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	12/12/2023

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
G0000	INITIAL COMMENTS This visit was for a 2nd Post Condition revisit for a home health Recertification, State licensure revisit, and Complaint survey on 7/3/2023. Survey Dates: December 5-8, 2023, December 11-12, 2023 Unduplicated Skilled Admissions for the last 12 Months: 109 The Administrator was notified of the Immediate Jeopardy related to §484.60 Care Planning, Coordination of Services, and Quality of Care on 12/11/2023 at 11:18 AM. The Immediate Jeopardy remained unabated at the time of exit on 12/12/2023. During this 2nd Post Condition Revisit survey, four [4] federal standard level deficiencies were	G0000	G 0000 01/02/2024 These deficiencies have now been corrected. Additionally, on 12/27/2023 the agency appointed a new Clinical Manager/DON	

	identified as back into compliance, 13 [thirteen] federal standard level deficiencies were recited, and six [6] new standard level deficiencies were cited, three [3] Conditions of Participation were recited 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 and one [1] additional Condition of Participation was found to be out of compliance and cited at 42 CFR §484.55 Comprehensive Assessment. 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			

	years beginning 7/3/2023 and continuing through 7/2/2025. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR: A 1 12/18/23			
G0412	Written notice of patient's rights 484.50(a)(1)(i) (i) Written notice of the patient's rights and responsibilities under this rule, and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities; Based on observation, record review, and interview, the agency failed to ensure written notice of the patient's rights and responsibilities were provided in a manner understandable 1 on 1 clinical record reviewed with English not the primary language. (Patient #2) The findings include: Based on observation, record review, and interview, the agency failed to ensure written notice of the patient's rights and responsibilities were provided in a manner understandable 1 on 1 clinical	G0412	The Administrator and Clinical Manager reviewed the following policies for reeducation and clarification of procedures C-380 HOME CARE BILL OF RIGHTS POLICY Patients and their representatives will be informed of their rights as a consumer of home care services prior to the start of care. This includes the right to voice grievances and request changes without discrimination, reprisal, or unreasonable interruption of service. The agency will provide verbal notice of the patient's rights and responsibilities in the person's primary or preferred language and in a manner the patient/representative understands, free of charge, with the use of competent interpreter if necessary no later than the completion of the second visit from a skilled	2023-12-28

	record reviewed with English not the primary language. (Patient #2) The findings include: During an observation of care at the home of Patient #2 on 12/11/2023, at 3:12 PM, the patient was observed speaking Spanish, and the caregiver was observed translating for the patient to the Clinical Manager. The patient was observed to be verbal and alert and was not observed speaking English. A clinical record review evidenced an agency document titled "Start of Care" completed by the Clinical Manager and dated 11/10/2023, which indicated the patient's primary language was Spanish and the patient was oriented to person, place, and time. Review failed to evidence the patient was provided patient rights and responsibilities in a language understood by the patient or by use of an interpreter. Review of an agency document titled "Admission Service Agreement" signed by the patient's caregiver and the Clinical Manager and dated		professional. C-145 COMPREHENSIVE PATIENT ASSESSMENT SS 2 2. The assessment will identify the patient's primary caregiver(s), if any, and other available supports, including their willingness and ability to provide care, and availability and schedules. If there is an identified patient representative, that will also be documented This deficiency has now been corrected. A Spanish version of the written notice of patient's rights and responsibilities in the patient's primary language has now been given to the patient. A review of all active patients showed that all patients have admission documentation written notice of patient's rights and responsibilities in the primary language understandable by the patient and caregiver. The Administrator and Clinical Manager and Quality Assurance (QA) team will review all admission documentation	

	patient had been provided a copy of the patient's rights and responsibilities and failed to indicate the patient's caregiver translated the patient's rights for the patient. Review of an undated agency document titled "Patient's Bill of Rights and Responsibilities" in the agency patient handbook evidenced to be in English. Review failed to evidence the agency provided the patient the written notice of patient's rights and responsibilities in a language understood by the patient. During an interview on 12/6/2023, at 1:56 PM, the Clinical Manager indicated the patient did not understand much English and the caregiver was used for interpretation for the patient. The Clinical Manager indicated the agency did not have a Spanish copy of the patient's rights and responsibilities and there was no documentation the caregiver was used to interpret the patient's rights for the patient. During an interview on 12/8/2023, at 10:01 AM, the		weekly to ensure that written notice of patient's rights and responsibilities are in the primary language understandable by the patient or there is the use of an interpreter. To prevent this deficiency in the future, the written notice of patient's rights and responsibilities is now part of the admission package for patients whose primary understandable language is Spanish. Also, patients who have a primary language other than English will have interpreters and this will be documented when performed. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	was not bilingual and needed an interpreter to understand English. 410 IAC 17-12-3(a) 1 (A)			
G0510	Comprehensive Assessment of Patients 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment was patient-specific in 5 of 7 complete active clinical records reviewed with a comprehensive assessment (Patient #1, 2, 3, 5, and 7); the home health agency failed to complete the initial assessment within 48 hours of referral (See G0514); failed to complete the comprehensive assessment no later than 5 days after the start of care (See G0520); failed to review the medications for potential adverse effects (See G0536); failed to include the assessment of the primary caregiver and their willingness and availability to provide care (See	G0510	G0510 Comprehensive Assessment of Patients The Administrator and Clinical Manager reviewed the following policies for reeducation and clarification of procedures C-580 PLAN OF CARE POLICY ProCare Home Health services are furnished under the general supervision and direction of the patient's physician. The Plan of Care is based on a comprehensive assessment and information provided by the patient/caregiver and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. C-145 COMPREHENSIVE PATIENT ASSESSMENT	2023-12-29

	G0538); and failed to conduct a comprehensive assessment at time of discharge (See G0550). 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 484.55 Comprehensive Assessment. *A record review conducted on 12/5/23 for Patient 1 revealed a diagnosis of Multiple Sclerosis (MS). The comprehensive assessment (CA) failed to identify neurological condition, musculoskeletal condition or status related to MS diagnosis. The CA failed to identify safety measures related to MS diagnosis. In an interview with the Clinical Manager (CM) on 12/7/23 at 11:00 AM the CM indicated assessment of Patient 1 status related to their MS diagnosis was not completed. A document titled OASIS-E Start of Care dated 11/22/23 included a comprehensive assessment (CA) for Patient 1 which indicated they have a history of incontinence. Embedded in the CA was a pressure sore risk assessment		POLICY: The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the patient's return home, or on the physician ordered start of care date. A thorough, well-organized, comprehensive, and accurate assessment, consistent with the patient's immediate needs will be completed for all patients in a timely manner, but no later than five (5) calendar days after start of care. All skilled Medicare and Medicaid patients except pediatric and post-partum will have comprehensive assessments that include the OASIS data set specific to mandated time points. C-155 PATIENT REASSESSMENT/UPDATE OF COMPREHENSIVE ASSESSMENT (SCIC) POLICY: The Comprehensive Assessment will be updated and revised as often as the patient's condition warrants due to major decline or improvement in health status. The clinical manager, therapists and registered nurses were reeducated on the Conditions of participation and	

	which did not identify incontinence as a risk factor; resulting in a medium risk for pressure wounds. During a home visit with the Clinical Manager on 12/6/23 at 3:30 PM it was observed the Clinical Manager failed to perform an assessment of Patient 1 boney prominences, back, buttock or feet. During an interview with the Clinical Manager (CM) on 12/7/23 at 11:00 AM they indicated a complete skin assessment should be completed at every visit and they failed to complete a skin assessment during the visit on 12/6/23. *A clinical record review for Patient 3 was conducted on 12/5/23 which included a Comprehensive Assessment (CA) dated 11/15/23. Embedded in the CA was a nutritional risk assessment that indicated the Patient to take 3 or more medications. The CA failed to identify diagnosis or indications for medications. During an interview with the Clinical Manager (CM) on		Comprehensive Assessments of Patients. A review of 10% active patients showed that the patients' Comprehensive Assessments were performed correctly. For Patient #7- The most recent Comprehensive Assessment dated on 12-1-2023 now includes the size, Stoma appearance and Patency of the GJ-Tube. For Patient #3- The most recent Plan of Care dated 11-15-2023 now updated to state that the patient does not take 3 or more medications due to the patient currently having no medications listed. For patient #5- The most recent Plan of Care dated 11-15-2023 is now updated to state the GJ-Tube size, stoma appearance, patency, placement and patient tolerance of feedings. The administrator and clinical manager and the QA team will review all patient’s admissions and discharges weekly to ensure that the following: Comprehensive assessments are patient specific, Initial	

	12/7/23 at 11:15 AM the CM indicated Patient 3 does not take medications and the nutritional status was an oversite. *A record review conducted on 12/6/23 for Patient 5 indicated the presence of a gastrostomy/jejunostomy tube (g/j-tube) (a surgically placed soft, plastic tube placed through the skin of the abdomen into the midsection of the small intestine), by which Patient 5 is continuously obtains nutrition. The Comprehensive Assessment failed to indicate an assessment of the surrounding skin integrity, tube placement, stoma, size of the tube, or tolerance of continuous feeding. During an interview on 12/12/23 at 12:30 PM the Clinical Manager (CM) indicated the assessment should include placement, condition of stoma, and size of the tube. The CM further indicates this assessment was not completed for Patient 5. 1. Review of agency procedures titled “Wound Assessment and		assessment completed within 48 hours of referral, complete the comprehensive assessment within 5 days of the start of care, review medications for potential adverse effects, include the assessment of the primary caregiver and their willingness and availability to provide care and completion of comprehensive assessment at time of discharge. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	Documentation" dated 2000, stated "... Assess the wound location and its size ... Assess the color of the wound bed ...Assess wound odor ... Assess the surrounding skin ... Evaluate the response to treatment ...." 2. Clinical record review for Patient #2 evidenced an agency document titled "Start of Care" identified as the initial assessment, completed by the registered nurse, and dated 11/10/2023. Review indicated the patient had an ischemic ulcer to the right ankle with a scab and serous (clear to yellow) drainage. Review failed to evidence the assessment was comprehensive and patient-specific to include an assessment of the wound. During an interview on 12/6/2023, at 2:03 PM, the Clinical Manager indicated the wound measurement should include measurements, assessment of the surrounding skin and the wound base, and patient tolerance of the wound care. 3. A clinical record review for Patient #7 evidenced an agency document titled			

	"Recertification" identified as the comprehensive assessment completed by the registered nurse on 12/1/2023, which indicated the patient had a gastrostomy (a tube surgically inserted to administer fluid, nutrition, and/or medication). Review failed to evidence the comprehensive assessment included the size, stoma (opening in the body) appearance, and patency of the tube. During an interview on 12/7/2023, at 12:54 PM, the Clinical Manager indicated the comprehensive assessment should include the verification of the placement, stoma appearance, size, and patency of the tube.			

	1. Review of an agency procedure titled "Wound Assessment and Documentation" dated 2000, stated "... Assess the wound location and its size ... Assess the color of the wound bed ...Assess wound odor ... Assess the surrounding skin ... Evaluate the response to treatment ...." 2. Clinical record review for Patient #2 evidenced a document titled "Start of Care" identified as the initial assessment and dated 11/10/2023 that indicated Patient had an ischemic ulcer to the right ankle with a scab and serous (clear to yellow) drainage. Review failed to evidence the assessment was comprehensive and patient-specific to include an assessment of the wound. During an interview on 12/6/2023, at 2:03 PM, the Clinical Manager indicated the wound assessment should include measurements, assessment of the surrounding skin and the wound base, and patient tolerance of the wound care. 3. A clinical record review for			

	Patient #7 evidenced a document titled "Recertification" identified as the comprehensive assessment dated 12/01/2023, which indicated Patient had a gastrostomy (a tube surgically inserted to administer fluid, nutrition, and/or medication). Review failed to evidence the comprehensive assessment included the size, stoma (opening in the body) appearance, and patency of the tube. During an interview on 12/7/2023, at 12:54 PM, the Clinical Manager indicated the comprehensive assessment should include the verification of the placement, stoma appearance, size, and patency of the tube. 4. A record review conducted on 12/5/23 for Patient 1 revealed a diagnosis of Multiple Sclerosis (MS). The comprehensive assessment (CA) failed to identify a neurological condition, musculoskeletal condition or status related to MS diagnosis and failed to identify safety measures related to MS diagnosis.			

	On 12/07/23 at 11:00 AM, the clinical manager indicated the assessment of Patient #1 and their status related to their MS diagnosis was not completed. The Start of Care comprehensive assessment (CA) for Patient 1, dated 11/22/23, indicated they had a history of incontinence. The assessment included a pressure ulcer risk assessment which did not identify incontinence as a risk factor for Patient's skin integrity, resulting in an inaccurate score of at medium risk for pressure wounds. During a home visit observation with the Clinical Manager on 12/06/23 at 3:30 PM, the Clinical Manager failed to perform an assessment of Patient #1's bony prominences, their back, buttocks nor their feet. During an interview on 12/7/23 at 11:00 AM, the clinical manager indicated a complete skin assessment should be completed at every visit and they failed to complete a skin assessment during the visit on 12/06/23. 5. A clinical record review for			

	Patient #3 included a Comprehensive Assessment, dated 11/15/23, that included a nutritional risk assessment that indicated the Patient was to take 3 or more medications. The assessment failed to identify the diagnosis or indications for the medications. During an interview on 12/7/23 at 11:15 AM, the clinical manager indicated Patient 3 did not take medications and the nutritional status was an oversite. 6. A record review conducted on 12/6/23 for Patient 5 indicated the presence of a gastrostomy/jejunostomy tube (g/j-tube) (a surgically placed soft, plastic tube placed through the skin of the abdomen into the midsection of the small intestine), by which Patient 5 is continuously obtains nutrition. The Comprehensive Assessment failed to evidence an assessment of the surrounding skin integrity, tube placement, stoma, size of the tube, or tolerance of continuous feeding. During an interview on 12/12/23 at 12:30 PM, the			

	Clinical Manager indicated the assessment should include placement, condition of stoma, and size of the tube and further indicated this assessment was not completed for Patient 5.			
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the agency failed to ensure the initial assessment visit was conducted within 48 hours of referral in 3 of 5 active clinical records reviewed with start of care dates since the date of the last survey of 8/30/2023. (Patient #2, 6, 8) The findings include: 1. A clinical record review for Patient #2 evidenced a document faxed from Entity A on 11/3/2023, which was identified to be a referral order from Person B (physician) dated	G0514	G0514 RN Performs Assessments The Administrator and Clinical Manager reviewed the following policies for reeducation and clarification of procedures C-145 COMPREHENSIVE PATIENT ASSESSMENT POLICY: The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the patient's return home, or on the physician ordered start of care date. With emphasis on SS1 1. The Comprehensive Assessment will be completed by a Registered Nurse, except in situations where therapy services are the only service ordered by the physician. C - 230 NURSING SERVICES The Agency shall provide Nursing services by appropriately Registered Nurses in accordance with a physician's order and under the direction and supervision of the Director of Nursing. With emphasis on SS1 1. Registered Nurse (RN) conducts the initial assessment (admission) of the patient to the agency by completing a comprehensive adult assessment. The clinical manager, PTs and registered nurses were reeducated on the admission requirement and completion of initial assessment within 48 hours of receiving	2023-12-29

	11/3/2023, which indicated the patient needed home heath services for skilled nursing for wound care, physical therapy (PT), and occupational therapy (OT). Review indicated the patient had an ischemic wound (wounds that occur when there is poor blood flow to an area of the body) to the right ankle noting fat exposure. The assessment document titled "Start of Care," completed by the registered nurse and dated 11/10/2023, failed to evidence the agency conducted the initial assessment visit within 48 hours of referral. During an interview on 12/6/2023, at 1:56 PM, the Clinical Manager indicated the agency did not see the referral until 11/10/2023. 2. A clinical record review for Patient #6 evidenced a document from Entity C (skilled nursing facility, SNF) identified as a referral for home health services dated 11/28/2023, which indicated the patient was his/her own responsible party and was to be discharged to home on 11/29/2023. Review indicated a referral order which		home. For patient #9- Most recent Medication Profile dated 12-3-2023 updated with Pain Gel used for BLE. The clinical manager and the administrator will review accepted referrals to ensure that initial assessment to determine the immediate care and support needs of the patient was completed within 48-hour of receiving the referral or patient returning home are performed to ensure deficiency does not recur. The administrator and clinical manager and the QA team will audit all new admissions weekly for a year to ensure this deficiency does not recur. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	indicated the physician ordered skilled nursing, PT, and OT services. Review on 12/5/2023 failed to evidence the agency had completed a comprehensive initial assessment. Review failed to evidence documentation of communication with the patient and the physician. Review evidenced a document titled "Physician Order" dated 11/30/2023, indicated the agency requested to start care on 12/4/2023. Review failed to evidence the attending physician was notified of the delay. During an interview on 12/7/2023, at 12:30 PM, the Clinical Manager indicated she would complete the comprehensive assessment that afternoon, 12/07/2023, indicated she was waiting for Patient's family member to be present to complete the comprehensive assessment and had not communicated with Patient. The Clinical Manager indicated she had not communicated with the physician regarding the delay in the start of care but had written the physician order and had not			

	yet sent the order to the physician. 3. A clinical record review for Patient #8 evidenced a document from Entity D (SNF) dated 11/30/2023, identified as a referral for home health physical therapy. Review of the electronic health record on 12/5/2023, indicated Patient's start of care date was 12/4/2023. Review failed to evidence an initial assessment was completed. During an interview on 12/7/2023, at 12:18 PM, the Clinical Manager indicated PT 1 completed the initial visit on 12/4/2023 and had not documented the visit yet. The Clinical Manager indicated she was unsure why the PT did not provide the initial visit until 12/4/2023 which was greater than 48 hours from the referral. 410 IAC 17-14-1(a)(1)(A)			
G0520	5 calendar days after start of care 484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later	G0520	G0520 5 calendar days after start of care The Administrator and Clinical Manager reviewed the following policies for	2023-12-29

	than 5 calendar days after the start of care. Based on record review and interview, the agency failed to ensure the comprehensive assessment was completed within 5 days of the start of care in 3 of 4 active clinical records reviewed with therapy services ordered upon referral since the last survey on 8/30/2023. (Patients #2, 6, 9) The findings include: 1. Clinical record review for Patient #2, start of care 11/10/2023, evidenced a referral order from Person B (physician) dated 11/3/2023, which indicated the patient needed home health services for skilled nursing for wound care, physical therapy (PT), and occupational therapy (OT). Review failed to evidence the PT contacted the patient regarding the scheduling of the PT assessment until 11/15/2023 and failed to evidence the PT completed the initial PT assessment until 11/27/2023. Review of agency documents titled "Communication Note" indicated the PT contacted the patient regarding the PT assessment on 11/15/2023, and the patient's caregiver reported		reeducation and clarification of procedures C-145 COMPREHENSIVE PATIENT ASSESSMENT POLICY: The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the patient's return home, or on the physician ordered start of care date. A thorough, well-organized, comprehensive, and accurate assessment, consistent with the patient's immediate needs will be completed for all patients in a timely manner, but no later than five (5) calendar days after start of care. All skilled Medicare and Medicaid patients except pediatric and post-partum will have comprehensive assessments that include the OASIS data set specific to mandated time points. The clinical manager and	

	the patient wasn't feeling well and to reschedule the visit on 11/20/2023. Review of document dated 11/20/2023 indicated there was a death in the patient's family and to reschedule the visit on 11/22/2023. Review of document dated 11/22/2023 indicated there was no answer when the PT called the patient. No further communication was documented by the PT after 11/22/2023 prior to the visit on 11/27/2023. During an interview on 12/6/2023, at 1:59 PM, the Clinical Manager indicated there was no documentation of any attempt for the PT to complete the comprehensive assessment until 11/15/2023 and no additional attempts after 11/22/2023. 2. A clinical record review for Patient #6, start of care 12/7/2023, evidenced a referral order dated 11/27/2023 from Person E (physician) for home health for skilled nursing, PT, and OT services. Review failed to evidence the PT and OT had completed the assessments. During an interview on		registered nurses were reeducated on completion of the comprehensive assessment in a timely manner, consistent with the patient's immediate needs, but not later than 5 calendar days from the start of care. For patient #2- PT and OT services have completed an initial assessment For patient #6- PT and OT services have completed an initial assessments The clinical manager and the QA team will audit all new admissions weekly for a year to ensure that comprehensive assessments are completed within 5 days of the start of care. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	12/12/2023, at 1:33 PM, the Clinical Manager indicated PT and OT had not yet completed an initial assessment yet, because the agency was needing to get orders from Person F (physician) before the therapy assessments could be scheduled since that was the patient's primary physician. 3. A clinical record review for Patient #9, start of care 12/3/2023, evidenced an agency document titled "Start of Care" identified as the initial assessment completed by the registered nurse and dated 12/3/2023, which indicated OT was to evaluate and treat. Review failed to evidence the OT had completed a comprehensive assessment as of 12/11/2023. During an interview on 12/11/2023, at 12:34 PM, the Clinical Manager indicated OT was scheduled for the comprehensive assessment on 12/9/2023 (greater than 5 days from the start of care) but was unsure if the visit was completed. No additional documentation or information was provided.			

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 observation, record review, and interview, the agency failed to ensure the patient's medications were reviewed to identify any potential adverse effects and drug reactions and failed to ensure the physician was notified of major drug interactions in 2 of 7 complete active clinical records reviewed. (Patient #2, 9) The findings include: 1. A review of an agency policy titled "Medication Profile" revised 11/7/2023, stated, "... The clinician shall promptly report any identified problems to the physician...." 2. Clinical record review for Patient #2 evidenced a Plan of Care for certification period 11/10/2023 - 01/08/2024, which indicated Patient's medications included, but were not limited	G0536	G0536 A review of all current medications The Administrator and Clinical Manager reviewed the following policies for reeducation and clarification of procedures C-700 MEDICATION PROFILE POLICY The Registered Nurse will complete a medication profile for each patient at the time of admission. The medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the patient is taking With emphasis on SS1 1. At the time of admission, the Registered Nurse shall check all medications 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	2023-12-29

	to, amiodarone (a medication used to treat a fast or irregular heartbeat) and furosemide (a medication used to rid the body of excess fluid). Review of a document titled "Drug-Drug Interactions" dated 12/6/2023, indicated a major drug interaction between amiodarone and furosemide with the increased risk of serious irregular heart rhythms. Review failed to evidence the agency notified the physician of the major drug interaction. During an interview at the entrance conference on 12/5/2023, 11:14 AM, the Clinical Manager indicated the agency was to inform the physician of all major drug interactions by faxing a communication note to the physician. During an interview on 12/6/2023, at 2:26 PM, the Clinical Manager indicated the agency should have sent a communication regarding the major drug interaction to the physician and there was not any communication sent to the physician, as it was an oversight. 3. A clinical record review for		physician The clinical manager and registered nurses were reeducated on notification of the physician and review of patient's medication to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant drug interaction, side effects, duplicate drug therapy and non-compliance with drug therapy. For patient #2- The Primary Care Physician has been notified of the Drug to Drug Interactions as of 12-12-2023 For patient #9- The Medication Profile has been updated with the pain Gel that is used for her BLE. Primary Care Physician also notified of updated medication. The administrator and clinical manager and the QA team will audit all new admissions weekly to ensure that the physician is notified of any potential adverse effects and drug reactions, including ineffective drug therapy, significant drug interaction, side effects, duplicate drug therapy and non-compliance with drug	

	Patient #9 evidenced a document titled "Start of Care" identified as the comprehensive assessment, completed by the Clinical Manager and dated 12/3/2023, which indicated the nurse instructed Patient to use pain relieving gel for pain management. Review of the agency document titled "Medication Profile" completed by the Clinical Manager and dated 12/3/2023, failed to evidence a pain relieving gel was included in Patient's medications that were reviewed. During an interview on 12/11/2023, at 12:42 PM, the Clinical Manager indicated Patient used a pain relieving gel on the legs for pain, could not remember the name of the medication. The Clinical Manager indicated the medication should have been reviewed and was not since it was not included on the medication profile. 410 IAC 17-14-1(a)(1)(B)		medication review. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	
G0538	Primary caregiver(s), if any	G0538	G0538 Primary caregiver(s), if any	2023-12-29

	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 availability, ability, and willingness of the caregiver in 2 of 7 active clinical records reviewed (Patient #2 and 7). The findings include: 1. Clinical record review for Patient #2 evidenced a document titled "Start of Care" identified as the initial assessment dated 11/10/2023. Review indicated Patient was bedbound, incontinent of bowel and bladder, had limited mobility and weakness, and was dependent for personal care and ADLs. Review indicated Patient had a wound to the right ankle that required wound care daily. Review indicated Patient lived with a caregiver around the clock and failed to evidence who was the caregiver and the availability, willingness, and ability of the caregiver. During an interview on		The Administrator and Clinical Manager reviewed the following policies for reeducation and clarification of procedures C-145 COMPREHENSIVE PATIENT ASSESSMENT The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the patient's return home, or on the physician ordered start of care date. With emphasis on SS 1 (g) g. The patient's primary caregiver(s), if any, and other available supports, including their willingness and ability to provide care, and their availability and schedules. SS 2 2. The assessment will identify the patient's primary caregiver(s), if any, and other available supports, including their willingness and ability to provide care, and availability and schedules. If there is an identified patient representative, that will also be documented For patient #2- Caregiver	

	12/6/2023, at 1:52 PM, the Clinical Manager indicated the patient lived with a family member who works during the day during which time there was another family member that took care of the patient. The Clinical Manager indicated the assessment should be more specific about the caregiver. 2. A clinical record review for Patient #7 evidenced a document titled "Recertification" identified as the comprehensive assessment, dated 12/1/2023, which indicated Patient was 9 years old; the primary diagnosis was gastrostomy (a tube surgically inserted into the stomach to deliver fluid, nutrition, and/or medication) through which fluid was to be administered and indicated Patient required suctioning after meals and as needed. The Assessment indicated Patient had a caregiver who worked Monday through Friday 8:00 AM – 4:00 PM and failed to evidence who was Patient's caregiver and their willingness and capability to provide care. During an interview on		availability, ability and willingness updated in Comprehensive Assessment dated 12-11-2023. For patient #7- Caregiver information update to be more detailed about who cares for patient when Home Care Services is not available. The Clinical Manager, PT and Registered nurses were reeducated on the admission requirements and completion of comprehensive assessment to include the availability, ability and willingness of the caregiver. The Clinical manager and the QA team will audit all new admissions weekly to ensure that the comprehensive assessment includes the availability, ability and willingness of the caregiver to ensure deficiency does not recur. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	Clinical Manager indicated the assessment should include who was the caregiver and their ability and willingness to provide care.			
G0550	At discharge 484.55(d)(3) At discharge. Based on record review and interview, the agency failed to ensure a comprehensive assessment was completed for 1 of 2 closed records reviewed with a discharge for goals met (Patient #12). The findings include: 1. A review of a policy revised 11/7/2023, titled "Patient Discharge Process" stated, "... Discharge OASIS [Outcome and Assessment Information Set] will be conducted within 48 hours of (or knowledge of) discharge to the community or death at home. The discharge comprehensive assessment ... is required for all situations that result in an Agency discharge except to an inpatient facility or patient death at home and	G0550	G0550 At discharge The Administrator and Clinical Manager reviewed the following policies for reeducation and clarification of procedures C-500 PATIENT DISCHARGE PROCESS POLICY Discharge Planning is initiated for every home care patient at the time of the patient's admission for home care. When patients are admitted for home health services, the expectation is that the patient will be discharged to self-care or care of family when goals are met. Discharging a patient to another provider is permitted under limited circumstances that are documented in the admission	2023-12-29

	conjunction with a visit, if possible…." 2. A clinical record review for Patient #12 evidenced a document titled "PT Discharge Summary" dated 10/19/2023, which indicated Patient was discharged due to goals met. Review failed to evidence the discharge summary was sent to the physician. Review of a document titled "OT [occupational therapy] Discharge Summary" dated 10/24/2023, indicated Patient was discharged due to goals met. Review evidenced a document titled "Discharge Patients" dated 12/5/2023, indicated Patient was discharged on 10/13/2023 for goals met. Review failed to evidence the discharge summary was sent to the physician. Review failed to evidence a discharge assessment was completed. During an interview on 12/11/2023, at 1:13 PM, the Administrator / PT indicated there was not a discharge assessment for this patient		notices. With emphasis on Discharge Criteria:SS6 Criteria for discharge may include, but are not limited to the following: Discharge OASIS will be conducted within 48 hours of (or knowledge of) discharge to the community or death at home. Patient #12 was a private pay and the discharge summary has now been sent to the physician. The Clinical Manager, Registered Nurses and Therapists were reeducated on the timely completion of discharge summaries and timely notification of discharge to the Primary Care Physician and completion of the comprehensive assessments and Discharge Summaries for all discharges for goals met. The Clinical manager and the	

	because the agency did not follow the rules for this patient due to the payor source of workmen's compensation.		QA team will audit all discharges daily to ensure that comprehensive assessment is completed for all discharges for goals met to ensure deficiency does not recur. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does 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 or who are discharged to a SNF, IRF or LTCH, 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 were met adequately upon	G0562	G0562 Discharge Planning The Administrator and Clinical Manager reviewed the following policies for reeducation and clarification of procedures C-495 DISCHARGE POLICY POLICY Patients are discharged from treatment in the home when the expectations that the patient's medical, nursing, and social needs have been met adequately by Agency in the patient's place of residence, upon death of the patient, or for another reason. With emphasis on SS 1 & 2	2023-12-29

	discharge in 2 of 2 closed records reviewed with a discharge reason of goals met (Patients #11 and 12) and failed to establish an agency policy in accordance with federal regulation related to their discharge process. The findings include: 1. A review of the policy revised 11/7/2023 titled "Discharge Policy" stated, "...planning with the patient shall occur throughout the course of care and shall include documentation of specific plans and the expected date of discharge at least fifteen (15) calendar days before the services are stopped. Prior to discharging the patient, the attending physician shall be consulted for discharge orders. A written discharge summary, which shall be prepared within fifteen (15) calendar days of discharge, will be sent to the physician ...." 2. A review of the policy revised 11/7/2023, 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		Discharge planning shall begin at the time of admission with patients being advised as to the expected duration of treatment. Additional planning with the patient shall occur throughout the course of care and shall include documentation of specific plans and the expected date of discharge at least fifteen (15) calendar days before the services are stopped. 2. Prior to discharging the patient, the attending physician shall be consulted for discharge orders. A written discharge summary, which shall be prepared within fifteen (15) calendar days of discharge, will be sent to the physician with a copy maintained in the clinical record. C-820 DISCHARGE SUMMARY POLICY A Discharge Summary will be completed for patients discharged from Agency With emphasis on SS1 When a patient is discharged	

	other health care professional responsible for providing care and services to the patient after discharge from the agency within 5 days of patient discharge per federal regulation. 3. A review of the policy revised 11/7/2023, titled "Patient Discharge Process" stated, "... The Registered Nurse/Therapist shall ensure that the treatment goals and patient outcomes have been met or, if unmet needs are present, appropriate referrals are made to agencies/institutions to meet continuing patient needs ... To avoid charges of "abandonment" at the time of discharge agency documentation will include the following: Evidence that the decision was not made unilaterally. The patient, family and physician participated in the decision to discharge patient from the agency...." 4. A clinical record review for Patient #11 evidenced a Home Health Certification and Plan of Care for certification period 9/1/2023 - 10/30/2023, which indicated the goals included moderate assistance for		from the agency, the supervising professional shall complete a Discharge Summary form within the time frame defined by the agency. A copy will be mailed to the physician upon request. C-500 PATIENT DISCHARGE PROCESS POLICY Discharge Planning is initiated for every home care patient at the time of the patient's admission for home care. When patients are admitted for home health services, the expectation is that the patient will be discharged to self-care or care of family when goals are met. Discharging a patient to another provider is permitted under limited circumstances that are documented in the admission notices. With emphasis on SS 5,6 ,7 & 8 5 The Registered Nurse or Therapist shall review the clinical record to assure accuracy and completion. A Discharge Plan shall be developed that is documented	

	sit-to-stand transfers and ambulate 5 feet with a rolling walker. A document titled "Discharge (PT) [Physical Therapy]," identified as the comprehensive discharge assessment and dated 10/26/2023, indicated Patient was discharged due to goals met. Review indicated Patient required maximum assistance with sit-to-stand transfers and was chairfast and unable to walk. Review failed to evidence a discharge notice was provided to Patient or discharge plans were discussed with Patient prior to 10/24/2023, less than 15 days notice. Review failed to evidence documentation with the physician, prior to discharge, regarding the decision to discharge Patient. Review failed to evidence the agency referred Patient to another agency for continued needs to meet goals. During an interview on 12/11/2023, the Clinical Manager indicated the goals		in writing and includes all written/verbal instruction regarding the patient's ongoing care needs and available resources provided to the patient and family 6 The Registered Nurse/Therapist shall ensure that the treatment goals and patient outcomes have been met or, if unmet needs are present, appropriate referrals are made to agencies/institutions to meet continuing patient needs. Patients will be given the Notice of Medicare Non-Coverage as indicated and/or appropriate Home Health Advance Beneficiary Notice to explain Agency decision related to discharge from services. 7. Upon discharge to self-care, the patient will receive verbal/written information regarding community services, medication use, any procedures/treatments to be performed, and follow-up visits for physician care.	

	Patient was discharged. During an interview on 12/11/2023, at 12:50 PM, the Administrator/PT indicated Patient was provided, at time of admission, an untitled agency document identified as the discharge policy that indicated a 15 day discharge notice would be provided and indicated Patient was not provided a discharge date at that time. At 1:32 PM, the Administrator/PT indicated Patient had functional decline throughout the provision of agency services and indicated, whether or not the physician is contacted prior to discharge to discuss the possibility of discharge, was dependent on if the patient's case was complicated or not. The Administrator/PT indicated he/she did not recall if the physician was contacted prior to discharge and indicated there was no documentation of communication with the physician regarding Patient's discharge. The document titled "Home Health Discharge Summary" indicated Patient's discharge date was 10/26/2023; the document was dated		8. To avoid charges of "abandonment" at the time of discharge agency documentation will include the following: Evidence that the decision was not made unilaterally. The patient, family and physician participated in the decision to discharge patient from the agency. b. Evidence that the patient no longer qualifies for home care services or there is no payer source for ongoing services. c. If there are unmet needs and the agency is no longer able to meet those needs, documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated. In this situation, the decision will be made with the physician as well as the patient and their representatives. d. Documentation of all communication with the patient, including the rationale for discharge, will be kept in the	

	11/1/2023. Review of the electronic health record indicated the document was not completed by the clinician until 11/02/2023 and failed to evidence the discharge summary was provided to the physician within 5 days of discharge. During an interview on 12/11/2023, at 12:47 PM, the Clinical Manager indicated the discharge summary is to be sent to the physician after it was reviewed by QA (Quality Assurance). 5. A clinical record review for Patient #12 evidenced an agency document titled "Occupational Therapy Assessment" dated 9/26/2023, which indicated Patient was to be discharged when the patient's goals were met and patient could safely perform activities of daily living (ADLs). Review of a document titled "Start of Care" identified as the initial comprehensive assessment completed by the PT and dated 9/19/2023, indicated Patient's discharge goal was to be independent with ambulation up to 150 and		summary is no longer required to be sent to the physician; however, this could be the communication documentation that clarifies the discharge process and plan. Patients #11 and 12 have now been discharged. The Clinical Manager, Registered Nurses and Therapists were reeducated on the importance of the 15 day notice and notification of notify patient and physicians 15 days prior to planned discharge. Along with the already included 15 day notice in the admission packet, clinicians will notify patient and physicians 15 days prior to planned discharge. The Clinical manager and the QA team will audit all planned discharges weekly to ensure deficiency does not recur. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	chair to bed transfers. Review evidenced an agency document titled "Discharge Patients" dated 12/5/2023, indicated Patient was discharged on 10/13/2023 for goals met and failed to evidence the discharge summary was sent to the physician. Review of a document titled "PT Discharge Summary" dated 10/19/2023 indicated Patient was discharged due to goals met and failed to evidence the discharge summary was sent to the physician. Review of an agency document titled "OT [occupational therapy] Discharge Summary" dated 10/24/2023, indicated the patient was discharged due to goals met. Review failed to evidence a discharge assessment. Review failed to evidence communication with the physician prior to discharge for agreement with patient discharge. Review failed to evidence the patient was provided discharge notice at least 15 days prior to discharge.			

	During an interview on 12/11/2023, at 1:13 PM, the Administrator/PT indicated the agency did not follow the rules with this patient regarding discharge, because payor source was workmen's compensation. The Administrator/PT indicated the agency did not follow the goals for Patient, because of the payor source and the agency was using a different electronic health record. The Administrator indicated Patient was provided discharge notice at time of admission and indicated the form provided to Patient was the discharge policy and did not have a date of discharge indicated. The Administrator indicated there was no other documentation of discharge notice provided to Patient. When queried how Patient was determined to have met goals without a completion of the discharge assessment, the Administrator/PT remained quiet before indicating the agency did not apply the rules for this patient. During an interview on 12/11/2023, at 12:54 PM, the Clinical Manager indicated the			

	by the PT and OT had not been sent to the physician.			
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 11/02/23 Corrected 7/23/23	G0564	Corrected 11/02/2023	2023-12-13
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 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	G0570	G0570 Care planning, coordination, quality of care The Administrator and Clinical Manager reviewed the following policies for reeducation and clarification of procedures C-660 CARE PLANS POLICY Each patient will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs. This plan is developed with the patient and family, as indicated, and is based on services needed to achieve specific measurable goals. With emphasis on SS 1 & 2 1. Following the initial assessment, a Care Plan shall be developed with the patient	2023-12-21

	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 G0572); the plan of care included all required information / elements for the treatment of the patient (See 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 G0588); physicians were promptly notified of a change in the patient's condition (See G0590); and coordination of care with all disciplines / services involved in care of the patient (See G0606).		and/or caregiver. The interventions shall correspond to the problems identified, services needed and the patient goals for the episode of care. 2. The Care Plan shall be reviewed, evaluated, and revised (minimally every sixty (60) days and as needed) based upon the patient's health status and/or environment, ongoing patient assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals. All updated entries must be signed and dated by the Registered Nurse or Therapist. All changes will be communicated to appropriate team members C-580 PLAN OF CARE ProCare Home Health services are furnished under the general supervision and direction of the patient's physician. The Plan of Care is based on a comprehensive assessment and information provided by the patient/caregiver and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. In cases where patient care is provided in a clinical setting with rotating team members of physicians, orders shall be processed in accordance with Agency policy and the agency shall accept the signature and date of the physician assigned to the clinic at the time orders are presented for signature as the attending physician for the patient PURPOSE To provide guidelines for agency team members to develop a plan of care	

	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 of Care. A deficient practice citation was also evidenced at this standard as follows: Based on observation, clinical record review, and interview, the agency failed to meet the patient's needs in 3 of 5 active clinical records reviewed accepted for services since the last survey date of 8/30/2023. (Patient #2, 6, 8) The findings include: 1. A clinical record review for Patient #2 evidenced a document faxed from Entity A on 11/3/2023, which was identified to be a referral order from Person B (physician) dated 11/3/2023, which indicated the patient needed home health services for skilled nursing for wound care, physical therapy (PT), and occupational therapy (OT). Review indicated the		individualized to meet specific identified needs. With emphasis on SS3 1. An individualized Plan of Care written and signed by a physician shall be required for each patient receiving home health and personal care services. The Plan of Care may be prepared as a written record by the ProCare Home Health Services agency based on the physician's verbal orders following Policy and Procedures re: Telephone Orders. C-360 COORDINATION OF PATIENT SERVICES POLICY The agency will integrate services, whether they are provided directly or under contract, to assure the identification of patient needs and factors that could affect patient safety and the effectiveness of treatment. The coordination of care is provided by all disciplines and included communication with physicians. C-300 CLINICAL SUPERVISION POLICY Skilled nursing and other therapeutic services are provided under the supervision of a Registered Nurse. The Director of Nursing or a designated qualified Registered Nurse will be available to provide ongoing supervision during the operating hours of the Agency. Under no circumstances will the administrative or supervisory responsibilities be delegated to another organization With emphasis on SS1 1. The Director of Nursing/Nursing Supervisor shall be responsible for the quality of care provided and supervision of all team members providing therapeutic	

	(wounds that occur when there is poor blood flow to an area of the body) to the right ankle with fat exposure. Review of an agency document titled "Start of Care" and identified as the initial assessment completed by the registered nurse and dated 11/10/2023, indicated the patient's primary diagnosis was peripheral vascular disease (a progressive circulation disorder which causes decreased blood flow to the limbs). Review indicated the patient had pain rated a 5 on a scale of 0-10 (0 being no pain and 10 being the worst pain) to the right leg which occasionally affected the patient's ability to sleep and participate in activities of daily living (ADLs). Review indicated the patient had an ischemic ulcer to the right ankle with serous (clear to yellow) drainage requiring wound care daily. Review indicated the patient was bedbound, incontinent of bowel and bladder, had limited mobility and weakness, and was dependent for personal care and ADLs. Review of an agency document identified as the OT initial		services, including contract team members. He/she will also be responsible for organizing and directing the Agency's ongoing functions. For patient #2- Occupational Therapy Services has been started as of 12-11-2023. When Home Health Aide (HHA) services were offered at start of care, the caregiver stated the services were not needed due to the patient having Structured Family Services and is never left alone. There were no physician orders for HHA services. For patient #6- Initial Start of Care done 12/07/2023 For patient #8- This situation is now resolved. Discovery made at Initial visit on 12-4-2023 that patient left the facility against the Facility Physicians Advice, no orders were received from the facility as requested and that the patient had a wound to her right leg that needed treatment and orders for homecare to treat the wound. Clinical Manager notified 3 agencies to help assist with the patient's care and none accepted the patient's insurance. The Clinical Manager notified the Nurse Practitioners office about the patient needing care and placement with another homecare agency. Clinical Manager was able to speak to patient as of 12-21-23 and patient stated her wound was now a 2cm scab, no drainage from scab and patient was able to ambulate safely with her walker and would be out of town for the holidays. The Clinical Manager, Registered Nurses and Therapists were reeducated on care planning, coordination of services and quality	

	assessment dated 11/14/2023 indicated the patient required maximum assistance with personal care and ADLs. Review indicated OT services were needed for motor training, cognitive training, and fine motor coordination. Review of an agency document identified as the PT initial assessment and dated 11/27/2023 indicated the patient had pain rated 4 on a scale of 0-10 to the left leg. Review indicated the patient was paraplegic (paralysis of the lower body) and required total assistance for bed mobility and transfers and was bedridden. Review indicated PT services were needed for balance training, functional mobility, caregiver training, and therapeutic exercise. Review failed to evidence the agency provided any services since the initial assessments completed by the registered nurse on 11/10/2023, the OT on 11/14/2023, and the PT on 11/27/2023. Review failed to evidence the agency offered and provided home health aide services.		of care with reference to notification of physician of all change in condition. The Clinical manager and the QA team will audit all discharges weekly to ensure that the agency plan of care for all patients are reviewed by the physician, individualized and followed by all the agency staff and that the plan of care included all required information/elements for the treatment of the patient and the plan of care revised by the agency and the patient's primary physician as frequently as patient's condition changes to ensure safe and effective transition of care and ensure this deficiency does not recur and the agency is able to meet the needs of patients. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	During an interview on 12/8/2023, at 10:01 AM, the patient's caregiver indicated both of the patient's knees were swollen and the right knee was painful and possibly was dislocated because the knee appeared twisted. The caregiver indicated he/she was afraid to move the patient out of bed for fear the patient's knee would break. The caregiver indicated the wound to the right ankle was present. The patient's caregiver indicated home health aide services would be helpful as the caregiver works and the replacement was not always available requiring the caregiver to leave work to take care of the patient. The caregiver indicated it was overwhelming at times to do all of the patient care and wanted to ask the agency about getting someone to help with the bathing and personal care.			

	During an interview on 12/6/2023, at 2:02 PM, the Clinical Manager indicated aide services were indicated based on assessment, but the patient's family refused aide services. The Clinical Manager indicated there was no documentation of the offer and refusal of aide services. During an interview on 12/7/2023, at 3:40 PM, the Administrator indicated the patient did have a need for care and no one was meeting the patient's needs just as no one was meeting the patient's need for care prior to the agency accepting the patient. The Administrator indicated the agency had a poor standard of practice for accepting patients with a need for care and not providing the services as needed. The Administrator indicated the agency should provide skilled nursing services for wound care while waiting for the authorization and indicated he was not aware skilled nursing services were not being provided. 2. A clinical record review for Patient #6 evidenced a document from Entity C (skilled			

	nursing facility, SNF) identified as a referral for home health services dated 11/28/2023, which indicated the patient was his/her own responsible party and was to be discharged to home on 11/29/2023. Review indicated a referral order which indicated the physician ordered skilled nursing, PT, and OT services. Review on 12/5/2023 failed to evidence the agency had provided any services to the patient. During an interview on 12/7/2023, at 12:30 PM, the Clinical Manager indicated she would complete the comprehensive assessment that afternoon. The Clinical Manager indicated she was waiting for the patient's brother to be present to complete the comprehensive assessment and had not communicated with the patient regarding scheduling of the initial assessment. 3. A clinical record review for Patient #8 evidenced a document from Entity D (SNF) dated 11/30/2023, identified as a referral for home health physical therapy. Review of the electronic health record on			

	patient's start of care date was 12/4/2023 but failed to evidence an initial assessment was completed. During an interview on 12/7/2023, at 12:18 PM, the Clinical Manager indicated the agency was not going to provide services to the patient, because PT 1 completed the initial visit on 12/4/2023 and assessed the patient to have a wound for which the agency could not provide staffing to meet the patient's needs for wound care. The Clinical Manager indicated the patient left Entity D against medical advice, the agency does not have physician orders for home care, and does not have a physician to notify of the agency's inability to provide care for the patient. The Clinical Manager indicated there had been no communication with the patient regarding the need for another home care agency to service the patient and no referral made to another home care agency on the patient's behalf. During an interview on 12/7/2023, at 1:38 PM, Patient #8 indicated PT 1 completed a			

visit on 12/4/2023 and informed the patient before the agency could accept the patient for care, the patient needed to see the doctor first so the State could pay for the home care services. Patient #8 indicated he/she had an appointment with the physician for that week. Patient #8 indicated he/she had not been informed the agency was not going to provide services and to contact another agency.

During an interview on 12/12/2023, at 1:40 PM, PT 1 indicated he/she assessed the patient on 12/4/2023 and assessed the patient had a surgical wound to the right leg with noted eschar (dead tissue). PT 1 indicated the patient needed PT services for strengthening and ambulation related to recent surgery to the right leg. PT 1 indicated the Administrator instructed PT 1 to inform the patient he/she needed to find another home care agency and indicated PT 1 did not provide the patient with contact information of other home health agencies. PT 1 indicated he/she did not notify the physician of the inability to provide services and assumed

	the Clinical Manager would do so. 410 IAC 17-13-1(a)			
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 ordered in the plan of care in 3 of 9 active clinical records reviewed.	G0572	G0572 Plan of care The Administrator and Clinical Manager reviewed the following policies for reeducation and clarification of procedures C-580 PLAN OF CARE ProCare Home Health services are furnished under the general supervision and direction of the patient's physician. The Plan of Care is based on a comprehensive assessment and information provided by the patient/caregiver and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that patient	2023-12-29

	(Patient #1, #3, and #5) The findings include: 1. The Plan of Care (POC) for Patient 1 with a certification period 11/22/23 - 01/20/24 included Intravenous Antibiotics and weekly venipuncture on Mondays or Tuesdays. The POC failed to identify who was to provide the IV antibiotic therapy. The clinical failed to evidence the agency provided IV antibiotic therapy nor drew the labs on Mondays or Tuesdays. The POC failed to identify who and how the antibiotics or weekly labs were administered, collected, and or was coordinated. On 12/07/23 beginning at 11 AM, the Clinical Manager indicated that neither the laboratory completing the lab draws nor the pharmacy providing supplies were on the POC and should be included. The POC revealed orders to assess and provide care for the Peripherally Inserted Central Catheter (PICC); the POC failed to include the status of the		needs are met, and will be updated as necessary, but at least every sixty (60) days. In cases where patient care is provided in a clinical setting with rotating team members of physicians, orders shall be processed in accordance with Agency policy and the agency shall accept the signature and date of the physician assigned to the clinic at the time orders are presented for signature as the attending physician for the patient PURPOSE To provide guidelines for agency team members to develop a plan of care individualized to meet specific identified needs. With emphasis on SS1 2. An individualized Plan of Care written and signed by a physician shall be required for each patient receiving home health and personal care services. The Plan of Care may be prepared as a written record by the ProCare Home Health Services agency based on the physician's verbal orders following Policy and Procedures re: Telephone Orders. For patient #1- the company	

	PICC, including length and circumference of arm. During a home visit observation, conducted on 12/6/23 beginning at 3:22 PM, observed PICC care performed by the Clinical Manager; the clinical manager failed to perform an assessment of the PICC including line measurements and arm circumference. When asked, the clinical manager indicated a better method would be to measure the length of the PICC, but I just eyeball the tubing. During an interview, on 12/7/23 beginning at 11 AM, the clinical manager indicated PICC measurements should be assessed at the start of care and included on the Plan of Care, and further indicated the assessment and measurements were not included in the POC for Patient 1. 2. The clinical record for Patient 3 included a recertification Plan of Care for the certification period 11/16/23 – 01/14/24; the plan of care failed to evidence it was individualized to meet the needs of a pediatric patient. The plan of care included adult		supplying the IV antibiotics is now listed on the Plan of Care. Weekly Labs done by Sacred Hearts Phlebotomy Services and listed on Plan of Care. Patients PICC line measurements from insertion site to bottom of line now listed on the Plan of Care. For patient #3- most recent Plan of Care dated 11-16-2023 is now updated with Pediatric parameters. For patient #5- The Clinical Manager indicated that although Medications are listed by the manufacturer as oral, patient receives medications per GJ-Tube route. Goals and interventions for Diagnosis of Pancreatitis now listed on the Plan of Care dated 11-16-2023. A review of 10% active patients charts showed that the patients' were receiving established individualized services as ordered by the physician in the plan of care. The Clinical Manager, Registered Nurses and Therapists were re educated on	

	perimeters; the respirations goal perimeters were 12 - 24 breaths per minute and a systolic blood pressure (pressure against the arteries when the heart is contracting and represented by the top number) of 90 to 160 and diastolic blood pressure (pressure against the arteries when the heart is at rest and represented by the bottom number) of 60 - 90. During an interview on 12/7/23 beginning at 11:15 AM, the clinical manager indicated the parameters on the Plan of Care were not specific for Patient #3. 3. The clinical record for Patient 5 included a document titled OASIS-E Recertification that revealed Patient 5 was aphasic, contracted, dependent for all care needs and with a diet of Vivonex 250 ml with 250 ml water continuous feeding with 1 hour rest from pump every 4 hours. The record included a Plan of Care for the certification period 11/18/23 – 01/16/24 which included the medications: levetiracetam (medication for prevention of seizures), simethicone (medication for		the importance that the patient's plan of care is established with a physician and also the plan of care of all patients are established, individualized and services provided as ordered by the physician. The Clinical manager and the QA team will audit all plans of care weekly ensure that the patient's plan of care was established with a physician and also the plan of care of all patients are established, individualized and services provided as ordered by the physician to ensure deficiency does not recur and the agency is able to meet the needs of patients. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	treatment of pain related to intestinal gas), metoclopramide (medication for treatment of nausea, vomiting, heartburn), acetaminophen (medication used to treat pain or fever), diazepam (medication used for treatment of anxiety), phenobarbital (medication used for the treatment of seizures), ondansetron (medication used for the treatment of nausea and vomiting), lansoprazole (medication used for the treatment of indigestion) and baclofen (medication used for the treatment of pain related to muscle stiffness) which indicated the medication is to be taken orally and per feeding tube. During an interview on 12/12/23 at 12:30 PM the Clinical Manager indicated all medications for Patient 5 are administered through the g/j-tube and indicated the medication list needs to state medications are to be administered via the g/j-tube. The plan of care indicated a medical necessity for services due to acute exacerbation of pancreatitis; the plan of care			

	intervention for the diagnosis of acute exacerbation of pancreatitis. In an interview on 12/12/23 the Clinical Manager indicated Patient 5 did not have a lot of pain and indicated there was no care plan for pain nor pancreatitis within the plan of care. 410 IAC 17-13-1(a)			
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	G0574	G0574 Plan of care must include the following The Administrator and Clinical Manager reviewed the following policies for reeducation and clarification of procedures C-580 PLAN OF CARE ProCare Home Health services are furnished under the general supervision and direction of the patient's physician. The Plan of Care is based on a comprehensive assessment and information provided by the patient/caregiver and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. In cases where patient care is provided in a clinical setting with rotating team members of physicians, orders shall be processed in accordance with Agency policy and the agency shall accept the signature and date of the physician assigned to the clinic at the time orders are presented for signature as the attending physician for the patient PURPOSE To provide guidelines for agency team members to develop a plan of care individualized to	2023-12-29

	emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the agency failed to ensure the plan of care was individualized to include interventions, medications, medical supplies, measurable outcomes and goals, and discharge plans for 6 of 7 active complete clinical records reviewed with a plan of care. (Patient #1, 2, 3, 5, 7, 9) The findings include: *A record review conducted on 12/5/23 for Patient 1 included a document titled Home Health Certification and Plan of Care revealed diagnosis of Multiple Sclerosis and Cerebral Vascular Accident. The plan of care failed to identify goals and interventions related to diagnosis. The plan of care failed to identify diagnosis of diabetes or goal and interventions related to		meet specific identified needs. With emphasis on SS1 2. An individualized Plan of Care written and signed by a physician shall be required for each patient receiving home health and personal care services. The Plan of Care may be prepared as a written record by the ProCare Home Health Services agency based on the physician's verbal orders following Policy and Procedures re: Telephone Orders. For patient #2- Most recent Plan of Care dated 11-10-2023 now updated to state Fall risk precautions, Oxygen Therapy goals, and Anticoagulation therapy care. For patient #7- Most current Plan of Care dated on 12-1-2023 now identifies location on patients body for use of Desonide Cream. Individual Pediatric Parameters also listed on Plan of Care along with Oral suctioning pressure and frequency and deletion of Diabetic Parameters. For patient #9- Pain relieving Gel now added to Medication Profile and Physician notified of medication For patient #1- No goals or Interventions for MS and CVA addressed due to patient admitted for IV antibiotic care of infection to the right knee. No exacerbations with CVA or MS indicated on physicians orders for care. For patient #3- Plan of Care dated 11-13-2023 updated to indicate goals and interventions for Diagnosis of Autism. For patient #5- Interventions related to prevention of skin breakdown or maintenance of skin Integrity including in orders on Plan of Care dated 11-18-2023 The Clinical Manager, Registered Nurses and Therapists were reeducated on the importance and need individualized plan of care to include interventions, medication, medical supplies, measurable outcomes and goals and discharge plans. The Clinical manager and the QA team will	

	diagnosis. During an interview with the Clinical Manager (CM) on 12/7/23 at 11:00 AM the CM the goals and interventions are not on the plan of care for those diagnoses. The CM further indicates a need to update the plan of care for Patient 1. *The record review on 12/5/23 for Patient 3 indicated an admission diagnosis of Autistic Disorder and included indications of anxious, abnormal behavior. The plan of care failed to identify goals and interventions related to diagnosis. During an interview with the Clinical Manager (CM) on 12/7/23 at 11:15 AM, the CM indicated there are no goals or interventions on the Plan of Care (POC) for Autistic Disorder for Patient 3. The CM further indicates a need to update the POC to reflect goals and interventions for Patient 3. *A clinical record review for Patient 5 was conducted on 12/6/23 included a document		audit all plans of care weekly to ensure that the plan of care of all patients include interventions, medication, medical supplies, measurable outcomes and goals and discharge plans, to prevent this deficiency from recurring. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	which included a comprehensive assessment (CA). Which indicated Patient 5 has a diagnosis of Cerebral Palsy, with contractures, limited mobility and chairbound status who was identified as a high risk for skin integrity issues with a score of 13 on the Norton Pressure Sore risk assessment. The Plan of Care for certification Period 11/18/23 – 1/16/24 failed to identify interventions related to prevention of skin breakdown or maintenance of skin integrity. During an interview on 12/12/23 at 12:30 PM the Clinical Manager (CM) there should be a skin integrity care plan with identified interventions for Patient 5. The CM further indicates it did not contain interventions for Patient 5. 1. A clinical record review of Patient #2 evidenced an agency document titled “Start of Care” identified as the initial comprehensive assessment completed by the registered nurse and dated 11/10/2023, which indicated the patient was a fall risk. Review indicated the			

	minimal exertion and received oxygen therapy. Review indicated the patient was at risk for bleeding due to anticoagulation therapy (receiving medication to thin the blood resulting in a bleeding risk). Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 11/10/2023-1/8/2024, failed to include fall risk as a safety precaution. Review failed to evidence the plan of care included a goal related to the oxygen therapy. Review indicated the skilled nurse was to monitor and assess the anticoagulation therapy and failed to include a goal related to the anticoagulation therapy. During an interview on 12/6/2023, at 2:20 PM, the Clinical Manager indicated the fall risk should be included in the plan of care. At 2:25 PM, the Clinical Manager indicated there were no goals on the plan of care related to anticoagulation and oxygen therapy. 2. A clinical record review for			

document titled "Recertification" identified as the comprehensive assessment completed by the registered nurse on 12/1/2023, which indicated the patient required suctioning after meals and as needed.

Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 12/3/2023-1/31/2024, which indicated the patient was 9 years old. Review indicated the patient's medications included, but were not limited to, desonide (a medication to treat reddened and itchy skin) topical cream to be applied daily, Pedialyte (electrolyte solution) as needed, and Flovent (medication to reduce airway inflammation and to be given by oral inhalation) nasally. Review failed to indicate to what part of the body desonide should be applied and how often Pedialyte should be given. Review indicated the plan of care was not individualized to meet the needs of a pediatric patient as the normal vital sign parameters were indicated to be respirations 12-24 breaths per minute and a systolic blood

	pressure (pressure against the arteries when the heart is contracting and represented by the top number) of 90-160 and diastolic blood pressure (pressure against the arteries when the heart is at rest and represented by the bottom number) of 60-90. Review evidenced the plan of care included parameters for blood sugar and failed to evidence a diagnosis of diabetes (a disease that affects the blood sugar). Review indicated the patient's primary diagnosis was gastrostomy (a tube surgically inserted into the stomach to deliver fluid, nutrition, and/or medication) through which fluid was to be administered. Review failed to evidenced goals related to the diagnosis of a gastrostomy and amount and frequency of fluid to be administered. Review failed to evidence the plan of care included the suctioning of the patient to include the route, pressure, and frequency. During an interview on 12/7/2023, at 12:45 PM, the Clinical Manager indicated she was unsure to what part of the body the desonide cream was			

	include the frequency, and Flovent should be administered by inhaling through the mouth. The Clinical Manager indicated the vital sign parameters were the same for all the patients and were not individualized for a pediatric patient. The Clinical Manager indicated the patient was not diabetic, and the plan of care should not include blood sugar parameters. The Clinical Manager indicated the patient did have a gastrostomy, but it should not be the primary diagnosis on the plan of care. The Clinical Manager indicated the goals on the plan of care should include the patient's use of the gastrostomy and the amount and frequency of the fluid to be administered via the gastrostomy. The Clinical Manager indicated the suctioning should be included on the plan of care.			

	3. A clinical record review for Patient #9 evidenced an agency document titled "Start of Care" identified as the comprehensive assessment completed by the Clinical Manager and dated 12/3/2023, which indicated the nurse instructed the patient to use pain relieving gel for pain management. During an interview on 12/11/2023, at 12:42 PM, the Clinical Manager indicated the patient used a pain relieving gel on the legs for pain but could not remember the name of the medication. The Clinical Manager indicated the medication should have been reviewed but was not since it was not included on the medication profile. Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 12/3/2023-1/31/2024, which indicated the patient's primary diagnosis was a urinary tract infection. Review failed to evidence the plan of care included interventions and goals related to the primary diagnosis and failed to evidence the medications included a pain			

	relieving gel. During an interview on 12/11/2023, at 12:39 PM, the Clinical Manager indicated the patient did not have a urinary tract infection at time of admission and indicated the patient's secondary diagnosis of other signs and symptoms involving the digestive system and abdomen should have been listed as the primary diagnosis on the plan of care. At 12:42 PM, the Clinical Manager indicated the patient used a pain relieving gel on the legs for pain but could not remember the name of the medication. The Clinical Manager indicated the medication should have been included on the plan of care.			
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	G0588	G0588 Reviewed, revised by physician every 60 days The Administrator and Clinical Manager reviewed the following policies for reeducation and clarification of procedures. C-660 CARE PLANS POLICY Each patient will have a	2023-12-28

	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 #4) The findings include: A clinical record review for Patient #4 evidenced a Plan of Care for the certification period 8/21/2023 - 10/19/2023 that indicated the physician signed it on 8/29/2023. A plan of care for the certification period 10/25/2023 - 12/23/2023 indicated the agency did not send the plan of care to the physician for review until 11/21/2023 and was signed the physician on 11/30/2023, which was greater than 60 days. During an interview on 12/7/2023, at 12:01 PM, the Clinical Manager indicated the agency sent the plan of care late to the physician and indicated the plan of care should be reviewed by the physician every 60 days. 410 IAC 17-13-1(a)(2)		care plan on file that addresses their identified needs and the agency's plan to respond to those needs. This plan is developed with the patient and family, as indicated, and is based on services needed to achieve specific measurable goals. With emphasis on SS 1 & 2 1. Following the initial assessment, a Care Plan shall be developed with the patient and/or caregiver. The interventions shall correspond to the problems identified, services needed and the patient goals for the episode of care. 2. The Care Plan shall be reviewed, evaluated, and revised (minimally every sixty (60) days and as needed) based upon the patient's health status and/or environment, ongoing patient assessments, caregiver support systems, and the	

			effectiveness of the interventions in achieving progress toward goals. All updated entries must be signed and dated by the Registered Nurse or Therapist. All changes will be communicated to appropriate team members. The Clinical Manager and Registered Nurses were reeducated on notifying the Primary Care Physician of Comprehensive Assessments of Patients and revision of the plan of care by the physician every 60 days and as the patient's condition requires. The Clinical manager and the QA team will audit all plans of care weekly for a year to ensure that the patient's plan of care was reviewed and revised with the physician as frequently as the patient's condition requires, to prevent this deficiency from recurring.	

			The Administrator and Clinical Manager are responsible for ensuring that this deficiency does 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 and of the inability to provide services as ordered in 4 of 9 active clinical records reviewed. (Patient #2, 6, 8, 9) The findings include: 1. A clinical record review for Patient #2, evidenced a Plan of Care for the certification period 11/10/2023 - 01/8/2023, which indicated the agency was to notify the physician for a diastolic blood pressure (the pressure against the arteries when the heart is at rest and	G0590	G0590 Promptly alert relevant physician of changes The Administrator and Clinical Manager reviewed the following policies for reeducation and clarification of procedures. C-370 REPORTING OF CRITICAL VALUES POLICY: The agency will review all critical test result values and promptly notify the physician or their designee of the critical values. Critical values will be reported in a timely manner and include a process for "read back" verification. C-360 COORDINATION OF PATIENT SERVICES POLICY: The agency will integrate services, whether they are provided directly or under contract, to assure the	2023-12-28

	indicated by the bottom number) less than 60. Review of an agency document titled "Start of Care" completed by the Clinical Manager and dated 11/10/2023, indicated Patient's diastolic blood pressure was 43 and failed to evidence the agency reported the diastolic blood pressure to the physician. During an interview on 12/6/2023, at 1:58 PM, the Clinical Manager indicated Patient's blood pressure was very low and indicated there was no documentation the physician was notified of the blood pressure. Review of an agency document titled "Communication Note" completed by the PT and dated 11/15/2023, indicated the caregiver reported Patient's knee was twisted and failed to evidence the agency reported to the physician. Review of an agency document titled "Communication Note" completed by the PT and dated 11/27/2023, indicated Patient required skilled nursing facility (SNF) placement or 24-hour care. Review failed to evidence		identification of patient needs and factors that could affect patient safety and the effectiveness of treatment. The coordination of care is provided by all disciplines and included communication with physicians. For patient #2- Primary physician notified that patients diastolic BP was 43, verbal orders received on 12-11-2023 that BP Diastolic parameter can be changed to notify MD if it is less than 50. All changes in conditions now reported to the Clinical Manager by the Therapists and Primary Care Physician notified of major changes in health. Agency will now provide care for patients while Prior Authorization is awaiting approval. The agency will ensure that a verbal order from the Primary Care Physician is received prior to care before or after initial assessment. The Clinical Manager will	

	the PT coordinated care with the nurse case manager and OT and failed to evidence the physician was notified. During an interview on 12/6/2023, beginning at 2:06 PM, the Clinical Manager indicated there was no documentation the physician was notified of the report of a twisted knee and indicated there was no documentation the physician was notified of the need for SNF placement or 24 hour care. The Plan of Care for the certification period 11/10/2023-1/8/2024, and signed by the physician, indicated the agency was to provide skilled nursing services 1 time a week for 1 week, 2 times a week for 2 weeks, and then 1 time a week for 7 weeks to include wound care; PT services 1 time a week for 8 weeks; and OT services 1 time a week for 1 week and then 2 times a week for 3 weeks once prior authorization was approved. Review indicated the agency did not send the plan of care to the physician for signature until 11/21/2023 and was returned to the agency		notify patients of initiating care to ensure that the patient is aware of receiving care. To prevent this deficiency from reoccurring in the future the Agency will ensure that referrals have signed orders from the primary care physician and before services start, the Primary Care Physician will be notified of all care required. For patient #9- The Primary Care physician has been notified of the elevated heart rate dated on 12-3-2023 on 12-4-2023 once office hours were started. The Clinical Manager and Registered Nurses were reeducated on the notification of the physician of change in condition of patients or inability to provide services as ordered. The clinical manager or the administrator will ensure that the patient's physician was notified of the change in condition and of the inability to provide services as ordered.	

	signed by the physician on 11/28/2023. Review failed to evidence the agency had provided any services since the initial assessments completed by the registered nurse on 11/10/2023, the OT on 11/14/2023, and the PT on 11/27/2023. Review of a document from Indiana Medicaid indicated the agency did not submit the signed plan of care for authorization until 12/5/2023. During an interview on 12/6/2023, beginning at 1:51 PM, the Clinical Manager indicated Medicaid required a signed plan of care before authorization could be provided, indicated she was unsure why the plan of care was sent to the physician late, and indicated the authorization was needed before services could be provided. The Clinical Manager indicated the agency did not have any communication with the physician on the delay in services or failure to provide services until authorization received. 2. A clinical record review for Patient #6 evidenced a		The Clinical manager and the QA team will audit all plans of care weekly to ensure that patients' physicians were notified of the change in condition and of the inability to provide services as ordered. to ensure deficiency does not recur. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	document from Entity C (skilled nursing facility, SNF) identified as a referral for home health services dated 11/28/2023, which indicated Patient was his/her own responsible party and was to be discharged to home on 11/29/2023. Review indicated a referral order which indicated the physician ordered skilled nursing, PT, and OT services. Review on 12/5/2023 failed to evidence the agency had provided any services to the patient. Review evidenced a Physician Order dated 11/30/2023, which indicated the agency requested to start care on 12/4/2023. Review failed to evidence the document had been sent to the physician.			

	During an interview on 12/7/2023, at 12:30 PM, the Clinical Manager indicated she was waiting for Patient's brother to be present to complete the comprehensive assessment. Clinical Manager indicated she had not communicated with the physician regarding the delay in the start of care but had written the physician order and had not yet sent the order to the physician. 3. A clinical record review for Patient #8 evidenced a document from Entity D (SNF) dated 11/30/2023, identified as a referral for home health physical therapy. Review of the electronic health record on 12/5/2023, indicated Patient's start of care date was 12/4/2023. Review failed to evidence an initial assessment was completed. Review failed to evidence documentation of communication with the physician. During an interview on 12/7/2023, at 12:18 PM, the Clinical Manager indicated the agency was not going to provide services to the patient, because PT 1 completed the initial visit on 12/4/2023 and			

	assessed Patient to have a wound for which the agency could not provide staffing to meet Patient's needs for wound care. The Clinical Manager indicated Patient left Entity D against medical advice, the agency does not have physician orders for home care, and does not have a physician to notify of the agency's inability to provide care for Patient. During an interview on 12/7/2023, at 1:38 PM, Patient #8 indicated PT 1 completed a visit on 12/4/2023 and informed Patient before the agency could accept for care, the patient needed to see their doctor first so the State could pay for the home care services. Patient #8 indicated he/she had an appointment with the physician for that week. During an interview on 12/12/2023, at 1:40 PM, PT 1 indicated he/she had not notified the physician of the agency's inability to provide services and assumed the Clinical Manager would notify the physician. 4. A clinical record review for Patient #9 evidenced a Plan of			

	Care for the certification period 12/03/2023 - 01/31/2024, which indicated the normal parameter for the heart rate was 60-100 beats per minute. Review of a document titled "Start of Care" completed by the Clinical Manager and dated 12/3/2023, indicated Patient's pulse was 108 beats per minute. Review failed to evidenced the agency notified the physician of the heart rate outside of the normal parameter. During an interview on 12/11/2023, at 12:41 PM, the Clinical Manager indicated she should have notified the doctor of the high heart rate. 410 IAC 17-13-1(a)(2)			
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 involved in the patient's care in 1	G0606	G0606 Integrate all services C-360 COORDINATION OF PATIENT SERVICES POLICY The agency will integrate services, whether they are provided directly or under contract, to assure the identification of patient needs and factors that could	2024-01-02

	of 2 complete active clinical records reviewed with a occupational therapy (OT) services. (Patient #2) The findings include: A clinical record review for Patient #2 evidenced a Plan of Care for certification period 11/10/2023 - 01/08/2023, which indicated the agency was to provide skilled nursing, physical therapy (PT), and OT services. Review of an agency document titled "Communication Note" completed by the PT and dated 11/15/2023, indicated the caregiver reported Patient's knee was twisted. Review failed to evidence the physical therapist coordinated care with the nurse case manager and the occupational therapist related the report of a twisted knee. Review of an agency document titled "Communication Note" completed by the PT and dated 11/27/2023, indicated Patient required skilled nursing facility (SNF) placement or 24-hour care. Review failed to evidence the PT coordinated care with the nurse case manager and OT and failed to evidence the physician was notified.		affect patient safety and the effectiveness of treatment. The coordination of care is provided by all disciplines and included communication with physicians. For patient #2- All the changes in the conditions are have now been reported to the Clinical Manager by the Therapists and the Primary Care Physician has been notified of major changes in patient #2's health. Agency is now providing care for patients while Prior Authorization is awaiting approval. The Clinical Manager, the therapists and Registered Nurses were reeducated on the requirement of the integration of all services to ensure coordination of care with all disciplines involved in the patient's care. To prevent this deficiency from reoccurring in the future the Agency will ensure	

	During an interview on 12/6/2023, at 2:06 PM, the Clinical Manager indicated there was no documentation of the nurse case manager and OT was notified by the PT of the report of a twisted knee. At 2:13 PM, the Clinical Manager indicated there was no documentation the nurse case manager and OT were notified of the need for SNF placement or 24 hour care. 410 IAC 17-12-2(g)		that referrals have signed orders from the primary care physician and before services start, the Primary Care Physician will be notified of all care required. The agency will ensure that a verbal order from the Primary Care Physician is received prior to care before or after initial assessment. The Clinical Manager will notify patients of initiating care to ensure that the patient is aware of receiving care. The Clinical manager and the QA team will audit all plans of care weekly to ensure that there is coordination with all disciplines involved in the patient's care. This audit will also be done upon admission and discharge to ensure this deficiency does not recur.	

			The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Corrected 07/23/23	G0614	Corrected 07/23/23	2023-12-13
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	2023-12-13
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services.	G0618	Corrected 7/23/2023	2023-12-13

	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.	G0640	G0640 Quality assessment/performance improvement The Administrator and the Clinical Manager reviewed the following policy for reeducation and clarification of procedures. B-260 Quality Assessment and Performance Improvement (QAPI) Agency will develop, implement, evaluate, and maintain an effective, ongoing agency wide, data driven QAPI program. This plan will be based on the organization’s mission and goals and designed to improve patient outcomes and the perceptions of patients/families about the quality and value of services. We laid emphasis on the responsibility of the Administrator to improve the Quality and Performance, in	2023-12-29

	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 patient's safety and quality of care, implementation of performance improvement actions, and identification of a performance improvement project. The findings include: Record review of the agency's QAPI binder on 12/12/2023, failed to evidence data since quarter 2 of 2023. Review of an agency document titled "Q2 2023 QAPI Report" indicated an increase in falls from quarter 1 2023 to quarter 2 2023. Review indicated 55% of patients were hospitalized within 30 days of admission. Review indicated only 3 comparisons to state averages which were transfers to/from bed, breathing, and acceptance of flu shot, which all were noted to be not meeting state averages. Review failed to evidence the quarter 2 report reviewed grievances. Review		accordance with state and federal regulations, accreditation standards, and the Agency mission. The QAPI program is in place. The late records have now been incorporated into the program. QAPI (quality assessment performance improvement) program is maintained. There is data collected up to 9/30/2023. The Administrator is responsible for providing direction and leadership for the agency's Quality Assessment and Performance Improvement Program (QAPI) and will ensure that this deficiency does not recur.	

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 with measurable progress achieved. Review of an agency document titled "Discharge Patients" dated 12/5/2023 noted 4 patients that were discharged from the agency due to hospital admissions which were not included on the undated agency document titled "Hospitalization Log". 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.

During an interview on 12/12/2023, at 12:55 PM, the Administrator indicated the minutes from the Governing Body meeting were not specific to the approval of what data was to be collected and the frequency of the data collection. The Administrator indicated the

	been collected yet and was waiting on a nurse consultant to send the information to him. The Administrator indicated all patients with hospitalization should be included in the data collection by logging the patient information on the hospitalization log. The Administrator indicated the agency's performance improvement project was timeliness of admissions and indicated there was no documentation on why the project was chosen or measurable progress achieved. 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)	G0682	G0682 Infection Prevention The Administrator and the Clinical Manager reviewed the following policy for	2023-12-28

	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 agency failed to ensure agency personnel practiced standard/universal precautions to prevent the transmission of infections and failed to follow agency infection control policies and procedures in 2 of 2 home visits. (Patient #1 and 2) The findings include: *During a home visit on 12/6/23 beginning at 3:22 PM for Patient 1 it was observed the Clinical Manager (CM) to perform Peripherally Inserted Central Catheter (PICC) care. During the observation, the CM cleansed the area with a betadine (a brown liquid disinfectant) swab using a circular motion around the insertion site going down the PICC catheter line and coming back up the catheter line on the underside of the catheter line. The CM then cleansed the area with a ChloroPrep (a clear liquid disinfectant) swap using back and forth as well as up and down, diagonal and circular motions at the PICC insertion site and surrounding area and back to the insertion site. The		reeducation and clarification of procedures. D-330 HANDWASHING/HAND HYGIENE POLICY In an effort to reduce the risk for infection in patients and team members, thorough hand washing/hand antisepsis is required of all employees. The agency will establish guidelines for all team members and will provide education and direction on accepted practices B-407 BAG TECHNIQUE POLICY Agency shall enforce bag technique practices involved in the provision of home health care services. PURPOSE To prevent contamination of the nursing bag and cross-contamination between patient and team member Emphasis on SS 1 & 2 1. Always observe principles of universal precautions and body substance isolation. The inside of the nursing bag shall be regarded and maintained as a clean area. 2. Place the bag on a cleaned	

	Clinical Manager then wiped the area with gauze at and around the insertion site. An untitled policy received from the agency revealed ChloroPrep should be used in back and forth strokes for 30 seconds, allowing a dry time of 30 seconds for dry surgical sites such as the arm. It also reveals the disinfectant should not be blotted or wiped away. In an interview with the Clinical Manager on 12/7/23 beginning 11:00 AM the CM indicated it is appropriate to go in any direction with ChloraPrep. The Clinical Manager was unable to indicate why they used gauze during the PICC care. 1. Review of an agency policy revised 11/7/2023, titled "Handwashing/Hand Hygiene" stated, "...Indications for hand washing and hand antisepsis: Between tasks on the same patient ... After removing gloves ... After touching objects that are potentially contaminated ...." 2. Review of an agency policy		convenient work area. All field staff have now received reeducation on standard infection prevention and following acceptable standards of practice including the use of standard precautions, to prevent the transmission of infections and communicable diseases. A field staff will be chosen at random monthly and observed for compliance with standard infection prevention and following acceptable standards of practice including the use of standard precautions, to prevent the transmission of infections and communicable diseases. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	Technique" stated, "... Place the bag on a cleaned convenient work area...." 3. During an observation of care at the home of Patient #2 on 12/11/2023, at 3:12 PM, the Clinical Manager placed the nurse bag on a bedside table without a barrier and was not observed cleaning the table before setting down the bag.			
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 were educated per agency policy on infection prevention and control for 1 of 2 personnel records reviewed of a registered nurse (RN) (RN 2). The findings include: Review of an agency policy revised 11/7/2023, titled "Infection Control	G0686	G0686 Infection control education The Administrator and the Clinical Manager reviewed the following policy for reeducation and clarification of procedures. D-325 INFECTION CONTROL EDUCATION/TRAINING	2024-01-02

	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." A personnel record review for RN 2, start date 5/26/2021, failed to indicate the employee had received infection control training since 6/3/2021. Review of a document identified as the sign-in sheet for Infection Control in-service dated 9/19/2023, failed to include RN 2. During an interview, on 12/12/2023 at 12:19 PM, the Administrator indicated RN 2 was not present for the infection control inservice on 9/19/2023. No other documentation or information was provided.		POLICY 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. Infection Control In services have now been done for RN 2 employee All field staff have now received reeducation on standard infection prevention and following acceptable standards of practice including the use of standard precautions, to prevent the transmission of infections and communicable diseases. The administrator, clinical manager and personnel officer will ensure that all agency personnel will have infection control training upon hire and annually.	

			The administrator, clinical manager and personnel officer will ensure that all agency personnel have infection control training upon hire and they will audit personnel records monthly to ensure that all agency personnel were reeducated on the policy and procedure of infection prevention and control in order to ensure that this deficiency does not recur. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on observation, record review, and interview, the skilled nurse failed to accurately prepare clinical notes in 3 of 9 active clinical records reviewed. (Patient #4, 7, 8)	G0716	G0716 Preparing clinical notes The Administrator and the Clinical Manager reviewed the following policy for reeducation and clarification of procedures. C-680 CLINICAL DOCUMENTATION POLICY Agency will document	2023-12-29

	The findings include: 1. The policy titled "Clinical Documentation" revised 11/7/2023, stated, "... Documentation of services ordered on the plan of care will be completed the day service is rendered ...." 2. A clinical record review for Patient #4 on 12/5/2023, evidenced a Home Health Certification and Plan of Care for the certification period 10/25/2023 - 12/23/2023, which indicated the agency was to provide skilled nursing services every other week for 9 weeks. Review failed to evidence the agency provided skilled nursing services since 11/3/2023. During an interview, on 12/7/2023 at 11:59 AM, the Clinical Manager indicated she was unaware there was no documentation of nursing visits since 11/3/2023. During an interview, on 12/7/2023 at 12:11 PM, Registered Nurse (RN) 1 indicated he/she has provided skilled nursing visits every other week to Patient but had not documented the visits yet. RN 1 indicated the last visit was made		each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the patient's care. Emphasis on SS 1,4,6 1 All skilled services provided by Nursing, Therapy, or Home Health Aides will be documented in the clinical record. 4 Documentation of services ordered on the plan of care will be completed the day service is rendered and incorporated into the clinical record within fourteen (14) days after the care has been provided 6. All patient care notes are to be completed no later than each Monday morning. If notes are going to be late, then the office should be notified RN1 has been reprimanded and will not be assigned any new patients for the next 3 months whilst her documentation habits are	

	to Patient was on 11/29/2023. During an interview, on 12/7/2023 at 2:21 PM, the Community Liaison indicated it has been an ongoing problem with RN 1 to get their clinical notes completed on time. 3. Clinical record review for Patient #7 evidenced a document titled "Recertification" identified as the comprehensive assessment completed by RN 2 and dated 12/1/2023, which indicated the skilled interventions included administering medications. Review failed to evidence the RN documented what medications and at what time were administered. Review of an agency document titled "Skilled Nurse Visit" completed by RN 2 and dated 12/4/2023, indicated RN 2 administered medications at 4:00 PM and failed to evidence documentation of which medications were administered. During an interview, on 12/7/2023 at 12:54 PM, the Clinical Manager indicated the nurse should document what medications they administered.		observed. Failure to complete her documentation in a timely manner within that period will result in termination of her employment with the Agency. All field staff have now received reeducation on preparation of visits notes. The Clinical manager and the QA team will audit all visit notes weekly to ensure that there is accurate documentation of skilled notes in order to prevent this deficiency from recurring. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	4. A clinical record review for Patient #8 evidenced a document from Entity D dated 11/30/2023, identified as a referral for home health physical therapy. Review of the electronic health record on 12/5/2023, indicated the patient's start of care date was 12/4/2023. Review failed to evidence an initial assessment was completed. During an interview on 12/7/2023, at 12:18 PM, the Clinical Manager indicated PT 1 completed the initial visit on 12/4/2023 and had not documented the visit yet. During an interview, on 12/12/2023 at 1:40 PM, PT 1 indicated he/she assessed Patient on 12/4/2023 and assessed Patient had a surgical wound to the right leg with noted eschar (dead tissue). PT 1 indicated Patient needed PT services for strengthening and ambulation related to recent surgery to the right leg. PT 1 indicated he/she did not document the visit because the agency told him not to document the visit completed on 12/4/2023.			

	5. During an interview at the entrance conference on 12/5/2023, at 11:14 AM, the Administrator indicated the agency policy indicated staff would complete visit documentation at the time of the visit and indicated the agency was only 60% compliant with timeliness of documentation. 410 IAC 17-14-1(a)(1)(E) 410 IAC 17-14-1(c)(5)			
G0768	Competency evaluation 484.80(c)(1)(2)(3) Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation.	G0768	G0768 Competency evaluation The Administrator and the Clinical Manager reviewed the following policy for reeducation and clarification of procedures. D-220 COMPETENCY EVALUATION OF HOME CARE TEAM MEMBERS POLICY 1. The agency will establish a program that allows for objective, measurable, assessment of the person's ability to perform required activities. Individuals working in the agency must be licensed, registered, or certified as	2023-12-19

	(2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. Based on record review and interview, the agency failed to ensure home health aides (HHA) successfully completed a competency evaluation program in 1 of 1 personnel record reviewed of home health aide with their first patient contact after 11/01/23 (HHA 3). The findings include: 1. The policy, revised 11/7/2023, titled "Competency Evaluation of Home Care Team Members" stated, "... The Home Health Aide must demonstrate evidence of: Successful completion of a training program totaling at least seventy-five (75) hours. At least sixteen (16) of those must have been devoted to supervised practical training. ... OR Successful completion of a competency evaluation program. The Home Health Aide will have successfully completed the competency evaluation program if he/she		required by law, policy, or standards of practice. 2. The assessment will verify and focus on the individual team members knowledge and skill appropriate to assigned responsibilities, communication skills, and the ability to respond to patient needs within their scope of responsibility. a. Competencies will address: • Age/type of patient. • Scope of services offered by Agency. • High risk procedures. • New procedures / technologies. • Areas identified in Performance Improvement Process. 3. The competency evaluations will be completed by individuals who have the knowledge and skills to assess performance and ability. 4. All competencies will be documented, and actions will be taken when opportunities for improvement are identified. For HHA # 3 now has her now successfully completed a competency evaluation and this has been incorporated in the employee personnel file.	

	demonstrates competency in a minimum of eleven (11) of the twelve (12) areas required in federal guidelines. ... Documentation of individual Home Health Aide training and/or competency shall be maintained in the Home Health Aide's personnel file..." 2. A personnel record review for HHA 3, first patient contact date 11/19/2023, failed to evidence any documentation regarding a completion of a HHA training program or completion of a competency evaluation. During an interview on 12/11/2023, at 2:09 PM, the Administrator indicated HHA 3 went with the Alternate Clinical Manager to evaluate competency but there was not any documentation for the competency. 3. During an interview on 12/11/2023, at 2:22 PM, the Administrator indicated there was no other documentation used to demonstrate the competency evaluation was completed for the HHA. The Administrator indicated the document titled "Orientation of the Home Health Aide" was the		This HHA Competency Form addresses all areas requiring competency for a home health aide (HHA). The Clinical Manager was reeducated on completion of the competency evaluation program by agency home health aides (HHA) before first contact with the patient. The administrator, clinical manager and personnel officer will ensure that all agency home health aides (HHA) complete the competency evaluation program before first contact with the patient upon hire. The Administrator, clinical manager and the Personnel team will audit all agency personnel records monthly to ensure that all agency home health aides (HHA) complete the competency evaluation before next/first contact with patients to ensure deficiency does not recur. The Administrator and the Personnel Officer for ensuring that this deficiency	

	form the agency used and did not indicate HHA competency nor the specific areas completed. 410 IAC 17-14-1(l)(A)		does not recur.	
G0788	Org. had partial/extended survey 484.80(f)(3) Was subjected to an extended (or partially extended) survey as a result of having been found to have furnished substandard care (or for other reasons as determined by CMS or the state); or Based on record review and interview, the agency failed to ensure the home health aide (HHA) competency evaluation program was not offered by the agency which was subjected to a fully extended survey and found to have furnished substandard care in the last 2 years in 1 of 3 personnel records reviewed of home health aides. (HHA 3) The findings include: The personnel record for HHA 3, with first patient contact date 11/19/2023, failed to evidence documentation regarding a completion of a HHA training program or completion of an	G0788	G0788 Org. had partial/extended survey 12/19/2023 The Administrator and the Clinical Manager reviewed the following policy for reeducation and clarification of procedures. D-220 COMPETENCY EVALUATION OF HOME CARE TEAM MEMBERS POLICY 1. The agency will establish a program that allows for objective, measurable, assessment of the person's ability to perform required activities. Individuals working in the agency must be licensed, registered, or certified as required by law, policy, or standards of practice. 2. The assessment will verify and focus on the individual team members knowledge and skill appropriate to assigned	2023-12-19

	evaluation. During an interview, on 12/11/2023 at 2:09 PM, the Administrator indicated HHA 3 went with the Alternate Clinical Manager to evaluate competency and there was not any documentation for the competency. During an interview on 12/12/2023, at 2:40 PM, the Clinical Manager indicated HHA 3 went with the Alternate Clinical Manager on 11/19/2023 to a patient's home for evaluation of competency to include bathing and personal care of the patient.		responsibilities, communication skills, and the ability to respond to patient needs within their scope of responsibility. a. Competencies will address: • Age/type of patient. • Scope of services offered by Agency. • High risk procedures. • New procedures/ technologies. • Areas identified in Performance Improvement Process. 3. The competency evaluations will be completed by individuals who have the knowledge and skills to assess performance and ability. 4. All competencies will be documented, and actions will be taken when opportunities for improvement are identified. HHA # 3 now has her competency done. For HHA # 3 The completed competency evaluation is now incorporated in the employee personnel file. The Clinical Manager was reeducated on completion of the competency evaluation program before first contact with patient by Home Health	

			Aides. The administrator, clinical manager and personnel officer will ensure that all agency home health aides (HHA) complete the competency evaluation program before first contact with the patient upon hire. The Administrator, clinical manager and the Personnel team will audit all agency personnel records monthly to ensure that all agency home health aides (HHA) complete the competency evaluation before first contact with patients to ensure deficiency does not recur. The Administrator and Personnel Officer are responsible for ensuring that this deficiency does not recur.	
G0798	Home health aide assignments and duties 484.80(g)(1)	G0798	Corrected 11/02/23	2023-12-13

	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). Corrected 11/02/23			
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 observation, 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); the clinical manager failed to provide oversight of the patient and personnel assignments (See	G0940	G0940 Organization and administration of services The Administrator and the Clinical Manager reviewed the following policy for reeducation and clarification of procedures. B-100 GOVERNING BODY POLICY The Governing Body (or designated persons so functioning) shall assume full legal authority and responsibility for the overall management and operation of Agency. With emphasis on SS2, 3 2 Appoint a qualified Administrator. Delegate to that individual the authority and responsibility for the day to day	2024-01-02

	G0960), and the agency failed to ensure coordination of their patient referrals (See G0964). 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.		include provision of home care services in accordance with state and federal regulations, accreditation standards, and Agency mission. A. The Administrator or a pre-designated person is available during all operating hours. The backup person assumes the administrator's responsibilities and obligations when acting in that role. This position must be approved by the Governing Body. Available means physically present in the office or able to be contacted by telephone or other electronic means. 3 Approves the appointment of a qualified Director of Nursing who will provide oversight of all patient care services and personnel. B-105 CLINICAL MANAGER POLICY: Agency will appoint one or more qualified individuals for the position of clinical manager. This position provides clinical oversight over all patient care	

			services and team members. The position must have at least one of the following qualifications: licensed physician, registered nurse-including a nurse practitioner or other advance practice nurse, physical therapist, speech language pathologist, occupational therapist, social worker, or audiologist. PURPOSE: To provide oversight of agency personnel to assure coordinated comprehensive care to patients. To coordinate referrals and patient care between disciplines and physicians. To assure the development, implementation, and updates of the individualized plan of care. C-139 PATIENT REFERRAL AND ACCEPTANCE POLICY The Agency shall have procedures for the receipt, processing, and evaluation of persons referred for service. All necessary steps have been	

			have been addressed and corrected as evidenced in corrections of Tags G0948, G0960 and G0964. The Administrator and Clinical Manager performed a total program review and 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 that patient referrals are properly coordinated and all entries into the clinical record are complete and appropriately authenticated. The administrator and clinical manager will conduct a quarterly audit to ensure that the day to day running of the agency, oversight of patients and personnel assignments as well as coordination of patient's referrals is performed in a way to provide quality health care in a safe environment to ensure this deficiency does not recur. The Administrator and Clinical	

			Manager are responsible for ensuring that this deficiency does not 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 observation, 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 the availability of a skilled nurse, and ensuring the personnel files were complete and current per agency policies. The findings include: 1. Review of the policy revised 11/7/2023, titled "Clinical Record Confidentiality" stated, "... Clinical records will be stored in a locked cabinet or room...." 2. Review of the policy revised 11/7/2023, titled "Provision for 24-Hour RN [registered nurse] Availability]" stated, "... A Registered Nurse shall be accessible at all times, 24 hours per day ... The Registered Nurse	G0948	G0948 Responsible for all day-to-day operations The Administrator and the Clinical Manager reviewed the following policy for reeducation and clarification of procedures. C-880 CLINICAL RECORD CONFIDENTIALITY POLICY All patient information shall be treated as confidential and will be available only to authorized users. PURPOSE To assure that confidentiality of data and information is preserved. To assure security measures are in place to safeguard the integrity of information in clinical and billing records. C-180 PROVISION FOR 24-HOUR RN AVAILABILITY POLICY Hours of operation are from 10:00 a.m. to 3:00 p.m., Monday through Thursday. A Registered Nurse shall be	2024-01-02

	will be available to make a home visit, if necessary…." 3. Review of the policy revised 11/7/2023, 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 … Medical History/Health Status – Maintained Confidentially … TB [tuberculosis, an infectious disease mostly affecting the lungs] screening (2-step Mantoux [a skin test to detect TB] if required … The agency will keep personnel records confidential …." 4. Review of the policy revised 11/7/2023, titled "Occupational Exposure to Tuberculosis Prevention Plan" stated, "… The agency will perform an annual risk assessment survey of the agency team members … At the time of employment, all health care personnel will receive a Mantoux Tuberculin skin test … If the employee does not have		accessible at all times, 24 hours per day, by telephone and/or pager to meet patient needs. The Registered Nurse will be available to make a home visit, if necessary. If medical emergencies occur and there is not an agency team member in the home, patients are instructed to call their physicians or 911 for treatment. D-180 PERSONNEL RECORDS POLICY Personnel files will be established and maintained for all personnel. All information will be considered confidential and made available to authorized personnel only. All patient-identifying data will be removed from employee personnel records. Personnel records may not be removed from Agency unless ordered by subpoena. D-257 OCCUPATIONAL EXPOSURE TO TUBERCULOSIS PREVENTION PLAN POLICY Agency will establish a program to identify individuals at risk for or with a diagnosis of active tuberculosis. The agency will perform annual and ongoing risk assessment	

	documentation of a negative Mantoux test within the previous 12 months, they must have the test repeated within one to three weeks of the first test….” 5. During an observation on 12/5/2023, at 11:02 AM, the door to the record room inside the agency’s break room was observed unlocked with the key in the lock on the door unattended. Inside of the record room, folders were observed on top of the middle filing cabinet which contained medical information for Persons G, H, and I. On a shelf across from the filing cabinets, folders labeled confidential were observed in open boxes which contained medical information for Persons J and K. During an interview on 12/5/2023, at 1:43 PM, the Clinical Manager indicated the folders in the open boxes labeled confidential for Persons J and K were personnel records to include medical information for former employees that needed to be shredded. The Clinical Manager indicated the folder on top of the filing cabinet containing information		surveillance for the agency. 1. The Director of Nursing/designee shall be given the authority to implement and enforce TB infection control policies and procedures. 2. The agency will perform an annual risk assessment survey of the agency team members and patients. Management of patients with known or suspected infectious TB will not vary. The administrator and clinical manager will ensure that the administrator provides oversight of the day to day operation of the agency to include ensuring the protection of the patient’s information, ensuring the availability of skilled nursing and ensuring the personnel files were complete and current per the agency’s policies of the agency to ensure deficiency does not recur. An audit will be conducted	

	for Persons G, H, and I were patient referrals that were not accepted by the agency. The Clinical Manager indicated they leave the door unlocked to the record room while they are at the agency. 6. During an interview on 12/9/2023, at 9:35 AM, the Clinical Manager indicated she was going to provide a skilled nursing visit to Patient #2 today and would provide the visit time once she was done with her appointment. At 12:29 PM, the Clinical Manager indicated she could not provide the skilled nursing visit today, because the Clinical Manager was in overtime and would conduct the visit on 12/11/2023. The Clinical Manager indicated there was not another nurse available to conduct the skilled nursing visit. 7. A personnel record review for Registered Nurse (RN) 2, first patient contact date 6/3/2021, failed to evidence an annual evaluation and failed to evidence RN 2 was screened for TB since 7/14/2022. During an interview on		quarterly to ensure that the administrator provides oversight of the day to day operation of the agency to include ensuring of the protection of the patient's information, ensuring the availability of skill nurse and ensuring the personnel files were cocomplete and current per the agency's policy. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	Intake Coordinator indicated there was no other documentation of an evaluation and TB screening in the record. 8. A personnel record review for RN 3, first patient contact date 11/26/2023, failed to evidence an orientation to the job. During an interview on 12/11/2023, at 2:22 PM, the Administrator indicated the Alternate Clinical Manager should have the documentation of RN 3's orientation. No additional documentation or information was provided. 9. A personnel record review for Home Health Aide (HHA) 3, first patient contact date 11/19/2023, failed to evidence a national criminal background check. During an interview on 12/11/2023, at 2:09 PM, the Administrator indicated there should be a background check that was completed, but it was not in the personnel record. 410 IAC 17-12-1(c)(1)			

G0960	Make patient and personnel assignments, 484.105(c)(1) Making patient and personnel assignments, Based on record review and interview, the clinical manager failed to provide oversight of the assignment of staff in 4 of 9 active clinical records reviewed. (Patient #3, 4, 7, 9) The findings include: 1. A review of an agency document titled "Agency Schedule Tasks" dated 12/5/2023, and identified as the visit schedule for the week beginning 12/3/2023, failed to evidence visits scheduled for Patients #3, 4, 7, 9. 2. A clinical record review for Patient #3 evidenced a Plan of Care for the certification period 11/16/2023-1/14/2024, which indicated the agency was to provide home health aide services 9 hours a day, 5 days a week for 9 weeks. Review failed to evidence Patient was included in the visit schedule for week of 12/3/2023. During an interview on	G0960	G0960 Make patient and personnel assignments The Administrator and the Clinical Manager reviewed the following policy for reeducation and clarification of procedures. B-105 CLINICAL MANAGER Agency will appoint one or more qualified individuals for the position of clinical manager. This position provides clinical oversight over all patient care services and team members. The position must have at least one of the following qualifications: licensed physician, registered nurse-including a nurse practitioner or other advance practice nurse, physical therapist, speech language pathologist, occupational therapist, social worker, or audiologist. PURPOSE: To provide oversight of agency personnel to assure coordinated comprehensive care to patients. The Clinical Manager was	2024-01-01

	12/12/2023, at 11:42 AM, the Clinical Manager indicated Patient was not included in the visit schedule because the visits were not scheduled in the electronic health record, which generated the visit schedule. 3. A clinical record review for Patient #4 evidenced a "Home Health Certification and Plan of Care" for the certification period 10/25/2023-12/23/2023, which indicated the agency was to provide a skilled nurse 1 time a week. Review failed to evidence Patient was included in the visit schedule for week of 12/3/2023. During an interview on 12/7/2023, at 12:06 PM, the Clinical Manager indicated the agency provided skilled nursing visits every week and should have been included on the visit schedule. 4. A clinical record review for Patient #7 evidenced a "Home Health Certification and Plan of Care" for the certification period 12/3/2023-1/31/2024, which indicated the agency was to provide a skilled nurse 8 hours a day, 5 days a week, for 9 weeks. Review failed to evidence		reeducated on ensuring oversight of the assignment of all staff in the agency. The Administrator and Clinical Manager will conduct a weekly audit to ensure that the agency clinical manager provides oversight of the assignment of the staff. The Administrator and Clinical Manager are responsible for ensuring that this deficiency does not recur.	

	schedule for week of 12/3/2023. During an interview on 12/7/2023, at 1:03 PM, the Clinical Manager indicated Patient's visits should have been included on the visit schedule and was unsure why they were not. 5. A clinical record review for Patient #9 evidenced a "Home Health Certification and Plan of Care" for the certification period 12/3/2023-1/31/2024, which indicated the agency was to provide physical therapy (PT) services 2 times a week for 3 weeks. Review failed to evidence the patient was included on the visit schedule for the week of 12/3/2023. During an interview on 12/11/2023, at 12:43 PM, the Clinical Manager indicated she was unsure why Patient's PT visits were not included on the visit schedule. 410 IAC 17-14-1(a)(1)(K)			
G0964	Coordinate referrals; 484.105(c)(3)	G0964	G0964 Coordinate referrals The following policy was reviewed by the Administrator and Clinical Manager for	2023-12-29

	Coordinating referrals, Based on record review and interview, the clinical manager failed to provide clinical oversight of the coordination of patient referrals in 4 of 4 active clinical records reviewed with therapy services referred since the last survey on 8/30/2023. (Patient #2, 6, 8, 9) The findings include: 1. A review of a policy titled "Patient Referral and Acceptance" revised 11/7/2023, stated, "... A log of all persons referred for service will be maintained. Persons rejected will be noted along with the reason for rejection." 2. On 12/05/23, a review of an undated agency document titled "Referrals," identified as the referral log, failed to evidence patients that were referred to the agency for services and not accepted, per agency policy.		clarification and understanding; C-139 PATIENT REFERRAL AND ACCEPTANCE The Agency shall have procedures for the receipt, processing, and evaluation of persons referred for service. With emphasis on SS 5 b & c b. Patients will be evaluated by a nurse or appropriate team member within 24-48 hours of referral or discharge from a facility whenever possible. c. Patients will be assigned to the appropriate team members by a registered nurse or under the supervision of the registered nurse according to geographical location, clinical needs of the patient, and the qualifications and availability of staff. The Clinical Manager was reeducated on ensuring clinical oversight of, and the coordination of patients' referrals.	

	During an interview on 12/12/2023, at 10:35 AM, the Clinical Manager indicated the agency has had referrals for patients which were not accepted for services and that they did not log those unaccepted referrals. The Clinical Manager indicated she was unable to retrieve the unaccepted referrals, because the agency did not maintain a log or list of their unaccepted referrals. 3. A clinical record review for Patient #2 evidenced a document faxed from Entity A on 11/3/2023, which was identified to be a referral order from Person B (physician) dated 11/3/2023, which indicated the patient needed home health services for skilled nursing, physical therapy (PT), and occupational therapy (OT). Review evidenced the registered nurse completed the initial comprehensive assessment on 11/10/2023, the occupational therapist completed the OT assessment on 11/14/2023, and the Physical Therapist completed the PT assessment on 11/27/2023.		The Administrator and Clinical Manager will conduct a weekly audit to ensure that the agency clinical manager provides clinical oversight of the patient's referrals to ensure deficiency does not recur. The Administrator is responsible for ensuring that this deficiency does not recur.	

	During an interview on 12/6/2023, at 1:56 PM, the Clinical Manager indicated the agency did not see the referral until 11/10/2023. 4. A clinical record review for Patient #6 evidenced a document from Entity C (skilled nursing facility) identified as a referral for home health services dated 11/28/2023, which indicated Patient was his/her own responsible party and was to be discharged to home on 11/29/2023. The referral order indicated the physician ordered skilled nursing, PT, and OT services. Review on 12/5/2023 failed to evidence the PT and OT had received the referral for services nor were the therapy assessments / evaluations completed. During an interview on 12/7/2023, at 12:30 PM, the Clinical Manager indicated she was unsure when the PT and OT were scheduled for the comprehensive assessments because they had not yet been provided the referral. 5. A clinical record review for Patient #8 evidenced a document from Entity D dated			

	11/30/2023, identified as a referral for home health physical therapy. Review of the electronic health record on 12/5/2023, indicated the patient's start of care date was 12/4/2023. Review failed to evidence an initial assessment was completed. During an interview on 12/7/2023, at 12:18 PM, the Clinical Manager indicated PT 1 completed the initial visit on 12/4/2023 and was unsure why the PT did not provide the initial visit until 12/4/2023. 6. A clinical record review for Patient #9, start of care 12/3/2023, evidenced an agency document titled "Start of Care" identified as the initial assessment completed by the registered nurse and dated 12/3/2023, which indicated OT was to evaluate and treat. Review failed to evidence the OT had completed a comprehensive assessment as of 12/11/2023. During an interview on 12/11/2023, at 12:34 PM, the Clinical Manager indicated OT was scheduled for the comprehensive assessment on			

	12/9/202 but was unsure if the visit was completed. No additional documentation or information was provided.			
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. Corrected 11/02/23	G1024	Corrected 11/02/23	2023-12-13

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Abel Dafiaghor	Administrator	1/3/2024 1:46:08 PM