STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157538	A. BUILDING B. WING	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROCARE HOME HEALTH SERVICES	8300 BROADWAY STREET STE B1, MERRILLVILLE, IN, 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: August 24, 25, 28, 28, and 30, 2023 Active Census: 17 At this Emergency Preparedness survey, ProCare Home Health Services was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000		
E0001	Establishment of the Emergency Program (EP) 483.73	E0001	Asked to ignore.	2023-09-30

§403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12

The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements:

* (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.)

*[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:

*[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:

Based on record review and interview, the home health agency

failed to develop and maintain a comprehensive emergency preparedness plan.

The findings include:

Record review of the agency's emergency preparedness plan on 8/24/2023, with the Administrator failed to evidence the following requirements for an emergency preparedness plan: A documented, facility-based and community-based risk assessment utilizing an all-hazards approach and included strategies for addressing emergency events identified by the risk assessment; included the high risk areas for the agency's patient population; they developed and maintained an emergency preparedness plan to include a process for cooperation and collaboration with local, State and Federal emergency preparedness officials and efforts to maintain an integrated response during a disaster or emergency situation; they developed and implemented an individualized emergency preparedness plan for the patients which provided appropriate instructions, in the event of an emergency, to

	communicate with the agency (see tag E0017), Maintained current patient information to determine the immediate needs in the event of service interruption; Included a system where clinical documentation preserves patient confidentiality; Included the use of volunteers; they developed and maintained an emergency preparedness communication plan which included contact information for State, tribal, regional, and local emergency preparedness staff and other sources of assistance; they developed and maintained an emergency preparedness communication plan which included primary and alternate means for communicating with agency staff and Federal, State, tribal, regional and local emergency management agencies; Established an emergency preparedness training program for new employees; And failed to ensure they conducted exercises to test the emergency plan annually. During an interview on 8/24/2023, at 12:39 PM, the Administrator indicated the			

	agency was focused on fixing the individualized emergency preparedness and did not update the emergency preparedness binder submitted for review.			
E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. During an observation of care on 8/25/2023, at 9:25 AM, at the home of Patient #5, the patient was observed to be bedbound with wounds to the right buttocks and right thigh. Review of an undated agency	E0017	Asked to ignore	2023-09-30

	titled "Emergency Plan" failed to evidence the name and number for the pharmacy and failed to evidence the wound care supplies needed for wound care. During an interview on 8/29/2023, at 11:12 AM, the Clinical Manager indicated the wound care supplies should be included in the individualized emergency plan and indicated the form should be completed to include the pharmacy name and number. *. During an observation of a home visit for Patient #1 on 8/28/2023, from 9:05 AM – 10:00 AM, the agency home folder was requested for review and received the information book from the patient's primary caregiver, who indicated that was all they had from ProCare. Review of the agency's information book failed to evidence an individualized emergency plan for the patient. Observation failed to evidence an emergency plan was maintained in the patient's home. Record review evidenced an agency document titled			

	"Emergency Plan" which failed to evidence an evacuation plan and DME (durable medical equipment) needed for ambulation. Review failed to evidence an individualized emergency plan maintained by the agency.			
G0000	INITIAL COMMENTS This visit was for a Post Condition Revisit of a Federal Recertification, State re-licensure, and a complaint survey of a home health provider. Survey Dates: August 24-25, 2023 and August 28-30, 2023 Unduplicated Skilled Admissions for the last 12 Months: 177 During this Post Condition Revisit survey, 19 federal citations remained not in compliance; 12 federal citations were put back into compliance, and 1 additional federal citation found not to be in compliance. Two Conditions of Participation were corrected, and 3 Conditions of Participation	G0000		

	remained out of compliance at 42 CFR §484.60 Care Planning, Coordination of Services, and Quality of Care; 42 CFR §484.65 Quality Assessment/Performance Improvement; and 42 CFR §484.105 Organization and Administration of Services. Based on the Condition-level deficiencies during the 7/3/2023 survey, ProCare Home Health Services was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 6/27/2023. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning 7/3/2023 and continuing through 7/2/2025. This deficiency report reflects State Findings cited in accordance with 410 IAC 17.			
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii)	G0434	The Administrator and Clinical Manager reviewed the following policy forreeducation and	2023-09-12

	Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the agency failed to ensure the patient's rights to participate in care and be informed in advance of the care to be furnished, the disciplines providing the care, and the frequency of the care to be furnished in 3 of 5 clinical records reviewed where PT services were provided (Patient #1, 6, 8). The findings include: 1. Clinical record review on 8/25/2023, for Patient #6, evidenced an agency document titled "Admission Service Agreement Home Health" signed by the patient's caregiver, which failed to evidence which services the		clarification of procedures. Service Agreement/Plan C-160 A Service Agreement/Plan shall be developed with all patients uponadmission before care is provided. The service agreement/plan will identify theservices to be provided, disciplines providing care, charges and expectedsources of reimbursement for services. The patient will be informed of theirliability for payment. With emphasis on sub section 4. The patient shall be advised, of anychanges in type or frequency of services, coverage of services and any changein financial liability. Changes in financial liability will be verbal and inwriting as soon as possible, but no later than, 30 calendar days from the datethe agency becomes aware of a change. The agency now ensures the patient's rights to participate in care and beinformed in advance of the care to be furnished, the disciplines providing thecare, and the frequency of the care to be furnished including discharge plan.	

	agency was to provide. During an interview on 8/29/2023, at 11:28 AM, the Clinical Manager indicated the service agreement is how the agency informs patients of services to be provided and indicated the form should have been completed. 2. Clinical record review on 8/25/2023, for Patient #8, evidenced an agency document titled "Admission Service Agreement Home Health" signed by the Administrator and the patient on 8/10/2023. Review indicated the agency was to provide physical therapy (PT) services 2 times a week for 4 weeks. Review of an agency document titled "Plan of Treatment" for certification period 8/10/2023-10/8/2023, indicated the agency would provide the patient PT services 3 times a week for 2 weeks and then 2 times a week for 1 week. Review failed to evidence the patient was informed of the change in frequency for PT services. During an interview on 8/25/2023, at 2:03 PM, the Administrator indicated the		For Patient#6, the "Admission Service Agreement Home Health" now has the services to beprovided. Patient #8is now discharged. Going forward patients will be informed of the change infrequency of their services. Patient #1is now discharged from PT. Going forward patients will be informed of theirdischarge and documented in the clinical record. The Clinical Manager and Administrator reviewed all active patients'clinical records and found that 5 out 20 patient's rights to participate incare and be informed in advance of the care to be furnished, the disciplinesproviding the care, and the frequency of the care to be furnished were notcompletely documented and this deficiency has now been corrected. The Administrator in-serviced the clinical manager on the importance ofinforming the patients in advance of the care to be furnished, the disciplinesproviding the care, and the frequency of the care to	

	patient was done with PT services at this time but the agency was trying to get the patient more PT visits. The Administrator remained quiet when asked why the PT services on the plan of care did not match the PT frequency on the patient's consent form. 410 IAC 17-3(ii)(AA)(BB) *. Review of an agency policy revised 1/21/2021, titled "Service Agreement/Plan" stated, "… The patient shall be advised, of any changes in type or frequency of services, coverage of services and any change in financial liability…." *. Clinical record review on 8/25/2023, for Patient #1, start of care 5/19/2023, for certification period 7/18/2023 – 9/15/2023, evidenced the plan of care ordered physical therapy (PT) twice a week for 8 weeks. Record review evidenced a PT discharge summary from 8/15/2023. Review failed to evidence communication to the patient/caregiver documented in the clinical record. During an interview on		be furnished includingdischarge plan. The Administrator and ClinicalManager will be responsible for all intakes and admissions to the agency. Theywill review all admissions to ensure that patients are informed in advance ofthe care to be furnished, the disciplines providing the care, and the frequencyof the care to be furnished including discharge plan. The Clinical Manager is responsible to ensure that this situation doesnot recur.	

	patient's primary caregiver indicated the patient received physical therapy services, but they did not come last week and did not know why. During an interview on 8/29/2023, at 4:20 PM, the Clinical Manager indicated the notification of changes communicated should have been documented and the notice was probably given verbally.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the agency failed to ensure all medication interactions were reported to the physician for 4 of 8 active clinical records reviewed (Patient #3, 5, 8, 9). The findings include: 1. Review of an agency policy revised 6/28/2022, titled	G0536	The Director of Nursing and Administrator reviewed the following policyfor reeducation and clarification of procedures. C-700 Medication Profile The Registered Nurse or Therapist will complete a medication profile foreach patient at the time of admission. The medication profile shall include all prescription and nonprescriptiondrugs, including regularly scheduled medications and those taken intermittentlyor as needed. The profile will be reviewed and updated as needed to reflectcurrent medications the patient is	2023-09-14

	"Medication Profile" stated, "… At the time of admission, the admission professional shall check all medication a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication. The clinician shall promptly report any identified problems to the physician…." 2. Clinical record review on 8/24/2023, for Patient #5, evidenced an undated agency document titled "Drug-Drug Interactions" which indicated major drug interactions between the patient's medications: labetalol (medication used to treat high blood pressure) and albuterol (medication used to treat spasms of the airways) which could lead to narrowing of the airways; amiodarone (medication used to treat abnormal heart rhythms) and venlafaxine (an antidepressant) which could increase irregular heart rhythms; amiodarone and furosemide (medication used to remove excess water in the body) which could increase the risk of irregular heart rhythms; amiodarone and hydrocortisone		taking. PURPOSE To provide a complete list of ALL medications the patient istaking and an evaluation of the patient's knowledge of the effects of thesemedications. To provide documentation of the comprehensive assessment of allmedications the patient is currently taking and identify discrepancies betweenpatient profile and the physician and/or agency profile. To identify possible ineffective drug therapy, adverse reactions,significant side effects, drug allergies, and contraindicated medications. With emphasis on Section 1 At the time of admission, the Clinician shall check all medications a patientmay be taking to identify possible ineffective drug therapy or adversereactions, significant side effects, drug allergies, and contraindicated medication.The clinician shall promptly report any identified problems to the physician. For Patient#5 agency has	

	(medication used to reduce inflammation and itching) which could increase the risk of abnormal heart rhythms; amiodarone and metolazone (a medication used to treat high blood pressure and excess fluid) which could increase the risk of abnormal heart rhythms; diazepam (a medication used to treat anxiety, seizures, and/or muscle spasms) and morphine (a narcotic pain medication) which could lead to respiratory distress, coma, and death; morphine and pregabalin (a medication used to treat nerve and muscle pain) which could lead to respiratory distress, coma, and death. Review failed to evidence the agency notified the physician of the major drug interactions involving labetalol, albuterol. amiodarone, hydrocortisone, metolazone, diazepam, and pregabalin. During an interview on 8/29/2023, at 11:09 AM, the Clinical Manager indicated she did not notify the physician of all of the major drug interactions because there was probably an issue with the electronic health record and not all medications interactions		major drug interactions. Patient #8is now discharged. Going forwards, the medications upon discharge from allentities will be reviewed for potential adverse side effects and documentedaccordingly. For Patient#9, the medication list has now been signed and dated by a clinician toindicate a review of the medications. For patient#3, the Clinical Manager has now reported the interaction to the patient'sphysician. The Clinical Manager and quality assurance (QA) team reviewed all activepatients' clinical records and found that 5 out of 20 charts did not includeMajor Drug to Drug interactions and side effects reported to the PrimaryPhysician. The Agency has now ensured that all medications were reviewed in thepatient's home and are on the medication profile list and in the patient'shome. All clinicians have now	

	review of medications. 3. Clinical record review on 8/25/2023, for Patient #8, start of care date 8/10/2023, evidenced an untitled document from Entity C, the referring hospital, dated 8/9/2023, which indicated the patient was to continue 17 medications upon discharge from Entity C. Review failed to evidence the agency reviewed the patient's medications for potential adverse side effects. During an interview on 8/25/2023, at 2:03 PM, the Administrator indicated he completed the patient's initial comprehensive assessment on 8/10/2023 and did not review the patient's medications. The Administrator indicated he was unable to find a list of the patient's medications in the electronic medical record. 4. Clinical record review on 8/30/2023, for Patient #9, start of care 8/25/2023, evidenced an undated agency document titled "Medications" which indicated the patient's medication included aspirin (medication used to treat pain/fever/blood clots),		submitted a list of the Major Drug to DrugInteractions and side effects to the Primary Care Physician on a Physician'sorder with request for any new medication changes. The Clinical Manager and quality assurance (QA) will review allmedication profiles at admission, recertification and resumptions for MajorDrug to Drug Interactions and side effects and ensure completeness andaccuracy. The Clinical Manager is responsible to ensure that this situation doesnot recur.	

	atorvastatin (medication used to treat high cholesterol), insulin (an injectable medication used to treat high blood sugar), Januvia (a medication used to treat high blood sugar), lisinopril (a medication used to treat high blood pressure), sertraline (antidepressant), and trazadone (a medication used to treat insomnia). Review failed to evidence the medication list was signed and dated by a clinician to indicate a review of the medications. During an interview on 8/30/2023, at 4:12 PM, the Clinical Manager indicated she completed the initial comprehensive assessment on 8/25/2023 and did not review the medications, because she thought the electronic medical record company was supposed to do the medication review. 410 IAC 17-14-1(a)(1)(B) *. Clinical record review on 8/24/2023, for patient #3, start of care 10/13/2023, evidenced a serious medication interaction between Aspirin (nonsteroidal anti-inflammatory drug/ blood thinner) and Lisinopril (used to treat high blood pressure)			

	which reported a significant decrease in renal function could occur. Review failed to evidence the Clinical Manager reported the interaction to the patient's physician. During an interview on 8/29/2023, at 3:38 PM, the Clinical Manager indicated they did not see the physician was notified of the serious medication interaction.			
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on record review and interview, the agency failed to ensure the comprehensive assessment included the identification of the patient's primary caregiver, their willingness and ability to provide care, and their availability and schedule in 1 of 6 clinical records reviewed. (Patient #1) The findings include: 1. Review of an agency policy revised 6/28/2022, titled	G0538	The Director of Nursing and Administrator reviewed the following policyfor reeducation and clarification of procedures. C-145 Comprehensive Patient Assessment The initial assessment visit must be held either within 48 hours ofreferral or within 48 hours of the patient's return home, or on the physicianordered start of care date. A thorough, well-organized, comprehensive, andaccurate assessment, consistent with the patient's immediate needs will becompleted for all patients in a timely manner, but no later than five (5)calendar days after	2023-09-14

	"Comprehensive Patient Assessment" stated, "... The assessment will identify the patient's primary caregiver(s), if any, and any other available supports, including their willingness and ability to provide care, and availability and schedules...." 2. Clinical record review on 8/25/2023, for Patient #8, start of care 8/10/2023, evidenced an agency document titled "Start of Care" dated 8/10/2023. Review indicated non-agency caregivers provided assistance and failed to identify who the caregiver was and their availability, ability, and willingness to provide care. During an interview on 8/25/2023, at 3:17 PM, the patient indicated they lived alone and did not have any assistance. 3. Clinical record review on 8/30/2023, for Patient #9, start of care 8/25/2023, evidenced an agency document titled "Plan of Treatment" for certification period 8/25/2023-10/23/2023, which indicated the patient's caregiver performed treatment, supervision, and medication		start of care. All skilled Medicare and Medicaid patientsexcept pediatric and post-partum will have comprehensive assessments thatinclude the OASIS data set specific to mandated time points. With emphasis on section 2. "Theassessment will identify the patient's primary caregiver(s), if any, and otheravailable supports, including their willingness and ability to provide care,and availability and schedules. If there is an identified patientrepresentative, that will also be documented." Patient #8is currently discharged. Going forwards, non-agency caregivers who provideassistance will be identified and their availability, ability, and willingnessto provide care will be documented. For Patient#9, the assessment now includes who the caregiver is and their availability,ability, and willingness to provide care.	

	administration. Review of an agency document titled "Start of Care" dated 8/25/2023, failed to evidence the assessment included who was the caregiver and their availability, ability, and willingness to provide care. 4. During an interview on 8/30/2023, at 3:59 PM, the Clinical Manager indicated the comprehensive assessment should identify any caregivers and include what the caregivers do to assist in the patient's care.		Goingforwards, the Comprehensive assessment will identify any caregivers and includewhat the caregivers do to assist in the patient's care. The Clinical Manager and quality assurance (QA) team reviewed all activepatients' clinical records for caregiver abilities, willingness andavailability in the Comprehensive Assessment and found 2 of 20 active patientsdid not have information. This deficiency has now been corrected. The Clinical Manager and quality assurance (QA) will review allComprehensive Assessments to ensure that caregiver status is included. The Clinical Manager is responsible for ensuring that this deficiencydoes not recur.	
G0562	Discharge Planning 484.58(a) Standard: Discharge planning. An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA	G0562	The Clinicmanager and Administrator reviewed the following policies for reeducation andclarification of procedures. C-500PATIENT DISCHARGE PROCESS	2023-09-12

	the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. Based on record review and interview, the agency failed to follow its policies for discharge planning to ensure the patient's needs have been met adequately upon discharge in 2 of 2 closed records reviewed (Patient #4, 10) and failed to establish an agency policy in accordance with federal regulation related to the discharge summary. The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Patient Discharge Process" stated, "... Discharge planning is initiated for every home care patient at the time of the patient's admission for home care ... The physician will be involved in the discharge plan and specific ongoing care needs will be identified and addressed as part of the plan ... A Discharge Plan shall be developed that is documented in writing and includes all written/verbal instruction		Discharge Planning is initiated for every homecare patient at the time of the patient's admission for home care. Whenpatients are admitted for home health services, the expectation is that thepatient will be discharged to self-care or care of family when goals are met.Discharging a patient to another provider is permitted under limitedcircumstances that are documented in the admission notices. B-250ENCODING AND REPORTING OASIS DATA The agencywill electronically report all OASIS (Outcome and Assessment Information Set)data collected in accordance with State and Federal regulations. The agency andagents acting on behalf of the agency will ensure confidentiality of allpatient specific information in the clinical record. C-495DISCHARGE POLICY Patients aredischarged from treatment in the home when the expectations that the patient'smedical, nursing, and social needs have been met	

	regarding the patient's ongoing care needs and available resources provided to the patient and family ...." 2. Review of an agency policy revised 6/28/2022, titled "Encoding and Reporting OASIS Data" stated, "... Discharge OASIS will be completed by the last skilled discipline whenever possible within 48 hours of the last visit ...." 3. Review of an agency policy revised 6/28/2022, titled "Discharge Policy" stated, "... Discharge planning ... shall include documentation of specific plans and the expected date of discharge at least fifteen (15) calendar days before the services are stopped ...." 4. Review of an agency policy revised 6/28/2022, titled "Discharge Summary" stated, "... Discharge Summary ... will be mailed to the physician upon request...." Review failed to evidence the policy included the discharge summary will be sent to the primary care practitioner or other health care professional responsible for providing care and services to the patient after discharge from		thepatient's place of residence, upon death of the patient, or for another reason. C-820 Discharge Summary A Discharge Summary will be completed for patients discharged fromAgency. PURPOSE To record a summary of care received by the patient from thestart of care through discharge. To document patient status at the time ofdischarge, identified unmet needs, and referrals initiated. To documentinstructions given to the patient/caregiver regarding medications, treatment,referrals, and necessary follow-up. The agencynow follows its policies for discharge planning to ensure the patient's needshave been met adequately upon discharge and has established an agency policy inaccordance with federal regulation related to the discharge summary. Patient #10is now discharged. Going forwards the agency will notify the referringPhysician regarding the plans to discharge and when the agency	

	the agency within 5 days of patient discharge per federal regulation. 5. Clinical record review on 8/29/2023, for Patient #10, evidenced an agency document titled "Skilled Nurse Visit" dated 7/21/2023, which indicated the patient was to be discharged within the next 15 days due to goals were almost met. Review indicated Person B, physician, was notified of the plans to discharge. Review indicated the patient patient's goals were not met at this time and failed to evidence any additional nurse visits prior to discharge on 8/7/2023. Review of agency document titled "Home Health Certification and Plan of Care" for certification period 6/9/2023-8/7/2023, indicated Person A, was the practitioner responsible for the plan of care. Review failed to evidence the agency notified Person A regarding the plans to discharge. Review of an agency document titled "Home Health Discharge Summary" dated 8/9/2023, indicated the patient was		the patient is being referred to another home care agency,the practitioner responsible for the plan of care will be notified of theagency's inability to provide care for the patient prior to discharge. Patient #4,is now discharged. Going forwards the agency will ensure discharge summariesare forwarded to the physician or receiving agency in a timely manner. Patient #10,is now discharged. Going forwards the agency will ensure verification ofmeasurable Therapy goals are indicated for all patients at time of discharge The Clinical Manager now ensures that all recently discharged patientshave their discharge summaries forwarded to thephysician or receiving agency in a timely manner. The Clinical Manager and quality assurance (QA) team review all dischargesummaries daily to ensure that they have been sent to the physician or receiving agency. The Clinical Manager is responsible to ensure that these	

	discharged due to goals met. Review indicated the goals included the patient will walk with a walker for 150 feet and the goal was met. Review indicated the patient agreed with the reason for discharge and indicated the patient requested to continue to receive services. Review indicated the agency was unable to provide services at this time and was referred to another home care agency. Review failed to evidence the practitioner responsible for the plan of care was notified of the agency's inability to provide care for the patient prior to discharge. Review of an agency document titled "PT [physical therapy] Visit" dated 7/31/2023, and identified as the PT discharge assessment, indicated the patient had inadequate hip and knee flexion on the left side and had decreased muscle strength to both lower extremities. Review indicated the patient could walk with a walker up to 100 feet. Review failed to evidence the patient met ambulation goal. During an interview on		situations donot recur.	

	8/29/2023, at 3:43 PM, the patient's caregiver indicated the agency informed them the agency could no longer provide care and the patient's time was up. The patient's caregiver indicated the patient still required home care and continued with services from another home health agency. During an interview on 8/20/2023, at 1:57 PM, the Clinical Manager indicated the agency discharged the patient because of the agency's Immediate Jeopardy status and indicated the patient still wanted home care at time of discharge so was referred to another agency. The Clinical Manager indicated the practitioner responsible for the plan of care should be notified of discharge plans prior to discharge. 6. Clinical record review of the agency's EHR on 8/24/2023 for patient #4, evidenced a skilled nurse (SN) visit scheduled for 8/19/2023, which had not yet been started. Record review of the EHR on 8/28/2023, evidenced the SN Visit changed to a Discharge			

	OASIS Assessment visit. Review of the activity log revealed the Discharge OASIS Assessment visit was deleted on 8/23/2023, and was restored on 8/27/2023. The Alternate Clinical Manager began documentation of the visit 8/28/2023, at 8:35 AM. Review failed to evidence the agency prepared OASIS documentation timely. During an interview on 8/29/2023, at 4:00 PM, the Administrator indicated the reason for the skilled professional starting a visit note 9 days post visit was due to late documentation. Record review evidenced an agency document titled "Home Health Discharge Summary (Auto-Generated)" electronically signed by the Alternate Clinical Manager on 8/28/2023, indicated the patient was transferred and Entity F would take over care on 8/21/2023. Review failed to evidence the discharge summary was sent to the physician within 5 days of discharge. On 8/29/2023, at 4:05 PM, when queried why the discharge			

	later than the discharge assessment, the Clinical Manager stated the patient, "Just yesterday made the decision to stay with [Entity F] ..." and indicated Entity F could not start services until ProCare discharged the patient.			
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. . Corrected 7/23/2023..	G0564	Corrected 7/23/2023	2023-08-30
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an	G0570	The Clinical manager and Administrator reviewed the following policies for reeducation andclarification of procedures. C-660CARE PLANS Each patientwill have a care plan on file that addresses their	2023-09-12

	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. Based on observation, record review, and interview, the home health agency failed to ensure: the plan of care was reviewed by the physician, individualized and followed by all agency staff (See tag G0572); the plan of care included all required information / elements for the treatment of the patient (See tag G0574); the plan of care was revised by the agency and the patient's primary care physician as frequently as patient's condition changes (See tag G0588); physicians were promptly notified of a change in the patient's condition (See tag G0590); coordination of care for all services provided to the patient (See tag G0606); and the written visit schedule was provided to patients (See tag G0614). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination of Care and Quality		identified needs and theagency's plan to respond to those needs. This plan is developed with thepatient and family, as indicated, and is based on services needed to achievespecific measurable goals. C-360COORDINATION OF PATIENT SERVICES The agencywill integrate services, whether they are provided directly or under contract,to assure the identification of patient needs and factors that could affectpatient safety and the effectiveness of treatment. The coordination of care isprovided by all disciplines and included communication with physicians. C-580 PLANOF CARE POLICY ProCare HomeHealth services are furnished under the general supervision and direction ofthe patient's physician. The Plan of Care is based on a comprehensiveassessment and information provided by the patient/caregiver and health teammembers. Planning for care is a dynamic process that addresses the care,treatment, and services to be provided. The	

	of Care. A deficient practice citation was also evidenced at this standard as follows: Based on record review and interview, the agency failed to meet the patient's needs in 2 of 8 active clinical records reviewed. (Patient #1, #6) The findings include: Clinical record review on 8/25/2023, for Patient #6, indicated an agency document titled "Home Health Certification and Plan of Care" for certification period 6/27/2023-8/25/2023, which indicated the patient's diagnoses included, but were not limited to, lack of coordination and abnormalities of gait and mobility. Review failed to evidence the agency provided therapy or home health aide services. Review of an agency document titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" completed by LPN 1 and dated 8/1/2023, indicated the patient had poor balance, unsteady gait, required supervision 24 hours a day,		plan will be consistently reviewedto ensure that patient needs are met, and will be updated as necessary, but atleast every sixty (60) days. In cases where patient care is provided in aclinical setting with rotating team members of physicians, orders shall beprocessed in accordance with Agency policy and the agency shall accept thesignature and date of the physician assigned to the clinic at the time ordersare presented for signature as the attending physician for the patient. For Patient#1, The occupational therapy (OT) evaluation and follow up visits have now been scheduled. has been done and the patient hasreceived the services as ordered. For Patient#6, the Clinical Manager assessed the patient and determined the services ofthe therapy or home health aide were not needed.	

	required physical therapy for exercises to increase strength and endurance and required home health aide services to assist patient with personal care and activities of daily living due to muscle weakness and unsteady gait. During an interview on 8/25/2023, at 12:14 PM, the patient could use assistance for personal care, balance, and strengthening. During an interview on 8/25/2023, at 12:33 PM, LPN 1 indicated he/she was the patient's priamy nurse and indicated physical therapy could benefit the patient, because the patient was very weak and slow. LPN 1 indicated the patient creeped along holding onto furniture while ambulating. LPN 1 indicated the patient's caregiver had their own health issues and could use the assistance of a home health aide. During an interview on 8/29/2023, at 11:30 AM, the Clinical Manager indicated the agency did not need to provide physical therapy, because the patient had not had any falls		The Clinical Manager and quality assurance (QA) team reviewed all activepatients' clinical records for patients needing additional services and found 1of 20 active patients needing services. This deficiency has now been corrected. The ClinicalManager and quality assurance (QA) will review all patients' notes weekly toensure that additional services identified as needed by clinicians are orderedand provided. The Clinical Manager is responsible for ensuring that this deficiencydoes not recur.	

	and indicated the agency had not provided any home health aide services, because the patient had not requested one. 410 IAC 17-13-1(a) *. Clinical record review on 8/25/2023, for Patient #1, start of care 5/19/2023, evidenced a prescription paper signed by the physician on 8/17/2021, which ordered an occupational therapy (OT) evaluation related to the diagnosis of right-sided hemiparesis (paralysis or weakness on one side of the body). Record review evidenced a physician order to put OT on hold "… due to ProCare Home Health Services is unable to staff the case at this time. Caregiver agrees to wait until OT services are available …." During an interview on 8/28/2023, at 9:57 AM, the patient's primary caregiver reported the agency indicated they did not have an OT available and did not help the patient/caregiver find another agency that had therapy services to meet the patient's needs.			

	On 8/29/2023, at 3:05 PM, Person E from Entity D (contracted therapy agency), indicated they did not have a referral documented from ProCare for Patient #1. On 8/29/2023, at 4:12 PM, the Clinical Manager indicated they reached out to Entity D via phone call or text message but was not documented.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure the plans of care were established with a physician and services provided as directed in the plan of care in 3 of 8 active clinical records reviewed. (Patient #2, #8, #9)	G0572	The Clinical manager and Administratorreviewed the following policy for reeducation and clarification of procedures. C-580 PLAN OF CARE POLICY ProCare Home Health services are furnishedunder the general supervision and direction of the patient's physician. ThePlan of Care is based on a comprehensive assessment and information provided bythe patient/caregiver and health team members. Planning for care is a dynamicprocess that addresses the care, treatment, and services to be provided. Theplan will be consistently reviewed to ensure that patient needs are met, andwill be updated as necessary, but at	2023-10-12

	The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Plan of Care" stated, "... If a physician refers a patient under a Plan of Care that cannot be completed until after an assessment visit, the physician shall be consulted to approve additions or modifications to the original plan...." 2. Clinical record review on 8/25/2023, for Patient #8, start of care date 8/10/2023, evidenced an agency document titled "Plan of Treatment" for certification period 8/10/2023-10/8/2023, which indicated the agency was to provide physical therapy services for a primary diagnosis of aftercare following a joint replacement to the left knee. Review failed to evidence the plan of care was established and reviewed by physician. During an interview on 8/25/2023, at 3:13 PM, the Administrator indicated the agency had not sent the plan of care to be reviewed by the physician and indicated the agency had not had any communication with the physician regarding the		least every sixty (60) days. In caseswhere patient care is provided in a clinical setting with rotating team membersof physicians, orders shall be processed in accordance with Agency policy andthe agency shall accept the signature and date of the physician assigned to theclinic at the time orders are presented for signature as the attendingphysician for the patient. With emphasis on Section 1 Patient #8 is nowdischarged. Going forwards the agency will ensure that the plan of care is established and reviewed by the attending physician or approved designate in atimely manner. For Patient #9, the plan ofcare is now established and sent to the attending physician 9/08/2023. Patient #9 is now discharged.Going forwards the agency will ensure that the plan of care is established andreviewed and approved by the attending physician or approved designate in atimely manner. For Patient #2, The SkilledNurse and Home Health Aide services are now resumed as of 8/21/2023.	

	admission of and plan of care for the patient. 3. Clinical record review on 8/30/2023, for Patient #9, start of care date 8/25/2023, evidenced an agency document titled "Plan of Treatment" for certification period 8/25/2023-10/23/2023, which indicated the agency was to provide skilled nursing, physical therapy, and occupational therapy services for a diagnosis of complications to an amputation stump. Review failed to evidence the plan of care was established and reviewed by physician. During an interview on 8/30/2023, at 4:01 PM, the Clinical Manager indicated the agency had not sent the plan of care to the physician and had not had any communication with the physician regarding the admission and plan of care for the patient. 410 IAC 17-13-1(a) *. Clinical record review on 8/25/2023, for patient #2, start of care 1/6/2023, evidenced an agency document titled "Home		The Clinical Manager and QAteam will monitor all plans of care to ensure that they are reviewed and approvedby the attending physician or approved designate in a timely manner. The Clinical Manager isresponsible for ensuring that this deficiency does not recur.	

	Health Certification and Plan of Care" for certification period 7/5/2023 – 9/2/2023, indicated home health aide (HHA) services were ordered 5 days a week for 8 weeks. Record review evidenced HHA visits were documented as ordered for the first 4 weeks of the care period. Review failed to evidence HHA visits documented in the clinical record since 7/29/2023 (28 days later). Record review failed to evidence the plan of care was followed as ordered by the physician. Record review evidenced an agency document titled "Physician Order" from 8/2/2023, that was signed by the physician and ordered the patient's insurance was on hold but SN and HHA would continue to see the patient to prevent disruption of care. During an interview on 8/29/2023, at 3:40 PM, the Clinical Manager indicated the HHA visits from 7/29/2023 and 8/21/2023 were not scheduled under direction of the Administrator because the visits were not billable. When queried why HHA visits had not been			

	8/21/2023, the Clinical Manager indicated they were unaware HHA visits were not started.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (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	G0574	TheClinic manager and Administrator reviewed the following policy for reeducationand clarification of procedures. C-580PLAN OF CARE POLICY ProCareHome Health services are furnished under the general supervision and directionof the patient’s physician. The Plan of Care is based on a comprehensiveassessment and information provided by the patient/caregiver and health teammembers. Planning for care is a dynamic process that addresses the care,treatment, and services to be provided. The plan will be consistently reviewedto ensure that patient needs are met, and will be updated as necessary, but atleast every sixty (60) days. In cases where patient care is provided in aclinical setting with rotating team members of physicians, orders shall beprocessed in accordance with Agency policy and the agency shall accept thesignature and	2023-09-12

	or allowed practitioner may choose to include. Based on record review and interview, the home health agency failed to ensure the plan of care contained individualized treatments and services for 6 of 8 active clinical records reviewed (Patient #2, 5, 6, 7, 8, 9). The findings include: 1. Clinical record review on 8/24/2023, for Patient #5, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/13/2023-9/10/2023, which indicated the patient's primary diagnosis was dehydration. The plan of care failed to evidence individualized goals and interventions related to the patient's primary diagnosis. During an interview on 8/29/2023, at 10:16 AM, the Clinical Manager indicated there was nothing specific to dehydration in the plan of care for interventions and goals. Review of an undated agency document titled "Medication Profile" for episode 7/13/2023-9/10/2023, indicated the patient's medications		date of the physician assigned to the clinic at the time ordersare presented for signature as the attending physician for the patient. Withemphasis on Section 2 ForPatient #5, the plan of care now has been individualized for goals andinterventions related to the patient's primary diagnosis. ForPatient #6, the plan of care now has been individualized to include bleedingprecautions in the safety measures as of 9/12/2023. ForPatient #7, the plan of care is now individualized, to indicate that thesuppository is to be given daily. The plan of care now has been individualizedto include directions on when to take 1 or 2 Tramadol tablets and how often totake Norco. Patient#8 is now discharged, going forwards the agency will ensure that Medicationslist and discharge plan are included in the patient's chart. Patient #9 is now discharged, going forwards theagency will ensure that Medications list is accurately listed, and frequency ofintervention is stated according to the physician's orders.	

	included, but were not limited to, diazepam (a medication used to treat anxiety, seizures, and/or muscle spasms), Allegra (a medication used to treat seasonal allergies), amiodarone (a medication used to treat heart rhythm problems), and atorvastatin (a medication used to treat high cholesterol). The plan of care failed to include the medications: diazepam, Allegra, amiodarone, and atorvastatin. During an interview on 8/29/2023, at 10:31 AM, the Clinical Manager indicated she had noticed not all of the patient's medications were included on the plan of care and was unsure why they had not printed on the plan of care. 2. Clinical record review on 8/25/2023, for Patient #6, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/27/2023-8/25/2023, which indicated the patient's medications included, but were not limited to, warfarin (a medication used to treat/prevent blood clots by thinning the blood). Review		ForPatient #2, going forwards the plan of care is now individualized to includethe correct medication information, and the frequency and duration of thetreatment. The Clinical Manager and Administrator reviewed all active patients'clinical records and found that 3 out 20 patient's Plan of Cares were notupdated with medications. The agency nowensures the Plan of Care is individualized to include interventions frequenciesand durations, medications, and discharge plans. The Clinical Managerand QA team will review all Plan of Cares whenever created to ensure they areindividualized for the patient. The Clinical Managerwill be responsible for ensuring that these deficiencies do not recur.	

	care was individualized to include bleeding precautions in the safety measures. Review indicated the patient's goals included, but were not limited to, the patient will attain optimal effectiveness of pain management and failed to evidence what was the patient's optimal pain level. During an interview on 8/29/2023, at 11:16 AM, the Clinical Manager indicated bleeding precautions should be included in the plan of care. The Clinical Manager indicated the patient did not have problems with pain so a pain goal should not be included on the plan of care. 3. Clinical record review on 8/24/2023, for Patient #7, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/6/2023-9/3/2023, indicated the medications included, but were not limited to, Tramadol 1-2 tablets as needed, Norco (a narcotic pain medication) 1 tablet every 4-6 hours, and bisacodyl (a laxative used to			

	treat constipation) suppository rectally every Monday, Wednesday, and Friday. Review indicated the agency was to provide skilled nursing services 7 days a week to include performing a bowel program daily to include checking for and removing, if necessary, a bowel impaction and inserting a bisacodyl rectal suppository. Review failed to evidence the plan of care was individualized to indicate if the suppository was to be given daily or on Mondays, Wednesdays, and Fridays. Review failed to evidence the plan of care was individualized to include directions on when to take 1 or 2 Tramadol tablets and how often to take Norco. During an interview on 8/30/2023, at 1:44 PM, the Clinical Manager indicated if the pain was not too bad, the patient could have 1 Tramadol tablet and if it was over his threshold for pain, the patient could have 2 tablets. The Clinical Manager indicated the frequency of the Norco administration depended on which pain medicine helps him the best. At 1:58 PM, the Clinical			

	directions for the bisacodyl suppository administration should match and was unsure if it was daily or 3 days a week. 4. Clinical record review on 8/25/2023, for Patient #8, start of care date 8/10/2023, evidenced an untitled document from Entity C, the referring hospital, dated 8/9/2023, which indicated the patient was to continue 17 medications upon discharge from Entity C. Review of an agency document titled "Plan of Treatment" for certification period 8/10/2023-10/8/2023, failed to evidence any medications for the patient. Review failed to evidence the plan of care included discharge plans. During an interview on 8/25/2023, at 2:03 PM, the Administrator indicated he did not include the medications in the plan of care because he did not know how to conduct the medication review in the electronic health record. The Administrator indicated the plan of care should be completed but he was still trying to learn the new electronic health			

	record. 5. Clinical record review on 8/30/2023, for Patient #9, start of care 8/25/2023, evidenced an agency document titled "Plan of Treatment" for certification period 8/25/2023-10/23/2023, which indicated the patient's medication included aspirin (medication used to treat pain/fever/blood clots), atorvastatin (medication used to treat high cholesterol), insulin (an injectable medication used to treat high blood sugar), Januvia (a medication used to treat high blood sugar), lisinopril (a medication used to treat high blood pressure), sertraline (antidepressant), and trazadone (a medication used to treat insomnia). Review indicated the list of medications was duplicated 9 times on the plan of care. Review indicated the patient had a wound to the right foot requiring a wound vac (a medical device used to treat wounds by applying suction) and failed to evidence the frequency of the wound vac dressing change. During an interview on 8/30/2023, at 4:12 PM, the Clinical Manager indicated she			

	was still learning the new electronic health record and was unsure why the medications were duplicated. The Clinical Manager indicated the frequency of the wound vac dressing change should be included in the plan of care. *. Clinical record review on 8/25/2023, for patient #2, start of care 1/6/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/5/2023 – 9/2/2023, which indicated the patient was prescribed to apply a thin layer of Miconozole (used to treat fungal infections and vaginal yeast infections) and failed to evidence where the medication should be applied and if it was a cream or powder. Review of this document evidenced skilled nurse (SN) services were ordered for the patient 1-2 times per week. Review failed to evidence the duration for SN services and when the patient would require 2 visits in a week instead of 1. Review failed to evidence the plan of care was individualized to the patient's treatment. During an interview on			

	8/29/2023, at 3:45 PM, the Clinical Manager indicated the Miconozole was a cream that was applied to the skin folds. The Clinical Manager indicated SN services would go for the duration of the certification period and a second visit would be needed with a new skin tear or wound.			
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Based on record review and interview, the agency failed to review and revise the plan of care with the physician as frequently as the patient's condition requires in 1 of 1 home visit with a registered nurse. (Patient #5) The findings include: Clinical record review on 8/24/2023, for Patient #5, evidenced an agency document titled "Physician Order" dated	G0588	TheClinic manager and Administrator reviewed the following policy for reeducationand clarification of procedures. C-580PLAN OF CARE POLICY ProCareHome Health services are furnished under the general supervision and directionof the patient's physician. The Plan of Care is based on a comprehensiveassessment and information provided by the patient/caregiver and health teammembers. Planning for care is a dynamic process that addresses the care,treatment, and services to be provided. The plan will be consistently reviewedto ensure that patient needs are met, and will be	2023-09-14

	7/31/2023, which indicated the patient had a new wound to the right thigh which required a wound treatment 2 times a week. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 7/13/2023-9/10/2023, failed to evidence the plan of care was revised to include the wound and wound treatment to the right thigh. During an interview on 8/29/2023, at 10:22 AM, the Clinical Manager indicated she did not remember how to revise the plan of care. Review of an agency document titled "COTA [certified occupational therapist assistant] Visit" dated 8/14/2023 indicated the patient's pain was so bad the patient could hardly move their neck and had to wear a neck brace the day before. Review failed to evidence the plan of care was revised to include the neck brace. During an interview on 8/29/2023, at 10:33 AM, the Clinical Manager indicated the neck brace should be included		updated as necessary, but atleast every sixty (60) days. In cases where patient care is provided in a clinicalsetting with rotating team members of physicians, orders shall be processed inaccordance with Agency policy and the agency shall accept the signature anddate of the physician assigned to the clinic at the time orders are presentedfor signature as the attending physician for the patient. With emphasis onSections 1 and 8. For Patient #5, the plan ofcare has been revised to include the wound and wound treatment to the rightthigh. The right thigh wound is now completely healed. The neck brace is nowincluded in the patient's plan of care. The revised plan of care has been sentto the physician for his signature approval. 09/08/2023 Going forwards, the agency will ensure that the plan of care has beenrevised to include any changes in the patient's condition and the revised planof care will be sent to the	

	in the plan of care. 410 IAC 17-13-1(a)(2)		attending physician for his signature and approval. The ClinicalManager and Administrator reviewed all active patients' clinical records andfound that 2 out 20 patient's Plan of Cares were not revised to include any changes in the patient's condition. The ClinicalManager and QA team will review all Plan of Cares whenever generated and weeklyto ensure that any changes in the patient'scondition are included in the patient's plan of care. The Clinical Manager will be responsible for ensuring that thesedeficiencies do not recur.	
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to notify the physician of changes in the patient's condition in 1 of 1 clinical record reviewed with a home visit with a registered nurse. (Patient #5)	G0590	TheClinic manager and Administrator reviewed the following policy for reeducationand clarification of procedures. C-580PLAN OF CARE POLICY ProCareHome Health services are furnished under the general supervision and directionof the patient's physician. The Plan of Care is based on a comprehensiveassessment and information provided by the patient/caregiver and health teammembers. Planning for	2023-09-14

	The findings include: Clinical record review on 8/24/2023, for Patient #5, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/13/2023-9/10/2023, which indicated the physician should be notified if the patient's pain was greater than 6 on a scale of 0-10 (0 being no pain and 10 being the worst pain). Review indicated the agency was to notify the physician for a diastolic blood pressure (pressure against the arteries when the heart is at rest, noted by the bottom number of a blood pressure reading) greater than 90. Review of agency documents titled "COTA [certified occupational therapist assistant] Visit" indicated the patient's pain was rated a 7 on a scale of 0-10 on document dated 7/31/2023. Review failed to evidence the agency notified the physician. Review of document dated 8/14/2023, indicated the patient's pain was rated a 7 on a scale of 0-10 and indicated the patient's pain was		care is a dynamic process that addresses the care,treatment, and services to be provided. The plan will be consistently reviewedto ensure that patient needs are met, and will be updated as necessary, but atleast every sixty (60) days. In cases where patient care is provided in aclinical setting with rotating team members of physicians, orders shall beprocessed in accordance with Agency policy and the agency shall accept thesignature and date of the physician assigned to the clinic at the time ordersare presented for signature as the attending physician for the patient. ForPatient #5, the physician has been notified of the diastolic blood pressuregreater than 90. The physician has also been notified of the pain rating of7/10. TheClinical Manager and Administrator reviewed all active patients' clinicalrecords and found that 3 out 20 patient's Plan of Cares where change incondition was not reported to the physician and these have been corrected.	

	move their neck and had to wear a neck brace the day before. Review failed to evidence the agency notified the physician. During an interview on 8/29/2023, at 10:23 AM, the Clinical Manager indicated the physician was not notified of the patient's pain greater than 6. Review of an agency document titled "Skilled Nurse Visit" dated 8/7/2023, indicated the patient's diastolic blood pressure was 93, and review failed to evidence the physician had been notified. During an interview on 8/29/2023, at 10:30 AM, the Clinical Manager indicated she usually rechecks any abnormal blood pressure but did not recheck the blood pressure at this visit and did not notify the physician. 410 IAC 17-13-1(a)(2)		TheClinical Manager and QA team will review all Plan of Cares to ensure that any changes in the patient'scondition are reported to the physician. TheClinical Manager will be responsible for ensuring that these deficiencies donot recur.	

G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the agency failed to coordinate care with all disciplines providing services to the patient in 1 of 1 home visit with a registered nurse. (Patient #5) The findings include: Clinical record review on 8/24/2023, for Patient #5, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/13/2023-9/10/2023, which indicated the agency provided skilled nursing 2 times a week, physical therapy (PT) 1 time a week, and occupational therapy (OT) services 2 times a week. Review evidenced an agency document titled "COTA [certified occupational therapist assistant] Visit" dated 8/9/2023, which indicated the patient was tired since PT just visited.	G0606	The Clinic manager and Administrator reviewed thefollowing policy for reeducation and clarification of procedures. C-360COORDINATION OF PATIENT SERVICES Theagency will integrate services, whether they are provided directly or undercontract, to assure the identification of patient needs and factors that couldaffect patient safety and the effectiveness of treatment. The coordination ofcare is provided by all disciplines and included communication with physicians. For Patient #5, the visits have now been spaced bythe disciplines to allow for respite between visits. The Agency now Coordination amongst all disciplines that are involved inactive patients care. The Administrator and Clinical Manager will be responsible for ensuringthat all Coordination of Care is documented for all agencies, physicians anddisciplines involved in each patient's care.	2023-09-19

	and COTA provided visits on the same day on 7/31/2023, 8/7/2023, and 8/14/2023. During an interview on 8/25/2023, at 9:32 AM, the patient's caregiver indicated they did not want all 3 visits with the nurse, PT, and OT on the same day since it made the patient very tired and the patient could not do the work needed with therapy when tired. The patient's caregiver indicated no one from the agency had asked about coordinating the patient's visits. During an interview on 8/29/2023, at 10:59 AM, the Clinical Manager indicated the agency should coordinate care with all of the disciplines to ensure the visits were spaced out during the week so not all 3 disciplines came the same day given the patient's status. Review of an agency document titled "COTA Visit" dated 8/14/2023, indicated the patient's pain was rated a 7 on a scale of 0-10 and indicated the patient's pain was so bad the patient could hardly move their neck and had to wear a neck brace the day before. Review		The Clinical Manager and QA team will review all active patients' chartsshared with other agencies and service providers for care coordination weekly. The Administrator and Clinical Manager are responsible for ensuring thatthis situation does not recur.	

	indicated the patient was supposed to have a CAT scan (a diagnostic imaging test) Review failed to evidence the COTA informed and coordinated care with the OT, PT, and registered nurse case manager to inform them of the patient's increase in pain and the neck brace. Review failed to evidence coordination with the physician regarding the results of the CAT scan. During an interview on 8/29/2023, at 10:23 AM, the Clinical Manager indicated she was not aware of the patient's report of increasing pain and of the use of the neck brace. At 10:33 AM, the Clinical Manager indicated no one had called for the results of the CAT scan. 410 IAC 17-12-2(g)			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.	G0614	The Agency now ensures that a visit schedule is utilized in the patient'shome for upcoming visit dates by the disciplines. ForPatient #1, the visit schedule in the patient's home folder has now beencompleted. Also, the visits schedule for all patients in the home folder hasnow been completed.	2023-09-19

	Based on observation and interview, the agency failed to provide the patient a written visit schedule in 2 of 2 home visits (Patient #1,.5). The findings include: During an observation at the home of Patient #5 on 8/25/2023, at 9:25 AM, the agency home folder observed in the patient's home to include a calendar. Review failed to evidence the calendar had been completed with dates of scheduled visits by clinicians since the week of 7/30/2023. No other written visit schedule provided by the agency was observed in the patient's home. During an interview on 8/25/2023, at 9:30 AM, the Clinical Manager indicated staff should be filling out the calendar with the scheduled visits to be made to the patient. 1. During an observation of a home visit for Patient #1 on 8/28/2023, from 9:05 AM – 10:00 AM, the agency home folder was requested for review and received the information book from the patient's primary caregiver, who indicated that was all they had from ProCare.		ForPatient #5, The Calendar in the home folder is now updated with currentfrequencies for the Skilled Nurse, PT and OT services. The Administrator and Clinical Manager In-serviced the field staff onensuring that the patient has a folder in the home with an updated visitschedule for each discipline 9/19/2023 The QA team will follow up with the new patient after the 1st week toconfirm the schedule is completed in the folder and there will be a quarterlyfollow up of 10% of the active patients. The Administrator and the Clinical Manager are responsible for ensuringthat this deficiency does not recur.	

	Observation failed to evidence a visit schedule for all disciplines in the patient's home. During an interview on 8/28/2023, at 9:26 AM, the patient's primary caregiver indicated they would like a schedule. The caregiver preferred the patient not answer the door when they were home alone. During an interview on 8/28/2023, at 9:57 AM, when queried how the agency scheduled visits, the patient's primary caregiver indicated the clinicians call the same day or not at all, and then do not come to the home.			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Corrected 7/23/2023	G0616	Corrected 7/23/2023	2023-09-30
G0618	Treatments and therapy services	G0618	Corrected 7/23/2023	2023-09-30

	484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Corrected 7/23/2023.			
G0640	Quality assessment/performance improvement 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview, the home health agency failed to develop and maintain a QAPI (quality assessment performance improvement) program that included aggregation of data, identification of issues affecting	G0640	The Administrator and the Clinical Manager reviewed the following policyfor reeducation and clarification of procedures. B-100 GOVERNING BODY POLICY The Governing Body (or designated persons sofunctioning) shall assume full legal authority and responsibility for theoverall management and operation of Agency. This includes the provision of homehealth services, fiscal operations, review of the agency's budget and itsoperational plans as well as the Quality Assessment and Performance ImprovementProgram. New governing body members/designees are oriented to the agency asappropriate to responsibilities. The roles of the Governing Body may not bedelegated. B-260 Quality Assessment and	2023-09-21

	care, implementation of performance improvement actions, and identification of a performance improvement project. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 484.65 Quality Assessment / Performance Improvement. The findings include: Record review of the agency's QAPI binder on 8/24/2023, evidenced a "Quality Measures Analysis & Improvement Plan" dated April 2023, which indicated the data collection period for the report was 4/1/2021 – 3/31/2022. Review failed to evidence any data was collected since 3/31/2022. Review indicated the patient was not meeting state and national averages for improved ambulation, improvement in bathing, improvement in breathing, and improvement in administration of oral medications. Review failed to		Performance Improvement (QAPI) Agency will develop, implement, evaluate, and maintain an effective, ongoingagency wide, data driven QAPI program. This plan will be based on theorganization's mission and goals and designed to improve patient outcomes andthe perceptions of patients/families about the quality and value of services. We laid emphasis on theresponsibility of the Administrator to improve the Quality and Performance, inaccordance with state and federal regulations, accreditation standards, and theAgency mission. QAPI (qualityassessment performance improvement) program is maintained. There is datacollected up to 6/30/2023. The Agency has a QAPIconsultant that reviews, monitors and recommend actions to improve our QualityAssessment and Performance.	

	evidence specific performance improvement activities for the areas not meeting state and national averages. Review failed to evidence the agency had measured the success and track performance to ensure the improvements were sustained after implementing the performance improvement activities. Review failed to evidence the program included a performance improvement project. Review indicated the agency had 4 patients with wounds to include 1 wound infection. Review failed to evidence the agency had any data related to wound care. Review of an agency document titled “Hospitalization Log” indicated the agency had 24 patient hospitalizations in 2023, and review failed to evidence the agency performance improvement activities to address the hospitalization rate. Review failed to evidence the governing body was responsible for the implementation and maintenance of the QAPI program to include defining the data to be collected and the frequency of the data collection.		The Administrator isresponsible for providing direction and leadership and be directly involved inthe agency’s Quality Assessment and Performance Improvement Program (QAPI)ensure that this deficiency does not recur.	

	During an interview on 8/30/2023, at 12:40 PM, the Administrator indicated the agency had a QAPI meeting on Sunday, 8/27/2023. When queried about the agency having a QAPI meeting on a Sunday, the Administrator indicated there was not actually a meeting but the report for Quarter 2 was generated and added to the QAPI binder. The Administrator indicated the data had not yet been reviewed. The Administrator indicated there was no data collected on wounds and indicated patients with wounds were at high risk. The Administrator indicated the agency did not have performance improvement activities for the hospitalization rate and indicated the agency needed to look at the data to determine why there was a rise in the patient hospitalizations. The Administrator indicated the governing body did not specify the detail of the data to be collected and the collection frequency. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe			

	environment for the condition of participation 42 CFR §484.65 Condition: Quality Assessment/Performance Improvement. 410 IAC 17-12-2(a)			
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 employees practiced standard/universal precautions to prevent the transmission of infections and failed to follow agency infection control policies and procedures in 1 of 2 home visits. (Patient #5) The findings include: Review of an agency policy revised 1/21/2021, titled "Handwashing/Hand Hygiene"	G0682	The Clinic manager and Administrator reviewed the followingpolicies for reeducation and clarification of procedures. D-330 HANDWASHING/HAND HYGIENE In an effort to reduce therisk for infection in patients and team members, thorough hand washing/handantisepsis is required of all employees. The agency will establish guidelinesfor all team members and will provide education and direction on acceptedpractices. B-403 INFECTION PREVENTION/CONTROL Agency will observe therecommended precautions for home care as identified by the Centers for DiseaseControl and Prevention (CDC). The precautions cover	2023-09-19

	stated, "... Indications for hand washing and hand antisepsis: Before touching a wound ... After removing gloves ... Hands are washed ... immediately after gloves are removed ... Decontaminate hands after ... contact with body fluids, excretions ... contact with inanimate objects including equipment in the immediate vicinity of the patient ...." During an observation of care at the home of Patient #5 on 8/25/2023, at 8:53 AM, the Clinical Manager was observed removing the dressings and measuring the 2 open areas to the right buttock while wearing gloves. The Clinical Manager was observed reaching into the package of clean gauze sponges with gloved hands without first removing gloves and performing hand hygiene. The Clinical Manager was observed cleaning both wounds with gloved hands and was not observed removing gloves and performing hand hygiene after cleansing one wound before cleansing the second wound. The Clinical Manager was observed applying the new		or suspected infection with highly transmissible orepidemiologically important pathogens that require additional precautions toprevent transmission. The agency will have an infection prevention and controlcomponent to the Infection program. This program will evaluate those patient populationsto be at risk and implement processes as needed. The Clinical Manager along with the field staff have beenIn-serviced on Standard Precautions to prevent the transmission of infectionsand communicable diseases. The Home Health Agency now follows standard universalprecautions to prevent the transmission of infections by preparing wound caresupplies prior to treatment and then performing hand hygiene before providingwound care between each wound and before applying dressings. The Human Resource and Personnel Team will monitor allemployees' files for timeliness of In-Services on a monthly	

	wound dressing with gloved hands and was not observed to have removed gloves and performed hand hygiene after cleansing the wounds and before applying the new dressing. During an interview on 8/29/2023, at 11:17 AM, the Clinical Manager indicated gloves should be removed and hands should be washed, or hand sanitizer should be applied after cleansing wounds and before applying a new dressing. 410 IAC 17-12-1(m)		basis. Going forward, we now ensure thatInfection Control and all required In-services are done within 12 months ofemployment for all employees. New direct care / clinical staff will be observedfor adherence to infection control standards and practices at first patientcontact. The Administrator and Clinical Manager are responsible forensuring that this situation does not recur.	
G0686	Infection control education 484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). Based on record review and interview, the agency failed to ensure the staff was educated per agency policy on infection prevention and control.	G0686	The Clinic manager and Administrator reviewedthe following policies for reeducation and clarification of procedures. D-325INFECTION CONTROL EDUCATION/TRAINING Foreach twelve (12) months of employment, all employees and contractors who havecontact with the patients in the patients' residence shall complete in-servicetraining about infection control practices to be used in the home. All clinical staff records were reviewed and 7out of 23 active personnel had not received infection control education. Thishas now been	2023-09-19

	The finding include: Review of an agency policy revised 1/21/2021, titled "Infection Control Education/Training" stated, "... For each twelve (12) months of employment, all employees and contractors who have contact with the patients in the patients' residence shall complete in-service training about infection control practices to be used in the home ... Training records will include dates, contents of the training sessions, names and qualifications of instructors, and the names and job titles of attendees." Review of an untitled agency document identified as the active personnel roster and dated 8/24/2023, indicated 50 active personnel. Personnel record review on 8/24/2023, for Physical Therapist (PT), date of hire 2/1/2023, failed to evidence infection control education. Personnel record review on 8/24/2023, for Home Health Aide (HHA) 3, date of hire 3/22/2021, failed to evidence		corrected. InfectionControl In-services have now been done for PT employee on hire date 2-1-2023,PT-2 9-24-2020, HHA-3 hire date 3-22-2021 and HHA-4 hire date 8-24-2021. On9/19/2023 the remaining staff were in serviced on Infection Control. Allclinical staff have now had Infection control education. Goingforward, we now ensure that Infection Control and all required In-services aredone within 12 months of employment for all employees. New direct care /clinical staff will be observed for adherence to infection control standardsand practices at first patient contact. TheHuman Resource and Personnel Team will monitor all employees' files fortimeliness of In-Services monthly. TheAdministrator and Clinical Manager are responsible for ensuring that thissituation does not recur.	

since 3/22/2021.

Personnel record review on 8/24/2023, for PT 2, date of hire 9/24/2020, failed to evidence infection control education 9/24/2020.

Personnel record review on 8/24/2023, for HHA 4, date of hire 8/24/2021, failed to evidence infection control education since 8/24/2021.

Review of an agency binder labeled "Inservice" on 8/24/2023, evidenced an agency document titled "In-Service Meeting" dated 7/28/2023, indicated infection control education was provided to 15 of the 50 active personnel received infection control education.

During an interview on 8/24/2023, at 2:14 PM, the Administrator indicated the last in-service for infection control education prior to the training offered 7/28/2023 was in October 2022. The Administrator indicated some of the active personnel were part time personnel and only come into the office when they can and did not come to the infection control training. The

	Administrator indicated there was no make-up or additional training time provided for infection control education.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the agency failed to ensure all skilled professionals prepared clinical notes timely for 4 of 8 clinical records reviewed (Patients #1, 5, 8, 9). The findings include: 1. Clinical record review on 8/24/2023, for Patient #5, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/13/2023-9/10/2023, which indicated the agency was to provide physical therapy (PT) 1 time a week for 9 weeks. Review of an agency document titled "Physician Order" dated 8/18/2023, indicated the agency was to provide occupational	G0716	The Clinic manager and Administrator reviewedthe following policies for reeducation and clarification of procedures. C-200 SKILLED PROFESSIONAL SERVICES Skilled professional services include skillednursing services, physical therapy, speech-language pathology services andoccupational therapy, as specified in the §409.44 of this chapter. Skilledprofessionals who provide services to home health agency patients directly orunder contract must participate in the coordination of care. C-680 CLINICAL DOCUMENTATION	2023-09-14

	week for 2 weeks and then 1 time a week for 1 week. Review evidenced the last PT visit was made on 8/14/2023 and the last OT visit was made on 8/18/2023 and failed to evidence PT and OT visits had been made for the week of 8/20/2023. During an interview on 8/29/2023, at 10:48 AM, the Clinical Manager indicated PT made a visit on 8/21/2023 and did not complete a visit note until 8/24/2023, and OT made a visit on 8/22/2023 and did not complete a visit note until 8/27/2023. During an interview on 8/29/2023, at 10:49 AM, the Administrator indicated clinicians should document the visits and complete the visit notes on the same day the visits are completed. Review evidenced an agency document titled "COTA [certified occupational therapist assistant] Visit" dated 8/9/2023, which indicated the patient's blood pressure was 119/7. Review failed to evidence the COTA completed the clinical notes accurately. During an interview on		Agency will document each direct contact withthe patient. This documentation will be completed by the direct caregivers andmonitored by the skilled professional responsible for managing the patient'scare… With emphasis on Sub-section 9: Signed and dated clinical notes contributed toby all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated withinfourteen (14) days. For Patient #1, discharge summarydocumentation is now complete. For Patient #5, the COTA note is now accurate and complete. For Patient #5, wound measurements are doneweekly, and they are now accurate and complete. Wound treatment is now providedas ordered. For Patient #8, the documentation of PT visitson 8/11/2023, 8/12/2023, 8/14/2023, 8/18/2023, 8/21/2023, and 8/24/2023 are nowcomplete and in the EHR. For Patient #9, subsequent documentation hasthe	

	8/29/2023, at 10:57 AM, the Clinical Manager indicated the COTA did not finish the visit note completely and indicated the blood pressure was an error. Review of an agency document titled "Skilled Visit Note" completed by the Clinical Manager and dated 8/18/2023, indicated the nurse did not provide wound care as the wound treatment was already performed that day by the caregiver. Review indicated a wound assessment to the wounds to the right buttocks to include wound measurements and indicated treatment was performed to include the wound dressing used. During an interview on 8/29/2023, at 11:01 AM, the Clinical Manager indicated she did not measure the wounds and provide wound treatment and indicated the documentation of wound measurements and wound treatment provided was a carry-over from a previous note and was not accurate for that visit. 2. Clinical record review on 8/25/2023, for Patient #8,		assessment of the wound to include the size, drainage, odor, and theappearance of the surrounding skin. TheClinical Manager and Administrator reviewed all active patients' clinicalcharts and found that 5 out 20 patient's charts had outstanding notes and theclinicians were notified to complete the notes and the notes are now done. 09/14/2023 TheClinical Manager and quality assurance (QA) team will monitor all visits notesand follow up with clinicians daily to ensure that notes are completed on the day service is rendered and incorporated within fourteen (14) daysin the patient's chart. TheClinical Manager is responsible for ensuring that this deficiency does notrecur.	

	evidenced an agency document titled "Plan of Treatment" for certification period 8/10/2023-10/8/2023, which indicated the agency was to provide PT services 3 times a week for 2 weeks and then 2 times a week for 1 week. Review failed to evidence documentation of any PT visits after the start of care visit on 8/10/2023. During an interview on 8/25/2023, 2:03 PM, the Administrator/PT indicated he made PT visits to Patient #8 on 8/11/2023, 8/12/2023, 8/14/2023, 8/18/2023, 8/21/2023, and 8/24/2023. The Administrator indicated he did not enter the documentation of the visits in the electronic health record because he was still learning the new system.			

	3. Clinical record review on 8/30/2023, for Patient #9, start of care 8/25/2023, evidenced an agency document titled "Plan of Treatment" for certification period 8/25/2023-10/23/2023, which indicated the patient had a wound to the right foot requiring a wound vac (a medical device used to treat wounds by applying suction). Review of an agency document titled "Start of Care" completed by the Clinical Manager and dated 8/25/2023, failed to evidence the assessment of the wound to the right foot. During an interview on 8/30/2023, at 4:16 PM, the Clinical Manager indicated the patient did have a wound to the right foot and indicated she performed wound care to the wound at the visit on 8/25/2023. The Clinical Manager indicated the documentation should include the assessment of the wound to include the size, drainage, odor, and the appearance of the surrounding skin. *. Review of an agency policy revised 1/21/2021, titled "Skilled			

	Skilled professionals must assume responsibility for, but not be restricted to the following: ... Preparing of clinical notes...." *. Review of an agency policy revised 6/28/2022, titled "Clinical Documentation" stated, "... Documentation of services ordered on the plan of care will be completed the day service is rendered ...." *. Clinical record review on 8/25/2023, for Patient #1, start of care 5/19/2023, evidenced documentation of a Speech Therapy (ST) visit from 8/9/2023, and failed to evidence documentation was started on the visit. Record review evidenced a ST discharge summary from 8/9/2023, that failed to evidence documentation had been started. During an interview on 8/29/2023, at 4:13 PM, the Clinical Manager indicated the patient was discharged from ST and stated, "That's therapy not doing their notes again."			

G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the agency failed to ensure the home health aides (HHA) had completed patient-specific written patient care instructions to be performed by the home health aides in 1 of 4 clinical records reviewed with home health aide services. (Patient #7) The findings include: Clinical record review on 8/24/2023, for Patient #7, evidenced an agency document titled "HHA Care Plan" completed by the Alternate Clinical Manager/registered nurse (RN) and dated 7/5/2023, which indicated the HHA was to take the patient's vital signs at every visit. Review indicated the	G0798	TheClinic manager and Administrator reviewed the following policies forreeducation and clarification of procedures. C-220HOME HEALTH AIDE SERVICES HomeHealth Aide services will be provided to appropriate patients on anintermittent, part-time or full-time basis, under the direct supervision of anagency Registered Nurse/Therapist in accordance with a medically approved Planof Care. The duties of a home health aide include the provision of hands-onpersonal care, performance of simple procedures as an extension of therapy ornursing services, assistance in administering medications that are ordinarily self-administered.All individuals providing home health aide services will be qualified throughtraining and/or competency evaluations. All HHA applicants must pass a writtenproficiency exam and a skills performance assessment before being hired. C-340HOME HEALTH AIDE SUPERVISION	2023-09-26

	patient refuses to allow the HHA to take vitals. Review failed to evidence the RN amended the care plan for the HHA to take vital signs every visit. During an interview on 8/29/2023, at 4:15 PM, the Alternate Clinical Manager indicated the Clinical Manager and Administrator would not allow the removal of the HHA to take vital signs at every visit. The Alternate Clinical Manager indicated the vital signs should be removed or amended to be taken as needed rather than at every visit due to the patient's refusal. During an interview on 8/30/2023, at 1:56 PM, the Clinical Manager indicated the HHA to take vital signs at every visits should be removed from the home health aide care plan. 410 IAC 17-14-1(m)		Agencyshall provide Home Health Aide services under the direction and supervision ofa Registered Professional Nurse/Therapist when personal care services areindicated and ordered by the physician. The frequency of supervision will be inresponse to Medicare regulations, agency policy and other state or federalrequirements. ProCare Home Health Services will conduct supervisory visits atleast every two (2) weeks. For Patient #7 theHHA task of taking the patient's vital signs at every visit has been amended inthe HHA Plan of Care to be taken as needed. The Clinical Manager now ensures that the Home Health Aide Care Plan isamended to reflect current realities of patient care. The Clinical Manager reviewed 100% of all active charts with Home HealthAide services and noted that 1 of 20 did not reflect the current realities ofpatient care. This situation has now been corrected. The Clinical Manager and the QA team review the home	

			health aide notesdaily, to ensure that the current realities of patient care are reflected inthe HHA care Plan. The Clinical Manager is responsible for ensuring that this situation doesnot recur.	
G0940	Organization and administration of services 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Based on record review and interview, the home health agency failed to ensure the organization and management of the home health agency as follows: the administrator failed to maintain the day-to-day operations of the agency (See G0948), failed to ensure the agency coordinated patient	G0940	TheClinic manager and Administrator reviewed the following policies forreeducation and clarification of procedures. B-100GOVERNING BODY TheGoverning Body (or designated persons so functioning) shall assume full legalauthority and responsibility for the overall management and operation ofAgency. This includes the provision of home health services, fiscal operations,review of the agency’s budget and its operational plans as well as the QualityAssessment and Performance Improvement Program. New governing bodymembers/designees are oriented to the agency as appropriate toresponsibilities. The roles of the Governing Body may not be delegated.	2023-09-21

	referrals (See G0964), and Based on record review and interview, the agency failed to ensure all entries into the clinical record were complete and appropriately authenticated (SeeG1024). The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.105 Organization and Administration of Services.		D-180PERSONNEL RECORDS Personnelfiles will be established and maintained for all personnel. All informationwill be considered confidential and made available to authorized personnelonly. All patient-identifying data will be removed from employee personnelrecords. Personnel records may not be removed from Agency unless ordered bysubpoena. D-110JOB DESCRIPTIONS Allpersonnel will receive a copy of their Job Description during the onboardingprocess. A signed copy will be kept in their personnel file. D-260PERFORMANCE EVALUATIONS Acompetency-based performance evaluation will be conducted for all employeesafter one (1) year of employment and at least annually thereafter. Theevaluation will be objectively based on criteria that are established in theposition description for each employee. Job performance will be documented onthe appropriate	

			form by the evaluator and will become a permanent part of theemployee personnel file. Contracted organizations/personnel are expected toadhere to these requirements as part of the contractual agreement and to submitcompleted documentation of competency and performance evaluations to theagency. D-300EMPLOYEE ORIENTATION PROGRAM Allteam members, volunteers, students, and members of the Board of Directors newto the Agency, will participate in a general orientation program beforebeginning any job responsibilities. An orientation department or positionorientation specific to team member's needs and specific responsibilities willbe provided following the general orientation. This orientation is tailored tothe educational background and experience, type of care provided, physical andmental condition of patients, and the roles and responsibilities of theposition. This may be completed by another team member in a	

			mentoring positionContent is based on identified needs assessment, program evaluations,competency assessments and all local, state, and federal laws, regulations, andstandards. Outcomes of the general and ongoing orientation programs areassessed and documented as part of the agency performance improvement program. D-220COMPETENCY EVALUATION OF HOME CARE TEAM MEMBERS 1.The agency will establish a program that allows for objective, measurableassessment of the person's ability to perform required activities. Individualsworking in the agency must be licensed, registered, or certified as required bylaw, policy, or standards of practice. 2.The assessment will verify and focus on the individual team members knowledgeand skill appropriate to assigned responsibilities, communication skills, andthe ability to respond to patient needs within their	

			Competencies will address: • Age/type of patient. • Scope of servicesoffered by Agency. • High risk procedures. • New procedures/technologies. •Areas identified in Performance Improvement Process. 3. The competencyevaluations will be completed by individuals who have the knowledge and skillsto assess performance and ability. 4. All competencies will be documented, andactions will be taken when opportunities for improvement are identified. 5.When improvement activities determine that person with performance problem isunable and/or unwilling to improve, the agency will modify job assignments ortake other appropriate actions. B-105CLINICAL MANAGER Agencywill appoint one or more qualified individuals for the position of clinicalmanager. This position provides clinical oversight over all patient careservices and team members. The position must have at least one of the followingqualifications: licensed physician, registered nurse-including a	

			advance practice nurse, physical therapist, speechlanguage pathologist, occupational therapist, social worker, or audiologist. C-139PATIENT REFERRAL AND ACCEPTANCE TheAgency shall have procedures for the receipt, processing, and evaluation ofpersons referred for service. C-140PATIENT ADMISSION PROCESS Servicesshall be provided to all persons without regard to race, color, creed, sex,national or ethnic origin, disability or handicap, sexual orientation, age,marital status, gender identity, genetic information status with regard topublic assistance or veteran status or any other characteristic protected underapplicable federal, state, or local law. All services are available withoutdistinction to all individuals admitted, regardless of their diagnosis. Agencyshall not deny admission to people with a contagious disease, including, butnot limited to, HIV, MRSA and Hepatitis. All persons and organizations	

			whoeither refer persons for services or recommend the services of the agency shallalso be advised of same. Services will not be initiated until an initialassessment has been completed and identified patient needs can be met by theagency. The agency determines that patient needs can be met by the agency. Theadministrator now maintains the day-to-day operations of the agency, ensuresthe agency patient referrals are properly coordinated and all entries into theclinical record were complete and appropriately authenticated as evidenced inthe corrections to Tags G0948, G0964 and G1024 Allnecessary steps have been taken and these deficiencies have been addressed andcorrected as evidenced in corrections of Tags G0948, G0964 and G1024 The Administrator and Clinical Manager performed a total program reviewand are now compliant with all aspects of the Agency management and operations.The Administrator now organizes, manages, and	

			administers all the processes. of the agency including ensuring thatpatient referrals are properly coordinated and all entries into the clinicalrecord are complete and appropriately authenticated. The Administrator is responsible for ensuring that these deficiencies donot recur.	
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the administrator failed to provide oversight of the day-to-operations of the agency to include ensuring protection of patient information, ensuring clinical staff had access to and knowledge of the electronic health record, and ensuring the personnel files were complete and current. The findings include: 1. Review of an agency policy revised 6/28/2022, titled "Governing Body" stated, "... a qualified Administrator ... delegate to that individual the authority and responsibility for	G0948	TheClinic manager and Administrator reviewed the following policies forreeducation and clarification of procedures. B-100GOVERNING BODY TheGoverning Body (or designated persons so functioning) shall assume full legalauthority and responsibility for the overall management and operation ofAgency. This includes the provision of home health services, fiscal operations,review of the agency's budget and its operational plans as well as the QualityAssessment and Performance Improvement Program. New governing bodymembers/designees are oriented to the agency as	2023-09-21

	the day to day operations of the agency to include provision of home care services in accordance with state and federal regulations, accreditation standards, and Agency mission…." 2. Review of an agency policy revised 6/28/2022, titled "Personnel Records" stated, "… The personnel record for an employee will include, but not be limited to: … Criminal history and background checks as required by law … Competency testing for home health aides … Signed job description … Orientation checklist … Performance appraisals … Updated license/certifications …." 3. Review of an agency policy revised 1/21/2021, titled "Job Descriptions" stated, "… All personnel will receive a copy of their Job Descriptions during the onboarding process. A signed copy will be kept in their personnel file." 4. Review of an agency policy revised 1/21/2021, titled "Performance Evaluations" stated, "… A competency-based performance evaluation will be		appropriate toresponsibilities. The roles of the Governing Body may not be delegated. D-180PERSONNEL RECORDS Personnelfiles will be established and maintained for all personnel. All informationwill be considered confidential and made available to authorized personnelonly. All patient-identifying data will be removed from employee personnelrecords. Personnel records may not be removed from Agency unless ordered by subpoena. D-110JOB DESCRIPTIONS Allpersonnel will receive a copy of their Job Description during the onboardingprocess. A signed copy will be kept in their personnel file. D-260PERFORMANCE EVALUATIONS Acompetency-based performance evaluation will be conducted for all employeesafter one (1) year of employment and at least annually thereafter. Theevaluation will be objectively based on criteria that are	

	conducted for all employees after one (1) year of employment and at least annually thereafter…." 5. Review of an agency policy revised 1/21/2021, titled "Employee Orientation Program" stated, "… All team members … will participate in a general orientation program before beginning any job responsibilities … orientation specific to team member's needs and specific responsibilities will be provided after the general orientation…." 6. Review of an agency policy revised 1/21/2021, titled "Competency Evaluation of Home Care Team Members" stated, "… Home Health Aide Competency: … Skills competency is evaluated by observing the aide with patient … A Home Health Aide will not be permitted to provide Home Health Aide services until evidence of adequate training and/or competency has been determined by the designated professional in the agency…." 7. On 8/24/2023, at 10:24 AM, a room off the break room in the agency was observed open and		established in theposition description for each employee. Job performance will be documented onthe appropriate form by the evaluator and will become a permanent part of theemployee personnel file. Contracted organizations/personnel are expected toadhere to these requirements as part of the contractual agreement and to submitcompleted documentation of competency and performance evaluations to theagency. D-300EMPLOYEE ORIENTATION PROGRAM Allteam members, volunteers, students, and members of the Board of Directors newto the Agency, will participate in a general orientation program beforebeginning any job responsibilities. An orientation department or positionorientation specific to team member's needs and specific responsibilities willbe provided following the general orientation. This orientation is tailored tothe educational background and experience, type of care provided, physical	

	without a lock. Inside of the room were multiple unlocked filing cabinets containing patient records. The filing cabinets were observed with tape over the top drawer inhibiting the top drawer to be closed and the cabinet locked. Inside of the unlocked room, open boxes on shelves were observed unsecured and labeled “Inactive Personnel Records” which contained medical files of inactive personnel. During an interview on 8/24/2023, at 1:55 PM, the Administrator indicated patient records should be locked in the cabinets and indicated the open boxes were in the room since the agency waits 7 years before destroying medical records. The Administrator indicated he was unaware the door to the room containing the medical records did not lock and was unaware of the tape on the filing cabinets inhibiting the ability to close and lock the cabinets. 8. Personnel record review on 8/24/2023, failed to evidence a criminal background check for Physical Therapist (PT) 1, first patient contact date 2/1/2023;		patients, and the roles and responsibilities of theposition. This may be completed by another team member in a mentoring positionContent is based on identified needs assessment, program evaluations,competency assessments and all local, state, and federal laws, regulations, andstandards. Outcomes of the general and ongoing orientation programs areassessed and documented as part of the agency performance improvement program. D-220COMPETENCY EVALUATION OF HOME CARE TEAM MEMBERS 1.The agency will establish a program that allows for objective, measurableassessment of the person’s ability to perform required activities. Individualsworking in the agency must be licensed, registered, or certified as required bylaw, policy, or standards of practice. 2.The assessment will verify and focus on the individual team members knowledgeand skill appropriate to assigned	

	the Alternate Clinical Manager/registered nurse (RN), first patient contact date 2/15/2021; Home Health Aide (HHA) 3, first patient contact date 3/27/2021; and HHA 4, first patient contact date 8/31/2021. Review failed to evidence current licensure/certification for PT 1, the Alternate Clinical Manager/RN, HHA 3, PT 2, first patient contact date 9/26/2020, Occupational Therapist (OT) 1, first patient contact date 8/26/2022, and OT 2, first patient contact date 9/1/2022. Review failed to evidence personnel files included orientation to the job for PT 1, PT 2, OT 1, and OT 2. Review failed to evidence personnel files included skill competency evaluation for HHA 3 and HHA 4. Review failed to evidence annual performance evaluations for PT 2, OT 1, the Alternate Clinical Manager, the Clinical Manager, HHA 3, and HHA 4. During an interview on 8/24/2023, at 1:10 PM, the Administrator indicated all personnel documents should be included in the personnel files. The Administrator indicated the agency probably ran the background checks but needed		responsibilities, communication skills, andthe ability to respond to patient needs within their scope of responsibility.a. Competencies will address: • Age/type of patient. • Scope of servicesoffered by Agency. • High risk procedures. • New procedures/technologies. •Areas identified in Performance Improvement Process. 3. The competencyevaluations will be completed by individuals who have the knowledge and skillsto assess performance and ability. 4. All competencies will be documented, andactions will be taken when opportunities for improvement are identified. 5.When improvement activities determine that person with performance problem isunable and/or unwilling to improve, the agency will modify job assignments ortake other appropriate actions. Alock with key has been installed on the door in the room off the break room.The multiple cabinets in the room now have locks. ThePersonnel record for Physical Therapist (PT) 1, and the Alternate ClinicalManager/registered	

	to include it in the personnel record. 9. During an interview at the entrance conference on 8/24/2023, at 9:47 AM, the Administrator indicated the agency's clinical records were in an electronic health record, Axxess. During an interview on 8/25/2023, at 1:26 PM, the Administrator indicated Patient #8 and Patient #9 were not in the electronic health record, Axxess, but were in a second electronic health record, Power Path. The Administrator indicated he was unable to provide access to Power Path and could not print documents from Power Path because he did not know how. The Administrator indicated new patients would be entered into Power Path as the agency transitions from Axxess to Power Path. During an interview on 8/25/2023, at 3:48 PM, the Alternate Clinical Manager indicated she did not have access to the electronic health record, Power Path.		nurse (RN), Home Health Aide 3, and HHA 4, now have thebackground check in them. Currentlicensure/certification for PT 1, the Alternate Clinical Manager/RN, HHA 3, PT2, Occupational Therapist (OT) 1, and OT 2, are now in the employee folder. Orientationto the job for PT 1, PT 2, OT 1, and OT 2 are now completed and in the employeefolders. Skillcompetency evaluations for HHA 3 and HHA 4 are now completed and in theemployee folders. Annualperformance evaluations for PT 2, OT 1, the Alternate Clinical Manager, theClinical Manager, HHA 3, and HHA 4 are now completed and in the employeefolders. ForPatient #8 and Patient #9 the electronic health records are now in Axxess. Allthe agency's clinical records are in an electronic health record Axxess. The agency now has the	

	410 IAC 17-12-1(c)(1)		Manager fullyresponsible for all day-to-day operations of the Home Health Agency. The Administrator and Clinical Manager performed a total program reviewand are now compliant with all aspects of the Agency management and operations. All the background checks,Current licensure/certification, Job Orientations, Skill competency evaluations,and Annual performance evaluations are now completed and in the relevantemployee folders. The Administrator and the Human Resource Officer will ensure that allneeded information are completed and in the staff personnel. The Administrator and the Clinical Manager will ensure that all the agency'sclinical records are in an electronic health record Axxess. The Administrator is responsible for ensuring that these deficiencies donot recur.	
G0964	Coordinate referrals;	G0964	TheClinic manager and	2023-09-21

	484.105(c)(3) Coordinating referrals, Based on record review and interview, the agency failed to ensure the coordination of referrals to provide patient services for 1 of 2 clinical records reviewed where a home visit was conducted (Patient #1). The findings include: 1. Review of an agency policy revised 6/28/2022, titled "Clinical Manager" stated, "... The oversight provided by the clinical manager(s) includes: Making patient and personnel assignments ... Coordinating referrals ..." 2. Review of an agency policy revised 1/21/2021, titled "Patient Referral and Acceptance" stated, "... Only qualified staff may take referral information ... Persons rejected will be noted along with the reason for rejection...." 3. Review of an agency policy revised 6/28/2022, titled "Patient Admission Process" stated, "... If the agency cannot fulfill the required health care need, a referral will be made to		Administrator reviewed the following policies forreeducation and clarification of procedures. B-105CLINICAL MANAGER Agencywill appoint one or more qualified individuals for the position of clinicalmanager. This position provides clinical oversight over all patient careservices and team members. The position must have at least one of the followingqualifications: licensed physician, registered nurse-including a nursepractitioner or other advance practice nurse, physical therapist, speech languagepathologist, occupational therapist, social worker, or audiologist. C-139PATIENT REFERRAL AND ACCEPTANCE TheAgency shall have procedures for the receipt, processing, and evaluation ofpersons referred for service. C-140PATIENT ADMISSION PROCESS Servicesshall be provided to all persons without regard to race,	

	other appropriate community resources ….” 4. Clinical record review on 8/25/2023, for Patient #1, start of care 5/19/2023, evidenced a prescription paper from 8/17/2023, signed by the physician which ordered Occupational Therapy (OT) to evaluate and treat the patient due to hemiparesis (muscle weakness or paralysis on one side of the body). Record review evidenced a physician order from 8/21/2023, which stated “Verbal order for Occupational Therapy to be on hold due to ProCare Home Health Services is unable to staff the case at this time. Caregiver agrees to wait until OT services are available….” During an interview on 8/28/2023, at 9:23 AM, the patient’s primary caregiver indicated the agency did not recommend or assist in finding an agency who could provide OT services to the patient. The primary caregiver indicated they did not know they had another option and agreed to wait for ProCare to find someone.		color, creed, sex,national or ethnic origin, disability or handicap, sexual orientation, age,marital status, gender identity, genetic information status with regard topublic assistance or veteran status or any other characteristic protected underapplicable federal, state, or local law. All services are available withoutdistinction to all individuals admitted, regardless of their diagnosis. Agencyshall not deny admission to people with a contagious disease, including, butnot limited to, HIV, MRSA and Hepatitis. All persons and organizations whoeither refer persons for services or recommend the services of the agency shallalso be advised of same. Services will not be initiated until an initialassessment has been completed and identified patient needs can be met by theagency. The agency determines that patient needs can be met by the agency. For Patient #1 OT services arenow available and are now being provided. The Agency now has a list of otheragencies available to patients as an	

			agencycannot provide. TheAgency now has a list of alternative agencies available to all patients. TheAdministrator is responsible for the availability of the list of alternative agencies to all patients and ensuring thatthis situation does not recur.	
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure all entries into the clinical record were complete and appropriately authenticated to include clinician's signature and date in 1 of 4 clinical records with home health aide (HHA) services. (Patient #7) The findings include: Clinical record review on	G1024	The Clinic manager andAdministrator reviewed the following policies for reeducation and clarificationof procedures. C-872 Electronic Signature An electronic signature will authenticate certain clinical recorddocuments generated in the computerized medical record system. The documentsaffected by this policy include visit notes, charting sessions, verbal orders,and summaries. For Patient #7, the documentshave been completed to include the HHA's signature and date. Going forwards,all documentation will be completed to include the	2023-09-21

	8/28/2023, for Patient #7, evidenced agency documents titled “HHA Visit” assigned to HHA 2 dated 8/23/2023 and 8/24/2023 and HHA 1 dated 8/25/2023, which were marked “saved” for the status in the electronic health record. Review failed to evidence the documents were completed to include the HHA’s signature and date. During an interview on 8/30/2023, at 1:50 PM, the Clinical Manager indicated HHA 1 and HHA 2 completed the visits as scheduled in the electronic health record but the documents were not completed with a signature and date because the agency was having issues with an overlap in hours which did allow for the HHAs to sign their notes. 410 IAC 17-15-1(a)(7)		timely manner. The Clinical Manager and the quality assurance team reviewed all activepatients’ clinical records and found that 4 out 20 patient’s electronic entrieswere not authenticated to include the name and date of the clinicianresponsible. This deficiency has now been corrected. The clinical Manager and the quality assurance team will monitor andreview all electronic daily entries including visit notes and are authenticatedto include the name and date of the clinician responsible. The Clinical Manager is responsible for ensuring that this situation doesnot recur.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Abel Dafiaghor	Administrator	11/1/2023 2:14:39 PM