DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157710	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/01/2023
NAME OF PROVIDER OR SUPPLIER: PRAIRIE HEALTHCARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 5920 HOHMAN AVENUE, HAMMOND, IN, 46320	

(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 for Home Health Providers and Suppliers. Survey Dates: 11/28/2023, 11/29/2023, 11/30/2023, and 12/1/2023 12 month unduplicated skilled admissions: 83 At this Emergency Preparedness survey, Prairie Home Health was found not to be in compliance with the requirements of Emergency Preparedness Requirements for Medicare participating providers and suppliers, 42 CFR 484.102. QR by Area 3 on 12-13-2023.	E0000		

E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. Based on record review and interview, the agency failed to ensure each patient had an individualized emergency plan in 7 of 7 records reviewed. (Patient #1, 2, 3, 4, 5, 6, 7) The findings include: *During record review for Patient # 6, the clinical record failed to evidence documentation of plans for evacuation location and directions for Patient #6 if evacuation required due to emergency or disaster is	E0017	**WHO:** The Administrator ensured each patient has a written IndividualizedEmergency Preparedness Plan with complete documentation according to thepatient's medical needs. **WHAT:** ConductedIn-Service Training on 12/20/2023 to educate all staff regarding the agency's ComprehensiveAssessment in Disaster (Emergency Preparedness Plan) Policies and Proceduresand the revised Individualized Emergency preparedness Plan form. The Administrator educated all clinicians on how toaccurately and completely document the patient's individualized emergencypreparedness plan using the revised form. The Administrator together with theQAPI team also developed Chart Audit Tool to monitor compliance with therequirement. **WHEN:** On 12/15/2023, theAdministrator (who is also the President of the Board)	2023-12-20

	needed. *On 11/29/23, beginning at 12:01 PM, during home observation, Patient # 7's home folder contained Individual Patient Emergency Preparedness Plan that failed to evidence emergency contact phone number as well as documentation of plans for evacuation location and instructions due to emergency or disaster if needed. 1. A review of an agency policy revised 5/26/2022 titled, "Disaster Preparedness Policies and Procedures," indicated individualized plans for patients during a natural or man-made disaster must be included as part of the comprehensive patient assessment. 2. A review of the initial assessment for patient #1, dated 07/23/2023, indicated the patient required a foley catheter (medical device that helps drain urine from your bladder. and had a port (an implantable device used for blood work and		reviewed and revised the Individual Emergency Preparedness Plan form (inour Admission packet) and included individualized plan as part of the patient'scomprehensive assessment including wound care, foley catheter, port-a-cath orany implantable device used for blood work and IV medication administration,supplies and instruction(s) for the patient, patient's contact number, emergency contact name and phone number,evacuation and transportation plans. **HOW:** The Administratorwill be using the developed Chart Audit Tool to review all our activepatients (100%) records to monitor the ONGOING implementation of the written IndividualizedEmergency Preparedness Plan with complete documentation according to thepatient's medical needs. The ongoing compliance monitoring will be every 30days for the next 6 months. The Governing Body together with the QAPI team	

	administration). A review of the patient's individualized emergency plan, failed to evidence the patient's foley catheter, port, and supplies and instructions for them. 2. During a home visit for patient #2, on 11/29/2023, at 5:15 PM, the home folder was observed. The home folder contained an undated document titled "Individual Patient Emergency Plan" which failed to specify an evacuation location and an emergency contact person. A clinical record review for patient #2, evidenced an undated document titled "Individual Patient Emergency Plan" which failed to specify an evacuation location and an emergency contact person. During an interview on 12/1/2023 at 11:32 Am, the Alternate Administrator indicated the patient lives alone that's why there was no emergency contact person one the emergency plan. 3. A clinical record review for patient #3, evidenced a start of		willdecide if there is a need for further monitoring. The criteria are set forthbased on patient record audit for completeness of all patient's Individualized EmergencyPreparedness Plan documentation for the next six months consecutivelyidentifiable as being compliant. The summary of ChartAudit result on a monthly basis will be reported to Governing Body and will beshared to all staff during our QAPI quarterly meetings. Ifafter 6 months of continuous monitoring and the target threshold of 100% is NOTachieved, the Administrator will schedule another In-Service Training to allclinicians by 06/20/2024 to immediately re-educate all clinicians on thepolicies and procedures regarding Home Health Agency Comprehensive Assessmenton Disaster. The Governing Body and QAPI team will also address/incorporatethis in our QAPI Program every quarter until the target threshold is achieved.	

	care assessment dated 6/15/2023 which evidenced the patient had wounds. A review of Patient #3's Individualized Emergency Plan failed to evidence an evacuation address and instructions and failed to include wound care instructions. 4. A review of the individualized emergency plan for Patient #4 failed to evidence evacuation and transportation plans. 5. A clinical record review for patient #5, evidenced a resumption of care assessment dated 6/29/2023 which evidenced the patient had wounds. A review of Patient #3's Individualized Emergency Plan failed to evidence an evacuation address and instructions and failed to include wound care instructions.			
E0019	Homebound HHA/Hospice Inform EP Officials 418.113(b)(2) §418.113(b)(2), §460.84(b)(4), §484.102(b)(2)	E0019	**WHO:** The Administratorensured our agency is implementing our revised Policy and Procedures on how toinform the State and Local Emergency officials about	2023-12-20

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:]

*[For homebound Hospice at §418.113(b)(2), PACE at §460.84(b)(4), and HHAs at §484.102(b)(2):] The procedures to inform State and local emergency preparedness officials about [homebound Hospice, PACE or HHA] patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.

Based on record review and interview, the home health agency failed to ensure they included the procedures to inform state and local emergency preparedness officials about patients in need of evacuation from their residences at any time due to an emergency based on the patient's medical, psychiatric, and home environment conditions for 1 of 1 agency.

Findings include:

An agency policy revised 5/26/20023, titled, "Disaster Preparedness Policies and Procedures," indicated the

patients in need ofevacuation from their residences at any time due to an emergency.

WHAT:

Conducted In-Service Training on12/20/2023 to re-educate all staff regarding the agency’s revised Policy andProcedures on how to inform the State and Local Emergency officials aboutpatients in need of evacuation from their residences at any time due to anemergency based on the patient’s medical, psychiatric and home environmentconditions of the patient. All assessing cliniciansmust obtain a complete and accurate Individualized EmergencyPreparedness Plan upon Start of Care to be able provideemergency officials with the appropriate information to facilitate thepatient’s evacuation and transportation. This should include, but is notlimited to, the following:

>Whether or not the patient is mobile.

	agency would have a means of informing state and local emergency preparedness officials of patients in need of evacuation due to their medical, behavioral health or conditions of the home environment. A review of the emergency preparedness binder on 11/29/2023, failed to evidence documentation of the procedure to inform state and local emergency preparedness officials about patients in need of evacuation from their residence if there is an emergency. During an interview on 12/1/2023, at 11:20 AM, the Alternate Administrator indicated the policy says the clinical manager will follow up with staff and patients and contact authorities if needed.		> Whattype of life-saving equipment does the patient require? > Isthe life-saving equipment able to be transported? (E.g., Battery operated,transportable, condition of equipment, etc.) > Does the patienthave special needs? (E.g., Communication challenges, language barriers, intellectual disabilities, special dietaryneeds, etc. **WHEN:** On 12/06/2023, the Administrator (who is also thePresident of the Board) together with the QAPI team reviewed and revised ourCommunication Plan in the Emergency Preparedness Plan Policy and Procedures onhow to inform the State and Local Emergency officials about patients in need ofevacuation from their residences if there is an emergency, which address whenand how this information is communicated to emergency officials and alsoinclude the clinical care needed for these patients. **HOW:**	

			All clinicianswent back to patients’ homes to ensure we provided all patients with a copy ofall the list of Emergency Contacts including Local and State Emergencyofficials whom patient/caregiver can call in the event of an actual Emergency aboutpatients in need of evacuation from their residences. The citation has beencorrected and is now in compliance with the standards. The Administratortogether with our QAPI team will ensure monitoring of the implementation andupdated at least every 2 years our agency’s Emergency Preparedness Plan basedon the Emergency Plan criteria set forth in relevance of the policy andprocedure to all applicable Federal and State laws, rules and important updatesapplicable to home healthcare providers in the State of Indiana for the nextsix months, consecutively identifiable as being compliant. The Governing Bodytogether with the QAPI team will decide if there is a need for furthermonitoring.	

E0021	HHA- Procedures for Follow up Staff/Pts. 484.102(b)(3) §484.102(b)(3) Condition of Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact. Based on record review and interview, the home health agency failed to ensure procedures were included to inform the state and local emergency official of any on-duty staff or patients the agency was unable to contact for 1 of 1 agency. Findings include: An agency policy revised 5/26/20023, titled, "Disaster Preparedness Policies and Procedures," indicated the	E0021	**WHO:** The Administratorensured our agency is implementing the Emergency Preparedness Plan Policy andProcedures that included informing the state and local emergency official ofany on-duty staff or patients the agency was unable to contact. **WHAT:** Conducted In-Service Training on12/20/2023 to re-educate all staff regarding our Emergency Preparedness Plandeveloped Policy and Procedures on 12/06/2023 that address the following: To follow up with on-duty staff and patients to determineservices that are needed, in the event that there is an interruption inservices during or due to an emergency. The agency will inform State and localofficials of any on-duty staff or patients that they are unable to contact. TheAdministrator designated an on-call staff in case the assigned clinician isunable to be contacted. **WHEN:** On 12/13/2023, theAdministrator (who is also the President of the Board) together with the QAPIteam reviewed and revised our Emergency Preparedness Policies and Proceduresfor Follow-up Staff/Patients to	2023-12-20

	emergency preparedness communication plan that would include how the agency coordinated patient care within the agency, across healthcare providers, and with the state and local public health departments. The plan indicated the agency should include how the agency interacts with emergency management agencies and systems. The policy failed to address what actions would be required due to the inability to contact staff or patients and reporting capabilities to the local and state emergency officials. A review of the emergency preparedness binder on 11/29/2023, failed to evidence documentation of a communication plan to include a means of informing state and local emergency officials of patients and on-duty staff who were unable to be contacted. During an interview on 12/1/2023, at 11:17 AM, the Alternate Administrator indicated the Administrator would be responsible for contacting local and state health officials.		determine services that are needed, in theevent that there is an interruption in services during or due to an emergency. **HOW:** All clinicianswent back to patients' homes to ensure we provided all patients with a copy ofall the list of Emergency Contacts Emergency Contacts whom patient/caregivercan call in the event of an actual Emergency. The citation has been correctedand is now in compliance with the standards. The Administrator togetherwith our QAPI team will ensure monitoring of the implementation and updated atleast every 2 years our agency's Emergency Preparedness Plan based on the EmergencyPlan criteria set forth in relevance of the policy and procedure to allapplicable Federal and State laws, rules and important updates applicable to homehealthcare providers in the State of Indiana for the next six months,consecutively identifiable as being compliant. The Governing Body together withthe QAPI team will decide if	

			there is a need for further monitoring.	
E0024	Policies/Procedures-Volunteers and Staffing 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.	E0024	**WHO:** The Administrator implementedthe developed Emergency Preparedness Plan Policy and Procedures that will use emergencystaff strategies to address surge needs during an emergency. **WHAT:**	2023-12-20

*[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

Based on record review and interview, the home health agency failed to evidence the process for the use of volunteers or other emergency staff strategies to address surge needs during an emergency for 1 of 1 agency.

The findings include:

An agency policy revised 5/26/20023, titled, "Disaster Preparedness Policies and Procedures," indicated the agency would use volunteers in an emergency or other emergency staffing strategy to address surge needs during and emergency.

A review of the emergency preparedness binder on 11/29/2023, failed to evidence documentation of the agency's procedure to define their role related to the use of volunteer and other emergency staffing to address the agency's surge needs.

Conducted In-Service Training on12/20/2023 to re-educate all staff regarding our Emergency Preparedness Plan Policyand Procedures regarding the use of volunteers or other emergency staffstrategies to address surge needs during an emergency for the agency. Informedall staff that we partnered with FHHSI to act as a support for the agency withvarying levels of skills and training/healthcare professionals who are able toperform services within their scope of practice and training in the event that thereis an interruption in home healthcare services during or due to an emergency.

WHEN:

On 12/13/2023, theagency partnered with ANOTHER HOME HEALTH AGENCY LOCATED AT MUNSTER INDIANA(FHHSI) in the event that there is an interruption in home healthcare services duringor due to an emergency.
The partner agency will act asa support for the agency with varying levels of skills and training/healthcareprofessionals who are able to perform services within their scope of practiceand training.

HOW:

Inthe event of an actual emergency, we have

	During an interview on 12/1/2023, at 11:28 AM, the Alternate Administrator indicated the agency does not use volunteers and does not have contact information for volunteers at this time.		partnered with another home healthagency located at Munster, IN on 12/13/2023 to support our agency to maintaincontinuity of home healthcare services to our patients. The citation has beencorrected and is now in compliance with the standards. The Administratortogether with our QAPI team will ensure monitoring of the implementation andupdated at least every 2 years our agency's Emergency Preparedness Plan based onthe Emergency Plan criteria set forth in relevance of the policy and procedure thatdefined the role related to the use of volunteer supportfrom individuals with varying levels of skills and training to addressour agency's surge needs based on all applicable Federal and State laws, rulesand important updates applicable to home healthcare providers in the State ofIndiana for the next six months, consecutively identifiable as being compliant.The Governing Body together with the QAPI team will decide if there is a needfor further monitoring.	
E0033	Methods for Sharing Information	E0033	**WHO:**	2023-12-20

	483.73(c)(4)-(6) §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.542(c)(4)-(6), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.		The Administrator establishedour agency's methods for sharing information and medical documentation forpatients under the agency's care, as necessary with other healthcare providersto maintain continuity of care. The Administrator also ensured that our agencyhas an Alternate Command Center (MUNSTER, INDIANA), and our Administrator is theresponsible person for sharing information in the event of an emergency. **WHAT:**	

	*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). Based on record review and interview, the home health agency failed to identify a method for sharing information and medical documentation for patients under the agency's care with other health care providers to maintain continuity of care, and in the event of an evacuation, a means of releasing patient information about the general condition and location of the patient for 1 of 1 agency. Findings include: An agency policy revised 5/26/20023, titled, "Disaster Preparedness Policies and Procedures," indicated the agency's communication plan would include a method for sharing information, medical documentation, and provide information about the general condition and location of the patients under the agency's care. A review of the emergency preparedness binder on		Conducted In-Service Training on12/20/2023 to re-educate all staff regarding the implementation of EmergencyPreparedness Plan revised Policy and Procedures dated 12/06/2023 regarding theagency's Method for Sharing Information and Care documentation for patientsunder our agency's care with other healthcare providers to maintain continuityof care, and in the event of an evacuation, a means of releasing patient informationabout the general condition and location of the patient. **WHEN:** On 12/06/2023, theAdministrator together with the QAPI team developed and maintained aCommunication Plan regarding method for sharing information and medicaldocumentation for patients under the agency's care, as necessary with otherhealthcare providers to maintain continuity of care, a means, in the event ofan evacuation, to release patient information, a means of	

	11/29/2023, failed to evidence the procedure to include a method to share information, medication documentation, and provide information about the general condition and location of the patients under the agency's care. During an interview on 11/29/2023, at 11:29 PM, the Alternate Administrator indicated the Administrator would set up a command center and would be responsible for sharing information in the event of an emergency.		general condition and location of patients under agency's care. On 12/01/2023, theAlternate Clinical Manager contacted the patient's Personal Care Assistant andcoordinated with his/her supervisor (other healthcare provider) to maintain andensure continuity of patient care. **HOW:** All clinicianswent back to patients' homes to ensure we provided all patients a communicationplan that includes method of sharing information, medical documentation andprovided all patients information about the general condition and location ofpatients under the agency's care in the event of an actual Emergency. Thecitation has been corrected and is now in compliance with the standards. The Administratortogether with our QAPI team will maintain and implement an Emergency PreparednessCommunication Plan that complies with Federal, State and local laws, reviewed andupdated at least every 2 years, which includes method for sharing informationand medical documentation for	

			patients under our agency’s care as necessary,with other health providers to maintain the continuity of care for the next sixmonths, consecutively identifiable as being compliant. The Governing Bodytogether with the QAPI team will decide if there is a need for furthermonitoring.	
G0000	INITIAL COMMENTS This visit was for a Federal Complaint survey of a Deemed Home Health provider. Survey Date: 11/28/2023, 11/29/2023, 11/30/2023, and 12/1/2023 Complaint # IN102869 Federal were cited. Unduplicated skilled admissions: 83 During this survey Prairie Home Health was found out of compliance with 2 Conditions of Participation at 484.60 Care Planning, coordination of services, and quality of care, and 484.58 Discharge Planning. Based on the Condition-level deficiencies during the 12/1/2023 survey, your HHA	G0000		

	was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 11/30/2023. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning 12/1/2023 and continuing through 11/30/2024. QR by Area 3 on 12-12-2023.			
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.	G0514	**WHO:** The ClinicalManager is responsible for monitoring and ensuring all clinicians' compliance withthe standard. **WHAT:** The Clinical Manager together withthe QAPI team members reviewed the agency Policy and Procedures on	2023-12-20

	Based on record review and interview the home health agency failed to ensure the comprehensive assessment was conducted within 48 hours of the referral in 1 of 2 discharged records reviewed. (Patient #1) The finding include: 1. An agency policy revised 11/4/20 2:22 titled "Initial Assessment/Comprehensive assessment indicated the initial assessment bridges the gap between when the patient encounter occurs and when a plan of care can be implemented. Immediate care and support needs are those items and services that will maintain the patient's health and safety throughout the interim. A registered nurse must conduct the initial assessment within 48 hours of referral within 48 hours of the Patient's return home or the physician ordered start date of care." 2. A review of Patient #1's clinical record evidenced a referral dated 6/28/2023 which indicated Patient #1 was referred for skilled nursing services for catheter changes. A clinical record review for		InitialAssessment/Comprehensive Assessment to ensure compliance with the standard ismet. **WHEN:** Conducted anIn-Service Training/Re-education of all clinicians regarding agency's Policiesand Procedures on InitialAssessment/Comprehensive Assessment on 12/20/2023. **HOW:** The CLINICALMANAGER will ensure all clinicians will perform initial assessment within 48hours from the of referral or within 48 hours of the patient's return home, oron the physician or allowed practitioner - ordered start of care date. The ongoingcompliance is monitored by our Clinical Manager together with the QAPI teammembers who conducted Clinical Record Audit of 100% of ACTIVE AND DISCHARGE patientcensus to	

	Patient #1, start of care 7/21/2023, evidenced an initial comprehensive assessment dated 7/21/2023 and electronically signed by the alternate Clinical Manager. A review of Patient #1's clinical record evidenced a communication note date 7/21/2023, which stated "Delay in start of care was due to infusion supplies (infusion needles)..." A review of patient #1's clinical record failed to evidence an order for infusion supplies. During an interview on 11/30/2023, the alternate Clinical Manager indicated they were trying to obtain infusion needles. When queried as to why there was a need for infusion needles, she indicated when they called Patient #1, the patient told them she needed the supplies and wanted her port a cath (an implantable device used for blood work and intravenous medication administration) flushed on the first visit as it needed to be done every 3 weeks. During an interview on		ensure eachpatient referred to agency will be seen for Initial Assessment within 48 hoursfrom the referral date of the MD/hospital or on the physician or allowedpractitioner - ordered start of care date. The frequency of auditis every 30 days for the next 6 months. Target threshold for compliance is 100%. Once the thresholdis met, the clinical records audit will be done quarterly with 50% of theagency's active and discharge patientrecords to ensure compliance with the standard. The monthly resultof the Chart Audit will be discussed/addressed and incorporated in our QAPIProgram for the 1st and 2nd Quarter of 2024.	

	Administrator indicated they tried to get the needles from area pharmacies and could not find them. Supply companies only sold them in large quantities. He indicated Physician #1 gave him the name of a supply company and they were able to obtain the needles. 410 IAC 17-14-1(a)(1)(A).		If after 6 months,the target threshold of 100% is NOT achieved, the Clinical Manager willschedule another In-Service Training to all clinicians on 06/20/2024 to immediatelyre-educate all clinicians on the policies andprocedures regarding Initial Assessment/Comprehensive Assessment.	
G0560	Discharge Planning 484.58 Condition of Participation: Discharge planning. Based on record review and interview, the home health agency failed to establish and follow policies for discharge planning to ensure patient needs were adequately met upon discharge (G0560) and failed to send all necessary medical information pertaining to the patient’s current course of illness and treatment to the receiving health care practitioner to ensure a safe and effective transition of care (G0564).	G0560	**Who:** The Clinical Manageris responsible for monitoring and ensuring all clinicians complies to Policiesand Procedures for patient discharge planning. **What:** The ClinicalManager together with the QAPI team members reviewed and revised our Policiesand Procedures on Discharge Planning on 12/18/2023. **When:** The Governing Bodyreviewed	2023-12-20

	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 484.58 Discharge Planning. Based on record review and interview, the agency failed to ensure the patient’s needs have been met adequately upon discharge in 1 of 2 discharge records reviewed (Patient #1) The findings include: 1. An agency policy revised 11/4/2023, titled “Discharge Criteria,” indicated the agency would provide the patient with contact information for other agencies or providers who may be able to provide care. The patient will be informed of a of a discharge plan in a timely manner.		and approved the revised Discharge Planning Policy on 12/18/2023. TheClinical Manager provided In-Service Training/Re-education of all clinicians on12/20/2023 regarding the REVISED written policies and procedures in the processof effective, appropriate, accurate and complete documentation of the patient’sDischarge Planning that includes informing (verbally) the patient/caregiver/familyof the discharge plan in a timely manner and to ensure that the patient’s needswere met upon discharge from our agency. **How:** The ongoingcompliance is monitored by our Clinical Manager together with the QAPI teammembers who conducted Clinical Record Audit to 100% active and discharge patientcensus to ensure our clinicians are providing a 15-day planned discharge noticeto the patient/caregiver prior to patient’s discharge from the agency.	

	2. A clinical record review for Patient #1 evidenced a communication note dated 11/11/2023 which indicated the patient had critical lab values for Potassium and Calcium. The Nurse Practitioner was notified and advised the patient should go the emergency room. A review of Patient #1's clinical record evidenced a Nursing visit note dated 11/11/2023 which indicated home care was necessary to monitor vital signs, Foley catheter care, wound care and patient education. A review of Patient #1's clinical evidenced a communication note dated 11/13/2023 which indicated Patient #1 called the office and indicated he/she did not go to the Emergency Room on 11/11/2023. During an interview on 11/30/2023 at the alternate Clinical Manager indicated she discharged Patient #1 due to noncompliance with the Physician Order to go to the Emergency Room. When queried as to what was done to ensure patient safety if the patient was discharged with critical labs, the Clinical		The frequency of auditis every 30 days for the next 6 months. Target threshold for compliance is 100%. Once the thresholdis met, the clinical records audit will be done quarterly with 50% of theagency's active and discharge patientrecords to ensure compliance with the standard. The monthly resultof the Chart Audit will be discussed/addressed and incorporated in our QAPIProgram for the 1st and 2nd Quarter of 2024. If after 6 months,the target threshold of 100% is NOT met, the Clinical Manager will scheduleanother In-Service Training to all clinicians on 06/20/2024 to immediatelyre-educate all clinicians on the policies and procedures regarding DischargePlanning.	

Manager indicated the patient would have lab work done at the Physician's office.

A review of Patient #1's clinical record evidenced a paper copy the laboratory results with the corrected values. This documented evidenced the corrected values were called and reported to the Administrator on 11/11/2023 and faxed to the agency on 11/12/2023.

A clinical record review for Patient #1 evidenced a discharge summary dated 11/13/2023, which indicated the patient was discharged for noncompliance. The agency failed to ensure the patients' needs were met upon discharge.

During an interview on 11/30/2023 at 2:57 PM, Patient #1 indicated the agency told him/her he/she had critical lab results but was unable to tell him/her what lab results were critical. He/She indicated she told the agency they did not have transportation and would need to call an ambulance and would like to let them know the

	Emergency Room. He/She indicated since it was Saturday, he/she decided to wait to contact the Physician on Monday. He/She indicated the Physician's office informed him/her laboratory results were contaminated and would need to be redone. Patient #1 indicated the alternate Clinical Manager called Patient #1 and discharged Patient #1 telling him/her he/she is fine, and he/she doesn’t need services any longer.			
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. Based on record review and interview, the agency failed to ensure the discharge/transfer summary contained all necessary information regarding the patient’s discharge including medications and treatments in 1 of 2 discharged	G0564	**Who:** The ClinicalManager is responsible for monitoring and ensuring all clinicians are documenting in the patient Transfer orDischarge Summary any instructions given to the patient/caregiver such as thepatient’s diagnoses, medications, wound care order(s), foley catheter careincluding frequency of foley catheter changes and/or port flushes and includingthe patient’s medications and treatment(s) provided to the patient will be sentto the receiving facility (for Transfer Summary) or the Physician (for	2023-12-20

	records reviewed The findings include: 1. An agency policy revised 11/4/2023, titled "Discharge Summary," indicated the summary will include any instructions given to the Patient. 2. A review of Patient #1's clinical record evidenced an agency document titled "SN [Skilled Nurse] Discharge Summary" dated 11/13/2023, which failed to include the instructions on medications, diagnosis, wound care orders, frequency of foley catheter changes, and frequency of port flushes. During an interview on 11/30/2023 at 4:37 PM, the Alternate Clinical Manager indicated she verbally instructed the patient and put all information in the discharge instructions. She indicated she did not specify what she instructed the patient on in the discharge summary. 410 IAC 17-15-1-(a)(6)		DischargeSummary). **What:** The ClinicalManager together with the QAPI team members reviewed and revised our Policiesand Procedures on Discharge or Transfer Summary Content on 12/18/2023. **When:** The Governing Bodyreviewed and approved the revised Discharge or Transfer Summary Content on12/18/2023. The Clinical Manager provided In-Service Training/Re-education toall our clinicians on 12/20/2023 regarding the REVISION of the written Policiesand Procedures on Discharge or Transfer Summary Content to ensure our cliniciansend all necessary medical information(INCLUDING MEDICATIONS AND TREATMENTS PERFORMED BY THE AGENCY TO THE PATIENT;ALL DISCHARGE INSTRUCTIONS FOR THE PATIENT/CAREGIVER)	

pertaining to thepatient's current course of illness and treatment, post-discharge goals ofcare, and treatment preferences, to the receiving facility or health carepractitioner to ensure the safe and effective transition of care.

How:

The ongoingcompliance is monitored by our Clinical Manager together with the QAPI teammembers who conducted Clinical Record Audit to 100% active and discharge patientcensus to ensure our clinicians are accurately and completely documenting thepatient’s Transfer and/or Discharge Summary content with the pertinent andimportant information about the patient’s current course of illness and treatment, post-discharge goals of care,and treatment preferences, to the receiving facility or health care practitionerto ensure the safe and effective transition of care.

The frequency of auditis every

			Target threshold for compliance is 100%. Once the thresholdis met, the clinical records audit will be done quarterly with 50% of theagency's active and discharge patientrecords to ensure compliance with the standard. The monthly resultof the Chart Audit will be discussed/addressed and incorporated in our QAPIProgram for the 1st and 2nd Quarter of 2024. If after 6 months,the target threshold of 100% is NOT achieved, the Clinical Manager willschedule another In-Service Training to all clinicians on 06/20/2024 to immediatelyre-educate all clinicians on the policies and procedures regarding Dischargeand Transfer Summary Contents.	
G0570	Care planning, coordination, quality of care 484.60	G0570	**Who:** The ClinicalManager is responsible for monitoring and ensuring all clinicians met the	2023-12-20

	Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review, and interview, the home health agency failed to ensure: the agency met the patient's needs (G0570); the plan of care was reviewed by the physician, individualized and followed by all agency staff (G0572); services and treatment were provided as ordered by a physician (G0578); all treatments provided by agency staff were ordered by a physician (G0580); coordination of care for all services provided to the patient (G0606); coordinate care delivery (G0608); the written visit schedule was provided to patients (G0614); written instructions were provided to the patient for the patient's		patient'sneeds; the plan of care was reviewed by the physician, Plan of Care must be individualizedand followed by all agency staff; services and treatment were provided asordered by a physician; all treatments provided by agency staff were ordered bya physician; coordination of care for all services provided to the patient;coordinate care delivery; the written visit schedule was provided to patients;written instructions were provided to the patient for the patient's medication schedule andinstructions; the treatments to be administered by agency personnel wereprovided to the patient and caregiver in writing. **What:** The ClinicalManager together with the QAPI team members reviewed Care Planning,Coordination and Quality Care Policies and Procedures. **When:** The ClinicalManager provided	

	medication schedule and instructions (G0616); the treatments to be administered by agency personnel were provided to the patient and caregiver in writing (G0618). 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. 410 IAC 17-13-1(a) The findings include: Findings include: Review of policy, "Plan of Care-CMS #485 and Physician Orders," revised 11/4/2022, indicates "Skilled nursing and other home health services will be in accordance with a Plan of Care based on the patient's diagnosis and assessment...needs...Patients are accepted for treatment on the reasonable expectation that the agency can meet the patient's...needs...". *Review of clinical record for		In-Service Training/Re-education to all our clinicians on12/20/2023 regarding the agency's Policies and Procedures on Care Planning,Coordination and Quality Care. **How:** The ongoingcompliance is monitored by our Clinical Manager together with the QAPI teammembers who conducted Clinical Record Audit to 100% active and discharge patientcensus to ensure our clinicians are accurately, effectively and completely assessingand documenting the (1) patient's medical, nursing, and social needs areadequately met (upon Start of Care the clinician will offer the patient otherhome health services based on patient's medical needs) to ensure the agency isproviding quality home healthcare services in a safe environment; (2) if theagency has meet the patient's medical needs in timely manner; (3) must haveCare Coordination for all disciplines involved in the patient care and fromother	

	initial comprehensive assessment, completed by Registered Nurse (RN) 2 on 10/16/2023, which indicated Patient #6 had a need for assistance with activities of daily living; grooming, dressing, bathing, toileting, and transferring. The assessment failed to evidence RN 2 assessed if Patient # 6 had need of home health aide services. *During an interview with caregiver of Patient #6 conducted on 11/30/23, beginning at 4:07 PM, caregiver confirms agency did not offer home health aide services to assist with Patient # 6's personal care needs. 1. An agency policy revised 11/4/2022, titled "Patient Admission Criteria," indicated patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be adequately met. 2. A clinical record review for Patient #2 evidenced an agency document titled, "Start of Care"		health providers; (4) each patient has an individualized Plan of Care that allclinicians followed; (5) must have MD order for all treatments and servicesprovided by the agency; (6) clinicians to provide all their patients withprojected visit calendar (schedule of visits per discipline) at home; (7)patient/caregiver must have an updated copy of the patient's medications schedule and instructions at home and (8) cliniciansto provide the patient/caregiver in writing all treatments to be administeredby agency personnel. The frequency of auditis every 30 days for the next 6 months. Target threshold for compliance is 100%. Once the thresholdis met, the clinical records audit will be done quarterly with 50% of theagency's active and discharge patientrecords to ensure compliance with the standard.	

	#2 needed assistance with grooming assistance, bathing assistance, toileting hygiene. During a home visit on 11/29/2023 at 5:00 PM, Patient #2 indicated the Occupational Therapist came the day before and she was able to finally shower for the first time since the end of September. Patient #2 indicated she was not offered home health aide services from the agency. During an interview on 11/29/2023 at 2:30 PM, Registered Nurse (RN) 2 indicated Patient #2 was not offered an aide because the Physician did not order one. RN 2 indicated Patient #2 could use a homemaker and a home health aide to help until they find out what is going on with his/her back, but it is so hard to find home health aides and Patient #2 is particular about who he/she wants to see. 3. A clinical record review for Patient #3 evidenced an agency document titled "Start of Care," dated 11/3/2023, which evidenced Patient #3 needed assistance with grooming assistance, bathing assistance,		The monthly resultof the Chart Audit will be discussed/addressed and incorporated in our QAPIProgram for the 1st and 2nd Quarter of 2024. If after 6 months,the target threshold of 100% is NOT achieved, the Clinical Manager willschedule another In-Service Trainingto all clinicians on 06/20/2024 to immediately re-educate all clinicians on thepolicies and procedures regarding Care Planning, Coordination and Quality Care.	

and toileting hygiene.

A record review for Patient #3 evidenced an skilled nursing notes dated 11/6/2023, 11/8/2023, 11/10/2023, 11/13/2023, 11/16/2023, 11/18/2023, 11/20/2023, 11/22/2023, 11/24/2023, 11/28/2023, evidenced Patient #3 had Cerebral Palsy (a group of disorders affecting a person's ability to move and maintain balance and posture), left hand contracture poor hand coordination inability to safely ambulate without human assistance has the inability to manage home care needs independently, and was unable to perform activities of daily living without considerable assistance.

A review of Patient #3's clinical record failed to indicate the Agency offered a Home Health Aide to meet Patient #3's needs.

During a interview of 12/1/2023 at 12:54 PM, the Alternate Administrator indicated they did not offer a home health aide and family lived with Patient #3.

4. A clinical record review for Patient #4 evidenced a Physician Order dated

	6/24/2023 for a Medical Social Worker. The patient called and had to reschedule visit and was told the MSW would not be able to see the Patient until 7/16/2023. A clinical record review of Patient #4 electronical medical record evidenced the MSW Evaluation was completed om 7/16/2023. The MSW failed to meet Patient #4's needs and have a timely MSW evaluation, During an interview on 12/1/2023 at 11:45 AM, the Alternate Administrator indicated the Patient was unable to be seen by the MSW because she was going on vacation and the do not have another MSW on staff or contracted. 5. Review of clinical record for Patient #6 which included an initial comprehensive assessment, completed by Registered Nurse (RN) 2 on 10/16/2023, which indicated Patient #6 had a need for assistance with activities of daily living; grooming, dressing, bathing, toileting, and transferring. The assessment			

	assessed if Patient # 6 had need of home health aide services. 6. During an interview with caregiver of Patient #6 conducted on 11/30/23, beginning at 4:07 PM, caregiver confirms agency did not offer home health aide services to assist with Patient # 6's personal care needs. 1. A review of an agency policy revised 11/4/2022, titled "Patient Admission Criteria," indicated patients ae accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be adequately met. 2. A clinical record review for Patient #2 evidenced an agency document titled "Start of Care" which evidenced Patient #2 need assistance with grooming assistance, bathing assistance, toileting hygiene. During a home visit on 11/29/2023 at 5:00 PM, Patient #2 indicated the Occupational Therapist came the day before and she was able to finally shower for the first time since			

	the end of September. Patient #2 indicated she was not offered a home health aide service from the agency. During an interview on 11/29/2023 at 2:30 PM, Registered Nurse (RN) 2 indicated Patient #2 was not offered an aide because the Physician did not order one. RN 2 indicated Patient #2 could use a homemaker and a home health aide to help until they find out what is going on with his/her back, but it is so hard to find home health aides and Patient #2 particular about who he/she wants to see. 3. A clinical record review for Patient #3 evidenced an agency document titled "Start of Care," dated 11/3/2023, which evidenced Patient #3 need assistance with grooming assistance, bathing assistance, toileting hygiene. A record review for Patient #3 evidenced an skilled nursing notes dated 11/6/2023, 11/8/2023, 11/10/2023, 11/13/2023, 11/16/2023, 11/18/2023, 11/20/2023, 11/22/2023, 11/24/2023, 11/28/2023, evidenced Patient			

#3 had Cerebral Palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), left hand contracture poor hand coordination inability to safely ambulate without human assistance has the inability to manage home care needs independently, and was unable to perform activities of daily living without considerable assistance.

A review of Patient #3's clinical record failed to indicate the Agency offered a Home Health Aide to meet Patient #3's needs.

During a interview of 12/1/2023 at 12:54 PM, the Alternate Administrator indicated they did not offer a home health aide and family lived with Patient #3.

4. A clinical record review for Patient #4 evidenced a Physician Order dated 6/24/2023 for a Medical Social Worker. The patient called and had to reschedule visit and was told the MSW would not be able to see the Patient until 7/16/2023.

A clinical record review of Patient #4 electronical medical

	Evaluation was completed om 7/16/2023. The MSW failed to meet Patient #4's needs and have a timely MSW evaluation, During an interview on 12/1/2023 at 11:45 AM, the Alternate Administrator indicated the Patient was unable to be seen by the MSW because she was going on vacation and the do not have another MSW on staff or contracted.			
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 observation, record review and interview, the home health agency failed to ensure the plan of care was individualized to include patient-specific measurable	G0572	**Who:** The ClinicalManager is responsible for monitoring and ensuring the implementation of individualizedPlan of Care that includes patient-specific measurable outcomes and goals. **What:** The ClinicalManager together with the QAPI team members reviewed the agency's written Policiesand Procedures on Plan of Care.	2023-12-20

	outcomes and goals in 5 of 7 clinical records reviewed. (#1, #2, #3, #4, #5) These findings include: 1. An agency policy revised 11/4/2023 titled "Plan of Care," indicated each patient must receive an individualized written plan of care and identifies patient specific goals. 2. A clinical record review for Patient #1 evidenced a plan of care, for the certification period 9/19/2023 -11/17/2023. The patient's goals were for all vital signs to be within normal limits. The patient will recognize the individual disease process, signs and symptoms, cause, risk factors, aggravating factors, complications, and prevention measures of aggravation of symptoms within five weeks. Patient/caregiver will verbalize understanding and adherence to prescribed medications and dietary regimen within five weeks. Patient/caregiver will be able to notify the physician for any significant changes in the patient's condition. The Patient caregiver will verbalize understanding regarding		**When:** The ClinicalManager provided In-Service Training/Re-education to all our clinicians on12/20/2023 regarding the agency's written Policies and Procedures on Plan ofCare. **How:** The ongoingcompliance is monitored by our Clinical Manager together with the QAPI teammembers who conducted Clinical Record Audit to 100% active and discharge patientcensus to ensure all clinicians are accurately, adequately,effectively and efficiently develop and document individualized written patientPlan of Care which specifies patient measurable outcomes andgoals. Our ClinicalManager's chart audit review frequency is every 30 days for the next 6 months. Targetthreshold for compliance is 100%. Once the threshold is met, the clinicalrecords audit will be done quarterly with 50% of the agency's active anddischarge patient records to	

	reduce risk of falls and injuries in the home environment. Patient will remain safe in the home environment setting without a fall or injury throughout the certification. Patient caregiver will be able to contact the assigned clinicians for medical questions or needs. Patient will have input on patient's medical needs and included and comprehensive discharge planning. Patient will demonstrate ability to effectively manage medication regimen. Patient will avoid direct sunlight and use sunscreen protection and wear protective clothing when going out within the episode of care. This plan of care failed to evidence individual goals for Patient #1. 3. A clinical record review for Patient #2 evidenced a plan of care for the certificationperiod 11/1/2023 -12/30/2023. The patient's goals were for all vital signs to be within normal limits. The patient will recognize the individual disease process, signs and symptoms, cause, risk factors, aggravating factors, complications, and prevention measures of aggravation of symptoms within five weeks.		ensure compliance with the standard. The monthly resultof the Chart Audit will be discussed/addressed and incorporated in our QAPIProgram for the 1st and 2nd Quarter of 2024. If after 6 months,the target threshold of 100% is unsuccessfully met, the Clinical Manager willschedule another In-Service Training to all clinicians on 06/20/2024 to immediatelyre-educate all clinicians on the policies and procedures regarding Plan ofCare.	

Patient/caregiver will verbalize understanding and adherence to prescribed medications and dietary regimen within 7 weeks. Patient will remain safe in the home environment setting without a fall or injury throughout the certification. Patient will avoid direct sunlight and use sunscreen protection and wear protective clothing when going out within the episode of care.

4. A clinical record review for Patient #3 evidenced a plan of care, for the certification period 11/3/2023 -1/1/2024. The patient's goals were to be free of Cellulitis and wound infection for the certification period, (Patient #3 was prescribed an antibiotic on 10/30/2023 for Cellulitis) for all vital signs to be within normal limits. The patient will recognize the individual disease process, signs and symptoms, cause, risk factors, aggravating factors, complications, and prevention measures of aggravation of symptoms within six weeks. Patient/caregiver will verbalize understanding and adherence to prescribed medications and dietary regimen within eight weeks. Patient will remain safe

	in the home environment setting without a fall or injury throughout the certification. 5. A clinical record review for Patient #4 evidenced a plan of care, for the certification period 6/15/2023 -8/3/2023. The patient's goals were for all vital signs to be within normal limits. The patient will recognize the individual disease process, signs and symptoms, cause, risk factors, aggravating factors, complications, and prevention measures of aggravation of symptoms within seven to eight weeks. Patient/caregiver will verbalize understanding and adherence to prescribed medications and dietary regimen within eight weeks. Patient will remain safe in the home environment setting without a fall or injury throughout the certification. Patient/caregiver will be able to notify the physician for any significant changes in the Patient's condition within three weeks, Patient/caregiver will verbalize understanding regarding measures to promote communication within three weeks, Patient will demonstrate measures to improve breathing capacity and activity tolerance			

within three to four weeks.

6. A clinical record review for Patient #5 evidenced a plan of care, for the certification period 6/9/2023 -8/7/2023. The patient's goals were for all vital signs to be within normal limits. The patient will recognize the individual disease process, signs and symptoms, cause, risk factors, aggravating factors, complications, and prevention measures of aggravation of symptoms within eight weeks. Patient/caregiver will verbalize understanding and adherence to prescribed medications and dietary regimen within eight weeks. Patient will remain safe in the home environment setting without a fall or injury throughout the certification. Patient/caregiver will be able to notify the physician for any significant changes in the Patient's condition within three weeks, Patient/caregiver will verbalize understanding regarding measures to promote communication within six weeks.

7. During an interview on 12/1/2023 at 12:44 PM, the Alternate Administrator

	should have included patient specific goals. 410 IAC 17-13-1(a).			
G0578	Conformance with physician orders 484.60(b) Standard: Conformance with physician or allowed practitioner orders. Based on observation, record review, and interview, the home health agency failed to ensure physician orders were conformed with regard to an integumentary assessment (skin) and call parameters for a heart rate less than 60 beats per minute in 1 of 7 clinical records reviewed. (Patient #7). Findings include: 1. During home visit on 11/29/2023 beginning at 12:01 PM, the Alternate Clinical Manager failed to complete the skin asssessment on Patient #7. Patient #7 asked the Alternate Clinical Manager if they were going to look at the patient's sacral area, the Alternate Clinical Manager refused and	G0578	**Who:** The CLINICALMANAGER will ensure implementation and monitoring of all clinician's assessmentand documentation as well as if clinicians are reporting to Physician for anyabnormality in vital signs such as heart rate and orders must conformed with regardto Integumentary assessment (skin). **What:** The ClinicalManager together with the QAPI team members reviewed the agency's writtenPolicies and Procedures on Plan of Care. **When:** The ClinicalManager conducted an In-Service Training/Re-education to all clinicians regardingthe agency Policy and Procedures on	2023-12-20

	verbalized the patient was good. A review of clinical record for Patient # 7 evidenced a Plan of Care (POC) for certification period 10/26/23 to 12/24/23. The POC indicated an assessment of the integumentary status was to be completed with each visit as well as parameters to notify the physician of a heart rate less than 60 beats per minute. On 10/31/23, 11/2/23, 11/24/23, and 11/27/23 the agency visit notes indicated the heart rate was documented as less than 60 beats per minute and the physician was not notified. During an interview with Alternate Clinical Manager on 11/30/23 at 4:37 PM, Alternate Clinical Manager confirmed the attending physician was never notified about the out-of-range heart rate for Patient #7. During an interview on 12/1/23 at 11:35 AM with Administrator 2, Administrator 2 confirmed a skin assessment should be performed by nursing staff at each visit.		Conformance with Physician Orders on12/20/2023. **How:** The ongoingcompliance is monitored and implemented by our Clinical Manager together withthe QAPI team members who conducted Clinical Record Audit to 100% active anddischarge patient census to ensure all clinicians are accurately, adequately, effectivelyand efficiently assessing and documenting head to toe assessment each homevisit and reporting to Physician for any abnormality in the patient's vitalsigns. Our ClinicalManager's chart audit review frequency is every 30 days for the next 6 months. Targetthreshold for compliance is 100%. Once the threshold is met, the clinicalrecords audit will be done quarterly with 50% of the agency's active anddischarge patient records to ensure compliance with the standard.	

			The monthly resultof the Chart Audit will be discussed/addressed and incorporated in our QAPIProgram for the 1st and 2nd Quarter of 2024. If after 6 months,the target threshold of 100% is NOT achieved, the Clinical Manager willschedule another In-Service Training to all clinicians on 06/20/2024 to immediatelyre-educate all clinicians on the policies and procedures regarding CONFORMANCEWITH PHYSICIAN ORDER.	
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on observation, record review, and interview, the agency failed to ensure the services and treatments were	G0580	**Who:** The CLINICAL MANAGERwill ensure implementation and monitoring of services and treatments were provided onlyas ordered by a Physician such as accessing the port and obtaining blood forthe labs.	2023-12-20

	provided only as ordered by a physician in 1 of 1 clinical record reviewed for a patient with a port a cath. The findings include: 1. A review of an agency policy revised 11/4/2022, titled "Plan of Care and Physician Orders," indicated drugs, services and treatments are administered only as ordered by a Physician. A review of the clinical record for Patient #1 dated 10/9/2023, evidenced a Skilled Nursing Note which evidenced the Alternate Clinical Manager attempted to draw blood from the patient's port (an implantable device used for blood work and intravenous medication administration) for labs. A review of the clinical record for Patient #1 dated 10/6/2023, evidenced a Skilled Nursing Note which evidenced the Alternate Clinical Manager flushed the patient's port. A review of the clinical record for Patient #1 dated 11/11/2023, evidenced a Skilled Nursing Note which evidenced the Alternate Clinical Manager		**What:** The ClinicalManager together with the QAPI team members reviewed the agency's writtenPolicies and Procedures on Plan of Care and Physician Orders. **When:** The ClinicalManager conducted an In-Service Training/Re-education to all clinicians regardingthe agency Policy and Procedures on Plan of Care and Physician Orders on12/20/2023. **How:** The ongoingcompliance is monitored and implemented by our Clinical Manager together withthe QAPI team members who conducted Clinical Record Audit to 100% active anddischarge patient census to ensure all services and treatments performed by theclinicians has an order from the Physician such as accessing the port andobtaining blood for	

	obtained labs from the patient's port. A review of the clinical record for Patient #1 failed to evidence orders to flush the Patient's port or obtain blood from the Patient's port. During an interview on 11/30/2023 at 4:21 PM, the Alternate Clinical Manager indicated the plan of care should have had the order for accessing the port and obtaining blood for the labs. 410 IAC 17-3-1(a)		the labs. Our ClinicalManager's chart audit review frequency is every 30 days for the next 6 months. Targetthreshold for compliance is 100%. Once the threshold is met, the clinicalrecords audit will be done quarterly with 50% of the agency's active anddischarge patient records to ensure compliance with the standard. The monthly resultof the Chart Audit will be discussed/addressed and incorporated in our QAPIProgram for the 1st and 2nd Quarter of 2024. If after 6 months,the target threshold of 100% is NOT met, the Clinical Manager will scheduleanother In-Service Training to all clinicians on 06/20/2024 to immediatelyre-educate all clinicians on the policies and procedures on PLAN OF CARE ANDPHYSICIAN ORDERS.	

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 other agencies providing services to the patient in 2 of 2 clinical record reviewed receiving services from another home care agency. (Patient #1, #7) and 1 of 1 records requiring coordination of care for laboratory services. (Patient #6) The findings include: Findings include: A review of policy, “Coordination of Patient Care,” revised 11/4/2022, “Care will be coordinated with other involved external organizations…Staff will:…Communicate with other individuals or organizations involved in patient’s care when significant changes occur…Share relevant information to facilitate	G0606	**Who:** The CLINICALMANAGER will ensure implementation and monitoring of coordination of care aredocumented in the patient’s clinical record regarding other agencies providingservices to the patient and reviewing the receiving services from anotherhomecare agency; for any patient requiring coordination of care for laboratoryservices. **What:** The ClinicalManager together with the QAPI team members reviewed the agency’s writtenPolicies and Procedures on Coordination of Patient Care. **When:** On 12/20/2023, theClinical Manager conducted an In-Service Training/Re-education to allclinicians regarding the agency Policy and Procedures on COORDINATION OFPATIENT	2023-12-20

	appropriate continuity and care coordination." 3.Review of clinical record for Patient #6 included all lab work per physician order and consulting physicians can provide orders on Plan of Care (POC) for certification period 10/16/23 to 12/14/23. Record review failed to evidence any communication with other physicians regarding lab work or coordination of care for lab work. 4.Review of clinical record for Patient #7 demonstrated patient use of caregiver services without any documentation found of coordination of care throughout record. During home visit observation on 11/29/23, beginning at 12:01 PM, visually observed caregiver staff from Agency 1 at Patient # 7's bedside assisting patient. 410 IAC 17-12-2(g). 1. An agency policy revised 11/4/2023 titled "Coordination of Patient Care," indicated the clinicians must integrate services, whether provided directly or under the		whether services are provided directly orunder arrangement, to assure the identification of patient needs and factorsthat could affect patient safety and treatment effectiveness and thecoordination of care provided by all disciplines. **How:** The cited patientchart (Patient#1) is now in compliance with the standard. On 12/01/2023, theassigned clinician coordinated already to another homecare agency who isproviding personal care to the patient. Care coordination documentation isalready incorporated in the patient's chart. The ongoingcompliance is monitored and implemented by our Clinical Manager together withthe QAPI team members who conducted Clinical Record Audit to 100% active anddischarge patient census to ensure all clinicians aredocumenting Care Coordination from any provider of the patient and include all	

	identification of patient needs. 2. A review of Patient #1's clinical record evidenced the initial comprehensive assessment indicated Patient #1 was receiving home health aide services through Entity 2. (home health agency). During a phone interview on 11/30/2023 at 2:57 PM, Patient #1 indicated he/she had a home health aide though Entity 2. During an interview on 11/30/2023 at 4:24 PM, the alternate Clinical Manager indicated there was not documentation of coordination of care with Entity 2. 410 IAC 17-12-2(g).		consulting Physicians providing orders on the Planof Care. Chart audit reviewfrequency is every 30 days for the next 6 months. Target threshold forcompliance is 100%. Once the threshold is met, the clinical records audit willbe done quarterly with 50% of the agency's active and discharge patient recordsto ensure compliance with the standard. The monthly resultof the Chart Audit will be discussed/addressed and incorporated in our QAPIProgram for the 1st and 2nd Quarter of 2024. If after 6 months,the target threshold of 100% is NOT met, the Clinical Manager will scheduleanother In-Service Training to all clinicians on 06/20/2024 to immediatelyre-educate all clinicians on the policies and procedures regarding COORDINATIONOF PATIENT CARE.	
G0614	Visit schedule	G0614	**Who:**	2023-12-20

	484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on observation and interview, the agency failed to ensure their patients received a written schedule of visits in 2 of 3 home visits conducted (Patient #1, 7). The findings include: 1. An agency policy revised 11/4/2022, titled "Coordination of Patient Care," indicated the agency would coordinate with the patient by providing a copy of written instructions outlining a visit schedule including the frequency of visit. 2. Observation of a home visit for Patient #3 on 11/28/2023 at 6:20 PM, failed to evidence a completed visit schedule. During the home visit for Patient #3 on 11/28/2023 at 6:20 PM, Registered Nurse (RN) 1 indicated the patient is called the night before to let them know what time the visit will be. 3. Observation of a home visit		The CLINICALMANAGER will ensure implementation and monitoring of patient's visit schedule,including frequency of visits by our agency's personnel and personnel acting onbehalf of the agency. **What:** The ClinicalManager together with the QAPI team members reviewed the agency's writtenPolicies and Procedures on Coordination of Patient Care. **When:** On 12/20/2023, theClinical Manager conducted an In-Service Training/Re-education to allclinicians regarding the agency Policy and Procedures regarding COORDINATION OFPATIENT CARE. **How:** All clinicianswent back to see their assigned new and current patients at home and provided avisit calendar and wrote their scheduled visits for the patient includingfrequency of visits. All patients of the agency have a visit calendar now andin compliance with the standard.	

	12:00 PM, failed to evidence a completed visit schedule. During an interview on 11/30/2023 at 4:11 PM, the alternate Clinical Manager indicated the patient is called the night before to let them know what time the visit will be.		All clinicians will check every home visit forcontinued compliance. The ongoingcompliance is monitored and implemented by our Clinical Manager together withthe QAPI team members to ensure all clinicians are providing a copy of writteninstructions at the patient's home outlining each discipline visit schedule includingtheir frequency of visits. Criteria is setforth based on the components for monitoring the implementation of providing acopy of written instructions outlining a visit schedule including the frequencyof visit as instituted by the Clinical Manager together with the QAPI teammembers, for the next six months, consecutively identifiable as beingcompliant. The Governing Bodytogether with the QAPI team will decide if there is a need for furthermonitoring.	

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 observation and interview, the agency failed to provide the patient a completed written medication schedule and instructions in 1 of 3 home visits. (Patient #3) The findings include: 1. An agency policy revised 11/4/2023 titled “Medication Reconciliation,” indicated they agency would provide the patient and/or caregiver with written patient medication schedule/instructions, including medication name, dose, schedule, route, and frequency as well as which medication will be administered by the agency staff. 2. During a home visit on 11/28/2023 at 6:25 PM, observation of the Patient’s medication schedule failed to evidence Silvadene cream (prevents infections in wounds),	G0616	**Who:** The CLINICALMANAGER will ensure implementation and monitoring of clinician documentation ofpatient medication schedule/instructions, including: medication name, dosageand frequency and which medications will be administered by the agencypersonnel and personnel acting on behalf of the agency. **What:** The ClinicalManager together with the QAPI team members reviewed the agency’s writtenPolicies and Procedures on Medication Reconciliation. **When:** On 12/20/2023, theClinical Manager conducted an In-Service Training/Re-education to allclinicians regarding the agency Policy and Procedures on MedicationReconciliation. **How:** All our clinicianswent to see all their assigned new and current patients at home and ensured	2023-12-20

	diclofenac (for pain). During an interview on 11/28/2023 from 6:20 to 6:55 PM, Registered Nurse (RN) 2 indicated the medications should have been included on the medication schedule.		allpatients have the most current/updated medication list at the patient’s home,discussed and explained to patients of any new or changes in the patient’smedications. The citation has been corrected and is now in compliance with thestandard. All clinicianswill continue to review and reconcile patient’s medications every home visit and update patient's medication list at home toensure continued compliance. The ongoing complianceis monitored and implemented by our Clinical Manager together with the QAPIteam members to ensure our assigned clinician provides ALL our patients and/ortheir respective caregiver’s (at the patient’s home) with written patientmedication schedule/instructions, including medication name, dose, schedule,route, and frequency as well as which medication will be administered by the agencystaff. Criteria is setforth based on the components for monitoring the implementation of providing	

			instructions as instituted by the Clinical Managertogether with the QAPI team members, for the next six months, consecutivelyidentifiable as being compliant. The Governing Body together with the QAPI teamwill decide if there is a need for further monitoring.	
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. Based on observation and interview, the agency failed to provide the patient in writing the services and treatments to be provided by the agency in 3 of 3 home visits. (Patient #2, #3, #7) The findings include: 1. An observation of a home visit was conducted on 11/28/2023, at 6:00 PM, for a skilled nursing visit with Patient #3. Observation failed to evidence the patient was	G0618	**Who:** The CLINICALMANAGER will ensure implementation and monitoring of all treatments to beadministered by the agency personnel and personnel acting on behalf of the agencyincluding therapy services. **What:** The ClinicalManager together with the QAPI team members reviewed the agency's writtenPolicies and Procedures on Rehabilitation Services. **When:** On 12/20/2023, theClinical Manager conducted an In-Service Training/Re-education to	2023-12-20

	current plan of care. During an interview on11/28/2023, at 9:31 AM, the Registered Nurse (RN) 1 indicated the plan of care does not get put in the Patient's home. 2. An observation of a home visit was conducted on 11/29/2023, at 12:00 PM, for a skilled nursing visit with Patient #7. Observation failed to evidence the Patient was provided with a copy of a current plan of care. During a home visit interview on 11/29/2023, at 12:30 AM, the Alternate Clinical Manager indicated the plan of care does not get put in the Patient's home folder. 3. An observation of a home visit was conducted on 11/29/2023, at 5:00 PM, for a skilled nursing visit with Patient #2. Observation failed to evidence the Patient was provided with a copy of a current plan of care. During an interview on 11/28/2023, at 5:00 PM at a home visit for Patient #2, the Registered Nurse (RN) 1		allclinicians regarding the agency Policy and Procedures on RehabilitationServices. **How:** All Therapistswent to see their new and current assigned patients at home and providedall patients with copies of their Therapy Care Plan at the patient's home. Thecitation has been corrected and is now in compliance with the standard. All Therapist willcheck every home visit if the Therapy Care Plan is in the patient's folder forcontinued compliance. The ongoingcompliance is monitored and implemented by our Clinical Manager together withthe QAPI team members to ensure our assigned clinician provide the patientand/or caregiver in the patient's home in writing the services and treatmentsto be provided by the agency. Criteria is setforth based on the components for monitoring the implementation of providing hepatient/caregiver the patient's Therapy Care Plan(s) as instituted by theClinical Manager together with the	

	indicated the plan of care does was not in the Patient's home.		next six months,consecutively identifiable as being compliant. The Governing Body together withthe QAPI team will decide if there is a need for further monitoring.	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections in 2 of 3 home visits with the registered nurse (RN). (#1, 6) The findings include: 1. An agency policy revised 11/4/2023 tilted "Hand Hygiene," indicated staff should perform hand hygiene before and after direct care, before and after each procedure, after removal of gloves, when hands	G0682	**Who:** The ALTERNATE CLINICALMANAGER will ensure implementation and monitoring of all clinician's complianceto accepted standards of practice, including the use of standard precautions,to prevent the transmission of infections and communicable diseases. **What:** The ALTERNATECLINICAL MANAGER together with the QAPI team members reviewed the agency'swritten Policies and Procedures on Hand Hygiene, Specific Procedures forEmployee and Patient Infection Control and Standard Precautions Training.	2023-12-20

	with contaminated materials, before reentering nursing bag or patients' clean supplies. 2. An agency policy revised 11/4/2023 titled "Specific Procedures for Employee and Patient Infection Control Training," indicated hands should be washed before and after wearing gloves, and should be worn with any contact with a moist body site any fluids or solids when handling items soiled with bodily fluids or substances. 3. An agency policy revised 11/4/2023 titled "Standard Precautions," indicated gloves will be worn before touching body and bodily fluids or non-intact skin of all patients. Gloves will be changed, and hands will be washed after contact with each patient. 4. During a home visit for Patient #1 at 6:25 PM on 12/28 2023 an observation was completed for a skilled nurse wound care visit. Registered Nurse (RN) 1 placed her bag on the bed, took out a trash bag from her bag and placed it on the bed and then placed the bag on top of the trash bag. RN		**When:** On 12/20/2023, theALTERNATE CLINICAL MANAGER conducted an In-Service Training/Re-education to allclinicians regarding the agency Policy and Procedures on Hand Hygiene, SpecificProcedures for Employee and Patient Infection Control and Standard Precautions Training. **How:** The ongoingcompliance is monitored and implemented by the Alternate Clinical Manager whoconducted Competency Evaluation for Hand Hygiene and Bag Technique to 100% ofthe agency's active direct patient care staff. CompetencyEvaluation for Hand Hygiene and Bag Technique frequency is every 3 months forthe next 6 months. Target threshold for compliance is 100%. Once the thresholdis met, the Competency Evaluation for Hand Hygiene and Bag Technique will bedone	

	1 removed her stethoscope from her bag listened to the patient's lungs and put the stethoscope back into her bag failing to clean the stethoscope. RN 1 took out a small plastic box with supplies: tape thermometer etcetera, and placed it on the table without a barrier. RN 1 placed a blue pad on the floor, placed the dressing on the pad, removed the patient's sock and old dressing, took off her gloves went back into her bag failing to wash or sanitize her hands. Removed another dressing then went into the patient's supply bag failing to sanitize her hands removed additional dressings. Placed theses supplies on the pad on the floor, placed scissors on the pad on the floor, she donned new gloves failing to wash her hands, removed the adhesive dressing from the wound, cleaned the wound with normal saline and gauze, and removed her gloves. RN 1went into the patient's supply bag, failing to sanitize her hands, went back into her bag and removed gloves, donned her gloves, failing to sanitize her hands, measured the wound with the outside of the dressing package, applied a cream to the		ANNUALLY with 100% of the agency's active direct patient care staff toensure compliance with the standard. The CompetencyEvaluation for Hand Hygiene and Bag Technique result will bediscussed/addressed and incorporated in our QAPI Program for the 1stand 2nd Quarter of 2024. If after 6 months,the target threshold of 100% is NOT MET, the ALTERNATE CLINICAL MANAGER willschedule another In-Service Training/Re-education to all clinicians on 06/20/2024to immediately re-educate all clinicians on the policies and procedures on HandHygiene, Specific Procedures for Employee and Patient Infection Control and StandardPrecautions Training.	

dressing and applied the dressing to the wound and wrapped the wound with gauze. RN 1 applied the patient socks on, and removed her gloves. RN 1 put hand sanitizer on her thermometer and cleaned her thermometer with gauze. She cleaned her blood pressure cuff with the gauze and obtained patient #1's vital signs with one glove on and one glove off. She removed the glove she had on her left hand and placed the plastic boxes from the patient's table back into her bag failing to sanitize her hand prior to going into her bag.

5. A home visit for Patient #6 on 11/29/2023 at 12:00 PM was scheduled to observe a skilled nurse wound care visit. The alternate clinical manager was observed performing wound care. The Alternate Administrator used the wipe cleaned her scissors placed the dirty wipe on top of clean gauze. RN 1 opened a dressing, cut the dressing to size, and poured normal saline on the dressing, while on top of the package, she cleaned the wound and applied the dressing. RN 1 failed to remove

	prior to applying the clean dressing. The alternate clinical manager removed her gloves and donned new gloves but failed to sanitize her hands prior to donning the gloves, she cleaned and applied a new dressing to the second wound. 6 During an interview the Alternate Clinical Manager indicated hands need to be washed with soap and water before and after each patient. Hand sanitizer should be used when going from a dirty to clean task, before going into the Nurse's bag or Patient supplied and before and after donning gloves. 410 IAC 17-12-1(m)			
G0714	Patient and caregiver education 484.75(b)(5) Patient and caregiver education;	G0714	**Who:** The CLINICALMANAGER will ensure implementation and monitoring of patient and caregivereducation provided by the clinician as directed in the Plan of Care. **What:** The ClinicalManager together	2023-12-20

Based on observation, record review, and interview, the skilled professional failed to provide patient and caregiver education as directed in the plan of care in 5 of 7 clinical records reviewed. (Patient #1, 2, 3, 4, 5)

The findings include:

1. An agency policy revised 11/4/2022 titled “Patient Education,” indicated the clinician will provide initial and ongoing education to meet each patients’ individual needs.

2. A review of Patient #1’s clinical record evidenced a plan of care for the certification period 9/19/2023 – 11/17/2023. This plan of care evidence the skilled nurse was to educate patient #1 on dietary restrictions, glucose monitoring , wound care, insertion, usage, and care of a urinary catheter, when to call 911, encourage patient to perform activities to keep blood pressure within normal limits educate on the importance of avoiding straining when eliminating bowel, how to prevent constipation, how to reduce edema, avoid direct exposure to sunlight, wear protective

with the QAPI team members reviewed the agency’s writtenPolicies and Procedures on Patient Education.

When:

On 12/20/2023, theClinical Manager conducted an In-Service Training/Re-education to allclinicians regarding the agency Policy and Procedures on Patient Education.

How:

The ongoingcompliance is monitored and implemented by our Clinical Manager together withthe QAPI team members who conducted Clinical Record Audit to 100% active anddischarge patient census to ensure the clinician provide initial and ongoingeducation to meet each patient’s individual medical needs.

Chart audit reviewfrequency is every 30 days for the next 6 months. Target threshold

	clothing an sunscreen when outside, educate on joint protection, educate on pain relief measures, and taking pain medication before pain escalates. A review of Patient #1's clinical record evidenced nursing visit notes dated 9/29/2023, 10/9/2023, 10/24/2023, 9/22/2023, 11/1/2023, and 11/11/2023. These documents failed to evidence what teaching was done with the patient. During an interview on 12/1/2023, the Alternate Administrator indicated teaching is done throughout the certification period and not everything is taught each visit. She indicated the notes should indicate what teaching was provided. 3. A review of Patient #2's clinical record evidenced a plan of care for the certification period 11/1/2023 – 12/30/2023. This plan of care evidenced the skilled nurse was to educate patient #2 on dietary regimen. Skilled nurse was to instruct on measures to promote safety		the threshold is achieved, the clinical records reviewwill be done quarterly with 50% of the agency's active and discharge patientrecords to ensure compliance with the standard. The monthly resultof the Chart Audit will be discussed/addressed and incorporated in our QAPIProgram for the 1st and 2nd Quarter of 2024. If after 6 months,the target threshold of 100% is NOT achieved, the Clinical Manager willschedule another In-Service Training to all clinicians on 06/20/2024 toimmediately re-educate all clinicians on the policies and procedures on PatientEducation.	

	related to poor vision to reduce risks of falls and injuries. Skilled nurse was to instruct the patient to use appropriate assistive devices whenever ambulating. Skilled nurse was to instruct patient to avoid direct exposure to sunlight and encourage use of sunscreen protection and wear protective clothing when going out., educate patient on proper uses of glucometer machine, proper administration of oral diabetic medication, proper foot and skin care, management preventative measures for hypo and hyperglycemia (high and low blood sugar) and when to report to the skilled nurse or physician, instruct on importance of constant monitoring of blood glucose levels and emphasize no concentration sweet diet. Skilled nurse was to instruct patient to check blood sugar level at least once a day, educate on signs of emergency symptoms of asthma, educate patient on lifestyle and home remedies to lessen the possibility of an asthma attack, instruct the patient on correct use of prescribed inhalant and safety principles with use. Skilled nurse was to instruct patient on how			

to record a pulse and instruct on cardiac limitations.

A review of Patient #2's clinical record evidenced nursing visit notes dated 11/11/2023, 11/15/2023, and 11/24/2023 failed to evidence all of the teaching was completed on each visit.

During an interview on 11/30/2023 at 2:30 PM, Registered Nurse (RN) 2 indicated she picks which topics to talk about each visit. She does not educate on everything.

4. A review of Patient #3's clinical record evidenced a plan of care for the certification period 11/3/2023 – 1/1/2023. This plan of care evidenced the skilled nurse was to educate patient #3 on the individual disease process/other medical condition of the patient, its signs and symptoms, etiology, risk and aggravating factors, complications and preventative measures, educate on the measures to promote safety, instruct on the patient to use appropriate assistive devices whenever ambulating, instruct regarding measures to promote communication, lifestyle

modification, instruct on the cognitive and physical limitations to Cerebral Palsy.

A record review for Patient #3 evidenced skilled nursing notes dated 11/6/2023, 11/8/2023, 11/10/2023, 11/13/2023, 11/16/2023, 11/18/2023, 11/20/2023, 11/22/2023, 11/24/2023, 11/28/2023 failed to evidence all of the teaching was completed on each visit.

During an interview on 11/30/2023 at 4:11 PM, the Alternate Clinical Manager indicated she picks which topics to talk about each visit. She does not educate on everything.

5. A review of Patient #4's clinical record evidenced a plan of care for the certification period 6/15/2023 – 8/13/2023. This plan of care evidenced the skilled nurse was to educate Patient #4 on educate to avoid foods that will aggravate symptoms of GERD, educate on managing the patient's behavioral problems, confusion, sleep problems and agitation, to call 911, and educate on the importance of avoiding straining when eliminating

constipation,

A review of Patient #4's clinical record evidenced nursing visit notes dated 6/24/2023, 7/3/2023, 7/13/2023, 7/22/2023, 7/28/2023, and 8/3/2023. These documents failed to evidence all the teaching was done with the patient and or caregiver.

6. A review of Patient #5's clinical record evidenced a plan of care for the certification period 6/9/2023 – 8/7/2023. This plan of care evidenced the skilled nurse was to educate patient/caregiver on orientation techniques, when to call 911, educate on preventative measures of reducing risk of reoccurrence of a stroke, instruct about safety measures with activities of daily living, and instruct on dietary needs.

A review of Patient #5's clinical record evidenced nursing visit notes dated 6/24/2023, 7/3/2023, 7/13/2023, 7/22/2023, 7/28/2023, and 8/3/2023. These documents failed to evidence all the teaching was done with the patient and or caregiver.

7. During an interview on

	11/30/2023 at 2:30 PM, the Alternate Clinical Manager indicated they do not educate on everything each visit. She indicated during a wound visit they may only educate on wound care. 410 IAC 17-14-1(a)(2)(E)			

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
Shahzad Khan	Administrator	1/4/2024 12:20:54 PM