STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157563	A. BUILDING B. WING	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OMNI HOME CARE	215 INDUSTRIAL PARKWAY, RICHMOND, IN, 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 10/23/2023-10/26/2023 Active Census: 195 At this Emergency Preparedness survey, Omni Home Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR Completed on 11/02/2023 by A4	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State	G0000		

	Re-Licensure survey of a Home Health Provider. Survey Dates: 10/23/2023-10/26/2023 12 Month Unduplicated Skilled Admissions: 762 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Survey was partially extended on 10/26/2023 at 8:20 AM.			
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits;	G0434	Patient # 16 has been discharged from home healthservices. An occurrence report was entered for patient # 16 forfailure to notify patient of discharge. During a mandatory team meeting held on 11/1/23, theExecutive Director (ED) instructed all staff on the discharge process usingpolicy	2023-11-10

	(vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview the agency failed to ensure patients participated in and were informed about factors that impacted treatment effectiveness and changes in the care to be furnished in 1 of 7 discharged patients. (Patient #16) Findings Include A policy titled, "Patient Rights and Responsibilities" located in the handbook provided by the agency to all new patients was provided by the Administrator on 10/23/2023 at 1:40 PM. The handbook indicated but was not limited to, "The patient has the following rights: ... Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to ... Completion of all assessments ... The care to be furnished, based on the comprehensive assessment ... Establishing and revising the plan of care ... The disciplines that will furnish the care ... The frequency of visits ... Expected outcomes of care, including		1.003 Notice of Non-Coverage, Expedited Determination andReconsideration for Discharge and 2.1.004 Patient Discharge/Transfer Processwith emphasis on ensuring patients are notified of pending discharge andprovided the Notice of Medicare Provider Non-Coverage Form (NOMNC) at least 15calendar days before services are stopped. For any staff unableto attend the mandatory meeting, the Executive Director provided individualinstruction by 11/10/23. Discharge planning is initiated upon admission andcontinued throughout the patient's plan of care. Patients are notified of discharge as soon as possibleprior to discharge. Revisions to plan for patient's discharge will becommunicated to the patient; patient's representative if any; caregiver, if any;all physicians issuing orders; and patient's primary	

	patient-identified goals, and anticipated risks and benefits ... Any factors that could impact treatment effectiveness ...Any changes in the care to be furnished ... Receive all services outlined in the plan of care ... To be informed of the HHA's policies for transfer and discharge". A document titled, "Visit Note Report" dated 05/11/2023 was provided by the Administrator on 10/24/2023 at 9:05 AM. The summarized document indicated but was not limited to an initial evaluation by a skilled nurse. The summarized note indicated Patient #16 with a health history of anemia (low blood count), COPD, heart disease, heart failure, and high blood pressure. A history of multiple emergency department visits, 2 or more hospitalizations in the past 6 months, and a decline in mental, emotional, or behavioral status in the past 3 months. Home oxygen requirement. Lives in cluttered/soiled home with insects/rodents. Walks occasionally for very short distances with and without assistance however spends majority of day in bed or chair.		care practitioner orhealth care professional who will provide care and services to patient afterdischarge, if any. A qualified clinician coordinates the discharge withthe attending physician and patient/family. When discharged, the patient isprovided the reason for discharge. Ongoing psychosocial or physical care needsare identified and appropriate referrals made. Before the termination of services, regardless ofwhether or not the Medicare beneficiary agrees with the discharge and/or goalsare met, the agency will deliver a valid written termination notice to theMedicare beneficiary of the decision to terminate services. The notice will be issued at least 15 calendar daysbefore services are stopped. The Executive Director is ultimately responsible for	

	Shortness of breath with minimal exertion. Risk for falls, decreased strength. Requires assistance to grooming, bathing, toileting, dressing, meal set-up/clean up, medication adherence, and walking. Bed bugs identified in the home. Lives with spouse. Identified as unstable as evidenced by significant and taxing effort to leave home due to weakness/unsteadiness and poor respiratory status. A document titled, "Visit Note Report" dated 05/11/2023 was provided by the Administrator on 10/24/2023 at 9:05 AM. The summarized document indicated but was not limited to an initial evaluation by Physical Therapy, an add-on service. The summarized note indicated a 65-year old with Chronic Obstructive Pulmonary Disease (condition of restricted airway). Patient #16 presented to the Emergency Department on 03/24/2023 for shortness of breath. Found hypoxic (absence of enough oxygen to adequately sustain body functions) and in respiratory failure. Patient #16 had a tracheostomy (opening in neck to assist with breathing) and		correction. Beginning 11/11/23, the Executive Director (ED) or Patient Care Manager, will review 6 discharge medical records per month to ensure patientwas notified of discharge at least 15 days in advance and Notice of MedicareProvider Non-Coverage Form is present in the medical record. Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months. Discussion of compliance will occur during thequarterly Quality Assurance Performance Improvement team meetings until 100%compliance is achieved.	

	PEG tube (percutaneous endoscopic gastrostomy), for nutritional assistance. History of Coronary Artery Disease, heart failure, COPD, anxiety, high blood pressure, increased cholesterol, and obesity. Oxygen required at night. Presented with generalized weakness, poor endurance, deficits in transfers and walking. Used 2 wheeled walker to prevent falls and maintain steadiness when walking. A document titled, "Home Health Certification and Plan of Care" Start of Care (SOC) date 05/11/2023, certification period 05/11/2023 through 07/09/2023 was provided by the Administrator on 10/24/2023 at 9:47 AM. The summarized plan of care included services ordered for skilled nursing, one visit weekly x 1 week, then two visits every four weeks x4, then one visit every week x 2 weeks. Physical Therapy services included were one visit weekly x1 week, then 3 visits every 4 weeks x4, then 2 visits weekly x1, then one visit weekly x3. A physician order dated 05/12/2023 8:59 AM was			

	provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "Due to bed bugs at residence, nursing and therapy visits on hold. Treatment scheduled 5/17/2023. Once all clear is verified with pest company on or after 5/31/23, visits will resume." A physician order dated 05/18/2023 8:23 PM was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "Visits moved to week of 6/4/23 as patient did not have extermination done on 05/17/23 due to an appointment. Extermination has been rescheduled for Tuesday 05/23/23". A physician order dated 06/12/2023 11:22 AM was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "[Company Name] Pest Control follow up visit to assess for bed bugs s/p treatment scheduled for 6/16/23. Will schedule Omni to call and verify all clear so we			

services".

A physician order dated 06/19/2023 12:11 PM was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "Pest inspection on 6/16 revealed patient still has bed bugs. Home retreated and will do follow up inspection on 7/7/23. Visits on hold".

A document titled, "Client Coordination Note Report" dated 05/11/2023 was provided by the Administrator on 10/26/2023 at 9:05 PM. The summarized document entered by RN2 indicated that Patient #16 was notified that a bed bug was found during a therapy visit. Patient #16 had called the pest company and set up an appointment for 5/17/2023. Patient #16 was made aware that home health services were placed on hold until 2 weeks post-pest treatment. Discussed PEG tube care & surgical wound care, patient comfortable with this care and understood protocol to put his home health care on hold.

A document titled, "Client

dated 05/12/2023 was provided by the Administrator on 10/26/2023 at 9:05 AM. The summarized document entered by RN2 indicated that Patient #16's bed bug treatment was scheduled for 05/17/23 but was moved to 05/23/23. Pending pest company outcome on bed bug status, home visits to resume 06/6/2023.

A document titled, "Visit Note Report" dated 07/09/2023 was provided by the Administrator on 10/24/2023 at 9:05 AM. The summarized documentation indicated a Visit Type: RN Discharge for Patient #16. Desk discharge. Discharging based on last skilled visit, 05/11/2023.

During a phone interview on 10/25/2023 at 5:19 PM, Patient #16 indicated he had begun home health services with Omni Home Care in May of 2023. and was to receive skilled nursing and physical therapy in the home after a hospitalization. However, after initial findings of active bedbugs in the home were identified by agency staff, services were placed on hold. Denied referral to another home health agency by Omni Health Care to assist with

	care/needs and was advised that a pest company would need to treat the home and conduct a follow up visit to ensure eradication of bedbugs prior to resuming home health services. Patient #16 indicated that in-home visits stopped after the initial visits by both physical therapy and skilled nursing and he/she just stopped hearing from the agency. Patient #16 indicated that he/she was not informed of discharge approximately 2 months later. No referral was provided by the agency to another agency to continue care in the home. Patient #16 continued with physical therapy exercises provided at the initial visit and still continues them to this day. Denied any negative outcome post discharge from agency such as a hospitalization, fall/injury. Patient #16 did follow up with the family nurse practitioner to receive care prompted by self. Reported that bedbug problems have since been resolved. During an interview on 10/26.2023 at 8:20 AM, the Administrator indicated that Patient #16 was to have 2 pest control treatments for			

	eradication of bedbugs with a written follow up from the pest company that indicated bed bugs were clear from the home. Once this information was received, staff could resume home visit treatments. The Administrator indicated home visits were not completed after 05/11/2023. Denied having a bed bug policy, however, will provide a Bed Bug Tip sheet. During an interview on 10/26/2023 at 10:23 AM, the Administrator indicated there was no documentation found in the medical record of Patient #16 being notified of discharge. Indicated a desk discharge was completed. IAC 17-12-3 (b)(2)(D)(i)(AA)			
G0436	Receive all services in plan of care 484.50(c)(5) Receive all services outlined in the plan of care.	G0436	Patient # 16 has been discharged from home healthservices. An occurrence report was entered for patient # 16 forfailure to provide services outlined in the plan of care (POC).	2023-11-10

	Based on record review and interview the agency failed to ensure services identified in the Plan of Care (POC) were received in 1 of 7 discharged patients'. (Patient #16) Findings Include: A policy titled, "Plan of Care (POC)", revised 12/1/2021 was provided by the Administrator on 10/26/2023 at 9:20 AM. The policy indicated but was not limited to, "Medications, treatments, and interventions are provided by qualified agency staff as ordered by the physician or authorized practitioner ... The patient is monitored for response to treatment and progress towards goals". A policy titled, "Patient Rights and Responsibilities" located in the handbook provided by the agency to all new patients was provided by the Administrator on 10/23/2023 at 1:40 PM. The handbook indicated but was not limited to, "The patient has the following rights: ... Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate,		During a mandatory team meeting held on 11/1/23, theExecutive Director (ED) instructed all staff on providing services andtreatments indicated on the POC using policy 2.1.007 Plan of Care with emphasison ensuring patients receive services ordered on the POC, and revising the POCwhen changes are indicated. For any staff unableto attend the mandatory meeting, the Executive Director provided individualinstruction by 11/10/23. Each patient has an individualized Plan of Care (POC)developed in consultation with the patient, physician or authorized practitioner,and staff that integrates comprehensive assessment findings to address patientproblems, needs, and goals, as well as to address specific services beingprovided. Medications, services, treatments, and interventionsare provided by qualified agency staff as ordered by the physician	

	with respect to ... Completion of all assessments ... The care to be furnished, based on the comprehensive assessment ... Establishing and revising the plan of care ... The disciplines that will furnish the care ... The frequency of visits ... Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits ... Any factors that could impact treatment effectiveness ...Any changes in the care to be furnished ... Receive all services outlined in the plan of care ... To be informed of the HHA's policies for transfer and discharge". A document titled, "Home Health Certification and Plan of Care" Start of Care (SOC) date 05/11/2023, certification period 05/11/2023 through 07/09/2023 was provided by the Administrator on 10/24/2023 at 9:47 AM. The summarized plan of care included services ordered for skilled nursing, one visit weekly x 1 week, then two visits every four weeks x4, then one visit every week x 2 weeks. Physical Therapy services included one visit weekly x1 week, then 3		orauthorized practitioner. The patient is monitored for response to treatment andprogress towards goals. The qualified clinician revises the POC under the directionof the physician or authorized practitioner. The Executive Director is ultimately responsible for implementing theplan of correction. Beginning 11/11/23, the Executive Director (ED) or Patient Care Manager, will review 12 active medical records per month to ensure patient receivedservices indicated on the Plan of Care. Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months.	

	visits weekly x1, then one visit weekly x3. A physician order dated 05/12/2023 was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated but was not limited to, "Due to bed bugs at residence, nursing and therapy visits on hold. Treatment scheduled 5/17/2023. Once all clear is verified with the pest company on or after 5/31/23, visits will resume." A physician order dated 05/18/2023 was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "Visits moved to the week of 6/4/23 as the patient did not have extermination done on 05/17/23 due to an appointment. Extermination has been rescheduled for Tuesday 05/23/23". A physician order dated 06/12/2023 was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "[Name of		Discussion ofcompliance will occur during the quarterly Quality Assurance PerformanceImprovement team meetings until 100% compliance is achieved.	

	Company] Pest Control follow up visit to assess for bed bugs s/p treatment scheduled for 6/16/23. Will schedule Omni to call and verify all clear so we can continue home health care services". A physician order dated 06/19/2023 was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "Pest inspection on 6/16 revealed patient still has bed bugs. Home retreated and will do follow up inspection on 7/7/23. Visits on hold". A document titled, "Client Coordination Note Report" dated 05/12/2023 was provided by the Administrator on 10/26/2023 at 9:05 AM. The summarized document entered by RN2 indicated that Patient #16's bed bug treatment was scheduled for 05/17/23 but was moved to 05/23/23. Pending pest company outcome on bed bug status, home visits to resume 06/6/2023. A document titled, "Visit Note Report" dated 07/09/2023 was provided by the Administrator			

	summarized document entered into the medical record by RN1 indicated a Discharge for Patient #16, a desk discharge. Discharging based on last skilled visit, 05/11/2023. During a phone interview on 10/25/2023 at 5:19 PM, Patient #16 indicated he had begun home health services with Omni Home Care in May of 2023. Was to receive skilled nursing and physical therapy in the home after a hospitalization. However, after initial findings of active bedbugs in the home were identified by agency staff, services were placed on hold. Denied referral to another home health agency by Omni Health Care to assist with care/needs and was advised that a pest company would need to treat the home and conduct a follow-up visit to ensure eradication of bedbugs prior to resuming home health services. Patient #16 indicated that in-home visits stopped after the initial visits by both physical therapy and skilled nursing and he/she just stopped hearing from the agency. Patient #16 indicated that he/she was not informed of discharge approximately 2			

	months later. No referral was provided by the agency to another agency to continue care in the home. Patient #16 continued with physical therapy exercises provided at the initial visit and still continues them to this day. Denied any negative outcome post-discharge from an agency such as a hospitalization, fall/injury. Patient #16 did follow up with the family nurse practitioner to receive care prompted by self. Reported that bedbug problems have since been resolved. During an interview on 10/26.2023 at 8:20 AM, the Administrator indicated that Patient #16 was to have 2 pest control treatments for eradication of bedbugs with a written follow-up from the pest company that indicated bed bugs were clear from the home. Once this information was received, staff could resume home visit treatments. The Administrator indicated home visits were not completed after 05/11/2023 and a desk discharge was completed on 07/07/2023.			

G0550	At discharge 484.55(d)(3) At discharge. Based on record review and interview the agency failed to complete a discharge comprehensive assessment including updating the patient's progress in meeting the goals specified in the Plan of Care in 1 of 7 discharged patients reviewed. (Patient #16) Findings Include: A policy titled, "Patient Rights and Responsibilities" located in the handbook provided by the agency to all new patients was provided by the Administrator on 10/23/2023 at 1:40 PM. The handbook indicated but was not limited to, "The patient has the following rights: ... Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to ... Completion of all assessments ... The care to be furnished, based on the	G0550	Patient # 16 has been discharged from home healthservices. An occurrence report was entered for patient # 16 forfailure to perform an in-home OASIS discharge assessment. During a mandatory team meeting held on 11/1/23, theExecutive Director (ED) instructed all staff on conducting an in-home dischargeOASIS assessment using policy 2.1.004 Patient Discharge/Transfer Process withemphasis on ensuring patients receive an in-home discharge OASIS assessment. For any staff unableto attend the mandatory meeting, the Executive Director provided individualinstruction by 11/10/23. A qualified clinician performs a comprehensiveassessment or reassessment visit at discharge.	2023-11-10

	comprehensive assessment ... Establishing and revising the plan of care ... The disciplines that will furnish the care ... The frequency of visits ... Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits ... Any factors that could impact treatment effectiveness ...Any changes in the care to be furnished ... Receive all services outlined in the plan of care ... To be informed of the HHA's policies for transfer and discharge". A document titled, "Home Health Certification and Plan of Care" Start of Care (SOC) date 05/11/2023, certification period 05/11/2023 through 07/09/2023 was provided by the Administrator on 10/24/2023 at 9:47 AM. The summarized plan of care included services ordered for skilled nursing, one visit weekly x 1 week, then two visits every four weeks x4, then one visit every week x 2 weeks. Physical Therapy services included were one visit weekly x1 week, then 3 visits every 4 weeks x4, then 2 visits weekly x1, then one visit weekly x3.		Comprehensive discharge assessments are completed viaan in-home visit. In the rare instances when the patient visit cannot be madeto complete the assessment, a “desk” OASIS discharge assessment may becompleted. In the rare instance a “desk” discharge is warranted, thisassessment must be completed by the last qualifying clinician to see thepatient based on the last visit’s assessed findings. Approval for “desk” discharges must be obtained fromthe Executive Director to ensure attempt to complete in-home was made. Documentation in the medical record will reflectattempts to complete in-home comprehensive discharge OASIS assessment.	

	A physician order dated 05/12/2023 8:59 AM was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "Due to bed bugs at residence, nursing and therapy visits on hold. Treatment scheduled 5/17/2023. Once all clear is verified with pest company on or after 5/31/23, visits will resume." A physician order dated 05/18/2023 8:23 PM was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "Visits moved to week of 6/4/23 as patient did not have extermination done on 05/17/23 due to an appointment. Extermination has been rescheduled for Tuesday 05/23/23". A physician order dated 06/12/2023 11:22 AM was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "[Company Name] Pest Control follow up visit to assess for bed bugs s/p treatment scheduled for 6/16/23. Will schedule Omni to		The Executive Director is ultimately responsible for implementing theplan of correction. Beginning 11/11/23, the Executive Director (ED) or , Patient Care Manager will review 6 discharge medical records per month to ensure anin-home comprehensive discharge OASIS assessment was completed. If “Desk”discharge OASIS assessment was completed, documentation is present to supportneed to complete in this manner. Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months. Discussion ofcompliance will occur during the quarterly Quality Assurance Performance Improvementteam meetings until 100% compliance is achieved.	

	call and verify all clear so we can continue home health care services". A physician order dated 06/19/2023 12:11 PM was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "Pest inspection on 6/16 revealed patient still has bed bugs. Home retreated and will do follow up inspection on 7/7/23. Visits on hold". A document titled, "Client Coordination Note Report" dated 05/11/2023 was provided by the Administrator on 10/26/2023 at 9:05 PM. The summarized document entered by RN2 indicated that Patient #16 was notified that a bed bug was found during a therapy visit. Patient #16 had called the pest company and set up an appointment for 5/17/2023. Patient #16 was made aware that home health services were placed on hold until 2 weeks post-pest treatment. Discussed PEG tube care & surgical wound care, patient comfortable with this care and understood protocol to put his home health care on hold.			

	A document titled, "Client Coordination Note Report" dated 05/12/2023 was provided by the Administrator on 10/26/2023 at 9:05 AM. The summarized document entered by RN2 indicated that Patient #16's bed bug treatment was scheduled for 05/17/23 but was moved to 05/23/23. Pending pest company outcome on bed bug status, home visits to resume 06/6/2023. A document titled, "Visit Note Report" dated 07/09/2023 was provided by the Administrator on 10/24/2023 at 9:05 AM. The summarized documentation indicated a Visit Type: RN Discharge for Patient #16. Desk discharge. Discharging based on last skilled visit, 05/11/2023. During a phone interview on 10/25/2023 at 5:19 PM, Patient #16 indicated he had begun home health services with Omni Home Care in May of 2023. and was to receive skilled nursing and physical therapy in the home after a hospitalization. However, after initial findings of active bedbugs in the home were identified by agency staff, services were placed on hold. Denied referral to another			

	home health agency by Omni Health Care to assist with care/needs and was advised that a pest company would need to treat the home and conduct a follow up visit to ensure eradication of bedbugs prior to resuming home health services. Patient #16 indicated that in-home visits stopped after the initial visits by both physical therapy and skilled nursing and he/she just stopped hearing from the agency. Patient #16 indicated that he/she was not informed of discharge approximately 2 months later. Denied any negative outcome post discharge from agency such as a hospitalization, fall/injury.			

	During an interview on 10/26.2023 at 8:20 AM, the Administrator indicated that Patient #16 was to have 2 pest control treatments for eradication of bedbugs with a written follow up from the pest company that indicated bed bugs were clear from the home. Once this information was received, staff could resume home visit treatments. The Administrator indicated home visits were not completed after 05/11/2023. During an interview on 10/26/2023 at 10:23 AM, the Administrator indicated there was no documentation found in the medical record of Patient #16 being notified of discharge. Indicated a desk discharge was completed.			
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	G0562	Patient # 16 has been discharged from home healthservices. An occurrence report was entered for patient # 16 forfailure to implement effective discharge planning.	2023-11-17

	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 implement an effective discharge plan including referral to another agency upon discharge in 1 of 7 discharged patients' records reviewed. (Patient #16) Findings Include: A policy titled, "Patient Discharge/Transfer Process", revised 10/1/2023 was provided by the Administrator on 10/24/2023 at 12:02 PM. The policy indicated but was not limited to, "The patient participates in the transfer process to another organization or level of care or service ... If patient is discharged because the agency can no longer meet the needs of the patient, the agency will assist the patient/patient representative in choosing an alternate provider that can meet the patient's needs. Documentation will support that the patient was		During a mandatory team meeting to be held on 11/15/23,the Executive Director (ED) instructed all staff on the discharge process usingpolicy 2.1.004 Patient Discharge/Transfer Process with emphasis on ensuringpatients are notified of pending discharge and measures are taken to assist andprovide the patient with alternate providers that can meet their care needs. For any staff unableto attend the mandatory meeting, the Executive Director provided individualinstruction by 11/17/23. Discharge planning is initiated upon admission andcontinued throughout the patient’s plan of care. Patients are notified of discharge as soon as possibleprior to discharge. If a patient is discharged because the agency can nolonger meet the needs of the	

	informed that the agency can no longer meet his/her needs and alternatives provided to patient ... Patients are notified of discharge as soon as possible prior to discharge as outlined in Notice of Non-Coverage, Expedited Determination and Reconsideration for Discharge Policy. The agency will also provide patient and legal representative (if any) with contact information and numbers for other community resources or providers and evidence will be documented in the in the medical record". A policy titled, "Notice of Non-Coverage, Expedited Determination & Reconsideration for Discharge", revised 12/01/2021 was provided by the Administrator on 10/24/2023 at 12:02 PM. The policy indicated but was not limited to, "State: Indiana ... Notice Timeframe: At least 15 calendar days before services are stopped". A policy titled, "Patient Rights and Responsibilities" located in the handbook provided by the agency to all new patients was provided by the Administrator on 10/23/2023 at 1:40 PM. The		thepatient/patient representative in choosing an alternate provider that can meetthe patient's needs. Documentation will support that the patient was informed that the agency can no longer meet his/herneeds and alternatives provided to patient. Revisions to plan for patient's discharge will becommunicated to the patient; patient's representative if any; caregiver, if any;all physicians issuing orders; and patient's primary care practitioner orhealth care professional who will provide care and services to patient afterdischarge, if any. A qualified clinician coordinates the discharge withthe attending physician and patient/family. When discharged, the patient isprovided the reason for discharge. Ongoing psychosocial or physical care needsare identified and appropriate referrals made.	

	handbook indicated but was not limited to, "The patient has the following rights: ... To be informed of the HHA's policies for transfer and discharge". An undated document titled, "Bed Bug Tip Sheet" was provided by the Administrator on 10/26/2023 at 9:05 AM. The summarized document indicated but was not limited to, how to prevent an infestation and what should be done when visiting a patient with known bedbugs. The document indicated whenever possible, hold visits until extermination and eradication can be completed. A document titled, "Visit Note Report" dated 05/11/2023 was provided by the Administrator on 10/24/2023 at 9:05 AM. The summarized document indicated but was not limited to an initial evaluation by RN 1 (Registered Nurse). The summarized note indicated Patient #16 with a health history of anemia (low blood count), COPD, heart disease, heart failure, and high blood pressure. A history of multiple emergency department visits, 2 or more		The Executive Director is ultimately responsible for implementing theplan of correction. Beginning 11/18/23, the Executive Director (ED) or Patient Care Manager, will review 6 discharge medical records per month to ensure patientwas notified of discharge in advance and referrals were made to an alternateprovider as indicated. Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months. Discussion of compliance will occur during thequarterly Quality Assurance Performance Improvement team meetings until 100%compliance is achieved.	

	months, and a decline in mental, emotional, or behavioral status in the past 3 months. Home oxygen requirement. Lives in cluttered/soiled home with insects/rodents. Walks occasionally for very short distances with and without assistance however spends majority of day in bed or chair. Shortness of breath with minimal exertion. Risk for falls, decreased strength. Requires assistance to grooming, bathing, toileting, dressing, meal set-up/clean up, medication adherence, and walking. Bed bugs identified in the home. Lives with spouse. Identified as unstable as evidenced by significant and taxing effort to leave home due to weakness/unsteadiness and poor respiratory status. A document titled, "Visit Note Report" dated 05/11/2023 was provided by the Administrator on 10/24/2023 at 9:05 AM. The summarized document indicated but was not limited to an initial evaluation by PT1 (Physical Therapy), an add-on service. The summarized note indicated a 65-year old with Chronic Obstructive Pulmonary			

	Disease (condition of restricted airway). Patient #16 presented to the Emergency Department on 03/24/2023 for shortness of breath. Found hypoxic (absence of enough oxygen to adequately sustain body functions) and in respiratory failure. Patient #16 had a tracheostomy (opening in neck to assist with breathing) and PEG tube (percutaneous endoscopic gastrostomy), for nutritional assistance. History of Coronary Artery Disease, heart failure, COPD, anxiety, high blood pressure, increased cholesterol, and obesity. Oxygen required at night. Presented with generalized weakness, poor endurance, deficits in transfers and walking. Used 2 wheeled walker to prevent falls and maintain steadiness when walking. A document titled, "Home Health Certification and Plan of Care" Start of Care (SOC) date 05/11/2023, certification period 05/11/2023 through 07/09/2023 was provided by the Administrator on 10/24/2023 at 9:47 AM. The summarized plan of care included services ordered for skilled nursing, one visit weekly			

	x 1 week, then two visits every four weeks x4, then one visit every week x 2 weeks. Physical Therapy services included were one visit weekly x1 week, then 3 visits every 4 weeks x4, then 2 visits weekly x1, then one visit weekly x3. A physician order dated 05/12/2023 was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated but was not limited to, "Due to bed bugs at residence, nursing and therapy visits on hold. Treatment scheduled 5/17/2023. Once all clear is verified with the pest company on or after 5/31/23, visits will resume." A physician order dated 05/18/2023 was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "Visits moved to the week of 6/4/23 as the patient did not have extermination done on 05/17/23 due to an appointment. Extermination has been rescheduled for Tuesday 05/23/23".			

	A physician order dated 06/12/2023 was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "[Name of Company] Pest Control follow up visit to assess for bed bugs s/p treatment scheduled for 6/16/23. Will schedule Omni to call and verify all clear so we can continue home health care services". A physician order dated 06/19/2023 PM was provided by the Administrator on 10/26/2023 at 9:40 AM. The document indicated, but was not limited to, "Pest inspection on 6/16 revealed patient still has bed bugs. Home retreated and will do follow up inspection on 7/7/23. Visits on hold". A document titled, "Client Coordination Note Report" dated 05/11/2023 was provided by the Administrator on 10/26/2023 at 9:05 PM. The summarized document entered by RN2 indicated that Patient #16 was notified that a bed bug was found during a therapy visit. Patient #16 had called pest company and set up			

	Patient #16 made aware that home health services were placed on hold until 2 weeks post pest treatment. Discussed PEG tube care & surgical wound care, patient comfortable with this care and understood protocol to put his home health care on hold. A document titled, "Client Coordination Note Report" dated 05/12/2023 was provided by the Administrator on 10/26/2023 at 9:05 AM. The summarized document entered by RN2 indicated that Patient #16's bed bug treatment was scheduled for 05/17/23 but was moved to 05/23/23. Pending pest company outcome on bed bug status, home visits to resume 06/6/2023. A document titled, "Visit Note Report" dated 07/09/2023 was provided by the Administrator on 10/24/2023 at 9:05 AM. The summarized document entered into the medical record by RN1 indicated a Discharge for Patient #16, a desk discharge. Discharging based on last skilled visit, 05/11/2023. During a phone interview on 10/25/2023 at 5:19 PM, Patient			

	#16 indicated he had begun home health services with Omni Home Care in May of 2023. Was to receive skilled nursing and physical therapy in the home after a hospitalization. However, after initial findings of active bedbugs in the home were identified by agency staff, services were placed on hold. Denied referral to another home health agency by Omni Health Care to assist with care/needs and was advised that a pest company would need to treat the home and conduct a follow-up visit to ensure eradication of bedbugs prior to resuming home health services. Patient #16 indicated that in-home visits stopped after the initial visits by both physical therapy and skilled nursing and he/she just stopped hearing from the agency. Patient #16 indicated that he/she was not informed pf discharge approximately 2 months later. No referral was provided by the agency to another agency to continue care in the home. Patient #16 continued with physical therapy exercises provided at the initial visit and still continues them to this day. Denied any negative outcome post-discharge from			

	the agency such as a hospitalization, fall/injury. Patient #16 did follow up with the family nurse practitioner to receive care prompted by self. Reported that bedbug problems have since been resolved. During an interview on 10/26.2023 at 8:20 AM, the Administrator indicated that Patient #16 was to have 2 pest control treatments for eradication of bedbugs with a written follow-up from the pest company that indicated bed bugs were clear from the home. Once this information was received, staff could resume home visit treatments. The Administrator indicated home visits were not completed after 05/11/2023. Denied having a bed bug policy, however, will provide a Bed Bug Tip sheet. During an interview on 10/26/2023 at 10:23 AM, the Administrator indicated there was no documentation found in the medical record of Patient #16 being notified of discharge. Indicated a desk discharge was completed.			
G0598	Discharge plans communication	G0598	Patient # 16 has been	2023-11-10

	484.60(c)(3)(ii) (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). Based on record review and interview the agency failed to ensure the patient and/or patient representative were notified of discharge in 1 of 7 discharged records reviewed. (Patient #16) Findings Include: A policy titled, "Patient Discharge/Transfer Process", revised 10/1/2023 was provided by the Administrator on 10/24/2023 at 12:02 PM. The policy indicated but was not limited to, "The patient participates in the transfer process to another organization or level of care or service ... If patient is discharged because the agency can no longer meet the needs of the patient, the agency will assist the patient/patient representative in choosing an alternate provider		discharged from home healthservices. An occurrence report was entered for patient # 16 forfailure to notify patient of discharge. During a mandatory team meeting held on 11/1/23, theExecutive Director (ED) instructed all staff on the discharge process usingpolicy 1.003 Notice of Non-Coverage, Expedited Determination andReconsideration for Discharge and 2.1.004 Patient Discharge/Transfer Processwith emphasis on ensuring patients are notified of pending discharge andprovided the Notice of Medicare Provider Non-Coverage Form (NOMNC) at least 15calendar days before services are stopped. For any staff unableto attend the mandatory meeting, the Executive Director provided individualinstruction by 11/10/23. Discharge planning is initiated upon admission andcontinued	

	that can meet the patient's needs. Documentation will support that the patient was informed that the agency can no longer meet his/her needs and alternatives provided to patient ... Patients are notified of discharge as soon as possible prior to discharge as outlined in Notice of Non-Coverage, Expedited Determination and Reconsideration for Discharge Policy. The agency will also provide patient and legal representative (if any) with contact information and numbers for other community resources or providers and evidence will be documented in the in the medical record". A policy titled, "Notice of Non-Coverage, Expedited Determination & Reconsideration for Discharge", revised 12/01/2021 was provided by the Administrator on 10/24/2023 at 12:02 PM. The policy indicated but was not limited to, "State: Indiana ... Notice Timeframe: At least 15 calendar days before services are stopped". A policy titled, "Patient Rights and Responsibilities" located in the handbook provided by the		throughout the patient's plan of care. Patients are notified of discharge as soon as possibleprior to discharge. Revisions to plan for patient's discharge will becommunicated to the patient; patient's representative if any; caregiver, if any;all physicians issuing orders; and patient's primary care practitioner orhealth care professional who will provide care and services to patient afterdischarge, if any. A qualified clinician coordinates the discharge withthe attending physician and patient/family. When discharged, the patient isprovided the reason for discharge. Ongoing psychosocial or physical care needsare identified and appropriate referrals made. Before the termination of	

	agency to all new patients was provided by the Administrator on 10/23/2023 at 1:40 PM. The handbook indicated but was not limited to, "The patient has the following rights: ... To be informed of the HHA's policies for transfer and discharge". A document titled, "Home Health Certification and Plan of Care" Start of Care (SOC) date 05/11/2023, certification period 05/11/2023 through 07/09/2023 was provided by the Administrator on 10/24/2023 at 9:47 AM. The summarized plan of care included services ordered for skilled nursing, one visit weekly x 1 week, then two visits every four weeks x4, then one visit every week x 2 weeks. Physical Therapy services included were one visit weekly x1 week, then 3 visits every 4 weeks x4, then 2 visits weekly x1, then one visit weekly x3. A document titled, "Client Coordination Note Report" dated 05/11/2023 was provided by the Administrator on 10/26/2023 at 9:05 PM. The summarized document entered by RN2 indicated that Patient #16 was notified that a bed bug		or not the Medicare beneficiary agrees with the discharge and/or goalsare met, the agency will deliver a valid written termination notice to theMedicare beneficiary of the decision to terminate services. The notice will be issued at least 15 calendar daysbefore services are stopped. The Executive Director is ultimately responsible for implementing theplan of correction. Beginning 11/11/23, the Executive Director (ED) or Patient Care Manager will review 6 discharge medical records per month to ensure patientwas notified of discharge at least 15 days in advance and Notice of MedicareProvider Non-Coverage Form is present in the medical record. Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months.	

	was found during a therapy visit. Patient #16 had called pest company and set up appointment for 5/17/2023. Patient #16 made aware that home health services were placed on hold until 2 weeks post pest treatment. A document titled, "Visit Note Report" dated 07/09/2023 was provided by the Administrator on 10/24/2023 at 9:05 AM. The summarized document entered into the medical record by RN1 indicated a Discharge for Patient #16, a desk discharge. Discharging based on last skilled visit, 05/11/2023. During a phone interview on 10/25/2023 at 5:19 PM, Patient #16 indicated he had begun home health services with Omni Home Care in May of 2023. Was to receive skilled nursing and physical therapy in the home after a hospitalization. However, after initial findings of active bedbugs in the home were identified by agency staff, services were placed on hold. Denied referral to another home health agency by Omni Health Care to assist with care/needs and was advised that a pest company would		Discussion of compliance will occur during thequarterly Quality Assurance Performance Improvement team meetings until 100%compliance is achieved.	

	need to treat the home and conduct a follow up visit to ensure eradication of bedbugs prior to resuming home health services. Patient #16 indicated that in-home visits stopped after the initial visits by both physical therapy and skilled nursing and he/she just stopped hearing from the agency. Patient #16 indicated that he/she was not informed pf discharge approximately 2 months later. No referral was provided by the agency to another agency to continue care in the home. Patient #16 continued with physical therapy exercise provided at initial visit and still continues them to this day. Denied any negative outcome post discharge from agency such as a hospitalization, fall/injury. Patient #16 did follow up with family nurse practitioner to receive care prompted by self. Reported that bedbug problems have since been resolved. During an interview on 10/26.2023 at 8:20 AM, the Administrator indicated that Patient #16 was to have 2 pest control treatments for eradication of bedbugs with a written follow up from the pest			

	company that indicated bed bugs were clear from the home. Once this information was received, staff could resume home visit treatments. The Administrator indicated home visits were not completed after 05/11/2023. During an interview on 10/26/2023 at 10:23 AM, the Administrator indicated there was no documentation found in the medical record of Patient #16 being notified of discharge. Indicated a desk discharge was completed.			
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. Based on record review and interview, the agency failed to update the Client's Medication Report and failed to provide the medication schedule including medication name, dosage, and frequency for 2 of 7 active records reviewed (Patient #3, #4). Findings include:	G0616	Patient # 3 and # 4 medications were reviewed andphysician order obtained to update the Plan of Care. During a mandatory team meeting held on 11/1/23, theExecutive Director (ED) instructed all staff on medication monitoring andreconciliation using policy 10.008 Monitoring Medications with emphasis on medicationreconciliation and maintaining an up to date medication list.	2023-11-10

	A policy revised 05/2019, titled "Monitoring Medications" was provided by the Administrator on 10/26/2023 at 9:25 AM. The policy indicated, but was not limited to, "all clinicians participating in the patient's care are responsible to assist with the maintenance of accurate patient medication information throughout the episode of care". During a record review in the home of Patient #3 on 10/25/2023 at 10:20 AM, the medication profile and Plan of Care (POC) were reviewed against medication bottles found in the home for the certification period 08/21/2023-10/19/2023. The POC and medication profile failed to have an updated/accurate list of medications, including a missing eye drop and Diclofenac 1% topical gel (used to treat pain and other symptoms of arthritis of the joints) that had been discontinued approximately 2-3 weeks prior. During a record review in the home of Patient #4 on 10/25/2023 at 12:15 PM, the		For any staff unable to attend the mandatory meeting,the Executive Director provided individual instruction by 11/10/23. A drug regimen review will be performed on allpatients in conjunction with all comprehensive assessments. Additionally, allclinicians will participate in medication review and reconciliation throughoutthe episode. For patients receiving skilled nursing and therapyservices, the skilled nurse is responsible for medication review and reconciliation throughout theepisode. The therapist will participate by monitoring and reporting anyidentified medication issues or non-compliance to the Patient Care Manager. For patients receiving only therapy services, thetherapist is responsible to facilitate drug regimen review and medicationreconciliation throughout the episode. One therapy discipline will hold	

	dication profile and POC were iewed against medication tles found in the home for the tification period 13/2023-11/11/2023. The POC l medication profile failed to e an updated/accurate list of dications. Missing medications uded Santyl Ointment daily n cream) and Oxy-Powder tural Digestive Cleanser (herbal ol softener/laxative) as needed. continued medications found ve on the medication profile l POC included: Colace (laxative) mg capsule at bedtime, Miralax ol softener) 17g/dose oral vder daily. Ferrous Sulfate (iron) mg every other day, however, listed as taken daily. During an interview on 10/26/2023 at 8:20 AM, the Administrator indicated that as soon as the new medications or changes to the current medications are made by the nurse in the field, the office gets an immediate notification and approves the changes, including over-the-counter and herbal medications. During an interview on 10/25/2023 at 10:20 AM, Patient #3 indicated missing an additional eye drop not found		medication reconciliation in therapy only episodesof care. When multiple therapy disciplines are being provided, the primaryresponsibility will be assigned as follows: Physical Therapy if ordered alone or inconjunction with other therapy disciplines; Occupational Therapy if orderedalone or in conjunction with only Speech Therapy; and Speech Therapy if onlydiscipline providing care to patient. The physician is contacted immediately if anydiscrepancies between agency information and patient medications are found. The agency will provide the patient with a completereconciled medication list. The Executive Director is ultimately responsible for implementing theplan of correction. Beginning 11/11/23, the	

	the medication profile and POC. able to provide medication tle or recall name of medication to being in daughter's home at time of the home visit. Patient s daughter indicated Diclofenac topical gel had been continued approximately 2-3 eks prior, and this was still listed an active medication on Client dication Report. During an interview on 10/25/2023 at 10:15 AM the patient indicated they were taking the following medications that were not listed on the POC or Client Medication Report: Santyl Ointment daily and Oxy-Powder Natural Digestive Cleanser as needed. The following medications had been discontinued but were still listed as active medications on the Client Medication Report: Colace 100mg capsule nightly and Miralax 17g/dose oral powder daily. Ferrous Sulfate 325mg tablet was listed as taken daily, however, the prescription bottle stated QOD (every other day).		Patient Care Manager , will complete 8 home observation visits per month to ensure patienthas an accurate medication list. Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months. Discussion of compliance will occur during thequarterly Quality Assurance Performance Improvement team meetings until 100%compliance is achieved.	

G0710	Provide services in the plan of care 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; Based on record review and interview, the agency failed to provide services for occupational therapy services ordered by the physician as indicated on the plan of care (POC) for 1 of 7 active patient records reviewed (Patient #3). Findings include: A revised 10/01/2023 policy titled "Physician Orders" was provided by the Administrator on 10/26/2023 at 9:20 AM. The policy indicated, but was not limited to, "services are provided according to the most recent orders updating the patient's Plan of Care". The clinical record review for Patient #3, the start of care 08/21/2023, was reviewed on 10/25/2023, and included a POC for the certification period 08/21/2023 to 10/19/2023, with orders for occupational therapy	G0710	Patient # 3 received Occupational Therapy (OT)evaluation 10/25/23. Occurrence report was entered for patient # 3 forfailure to provide OT evaluation in a timely manner. During a mandatory team meeting to be held on 11/15/23,the Executive Director (ED) instructed all field staff, intake staff, PatientCare Managers (PCM), and Quality Review staff on Plan of Care (POC) developmentusing policy 2.1.007 Plan of Care with emphasis on ensuring all ordereddisciplines are added to the Clinical Comment Intake Note upon referral; servicesincluded in the referral are incorporated in to the POC; and referral documentsare reviewed as part of the comprehensive assessment and quality reviewprocess.	2023-11-17

	; week. The agency failed to vide the ordered number of upational therapy visits during ; certification period. During an interview with the Administrator on 10/26/2023 at 11:31 AM, the Administrator indicated that the agency did not complete OT visits during the certification period 08/21/2023-10/19/2023. The Administrator could not give reasoning as to why this did not happen and did not have documentation of efforts made to attempt to provide this service to the patient. '-14-1(a)(1)(H)		For any staff unableto attend the mandatory meeting, the Executive Director provided individualinstruction by 11/17/23. Each patient has an individualized Plan of Care (POC)developed in consultation with the patient, physician or authorizedpractitioner, and staff that integrates comprehensive assessment findings andphysician/ referral orders to address patient problems, needs, and goals, aswell as to address specific services being provided. Intake staff will enter all ordered disciplines intothe Clinical Comment Intake Note at time of referral. Clinicians completing the comprehensive assessmentwill reference the Clinical Comment Intake Note and referral documents toensure all services and treatments are addressed in the POC. The POC Review Tool will be	

			CareManagers (PCM) and Quality Review staff to ensure the referral/referral ordersare reviewed as part of the comprehensive assessment/POC review process toensure all ordered disciplines and treatments are addressed on the POC. The Executive Director is ultimately responsible for implementing theplan of correction. Beginning 11/18/23, the Executive Director (ED) or Patient Care Manager, will review 12 SOC assessments per month to ensure patient receivedservices indicated on the referral. Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months.	

			Discussion ofcompliance will occur during the quarterly Quality Assurance PerformanceImprovement team meetings until 100% compliance is achieved.	

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
Tonya L. Geise	Executive Director	11/13/2023 4:38:17 PM