023 (12 days after referral received). Record review evidenced an order dated 4/25/2023, for physical therapy services to see the patient. Record review evidenced a communication note dated 4/27/2023, which indicated the physical therapist was unable to see the patient the week of 4/23/2023, due to the physical			

	therapist's schedule conflicts. Record review evidenced the patient received a physical therapy evaluation on 5/3/2023 (19 days after the initial referral order). During an interview on 5/23/2023, at 11:07 AM, the Administrator indicated this patient's start of care assessment was delayed to due scheduling issues. The Administrator indicated they should have had an order for the delay in start of care. The Administrator indicated the agency had 48 hours to see the patient or get a physician order to delay the start of care assessment, once the referral was received. At 11:28 AM, the Administrator indicated the physical therapist should have delayed starting services only if the patient requested the delay. 3. Clinical record review for Patient #12 was completed on 5/23/2023, for certification period 2/18/2023 - 4/18/2023. Record review evidenced a referral order dated 2/9/2023, which indicated the patient would discharge home from the nursing home on 2/13/2023,			

	and would require skilled nursing, physical therapy, home health aide, and occupational therapy services. Record review evidenced a start of care visit note dated 2/18/2023, which indicated the patient was not seen for services until 2/18/2023 (5 days after discharge home). Record review evidenced a communication note dated 2/17/2023, which indicated the agency could not get ahold of the physician, and this was why the initial assessment visit was delayed. Record review evidenced an order dated 2/17/2023, which indicated the home health agency notified the physician that they could not offer the patient occupational therapy or home health aide services as ordered, but failed to evidence the patient was referred to another home health agency which could offer the patient the necessary home health services. Record review failed to evidence the patient received home health aide services or			

	ordered. During an interview on 5/23/2023, at 2:50 PM, the Clinical Manager indicated the agency couldn't staff occupational therapy or home health aide services for this patient. The Clinical Manager indicated they notified the patient and the physician and reviewed a list of community resources with the patient. The Clinical Manager indicated the patient did not want a bath aide but was not sure if this was documented.			
N0522	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on observation, record review, and interview, the home health agency failed to ensure the patient received all care/treatment based on the plan of care, for 6 of 12 active	N0522	Agency educated all field staff with a special in-service to admitting clinicians on medical care following a written a plan of care that is established and periodically reviewed by the physician. Effective 06/19/23 DCS is responsible for QA of all wound care patients every 2 weeks to ensure all wound care orders are being followed and documented appropriately, agency has implemented this in QAPI. DCS is responsible for ensuring 20% of discharges occurring effective 06/19/2023 have a QA to ensure 100% compliance with following a plan of care for the next 30 days.	2023-06-07

clinical records reviewed (Patient #1, 2, 7, 9, 11, 12)

The findings include:

5. Clinical record review for Patient #1 was completed on 5/25/2023. Record review evidenced an initial plan of care for certification period 4/27/2023 - 6/25/2023. The document evidenced Physical Therapy (PT) orders to perform the following tasks: core strengthening, bed mobility training, teach safe stair climbing skills, and teach fall prevention/safety.

Record review evidenced Physical Therapy Assistant (PTA) visit notes, dated 5/4/2023, 5/06/2023, 5/09/2023, and 5/11/2023, all of which failed to evidence the PTA provided core strengthening or bed mobility training; or taught safe stair climbing skills or fall prevention/safety.

During an interview on 5/25/2023 at 11:15 AM, the Administrator indicated she would expect the clinicians to perform ordered tasks on the plans of care.

6. A home visit occurred on

	5/19/2023 at 11:40 AM with Patient #2 and Registered Nurse (RN) #1. Observed the patient wore supplemental oxygen via nasal canula (small tubes inserted into the nares to administer oxygen), was sitting in a wheelchair with neither leg elevated, was visibly obese, and the right lower leg had a dressing on from below the knee down to toe toes. RN #1 removed the old dressing, which revealed a copious amount of drainage and severe wounds. RN #1 failed to educate the patient about food choices to promote wound healing and weight loss, or signs/symptoms of congestive heart failure (CHF) (inability of the heart to effectively pump blood, which causes fluid build up) and chronic obstructive pulmonary disease (COPD) (breathing problems due to poor lung function) exacerbation to report. Record review for Patient #2 was completed on 5/25/2023, which evidenced a plan of care for certification period 5/07/2023 - 7/05/2023 (start of care date 11/08/2022). The document evidenced the patient's diagnoses included			

CHF and COPD; and the patient used oxygen continuously.

Record review evidenced skilled nursing visit notes dated 5/09/2023, 5/12/2023, 5/16/2023, and 5/19/2023, all of which failed to evidence the nurse educated the patient related to diagnoses of CHF or COPD, dietary needs, or oxygen use/precautions.

During an interview on 5/25/2023 at 11:36 AM, the Clinical Manager indicated the nurses should educate patients about disease processes on the plans of care.

1. Record review evidenced an undated agency policy, obtained 5/24/2023, titled "Therapy Services" which stated, "... Any therapy services offered by AuNOVA Home Care, directly or under contractual agreement, shall be performed by or under the supervision of qualified Therapist in accordance with the Plan of Care ...."

2. Clinical record review for Patient #7 was completed on 5/23/2023. Record review evidenced a physical therapy plan of care for certification period 4/26/2023 - 6/24/2023,

	which indicated the physical therapist or assistant was to perform the following tasks: core strengthening, teach safe stair climbing skills, teach fall prevention/safety, and establish/upgrade home exercise program. Record review evidenced a physical therapy visit note dated 5/9/2023, which indicated the therapy assistant failed to perform core strengthening and failed to teach safe stair climbing skills and fall prevention/safety. Record review evidenced a physical therapy visit note dated 5/12/2023, which indicated the therapy assistant failed to perform core strengthening, and failed to teach safe stair climbing skills and fall prevention/safety. Record review evidenced a physical therapy visit note dated 5/16/2023, which indicated the therapy assistant failed to perform core strengthening, and failed to teach safe stair climbing skills and fall prevention/safety, and failed to establish/upgrade home exercise program.			

During an interview on 5/23/2023, at 12:00 PM, the Administrator indicated the clinicians weren't performing every intervention ordered every visit, but were performing the pertinent interventions.

3. Clinical record review for Patient #9 was completed on 5/23/2023, for certification periods 3/8/2023 - 5/6/2023, and 5/7/2023 - 7/5/2023. Record review evidenced a wound care order dated 3/16/2023, which included the following left great toe wound care orders: apply prisma (collagen wound dressing) to base of great toe, paint remainder of toes with betadine (antiseptic wound treatment), pad the toe with gauze and kerlix (gauze wrap), change dressing twice weekly.

Record review evidenced a skilled nurse visit note dated 3/28/2023, which failed to evidence the nurse applied kerlix to the wound as ordered.

Record review evidenced a skilled nurse visit note dated 4/1/2023, which failed to evidence the nurse applied kerlix to the wound as ordered.

	Record review evidenced a skilled nurse visit note dated 4/8/2023, which failed to evidence the nurse applied kerlix to the wound as ordered. Record review evidenced a wound care order dated 4/13/2023, which included the following left great toe wound care orders: paint the toes with betadine, pad toe with gauze and kerlix, change dressing twice weekly. Record review evidenced a skilled nurse visit note dated 4/18/2023, which failed to evidence the nurse applied gauze and kerlix to the wound as ordered. Record review evidenced a skilled nurse visit note dated 4/21/2023, which failed to evidence the nurse applied gauze and kerlix to the wound as ordered. Record review evidenced a skilled nurse visit note dated 4/25/2023, which failed to evidence the nurse applied gauze and kerlix to the wound as ordered. Record review evidenced a skilled nurse visit note dated			

	4/28/2023, which failed to evidence the nurse applied gauze and kerlix to the wound as ordered. Record review evidenced a skilled nurse visit note dated 5/2/2023, which failed to evidence the nurse applied gauze and kerlix to the wound as ordered. Record review evidenced a skilled nurse visit note dated 5/9/2023, which failed to evidence the nurse applied gauze and kerlix to the wound as ordered. During an interview on 5/23/2023, at 2:20 PM, the Clinical Manager indicated the nurses should have been providing wound care as was ordered. 4. Clinical record review for Patient #11 was completed on 5/23/2023. Record review evidenced a plan of care for certification period 4/7/2023 - 6/5/2023, which included the following wound care: clean wound with soap and water or wound cleanser, apply hydrofera blue (antimicrobial wound dressing), apply ABD			

	kerlix (gauze roll), and tubigrips (compression stockinette), change daily. Record review evidenced skilled nurse visit notes dated 4/11/2023, and 4/18/2023, which failed to evidence the nurse applied tubigrips as ordered. Record review evidenced an order dated 4/24/2023, which included the following wound care orders: place black foam to right lower extremity wounds, and bridge over to communicate with eachother, skin prep to peri wound, then duoderm (protective wound dressing), apply tubigrips, change twice weekly. Record review evidenced a skilled nurse visit note dated 4/26/2023, which failed to evidence the nurse applied the skin prep, duoderm, and tubigrips as ordered. During an interview on 5/23/2023, at 4:25 PM, the Clinical Manager indicated the clinicians should always have applied dressing care as was ordered. 5. Clinical record review for			

	Patient #12 was completed on 5/23/2023, for certification periods 2/18/2023 - 4/18/2023, and 4/19/2023 - 6/17/2023. Record review evidenced a plan of care for certification period 2/18/2023 - 4/18/2023, which indicated wound care was to be performed to a back wound as follows: cleanse wound with normal saline, apply granulofoam (foam dressing) to wound, apply wound vac at 125 mmHg (millimeters of mercury), change three times weekly. This plan of care indicated the nurses were to change a PICC (peripherally inserted central catheter/intravenous line) line dressing weekly. Record review evidenced skilled nurse visit notes dated 4/4/2023, and 4/7/2023, which failed to evidence the wound was cleansed with normal saline, and failed to evidence the wound vac was set to 125 mmHg as ordered. Record review evidenced a plan of care for certification period 4/19/2023 - 6/17/2023, which indicated wound care was to be performed to a back wound as follows: cleanse wound with normal saline, apply			

	granulofoam (foam dressing) to wound, apply wound vac at 125 mmHg (millimeters of mercury), change twice weekly. This plan of care indicated the nurses were to change a PICC (peripherally inserted central catheter/intravenous line) line dressing weekly. Record review evidenced skilled nurse visit notes dated 4/24/2023, 4/28/2023, 5/3/2023, 5/5/2023, 5/10/2022, and 5/11/2023, which failed to evidence the wound was cleansed with normal saline as ordered. Record review evidenced skilled nurse visit notes dated 4/11/2023, 4/13/2023, 4/14/2023, which failed to evidence the PICC line dressing change was performed for the week of 4/9/2023, as ordered. Record review evidenced a skilled nurse visit note dated 5/5/2023, which indicated a dry dressing was applied to a new right heel wound. Record review failed to evidence orders for a dry dressing. During an interview on 5/23/2023, at 3:00 PM, the Clinical Manager indicated the			

	nurses should have been performing wound care and PICC dressing changes as ordered. At 3:35 PM, the Clinical Manager indicated they should have put in orders for the dry dressing being applied to the right heel.			
N0524	Patient Care 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	N0524	Agency Inserviced on 06/07/2023 with all admitting clinicians to ensure they were noting all PLAN OF CARE requirements. Administrative staff was also educated on importance of formatting a plan of care to be sent to the physician timely. Effective 06/12/2023 Administrator assigning plan of cares weekly to be completed and reviewed for 100% completion. Administrator and DCS are responsible for ensuring 100% compliance with weekly completion and review of plan of cares.	2023-06-12

	referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on observation, record review, and interview, the home health agency failed to ensure plans of care contained all the required elements in 6 of 12 active clinical records reviewed (Patient #1, 2, 7, 9, 11, 12). The findings include: 6. Clinical record review for Patient #1 was completed on 5/25/2023. Record review evidenced a PT initial comprehensive assessment dated 4/27/2023. The document evidenced the patient lived alone, but family was staying day and night due to recent gastrointestinal (GI) issues (not further specified); needed help with personal care, human assist to transfer and ambulate, had left knee and ankle pain that limited the patient at times; if the patient had a fall or uncontrolled pain, he may have difficulty achieving goals or end up hospitalized; the patient			

	wore an ankle brace (not specified which ankle), and was instructed to refrain from using ankle weights; and PT would treat for knee and ankle pain. Record review evidenced an initial plan of care for certification period 4/27/2023 - 6/25/2023. The plan of care evidenced the patient had a hired caregiver daily, but failed to evidence what the caregiver did for the patient; failed to evidence how the patient's personal care needs were met, who assisted the patient for transfers or ambulation, what GI issues the patient experienced, or interventions/goals to mitigate the issue(s); interventions to mitigate pain, the use of an ankle brace, or instructions to refrain from the use of ankle weights. During an interview on 5/25/2023 at 11:15 AM, the Administrator indicated the plan of care was still a draft (not completed), they were behind, and they had to incorporate everything by hand into the plan of care because it didn't all flow over from the comprehensive assessment.			

	7. A home visit occurred on 5/19/2023 at 11:40 AM with Patient #2 and Registered Nurse (RN) #1. Observed the patient wore supplemental oxygen via nasal canula (small tubes inserted into the nares to administer oxygen), was sitting in a wheelchair with neither leg elevated, was visibly obese, and the right lower leg had a dressing on from below the knee down to toe toes. Record review evidenced an untitled Entity #1 (a skilled nursing facility) referral document dated 11/02/2022, which evidenced the patient's diagnoses that could increase the risk for worsening/delayed wound healing included obesity and peripheral vascular disease (PVD) (impaired circulation which causes swelling, fluid buildup in the tissues under the skin, and wounds). Record review for Patient #2 was completed on 5/25/2023, which evidenced plans of care for certification periods 3/08/2023 - 5/06/2023, and 5/07/2023 - 7/05/2023 (start of care date 11/08/2022). The document failed to evidenced the patient's diagnoses included			

obesity or PVD.

During an interview on 5/25/2023 at 11:36 AM, the Clinical Manager indicated pertinent diagnoses should be on the plans of care. The Administrator indicated the current plan of care wasn't completed yet.

1. Record review evidenced an undated agency policy obtained 5/24/2023, titled "Physician Role in Home Care of Patient's Plan of Care and Interim Orders" which stated, "... The plan of care includes: ... All pertinent diagnoses ... all patient care orders ... Client's mental, cognitive, psychosocial status ... types of services, supplies, and equipment required ... Nutritional requirements ... All medications and treatments ... Food or drug allergies ... Patient-specific interventions and education ...."

2. Observation of a home visit for Patient #7 was conducted on 5/18/2023, to observe a routine physical therapy visit. During the visit, the patient's medications were reviewed. The

	taking the following medications which were included on the plan of care: biofreeze (for pain), benzonatate (for cough), Guaifenesin (for cough), docusate (stool softener), Furosemide (water pill), isavuconazonium (anti-fungal), and potassium (supplement). During the visit, the following medication was observed and the patient indicated they were taking: keflex (antibiotic). The patient was observed to be wearing oxygen via nasal cannula at 2 liters per minute. During the visit, the following equipment was observed in the patient's home: oxygen and cane. Clinical record review for Patient #7 was completed on 5/23/2023. Record review evidenced a plan of care for certification period 4/26/2023 - 6/24/2023, which included the following medications the patient was not taking: biofreeze, benzonatate, guaifenesin, docusate, furosemid, isavuconazonium, and potassium. The plan of care failed to include orders for keflex. The plan of care failed to include orders for oxygen			

	administration. The plan of care failed to include oxygen equipment, raised toilet seat, and cane. Record review evidenced a physical therapy evaluation dated 5/3/2023, which indicated the patient used a raised toilet seat. During an interview on 5/23/2023, at 11:39 PM, the Administrator indicated all medications the patient was taking should have been included in the plan of care. The Administrator indicated all equipment the patient was using should have been included on the plan of care. During an interview on 5/23/2023, at 11:43 PM, the Clinical Manager indicated the plan of care should have included the orders for oxygen use. 3. Observation of a home visit for Patient #9 was conducted on 5/18/2023, at 2:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was observed to have a fatty deposit (lipoma) on the back of their neck. The patient was audibly wheezy. The patient fell			

	asleep during the visit, and the oxygen levels were 88% while sleeping. Clinical record review for Patient #9 was completed on 5/23/2023, for certification period 3/8/2023 - 5/6/2023. Record review evidenced a referral/history and physical dated 3/7/2023, which included the following diagnoses: lipoma (fatty growth of tissue), obstructive sleep apnea (low oxygen levels when sleeping), and wheezing (lung sounds, which signal constricted airflow). This document indicated the patient was to take eliquis (blood thinner) 5 milligrams twice daily. Record review evidenced a plan of care for certification period 3/8/2023 - 5/6/2023, which failed to include diagnoses of lipoma, obstructive sleep apnea, and wheezing. The plan of care included an order for eliquis 5 milligrams once daily. During an interview on 5/23/2023, at 1:34 PM, the Administrator indicated all primary and pertinent diagnoses should have been included in the plans of care.			

	During an interview on 5/23/2023, at 1:45 PM, the Clinical Manager indicated the eliquis should have been ordered twice daily on the plan of care. 4. Clinical record review for Patient #11 was completed on 5/23/2023, for certification period 4/7/2023 - 6/5/2023. Record review evidenced a wound clinic visit note dated 4/10/2023, which indicated the patient was to receive home health nurse visits 2 times weekly for wound dressing changes. Record review evidenced a plan of care for certification period 4/7/2023 - 6/5/2023, which failed to include the orders for twice weekly dressing changes. The plan of care indicated nursing was to visit the patient 1 time weekly for dressing changes. During an interview on 5/23/2023, at 4:18 PM, the Clinical Manager indicated the wound clinic had added the twice weekly wound care orders, and that was why the plan of care did not include them.			

	5. Clinical record review for Patient #12 was completed on 5/23/2023, for certification period 4/19/2023 - 6/17/2023. Record review evidenced a referral order dated 2/9/2023, which indicated the patient was allergic to dimethyl fumarate (medication to treat multiple sclerosis), achromycin (antibiotic), and penicillin (antibiotic). The referral order indicated the patient was taking ensure (nutritional supplement) twice daily. Record review evidenced a plan of care for certification period 4/19/2023 - 6/27/2023, which failed to include the allergies to dimethyl fumarate, and achromycin. The plan of care failed to include the ensure in nutritional information. During an interview on 5/23/2023, at 2:52 PM, the Clinical Manager indicated the plan of care should have included all allergies and nutritional information.			
N0527	Patient Care 410 IAC 17-13-1(a)(2)	N0527	Agency educated staff on 05/25/2023 and on 06/07/2023 to licensure requirement that agency shall promptly alert the person responsible for the medical component of the patient's plan of care to any changes that suggest a need to alter the medical plan of	2023-06-12

	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. Based on observation, record review, and interview, the home health agency failed to ensure clinicians promptly alerted the responsible physician to any changes which suggested a need to alter the plan of care in 1 of 7 home visits conducted. (Patient #7) The findings include: Record review evidenced an undated agency policy obtained on 5/24/2023, titled "Physician Role in Home Care of Patient's Plan of Care and Interim Orders" which stated, "... Agency clinical professional staff will maintain contact with the Provider or designee regarding the patient's changing condition and for clinical updates and their requests for information ...." Observation of a home visit for Patient #7 was conducted on		care. Clinicians educated on notification to person responsible for the medical component of the patient's plan of care to include the DCS and Physicians and updating the plan of care accordingly. DCS responsible for weekly communication with all clinicians regarding any changes / concerns noted during their skilled visits to ensure physicians are being notified of any changes / concerns noted and if plan of care needs revision. Effective 06/19/2023 DCS logging weekly communication with all field staff to inquire about physician notification for any noncompliance noted with patients, revisions needed to pan of cares and if any changes to patient status,	

	5/18/2023, at 10:40 AM, to observe a routine physical therapy visit. During the visit, the patient was observed initially to be wearing 2 liters of oxygen via nasal cannula. When the patient was ambulating, they removed the oxygen, and indicated they felt they did not need the oxygen and would go out for dinner without bringing the oxygen with them. Clinical record review for Patient #7 was completed on 5/23/2023, for certification period 4/26/2023 - 6/24/2023, and evidenced a referral order dated 4/7/2023, which indicated the patient was to wear 2 liters of oxygen at rest and 4 liters of oxygen during ambulation. Record review evidenced a physical therapy visit note dated 5/18/2023, which failed to include any information regarding the patient's non-compliance with oxygen use, or notification of physician the patient was not wearing oxygen as ordered. During an interview on 5/23/2023, at 11:49 AM, the Clinical Manager indicated the			

	should have notified the physician that the patient was not using their oxygen as ordered.			
N0529	Patient Care 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; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on record review and interview, the home health agency failed to send written summary reports to the physician every 60 days in 3 of 3 patients who received services longer than 60 days. (Patient #2, 9, 12) The findings include: 4. Record review for Patient #2 was completed on 5/25/2023, which evidenced plans of care	N0529	Agency educated all field staff on 5/25/23 and 6/7/23 on licensure requirement needing to be met to ensure case conference were being performed every 60 days and 60 day summary was being sent to the physician. Effective 5/29/23 DCS and Administrator review a report of all upcoming patients due for 60 day summaries (recertification) and DCS communicating with clinicians on case to get update on patient care/status. DCS completing a 60 day summary based on care coordination and review of the chart to send to the physician. DCS is responsible to ensure a 100% compliance.	2023-05-29

	3/08/2023 - 5/06/2023 and 5/07/2023 - 7/05/2023 (start of care date 11/08/2022). Record review failed to evidence a written summary report was sent to the physician every 60 days. During an interview on 5/25/2023 at 11:36 AM, the Clinical Manager indicated a summary wasn't sent to the physician. 1. Record review evidenced an undated agency policy obtained 5/24/2023, titled "Recertification/Resumption Assessments Policy" which stated, "... Agency must keep physicians updated on patient care/status and coordinate care throughout the 2 months or send a written summary report to the physician at least every 2 months ...." 2. Clinical record review for Patient #9 was completed on 5/23/2023, for certification periods 3/8/2023 - 5/6/2023, and 5/7/2023 - 7/5/2023. Record review failed to evidence a written summary report was sent to the physician every 60 days. During an interview on			

	5/23/2023, at 2:15 PM, the Clinical Manager indicated the agency did not sent written summary reports because they gave a verbal update to the physician during recertification assessments. 3. Clinical record review for Patient #12 was completed on 5/23/2023, for certification periods 2/18/2023 - 4/18/2023, and 4/19/2023 - 6/17/2023. Record review failed to evidence a written summary report was sent to the physician every 60 days. During an interview on 5/23/2023, at 2:41 PM, the Administrator indicated the summary reports were verbally given to the physician every 60 days.			
N0532	Patient Care 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.	N0532	Agency educated staff on 05/25/2023 and on 06/07/2023 to licensure requirement that agency shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative if any of any significant physical and mental changes observed or reported by the patient. DCS responsible for weekly communication with all clinicians regarding any changes / concerns noted during their skilled visits to ensure physicians are being notified of any changes / concerns noted and if plan of care needs revision.	2023-06-12

	Based on observation, record review, and interview, the home health agency failed to ensure the clinicians notified the physician of any significant physical or mental changes observed or reported by the patient in 4 of 12 active clinical records reviewed. (Patient #3, 9, 10, 12) The findings include: 1. Record review evidenced an undated agency policy obtained 5/24/2023, titled "Physician Role in Home Care of Patient's Plan of Care and Interim Orders" which stated, "... Agency clinical professional staff will maintain contact with the Provider or designee regarding the patient's changing condition and for clinical updates and their requests for information ...." 2. Observation of a home visit for Patient #9 was conducted on 5/18/2023, at 2:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was audibly wheezy and oxygen		Effective 06/19/2023 DCS logging weekly communication with all field staff to inquire about physician notification for any noncompliance noted with patients, revisions needed to pan of cares and if any changes to patient status,	

saturations ranged from 88% - 90%. The patient fell asleep during the visit, and oxygen saturation was 88% during sleep.

Clinical record review for Patient #9 was completed on 5/23/2023, for certification period 5/7/2023 - 7/5/2023, and evidenced a recertification comprehensive assessment dated 5/6/2023, which indicated the patient had clear breath sounds, and no wheezing.

Record review evidenced a skilled nurse visit note dated 5/9/2023, which indicated the patient had no respiratory distress or wheezing noted.

Record review failed to evidence the physician or designee was notified of the change in respiratory status and wheezing noted during the 5/18/2023, skilled nurse visit.

During an interview on 5/23/2023, at 1:50 PM, the Clinical Manager indicated they and the physician should have been notified of the change in patient's respiratory status.

Record review evidenced a wound clinic visit note dated

	4/13/2023, which indicated the patient's left great toe was necrotic but intact. Record review evidenced a skilled nurse visit note dated 4/21/2023, which indicated the patient's left great toe was almost detached from the foot. Record review evidenced a skilled nurse visit note dated 4/25/2023, which indicated the patient's left great toe was detached. Record review failed to evidence the physician was notified of the change in the patient's physical wound status. During an interview on 5/23/2023, at 2:36 PM, the Administrator indicated the physician was not notified of the detached toe but should have been. 3. Observation of a home visit for Patient #10 was conducted on 5/18/2023, at 3:00 PM, to observe a routine physical therapy visit. During the visit, 2 open areas were observed to the patient's left heel and left second toe. Clinical record review for Patient			

	#10 was completed on 5/23/2023, for certification period 5/10/2023 - 7/8/2023, and evidenced a start of care assessment dated 5/10/2023, which indicated the patient did not have any open areas to their skin. Record review failed to evidence the physician was notified of the change in integumentary status on 5/18/2023. During an interview on 5/23/2023, at 3:50 PM, the Clinical Manager indicated the physician should have been notified of any open areas to the patient's skin. 4. Clinical record review for Patient #3 was completed on 5/24/2023, for certification period 5/11/2023 - 7/9/2023, and evidenced a start of care comprehensive assessment conducted on 5/11/2023, which indicated the patient was ordered oxygen therapy prior to discharging home from a rehabilitation center. This document indicated the patient was not using any oxygen because they felt like they didn't need it. The start of care			

assessment indicated the patient's oxygen saturation dropped to 88% and their heart rate increased to 129 beats per minute after walking from one room to another room.

Record review failed to evidence the physician was notified of the change in vital signs during ambulation, and patient's non-compliance with oxygen therapy.

During an interview on 5/24/2023, at 3:20 PM, the Administrator indicated the physician should have been notified of the low oxygen level, increased heart rate, and non-compliance with oxygen therapy orders.

5. Clinical record review for Patient #12 was completed on 5/23/2023, for certification periods 2/18/2023 - 4/18/2023, and 4/19/2023 - 6/17/2023, and evidenced a skilled nurse visit note dated 4/13/2023, which indicated the patient's back wound had wound edge breakdown noted, but failed to evidence the physician was notified of the change in wound status.

Record review evidenced a

	skilled nurse visit note dated 4/24/2023, which indicated the patient developed a new wound to their right heel. Record review failed to evidence the physician on the plan of care was notified of the new wound. During an interview on 5/23/2023, at 3:15 PM, the Clinical Manager indicated the physician should have been notified of the wound edge breakdown, but they did not see this documented. At 3:30 PM, the Clinical Manager indicated the physician should have been notified of the new wound.			
N0544	Scope of Services 410 IAC 17-14-1(a)(1)(E) Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on observation, record review, and interview, the home health agency failed to ensure registered nurses completely and accurately completed clinical notes in 4 of 12 active	N0544	Agency educated all RNs on 06/07/2023 on completing and accurately completing clinical notes. Effective 6/19/2023 DCS reviewing a 100% of wound care patients and 20% of nursing visit notes to ensure compliance with RNs completing and accurately completing clinical notes. Every monday all visits notes will be reviewed for completion from the prior week. DCS responsible for ensuring a 100% compliance.	2023-06-07

clinical records reviewed. (Patient #2, 7, 9, 12)

The findings include:

6. A home visit occurred on 5/19/2023 at 11:40 AM with Patient #2 and Registered Nurse (RN) #1. Observed the patient seated in a wheelchair, was visibly obese, made limited changes in position during the visit, used oxygen, and had severe wounds on the right lower leg. RN #1 failed to assess the patient's bottom for skin breakdown/wounds.

Record review for Patient #2 occurred on 5/25/2023, which evidenced an untitled Entity #1 (a skilled nursing facility) referral document dated 11/02/2022, which evidenced the patient's diagnoses that could increase the risk for worsening/delayed wound healing included obesity and peripheral vascular disease (PVD) (impaired circulation which causes swelling, fluid buildup in the tissues under the skin, and wounds).

Record review evidenced a plan of care for certification period 5/07/2023 - 7/05/2023. The document evidenced the patient's diagnoses included

	congestive heart failure (CHF) (inability of the heart to effectively pump blood, which causes fluid build up), chronic obstructive pulmonary disease (COPD) (breathing problems due to poor lung function), and atrial fibrillation (irregular heart rhythm); and the patient used oxygen continuously. Record review evidenced a nursing comprehensive reassessment dated 5/05/2023. The document evidenced the patient had wounds on the right lower leg, was at risk for skin breakdown, was confined to a chair, required a mechanical lift for transfers, and was incontinent of urine. The nurse documented the patient was unable to raise herself from the chair to allow the nurse to assess her buttocks, but the patient related she didn't have any open areas. Record review evidenced a skilled nursing visit note dated 5/09/2023. The document evidenced the patient had wounds on the right lower extremity, which "varied in depth and tissue type", but failed to evidence wound measurements or detailed			

	descriptions of the wounds; no cardiopulmonary (heart/lung) problems, and marked "same", but failed to evidence heart sounds were assessed; gastrointestinal (GI) (The organs that food and liquids travel through when they are swallowed, digested, absorbed, and leave the body as feces).and genitourinary (GU) (The parts of the body that play a role in reproduction, getting rid of waste products in the form of urine, or both) were marked "same"; or if the patient had any new or changed medications since the last nursing visit. Record review evidenced skilled nursing visit notes dated 5/12/2023, 5/16/2023, and 5/19/2023, all of which failed to evidence the nurse assessed the patient's pedal pulses (pulses on the tops of the feet to determine presence of adequate blood flow); cardiopulmonary, neuromuscular, GI, and GU systems were marked "same"; and failed to evidence detailed measurements/descriptions of the wounds and surrounding skin.			

	During an interview on 5/25/2023 at 11:36 AM, the Clinical Manager indicated the nurses should assess all body systems, and should measure wounds and provide detailed descriptions. The Administrator indicated the electronic medical record (EMR) pre-filled nursing notes from one visit to the next in certain parts, she could turn that feature off, and nurses could document assessment findings in the "comments" boxes. 1. Record review evidenced an undated agency policy obtained on 5/24/2023, titled "Client Care Records" which stated, "... It is crucial that accurate and complete client care records be maintained to meet the legal purposes of documentation ...." 2. Record review evidenced an undated agency policy obtained on 5/24/2023, titled "Wound Care Management" which stated, "... For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage [color, odor, consistency, and quantity], and condition and appearance of the skin			

	documented in the clinical findings so that an assessment of the need for skilled nursing care can be made .... At a minimum, the above should be documented weekly, but recommended at each skilled nursing visit ...." 3. Clinical record review for Patient #7 was completed on 5/23/2023, for certification period 4/26/2023 - 6/24/2023. Record review evidenced a history and physical dated 4/7/2023, which indicated the patient had a diagnosis of pre-diabetes (problem regulating blood sugars), and their hemoglobin A1C (blood test which shows the 3 month average blood sugar reading) was 6.6. Record review evidenced a start of care assessment signed and dated by the registered nurse on 4/26/2023, which indicated the patient had no history of diabetes. The start of care assessment failed to include an assessment of heart or lung sounds, pedal pulses, and swelling. During an interview on			

Clinical Manager indicated the start of care assessment was not documented accurately. The Clinical Manager indicated the start of care assessment should have included heart sounds, lung sounds, and an assessment of pulses and edema.

4. Clinical record review for Patient #9 was completed on 5/23/2023, for certification period 5/7/2023 - 7/5/2023. Record review evidenced a wound clinic visit note dated 3/18/2023, which indicated the patient's left great toe wound measured 3cm (centimeters) x 2.1cm x 0cm.

Record review evidenced a wound clinic visit note dated 4/14/2023, which indicated the patient's left great toe wound measured 3cm x 2.3cm x 0cm.

Record review evidenced a wound clinic visit note dated 5/18/20203, which indicated the patient's left great toe wound measured 0.1 cm x 0.1 cm x 0 cm.

Record review evidenced registered nurse visit notes dated 3/28/2023, 4/1/2023, 4/4/2023, 4/8/2023, 4/11/2023, 4/15/2023, 5/6/2023, and

	5/18/2023, which all failed to include wound measurements, due to wound being "unmeasurable". Record review evidenced a plan of care for certification period 3/8/2023 - 5/6/2023, which indicated the patient had a diagnosis of diabetes (problem regulating blood sugars). Record review evidenced a recertification comprehensive assessment dated 5/6/2023, which was conducted by the registered nurse, which failed to include a documented blood glucose reading. During an interview on 5/23/2023, at 2:02 PM, the Administrator indicated wound should have been measured weekly, and nurses didn't do a good job of measuring wounds weekly as per policy. The Administrator indicated the comprehensive assessment should have included a blood glucose measurement. 5. Clinical record review for Patient #12 was completed on 5/23/2023, for certification periods 2/18/2023 - 4/18/2023, and 4/19/2023 - 6/17/2023. Record review evidenced			

	registered nurse visit notes dated 4/4/2023, 4/7/2023, 4/8/2023, 4/11/2023, 4/13/2023, 4/24/2023, 4/28/2023, 5/3/2023, 5/5/2023, 5/10/2023, and 5/11/2023, which all indicated "same" under pain assessment, cardiopulmonary assessment, neuromuscular assessment, gastrointestinal assessment, and genitourinary assessment. These visit notes failed to include specific assessment parameters, heart, lung, or gastric sounds, pain ratings, or any additional assessment information. Record review evidenced a recertification assessment completed by the registered nurse on 4/18/2023, which indicated the patient had a PICC line (peripherally inserted central catheter) but failed to document an assessment of the PICC line to include location, site assessment, or status. Record review evidenced registered nurse visit notes dated 4/4/2023, 4/7/2023, 4/8/2023, 4/11/2023, and 4/13/2023, which all failed to include an assessment of the PICC line status, to include			

	status. During an interview on 5/23/2023, at 2:58 PM, the Clinical Manager indicated "same" meant nothing had changed in the assessment. At 3:06 PM, the Clinical Manager indicated the PICC line should have been assessed at every visit and documented.			
N0554	Scope of Services 410 IAC 17-14-1(a)(2)(B) Rule 14 Sec. 1(a) (2) (B) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (B) Prepare clinical notes. Based on record review and interview, the home health agency failed to ensure licensed practical nurses accurately and completely prepared clinical notes in 2 of 12 active clinical records reviewed. (Patient #2, 9) The findings include: 4. Record review for Patient #2 occurred on 5/25/2023, which evidenced a nursing	N0554	LPN identified in the chart reviews was already identified by the agency to be in noncompliance with timely completion and accurately completing notes prior to survey and is no longer with the agency. Agency educated all RNs on 06/07/2023 regarding the importance of performing supervisory visits to include review of all completed LPN notes to ensure plan of care being followed and documentation accurately reflects patient status. Agency currently does not have any LPNs on staff. DCS responsible for ensuring all LPN notes are reviewed weekly for completion and accuracy.	2023-06-07

	comprehensive reassessment dated 5/05/2023. The document evidenced the RN performed a supervisory visit on Licensed Practical Nurse (LPN) #1, but she was awaiting LPN #1 to update her recent charting (clinical visit notes) to ensure that proper care was provided. During an interview on 5/25/2023 at 11:36 AM, the Administrator indicated the LPN visit notes should have been completed. 1. Record review evidenced an undated agency policy obtained on 5/24/2023, titled "Client Care Records" which stated, "... It is crucial that accurate and complete client care records be maintained to meet the legal purposes of documentation ...." 2. Record review evidenced an undated agency policy obtained on 5/24/2023, titled "Wound Care Management" which stated, "... For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage [color, odor, consistency, and quantity], and condition and appearance of the skin			

documented in the clinical findings so that an assessment of the need for skilled nursing care can be made .... At a minimum, the above should be documented weekly, but recommended at each skilled nursing visit ...."

3. Clinical record review for Patient #9 was completed on 5/23/2023, for certification period 5/7/2023 - 7/5/2023. Record review evidenced a wound clinic visit note dated 3/18/2023, which indicated the patient's left great toe wound measured 3cm (centimeters) x 2.1cm x 0cm.

Record review evidenced a wound clinic visit note dated 4/14/2023, which indicated the patient's left great toe wound measured 3cm x 2.3cm x 0cm.

Record review evidenced a wound clinic visit note dated 5/18/20203, which indicated the patient's left great toe wound measured 0.1 cm x 0.1 cm x 0 cm.

Record review evidenced licensed practical nurse visit notes dated 4/18/2023, 4/21/2023, 4/25/2023, 4/28/2023, 5/2/2023, and

	5/9/2023, which all failed to include wound measurements, due to wound being "unmeasurable". Record review evidenced a plan of care for certification period 3/8/2023 - 5/6/2023, which indicated the patient had a diagnosis of diabetes (problem regulating blood sugars). Record review evidenced licensed practical nurse visit notes dated /18/2023, 4/25/2023, 4/28/2023, 5/2/2023, and 5/9/2023, which all failed to include a blood glucose measurement. During an interview on 5/23/2023, at 2:02 PM, the Administrator indicated wound should have been measured weekly, and nurses didn't do a good job of measuring wounds weekly as per policy. At 2:04 PM, the Administrator indicated the nurses should have documented the patient's blood glucose measurement every visit.			

N0566	Scope of Services 410 IAC 17-14-1(c)(5) Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (5) prepare clinical notes; Based on observation, record review, and interview, the home health agency failed to ensure therapists accurately and completely prepared clinical notes in 4 of 12 active clinical records reviewed. (Patient #1, 3, 7, 8) The findings include: 5. Clinical record review for Patient #1 was completed on 5/25/2023. Record review evidenced a PT initial comprehensive assessment dated 4/27/2023. Review of the electronic medical record (EMR) on 5/16/2023 at 3:43 PM evidenced the initial comprehensive assessment was "in progress" (19 days after the visit occurred). Record review evidenced a PT functional reassessment visit note, which occurred on	N0566	Agency educated all Therapy field staff on 05/31/2023 and 06/07/2023 regarding licensure requirement not being met with accurately and completely preparing clinical notes. Agency educated all supervising Therapists to review assistant skilled notes prior to supervisory visits being performed for completion and accuracy. Effective 6/19/2023 DCS reviewing of 20% of therapy visit notes to ensure compliance with therapy skilled notes completion and accuracy. Every Monday all visit notes will be reviewed for completion from prior week. DCS responsible for ensuring a 100% compliance.	2023-06-07

12:40 PM. The visit note was blank (10 days after the visit occurred).

During an interview on 5/25/2023 at 11:15 AM, the Administrator indicated the notes weren't completed.

1. Record review evidenced an undated agency policy obtained on 5/24/2023, titled "Client Care Records" which stated, "... It is crucial that accurate and complete client care records be maintained to meet the legal purposes of documentation ... All entries in the health record must be: ... Recorded within 10 days of the provision of service performed ...."

2. Observation of a home visit for Patient #7 was completed on 5/18/2023, at 10:40 AM, to observe a routine physical therapy visit. During the visit, the patient indicated they had pain to their back, but the physical therapy assistant failed to inquire about a pain rating.

Clinical record review for Patient #7 was completed on 5/23/2023, for certification period 4/26/2023 - 6/24/2023. Record review evidenced a

	and signed by the physical therapy assistant on 5/18/2023, which indicated the patient's pain rating was 3 out of 10. During an interview on 5/23/2023, at 11:58 AM, the Clinical Manager indicated they did not know why the physical therapy assistant documented a pain rating, if it wasn't assessed. 3. Clinical record review for Patient #8 was completed on 5/23/2023, for certification period 5/4/2023 - 7/2/2022. Review of the electronic medical record on 5/17/2023, evidenced a physical therapy visit for 5/6/2023, which failed to include any documentation as to whether the visit was completed or not (11 days after visit). Review of the electronic medical record on 5/22/2023, evidenced a missed visit note dated 5/6/2023, which indicated the visit was not completed (documented 16 days later). Record review evidenced a start of care comprehensive assessment completed by the physical therapist on 5/4/2023, which failed to include a cardiac			

as lung and heart sounds, swelling assessment, or pulse assessment.

During an interview on 5/23/2023, at 12:15 PM, the Administrator indicated the clinician probably got busy, and forgot to document the missed visit note in time. At 12:41 PM, the Administrator indicated the start of care comprehensive assessment should have included documentation of lung and heart sounds, pulse assessments and an assessment of swelling.

4. 5. Clinical record review for Patient #3 was completed on 5/24/2023, for certification period 5/11/2023 - 7/9/2023. Record review evidenced a start of care assessment conducted by the registered nurse on 5/11/2023, which failed to include a cardiac or respiratory assessment such as lung and heart sounds, swelling assessment or assessment of pulses.

During an interview on 5/24/2023, at 3:15 PM, the Administrator indicated the start of care assessment should have included a cardiac and

	respiratory assessment.			
N0567	Scope of Services 410 IAC 17-14-1(c)(6) Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel; Based on observation, record review, and interview, the home health agency failed to ensure the therapists consulted with other home health agency personnel in 1 of 7 home visits conducted. (Patient #10) The findings include: Record review evidenced an undated agency policy obtained 5/24/2023, titled "Care Coordination Policy/Case Management" which stated, "... When multiple services are provided by the agency, the clinicians are to communicate and coordinate care with each other but also with the Clinical Manager ...." Observation of a home visit for Patient #10 was conducted on 5/18/2023, at 3:00 PM, to	N0567	Agency educated staff on 05/25/2023 and on 06/07/2023 - Clinicians educated on consult/advise/notification to include the DCS and disciplines involved to ensure timely and adequate care coordination is being performed. DCS responsible for weekly communication with all clinicians regarding any changes / concerns noted during their skilled visits to ensure all disciplines related to patient care and physicians are being notified of any changes / concerns noted and if plan of care needs revision. Effective 06/19/2023 DCS logging weekly communication with all field staff to include interdisciplinary team related to patient status/concerns.	2023-06-07

	observe a routine physical therapy visit. During the visit, the patient was observed wearing their urinary catheter drainage bag around their neck. Clinical record review for Patient #10 was completed on 5/23/2023, for certification period 5/10/2023 - 7/8/2023, which evidenced the patient was receiving skilled nursing visits for catheter education and care 1 time weekly for 5 weeks. Record review failed to evidence the physical therapist consulted with the Clinical Manager or nursing services regarding the patient wearing their catheter drainage bag around their neck. During an interview on 5/23/2023, at 3:55 PM, the Clinical Manager indicated the physical therapist should have consulted with the Clinical Manager regarding the patient's need for education about catheter care.			
N0608	Clinical Records 410 IAC 17-15-1(a)(1-6)	N0608	Agency educated all staff on 05/31/2023 and 06/07/2023 regarding completion of all clinical notes timely and plan of cares to be completed timely to be sent out to they physician. Administrative staff also educated on timely formatting (compiling) of all POC data from admitting clinicians/supervising	2023-06-12

	Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the home health agency failed to ensure all clinical visit notes were completed the day the services were rendered, the clinical record contained the completed plan of care, and/or completed clinical documents were incorporated into the clinical record within 14 days, for 5 of 12 active clinical records reviewed (Patient #1, 3, 8, 9, 10) The findings include: *Review of an undated agency policy, obtained 5/24/2023,		clinicians to incorporate in the poc format to be sent. Effective 06/12/2023 Administrator assigning plan of cares weekly to be completed and reviewed for 100% completion. Effective 06/19/2023 all visit notes are reviewed for completion from the prior week. Administrator and DCS are responsible for ensuring 100% compliance with weekly completion of all skilled notes and timely completion and review of plan of cares.	

	titled "Physician (Provider) Role in Home Care of Patients Plan of Care and Interim Orders", stated, "... Upon completion of the initial assessment, the [clinician] will contact the [certifying physician] regarding the results of the assessment and complete the development of the plan of care ... plan of care is reviewed ... no less than once every 60 days ...." *Review of an undated agency policy, obtained 5/24/2023, titled "Client Care Records", evidenced the agency preferred all entries in the patient's clinical record to be recorded within 10 days of the service(s) rendered, and incorporated into the clinical record within 14 days of receipt. *Clinical record review for Patient #1 was completed on 5/25/2023. Record review evidenced a PT initial comprehensive assessment dated 4/27/2023. Review of the electronic medical record (EMR) on 5/16/2023 at 3:43 PM evidenced the initial comprehensive assessment was "in progress". Record review evidenced an			

	initial plan of care for certification period 4/27/2023 - 6/25/2023. Review of the EMR on 5/16/2023 at 3:43 PM evidenced the initial plan of care was "in progress". Record review evidenced a PT functional reassessment visit note, which occurred on 5/15/2023 from 12:00 PM-12:40 PM. The visit note was blank. During an interview on 5/25/2023 at 11:15 AM, the Administrator indicated the plan of care was still a draft (not completed), they were behind, and they had to incorporate everything by hand into the plan of care because it didn't all flow over from the comprehensive assessment. *Record review for Patient #2 occurred on 5/25/2023, which evidenced a plan of care for certification period 5/07/2023 - 7/05/2023. The document evidenced it was a "draft", and wasn't completed (18 days after the comprehensive assessment occurred). During an interview on 5/25/2023 at 11:36 AM, the			

of care wasn't completed.

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**During an interview on 5/16/2023 at 12:41 PM, the Administrator indicated some clinicians used their tablets during their visits, some used paper, some charted after the visit was made, and some rural areas made it difficult to get internet access for the EMR; and indicated the agency policy allowed 10 days for clinicians to complete their visit notes. The Quality Assurance Manager indicated some clinicians waited until they got home to chart.

1. Record review evidenced an undated agency policy obtained 5/24/2023, titled "Client Care Records" which stated, "... Client records for patient receiving skilled care contain: ... An initial and updated [as appropriate] care plan ...."

2. Clinical record review for Patient #8 was completed on 5/23/2023. Record review evidenced a plan of care for certification period 5/4/2023 - 7/2/2023, which failed to include all necessary

	signed by the nurse or physician. Review of the electronic medical record on 5/25/2023, at 11:03 AM, evidenced the plan of care was "in progress". During an interview on 5/23/2023, at 12:15 PM, the Administrator indicated the plan of care was not completed yet, and was still in process. The Administrator indicated the plans of care took a long time to format due to manually inputting all the necessary fields. 3. Clinical record review for Patient #9 was completed on 5/23/2023. Record review evidenced a plan of care for certification period 5/7/2023 - 7/5/2023, which failed to include all necessary components, and was not completed. Review of the electronic medical record on 5/23/2023, at 12:42 PM, evidenced the plan of care was "in progress". During an interview on 5/23/2023, at 1:34 PM, the Administrator indicated the			

	complete and was still being formatted to include all the required elements. 4. Clinical record review for Patient #10 was completed on 5/23/2023. Record review evidenced a plan of care for certification period 5/10/2023 - 7/8/2023, which failed to include all necessary components, was not signed or dated, and was not completed. Review of the electronic medical record on 5/22/2023, at 1:25 PM, evidenced the plan of care was "in progress". During an interview on 5/23/2023, at 3:41 PM, the Administrator indicated the patient's plan of care was not completed, because it was still being formatted. The Administrator indicated the goal was to have plans of care completed within 3 weeks of start of care. 5. Clinical record review for Patient #3 was completed on 5/24/2023. Record review evidenced a plan of care for certification period 5/11/2023 - 7/9/2023, which was not completed to include all			

	not signed or dated. Review of the electronical medical record on 5/25/2023, at 11:59 AM, evidenced the plan of care was "in progress". During an interview on 5/24/2023, at 3:07 PM, the Administrator indicated the patient's plan of care was not completed, and was still being put together.			
N0610	Clinical Records 410 IAC 17-15-1(a)(7) Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. Based on record review and interview, the home health agency failed to ensure entries in the medical record were appropriately authenticated, dated, and signed in 4 of 12 active clinical records reviewed. (Patient #3, 7, 9, 10) The findings include: 1. Record review evidenced an	N0610	Agency educated all staff on 5/25/2023, 5/31/2023, 6/7/2023 and 06/15/2023 regarding timely completion of all notes and assessments to include timely electronic signatures to include authentication, dates and signatures. Effective 06/19/2023 all notes are reviewed every Monday to ensure completion to include electronic signatures completion. All clinicians assigned (task list in software) visits and OASIS are reviewed every Monday, Wednesday and Friday to ensure timely documentation and electronic signatures are completed. Administrator and DCS responsible to ensure 100% .	2023-06-19

undated agency policy obtained on 5/24/2023, titled "Client Care Records" which stated, "... All entries in the health record must be: ... Recorded within 10 days of the provision of service performed ... Electronically signed and dated ...."

2. Clinical record review for Patient #7 was completed on 5/23/2023, for certification period 4/26/2023 - 6/24/2023, and evidenced a start of care assessment completed on 4/26/2023, which failed to include the signature of the person completing the assessment and failed to include the date.

During an interview on 5/23/2023, at 11:58 AM, the Administrator indicated the document should have been signed and dated.

3. Clinical record review for Patient #9 was completed on 5/23/2023, for certification period 5/7/2023 - 7/5/2023, and evidenced a recertification comprehensive assessment completed on 5/6/2023, which failed to include the signature of the person completing the

	dated. During an interview on 5/23/2023, at 2:40 PM, the Administrator indicated the recertification assessment should have been signed and dated. 4. Clinical record review for Patient #10 was completed on 5/23/2023, for certification period 5/10/2023 - 7/8/2023, and evidenced a start of care assessment completed on 5/10/2023, which failed to include the signature of the person completing the assessment and failed to be dated. During an interview on 5/23/2023, at 3:56 PM, the Clinical Manager indicated they forgot to sign the assessment and date it.			

	5. Clinical record review for Patient #3 was completed on 5/24/2023, for certification period 5/11/2023 - 7/9/2023, and evidenced a start of care assessment conducted on 5/11/2023, which failed to include the signature of the person completing the assessment and failed to be dated. During an interview on 5/24/2023, at 3:37 PM, the Administrator indicated the assessment was not signed by the physical therapist, which was unusual.			

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Swati Douglas	Administrator	6/16/2023 7:28:11 PM