STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157624	A. BUILDING B. WING	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Physiocare Home Healthcare Llc	1440 INNOVATION PLACE, WEST LAFAYETTE, IN, 47906

(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
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: September 25, 26, 27; 2023 Active Census: 55 At this Emergency Preparedness survey, Physiocare Home Healthcare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR: A 2 10/10/23	E0000		
G0000	INITIAL COMMENTS This was the second Post Condition Revisit for the home	G0000		

	health Federal and State complaint investigation conducted on July 11, 2023. Survey Dates: September 25, 26, 27; 2023 Unduplicated Skilled Admissions for Previous 12 Months: 516 During this Post Condition Revisit survey, two condition level deficiencies and two standard-level deficiencies were found corrected; four standard-level deficiencies were re-cited, and one standard level deficiency was newly cited. Pursuant to sections 1891(c)(2)(D) and 1891(a)(3)(D)(iii) of the Social Security Act, Physiocare Home Healthcare continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning July 11, 2023, and continuing through July 10, 2025. QR: A 2 10/10/23			
G0544	Update of the comprehensive assessment	G0544	The actions taken to correct the deficiencies related to Tag G-0544 are as follows: The Administrator provided education to all	2023-10-04

	484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on observation, record review, and interview, the home health agency failed to ensure the recertification comprehensive assessment included a complete pain assessment for 1 of 1 home visit observation of a recertification comprehensive assessment (Patient #25) and 2 of 2 records reviewed which included a recertification comprehensive assessment (Patients #27 and #30). Findings include: 1. Review of agency policy #1-021 titled “Pain Assessment” indicated when the patient or clinician identified pain, and in-depth pain assessment would be obtained and would include but not be limited to pain intensity, location, quality, duration, and factors which improved or worsened the pain. 2. Review of the clinical record for Patient #25 indicated a start		agency staff on the requirement for completing a pain assessment on all patients during certification and recertification. The Administrator and Clinical Manager will review 100% of certification and recertification documentation to ensure compliance with this requirement. Ongoing education will be provided to any agency staff found to be out of compliance. If an agency staff member continues to be non-compliant despite ongoing education then disciplinary action will take place that may lead to termination of employment.	

	record included a plan of care for the recertification period 07/30/2023 – 09/27/2023, which indicated patient's functional limitations included pain. The plan of care indicated the patient was to receive skilled nursing services, with nursing interventions to include assessing Patient #25's pain, and the agency's goals for the patient included for the patient's pain to be "controlled." A home visit observation was conducted with Patient #25 on 09/26/2023 beginning at 9:35 AM. Prior to entering the home, RN 1 confirmed they were to complete a recertification comprehensive assessment during the visit. During the visit, Patient #25 denied currently experiencing pain. RN 1 failed to conduct a complete pain assessment during the visit, including pain location, quality, duration, and factors with improved or worsened the pain. 3. Review of the clinical record for Patient #27 indicated a start of care of 05/17/2023. The record included a plan of care for the recertification period 09/14/2023 – 11/12/2023, which indicated the patient's			

	medications included Tylenol (an over-the-counter medication given to treat pain and fever) taken as needed for pain and the patient's functional limitations included "pain." The plan of care indicated the patient was to receive skilled nursing services, with nursing interventions to include assessing Patient #27's pain, and the agency's goals for the patient included for patient's pain to be "controlled." The record included a recertification comprehensive assessment completed on 09/13/2023 by Registered Nurse (RN) 1. The comprehensive assessment failed to evidence a complete pain assessment was conducted, including pain location, quality, duration, and factors which improved or worsened the pain. 4. Review of the clinical record for Patient #30 indicated a start of care of 07/18/2023. The record included a plan of care for the recertification period of 09/16/2023 – 11/14/2023, which indicated the patient's medications included Tylenol and Meloxicam (a medication used to treat pain caused by arthritis) and the patient's			

	functional limitations included pain. The plan of care indicated the patient was to receive skilled nursing services, with nursing interventions to include Patient #30's pain, and the agency's goals for the patient included the patient's pain would be "controlled." The record included a recertification comprehensive assessment completed on 09/15/2023 by RN 1. The comprehensive assessment failed to evidence a complete pain assessment was conducted, including pain location, quality, duration, and factors which improved or worsened the pain. 5. During an interview with RN 1 on 09/27/2023 beginning at 3:22 PM, the nurse reported if the patient denied pain at the time of a recertification comprehensive assessment, the nurse would not conduct a complete pain assessment during the assessment.			
G0570	Care planning, coordination, quality of care 484.60	G0570	The deficiencies related to Tag G-0570 were resolved.	2023-09-27

	Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. *			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted;	G0574	The actions taken to correct the deficiencies related to Tag G-0574 are as follows: The Administrator contacted the agency EMR system on 9/28/203 to expediate the process needed to allow for all hospitalization risk factors to be included on the recertification of all patients. The EMR system implemented this action on 10/10/2023. The Administrator and Clinical Manager will review 100% of all recertification visit notes to ensure that all hospitalization risk factors are included and pertinent to the patient. This will be an ongoing process to ensure 100% compliance. Any deficiencies will be reviewed with the agency staff and education will be provided as needed. Continued deficiencies will result in disciplinary action up to termination of employment.	2023-10-11

	(ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the home health agency failed to ensure the plan of care included all the patient's risk factors for hospitalization as indicated in the comprehensive assessment for 5 of 5 active records reviewed (Patients #25, 26, 27. 28. 30). Findings include: 1. Review of agency policy #1-007 titled "Care Planning Process," dated 05/2022, indicated the plan of care would be individualized and would include "measurable outcomes and goals identified by the organization" and "a description of the patient's risk for			

	and hospital readmissions." 2. Review of the clinical record for Patient #25 indicated a start of care of 04/06/2022. The record included a recertification comprehensive assessment completed on 07/26/2023 by Registered Nurse (RN) 1. The assessment indicated Patient #25's risk factors for hospitalization included but were not limited to the patient needed help with managing medications and ADLs (activities of daily living, such as bathing, ambulating, dressing, etc), home safety risks were identified, the patient had more than 2 secondary diagnoses, and the patient was confused. The record included a plan of care for the recertification period 07/30/2023 – 09/27/2023. The record failed to evidence the agency updated the plan of care to include all of Patient #25's risk factors for hospitalization as indicated in the comprehensive assessment. 3. Review of the clinical record for Patient #26 indicated a start of care of 09/22/2023. The record included an initial comprehensive assessment completed on 09/22/2023 by			

	the Alternate Clinical Supervisor. The assessment indicated Patient #26's risk factors for hospitalization included but were not limited to the patient needed help with managing medications and ADLs, lived alone, and the patient had more than 2 secondary diagnoses and dyspnea (difficulty breathing). The record included a plan of care for the recertification period of 09/22/2023 – 11/20/2023 which failed to evidence all of Patient #26's risk factors for hospitalization as indicated in the comprehensive assessment. 4. Review of the clinical record for Patient #27 indicated a start of care of 05/17/2023 and resumption of care date 09/06/2023. The record included a recertification comprehensive assessment completed on 09/13/2023 by Registered Nurse (RN) 1. The assessment indicated Patient #27's risk factors for hospitalization included but were not limited to the patient needed help with managing medications and ADLs (activities of daily living, such as bathing, ambulating, dressing, etc), lived			

	than 2 secondary diagnoses, an inadequate support network, home safety risks, confusion, dyspnea, and depression. The record included a plan of care for the recertification period 09/14/2023 – 11/12/2023 which failed to evidence all of Patient #27's risk factors for hospitalization as indicated in the comprehensive assessment. 5. Review of the clinical record for Patient #28 indicated a start of care of 08/23/2023. The record included an initial comprehensive assessment completed on 08/23/2023 by Physical Therapist (PT) 2. The assessment indicated Patient #28's risk factors for hospitalization included but were not limited to the patient needed help with managing medications and ADLs, home safety risks were identified, and the patient had more than 2 secondary diagnoses, at least one pressure ulcer (type of wound caused by prolonged pressure to a body site), and diagnosis of depression. The record included a plan of care for the recertification period 08/23/2023 – 10/21/2023. The record failed to evidence the agency updated the plan of			

	care to include all of Patient #28's risk factors for hospitalization as indicated in the comprehensive assessment. 6. Review of the clinical record for Patient #30 indicated a start of care of 07/18/2023. The record included a recertification comprehensive assessment completed on 09/15/2023 by RN 1. The assessment indicated the patient's risk factors for hospitalization included but were not limited to Patient #30 needed help with managing medications and ADLs, lived alone, had more than 2 secondary diagnoses, home safety risks were identified, and the patient had more than 2 secondary diagnoses, an inadequate support system, confusion, dyspnea, and depression. The record included a plan of care for the recertification period of 09/16/2023 – 11/14/2023. 7. During an interview with the clinical manager conducted on 09/27/2023 beginning at 4:25 PM, the Clinical Manager reported after the agency's previous survey, they had put a help desk ticket in to their electronic medical record (EMR)			

	system to ensure all hospitalization risk factors identified in the comprehensive assessment were also in the plan of care, but the EMR system was still working on this change.			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. *	G0590	The deficiencies related to Tag G-0590 were resolved.	2023-09-27
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the home health agency failed to ensure all staff followed infection control policies and procedures specific to disinfection of	G0682	The actions taken to correct the deficiencies related to Tag G-0682 are as follows: Education and demonstration was provided to all agency staff on 10/4/2023 regarding the proper techniques for cleaning of equipment and bag procedure. The Administrator will complete 4 home visits per month with different clinicians to ensure proper infection control procedures are being met at 100%.	2023-10-04

	re-usable equipment during a home visit for 2 of 2 home visit observations observed (Physical Therapist 2, Registered Nurse 1). Findings include: 1. Review of an agency document titled "Mandatory Education," reported by the Administrator as documentation of education provided to all clinical staff after the agency's initial survey on 07/11/2023, indicated when cleaning supplies used during the visit, each item should be cleaned with disinfectant and allowed to air dry prior to returning it to the clinician's supply bag. The documentation also indicated staff was educated to avoid placing cleaned items "next to or on top of" dirty items. 2. During a home visit with Patient #26 conducted on 09/25/2023 beginning at 12:40 PM, Physical Therapist (PT) 2 was observed disinfecting their vital sign equipment, including a thermometer, oxygen saturation (SpO2) probe, blood pressure cuff, and stethoscope. The therapist wiped the equipment with a disinfectant			

	wipe then placed the equipment on top of each other while drying. 3. During an interview with PT 2 conducted on 09/25/2023 beginning at 1:35 PM, the therapist reported they used Sani-Cloth disinfecting wipes to clean their vital sign equipment. PT 2 confirmed the disinfecting wipe dry time was "3-4" minutes. 4. A home visit observation was conducted with Patient #25 on 09/26/2023 beginning at 9:35 AM, Registered Nurse (RN) 1 was observed disinfecting their vital sign equipment, including a thermometer, SpO2 probe, blood pressure cuff, and stethoscope. The nurse wiped the equipment with a disinfectant wipe then placed the equipment on top of each other while drying.			
G0700	Skilled professional services 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy,	G0700	The deficiencies related to Tag G-0700 were resolved.	2023-09-27

	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. *			
G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on observation, record review, and interview, the skilled professional failed to perform a complete assessment of the patient's gastrointestinal system for 1 of 1 home visit observations of a Physical Therapist (PT) evaluation visit (Patient #26) and failed to document a re-assessment of a skin alteration for 2 of 2 records which evidenced a skin alteration (Patients #27, 30). Findings include: 1. Review of an agency document titled "Mandatory Education," reported by the Administrator as documentation of education provided to all	G0706	The actions taken to correct the deficiencies related to Tag G-0706 are as follows: On 10/04/2023 the Administrator and Clinical Manager provided mandatory education to all agency staff on the requirements of assessing for bowel status, skin condition, and pain during all visits. Education was provided to agency staff on 10/4/2023 regarding the requirements to document all assessments and assessment findings. The Administrator and Clinical Manager will review 100% of all visit notes to ensure proper documentation is being completed for all patients. On-going education will be provided to staff who are found to be deficient. Further deficiencies by agency staff despite on-going education and training can and may result in termination of employment. All staff education will be documented and placed into the agency staff member's personnel file for reference.	2023-10-04

	initial survey on 07/11/2023, indicated the skilled professional was to ask the patient the date of the last bowel movement with each assessment. 2. During a home visit with Patient #26 conducted on 09/25/2023 beginning at 12:40 PM, Physical Therapist (PT) 2 was observed performing an initial evaluation on the patient. While reviewing the patient's medications, the patient confirmed they were taking Oxycodone (an opioid pain medication with a known side effect of constipation). PT 2 failed to ask Patient #26 the date of their last bowel movement. During an interview with PT 2 on 09/25/2023 beginning at 1:35 PM, the therapist confirmed they did not ask Patient #25 the date of their last bowel movement. 3. Review of the clinical record for Patient #27 indicated a start of care of 05/17/2023 and resumption of care date 09/06/2023. The record included a recertification			

	completed on 09/13/2023 by Registered Nurse (RN) 1 which indicated the patient had a new rash underneath their breast. The record indicated RN 1 obtained recertification orders on 09/13/2023 from Patient #27's physician which included the patient was to receive skilled nursing services and nursing interventions included assessing any skin alterations or wounds. The record indicated the next nursing visit was conducted on 09/20/2023 by RN. The visit note failed to evidence the nurse conducted a re-assessment of the patient's rash. During an interview with RN 1 on 09/26/2023 beginning at 2:05 PM, the nurse reported they did re-assess the rash under the breast during the 09/20/2023. RN 1 confirmed they did not document their re-assessment of the skin alteration. 4. Review of the clinical record for Patient #30 indicated a start of care of 07/18/2023. The record included a plan of care for the recertification period of 09/16/2023 – 11/14/2023 which indicated the patient was to			

	receive skilled nursing services and nursing interventions were to include assessment of any skin alterations. The record included a visit note completed on 09/21/2023 by Physical Therapist 1 which indicated the presence of a "new scratch" from their cat on the patient's posterior left calf. The visit note indicated PT 1 reported the scratch to Patient #30's wound clinic and was informed by the wound clinic nurse to leave the area open and the agency nurse was to reassess on 09/22/2023. The record included a visit note completed on 09/22/2023 by RN 1. The note failed to evidence the nurse assessed the scratch. During an interview with RN 1 on 09/27/2023 beginning at 3:22 PM, the nurse reported they had not seen PT 1's email regarding the scratch until after their 09/22/2023 visit. RN 1 reported the patient had mentioned the scratch and the nurse had assessed it during the visit on 09/22/2023, however the nurse reported they did not document their assessment of the alteration.			

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; *	G0710	The deficiencies related to Tag G-0710 were resolved.	2023-09-27
G0944	Administrator must: 484.105(b)(1) Standard: Administrator. The administrator must: Based on record review and interview, the clinical supervisor failed to assure all patient needs, including need for assistance with personal care, were assessed and addressed by agency staff for 1 of 5 clinical records reviewed (Patient #27). Findings include: Review of an agency's job description for the title of "Clinical Supervisor," revised 10/2019, indicated the clinical supervisor was responsible for ensuring care and services provided by staff were "delivered appropriately." Review of the clinical record for	G0944	The actions taken to correct the deficiencies related to Tag G-0944 are as follows: The HHA does have aide services available and is actively providing aide services. Education was provided to all agency staff on 09/28/2023 regarding the availability of aide services. All agency patients were contacted on 09/27/2023 to discuss the need and availability of aide services. All discussions with patients or caregivers is documented in the patient chart. One patient was found to require aide services on 9/27/2023. Aide services for this patient were started on 09/28/2023. The Administrator and Clinical Manager will continue to review all certifications and re-certifications to asses for the need of agency aide services to ensure 100% compliance. All agency staff will discuss the need for aide services during each visit with a patient to ensure that the patient is aware of the availability of aide services to ensure 100% compliance.	2023-09-28

	Patient #27 indicated a resumption of care date of 09/06/2023. The record included a resumption of care comprehensive assessment completed on 09/06/2023 by Registered Nurse (RN) 1. The assessment indicated the patient was homebound, lived alone, was a high fall risk, and required assistance from another person with grooming, dressing, bathing, and ambulation. The assessment indicated the patient had a history of dizziness and during the visit RN 1 obtained orthostatic blood pressure and heart rate readings (performed when the patient was lying down, then sitting, then standing). The patient's blood pressure lying down was 96/68 and heart rate was 75, sitting blood pressure was 77/58 and heart rate was 52, and standing blood pressure was 72/56 and heart rate was 50, indicating orthostatic hypotension (condition where a person's blood pressure decreases when moving positions). The assessment also indicated the patient had a diagnosis of ovarian cancer and was due to resume chemotherapy that week. The record failed to evidence RN 1			

offered Patient #1 services, such as home health aide, to assist with their personal care needs.

During an interview with RN 1 on 09/26/2023 beginning at 2:05 PM, the nurse reported Patient #27 had a family member who visited daily to assist the patient with their personal care needs. The nurse could not recall nor could provide documentation of discussing and/or offering agency services to Patient #27 to assist with their personal care needs.

The record included a physical therapy (PT) evaluation completed on 09/11/2023 by PT 1. The evaluation note indicated Patient #27 was homebound, required assistance for all activities, and had "weakness, impaired transfers, gait [walking] instability, impaired balance, [and was an] increased risk for falls." The evaluation note also indicated the patient was sponge bathing independently and needed caregiver assistance to shower.

During an interview with PT 1 on 09/27/2023 beginning at 10:21 AM, the therapist

	offer services, such as a home health aide, to assist with the patient's personal care needs because at the time of the evaluation, the agency did not have home health aides available to provide services. During an interview with Patient #27 on 09/26/2023 beginning at 2:33 PM, the patient reported they were currently sponge-bathing only by him/herself due to being too weak to shower. The patient stated they had been previously informed by the agency that there were no services available to assist the patient with their personal care needs. Patient #27 reported they would be interested in home health agency services to assist them with personal care needs, such as showering, as they were very weak due to currently receiving chemotherapy treatments.			
N0000	Initial Comments This was the second Post Condition Revisit for the home health State complaint	N0000		

	investigation conducted on July 11, 2023. Complaint #99313 was investigated during the initial survey with related and unrelated State findings cited. Survey Dates: September 25, 26, 27; 2023 Unduplicated Skilled Admissions for Previous 12 Months: 516 During this Post Condition Revisit survey, one deficiency was found corrected, one deficiency was recited, and two deficiencies were newly cited. QR: A 2 10/10/23			
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has	N0464	The actions taken to correct the deficiencies related to Tag N-0464 are as follows: On 09/28/2023 the Administrator provided education to the HR Director on the proper procedure for TB testing for new hires to include the two-step testing process or the quantiferon-TB assay upon hire. Discussion with the HR Director occurred and effective 09/28/2023 all new hire staff will be required to have the quantiferon -TB Assay during their new hire physical. The Administrator will review 100% of all new hire paperwork within 14 days of hire to ensure that this standard is met and maintained at 100%. If a deficiency is found during the review of any new hire paperwork then disciplinary action will be taken against the HR Director immediately.	2023-09-28

	been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.			

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N0470	Home health agency administration/management 410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review, and interview, the home health agency failed to ensure all staff followed infection control policies and procedures specific to disinfection of re-usable equipment during a home visit for 2 of 2 home visit observations observed (Physical Therapist 2, Registered Nurse 1). Findings include: 1. Review of an agency document titled "Mandatory Education," reported by the Administrator as documentation of education provided to all clinical staff after the agency's initial survey on 07/11/2023, indicated when cleaning	N0470	The actions taken to correct the deficiencies related to Tag N-0470 are as follows: Education and demonstration was provided to all agency staff on 10/4/2023 regarding the proper techniques for cleaning of equipment and bag procedure. The Administrator will complete 4 home visits per month with different clinicians to ensure proper infection control procedures are being met at 100%.	2023-10-04

	supplies used during the visit, each item should be cleaned with disinfectant and allowed to air dry prior to returning it to the clinician's supply bag. The documentation also indicated staff was educated to avoid placing cleaned items "next to or on top of" dirty items. 2. During a home visit with Patient #26 conducted on 09/25/2023 beginning at 12:40 PM, Physical Therapist (PT) 2 was observed disinfecting their vital sign equipment, including a thermometer, oxygen saturation (SpO2) probe, blood pressure cuff, and stethoscope. The therapist wiped the equipment with a disinfectant wipe then placed the equipment on top of each other while drying. 3. During an interview with PT 2 conducted on 09/25/2023 beginning at 1:35 PM, the therapist reported they used Sani-Cloth disinfecting wipes to clean their vital sign equipment. PT 2 confirmed the disinfecting wipe dry time was "3-4" minutes. 4. A home visit observation was			

	09/26/2023 beginning at 9:35 AM, Registered Nurse (RN) 1 was observed disinfecting their vital sign equipment, including a thermometer, SpO2 probe, blood pressure cuff, and stethoscope. The nurse wiped the equipment with a disinfectant wipe then placed the equipment on top of each other while drying.			
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.	N0524	The actions taken to correct the deficiencies related to Tag N-0524 are as follows: The Administrator contacted the agency EMR system on 9/28/203 to expediate the process needed to allow for all hospitalization risk factors to be included on the recertification of all patients. The EMR system implemented this action on 10/10/2023. The Administrator and Clinical Manager will review 100% of all recertification visit notes to ensure that all hospitalization risk factors are included and pertinent to the patient. This will be an ongoing process to ensure 100% compliance. Any deficiencies will be reviewed with the agency staff and education will be provided as needed. Continued deficiencies will result in disciplinary action up to termination of employment.	2023-10-11

	(x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview, the home health agency failed to ensure the plan of care included all the patient's risk factors for hospitalization as indicated in the comprehensive assessment for 5 of 5 active records reviewed (Patients #25, 26, 27. 28. 30). Findings include: 1. Review of agency policy #1-007 titled "Care Planning Process," dated 05/2022, indicated the plan of care would be individualized and would include "measurable outcomes and goals identified by the organization" and "a description of the patient's risk for emergency department visits and hospital readmissions." 2. Review of the clinical record for Patient #25 indicated a start of care of 04/06/2022. The			

	record included a recertification comprehensive assessment completed on 07/26/2023 by Registered Nurse (RN) 1. The assessment indicated Patient #25's risk factors for hospitalization included but were not limited to the patient needed help with managing medications and ADLs (activities of daily living, such as bathing, ambulating, dressing, etc), home safety risks were identified, the patient had more than 2 secondary diagnoses, and the patient was confused. The record included a plan of care for the recertification period 07/30/2023 – 09/27/2023. The record failed to evidence the agency updated the plan of care to include all of Patient #25's risk factors for hospitalization as indicated in the comprehensive assessment. 3. Review of the clinical record for Patient #26 indicated a start of care of 09/22/2023. The record included an initial comprehensive assessment completed on 09/22/2023 by the Alternate Clinical Supervisor. The assessment indicated Patient #26's risk factors for hospitalization included but were not limited to the patient			

	needed help with managing medications and ADLs, lived alone, and the patient had more than 2 secondary diagnoses and dyspnea (difficulty breathing). The record included a plan of care for the recertification period of 09/22/2023 – 11/20/2023 which failed to evidence all of Patient #26's risk factors for hospitalization as indicated in the comprehensive assessment. 4. Review of the clinical record for Patient #27 indicated a start of care of 05/17/2023 and resumption of care date 09/06/2023. The record included a recertification comprehensive assessment completed on 09/13/2023 by Registered Nurse (RN) 1. The assessment indicated Patient #27's risk factors for hospitalization included but were not limited to the patient needed help with managing medications and ADLs (activities of daily living, such as bathing, ambulating, dressing, etc), lived alone, and the patient had more than 2 secondary diagnoses, an inadequate support network, home safety risks, confusion, dyspnea, and depression. The record included a plan of care			

	for the recertification period 09/14/2023 – 11/12/2023 which failed to evidence all of Patient #27's risk factors for hospitalization as indicated in the comprehensive assessment. 5. Review of the clinical record for Patient #28 indicated a start of care of 08/23/2023. The record included an initial comprehensive assessment completed on 08/23/2023 by Physical Therapist (PT) 2. The assessment indicated Patient #28's risk factors for hospitalization included but were not limited to the patient needed help with managing medications and ADLs, home safety risks were identified, and the patient had more than 2 secondary diagnoses, at least one pressure ulcer (type of wound caused by prolonged pressure to a body site), and diagnosis of depression. The record included a plan of care for the recertification period 08/23/2023 – 10/21/2023. The record failed to evidence the agency updated the plan of care to include all of Patient #28's risk factors for hospitalization as indicated in the comprehensive assessment.			

	6. Review of the clinical record for Patient #30 indicated a start of care of 07/18/2023. The record included a recertification comprehensive assessment completed on 09/15/2023 by RN 1. The assessment indicated the patient's risk factors for hospitalization included but were not limited to Patient #30 needed help with managing medications and ADLs, lived alone, had more than 2 secondary diagnoses, home safety risks were identified, and the patient had more than 2 secondary diagnoses, an inadequate support system, confusion, dyspnea, and depression. The record included a plan of care for the recertification period of 09/16/2023 – 11/14/2023. 7. During an interview with the clinical manager conducted on 09/27/2023 beginning at 4:25 PM, the Clinical Manager reported after the agency's previous survey, they had put a help desk ticket in to their electronic medical record (EMR) system to ensure all hospitalization risk factors identified in the comprehensive assessment were also in the plan of care, but the EMR			

	system was still working on this change.			
N0541	Scope of Services 410 IAC 17-14-1(a)(1)(B) Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on observation, record review, and interview, the home health agency failed to ensure the recertification comprehensive assessment included a complete pain assessment for 1 of 1 home visit observation of a recertification comprehensive assessment (Patient #25) and 2 of 2 records reviewed which included a recertification comprehensive assessment (Patients #27 and #30). Findings include: 1. Review of agency policy #1-021 titled “Pain Assessment” indicated when the patient or clinician identified pain, and in-depth pain assessment would be obtained and would include but not be limited to pain intensity, location, quality, duration, and factors which	N0541	The actions taken to correct the deficiencies related to Tag N-0541 are as follows: The Administrator provided education to all agency staff on the requirement for completing a pain assessment on all patients during certification and recertification. The Administrator and Clinical Manager will review 100% of certification and recertification documentation to ensure compliance with this requirement. Ongoing education will be provided to any agency staff found to be out of compliance. If an agency staff member continues to be non-compliant despite ongoing education then disciplinary action will take place that may lead to termination of employment.	2023-10-04

	improved or worsened the pain. 2. Review of the clinical record for Patient #25 indicated a start of care of 04/06/2022. The record included a plan of care for the recertification period 07/30/2023 – 09/27/2023, which indicated patient's functional limitations included pain. The plan of care indicated the patient was to receive skilled nursing services, with nursing interventions to include assessing Patient #25's pain, and the agency's goals for the patient included for the patient's pain to be "controlled." A home visit observation was conducted with Patient #25 on 09/26/2023 beginning at 9:35 AM. Prior to entering the home, RN 1 confirmed they were to complete a recertification comprehensive assessment during the visit. During the visit, Patient #25 denied currently experiencing pain. RN 1 failed to conduct a complete pain assessment during the visit, including pain location, quality, duration, and factors with improved or worsened the pain. 3. Review of the clinical record for Patient #27 indicated a start			

of care of 05/17/2023. The record included a plan of care for the recertification period 09/14/2023 – 11/12/2023, which indicated the patient's medications included Tylenol (an over-the-counter medication given to treat pain and fever) taken as needed for pain and the patient's functional limitations included "pain." The plan of care indicated the patient was to receive skilled nursing services, with nursing interventions to include assessing Patient #27's pain, and the agency's goals for the patient included for patient's pain to be "controlled." The record included a recertification comprehensive assessment completed on 09/13/2023 by Registered Nurse (RN) 1. The comprehensive assessment failed to evidence a complete pain assessment was conducted, including pain location, quality, duration, and factors which improved or worsened the pain.

4. Review of the clinical record for Patient #30 indicated a start of care of 07/18/2023. The record included a plan of care for the recertification period of

which indicated the patient's medications included Tylenol and Meloxicam (a medication used to treat pain caused by arthritis) and the patient's functional limitations included pain. The plan of care indicated the patient was to receive skilled nursing services, with nursing interventions to include Patient #30's pain, and the agency's goals for the patient included the patient's pain would be "controlled." The record included a recertification comprehensive assessment completed on 09/15/2023 by RN 1. The comprehensive assessment failed to evidence a complete pain assessment was conducted, including pain location, quality, duration, and factors which improved or worsened the pain.

5. During an interview with RN 1 on 09/27/2023 beginning at 3:22 PM, the nurse reported if the patient denied pain at the time of a recertification comprehensive assessment, the nurse would not conduct a complete pain assessment during the assessment.

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
Tamara Dodt	Administrator	10/16/2023 3:08:05 PM