STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K133	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D-BEST HOME CARE	2346 S LYNHURST DRIVE SUITE 600 , INDIANAPOLIS, Indiana, 46241

(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 follow-up survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102, for a Medicare and Medicaid participating non-deemed Home Health Agency. Survey Dates: 06-12-2024, 06-13-2024, and 06-14-2024. Active Census: 16 Unduplicated Skilled Admissions: 1 At this Emergency Preparedness survey, D-Best Home Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers 42 CFR 484.102. QR completed by Area 3 on 6-20-2024.	E0000		
G0000	INITIAL COMMENTS This visit was a Post-Condition revisit for a home health agency recertification and re-licensure survey conducted on 05-02-2024. Survey Dates: 06-12-2024, 06-13-2024, and 06-14-2024 12-Month Unduplicated Skilled Admissions: 1 During the post-condition revisit survey D-Best Home Care remained out of compliance with one previously cited condition, six standard-level deficiencies were corrected, and two additional standard-level deficiencies were cited. D-Best Home Care was found to be in compliance with CoP 484.55 Comprehensive Assessment of Patients, CoP 484.65 Quality Assurance and Performance Improvement, CoP 484.80 Home Health Aide Services, and CoP 484.102 Emergency Preparedness. D-Best Home Care continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning May 2, 2024, and continuing through May 2, 2026. QR completed by Area 3 on 6-20-2024.	G0000		

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

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G0000 G0412	Written notice of patient's rights CFR(s): 484.50(a)(1)(i) (i) Written notice of the patient's rights and responsibilities under this rule, and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure patients or their legal representatives were provided with a written notice of the patient's rights and responsibilities, the agency's transfer and discharge policies, consent for treatment, and ensured they were understandable and accessible in 3 of 3 active record reviews. (Patients #1, 2, and 3) Findings Include: 1. A review of a D-Best Home Care policy revised on 04-11-2016 and titled "Notice of Rights" indicated but was not limited to, " … Procedure: … The patient/family shall sign and date a form, signifying his/her receipt and understanding of the Patient Rights and Responsibilities. …" 2. A review of Patient #1's clinical record evidenced a Plan of Care (POC) with a start of care date of 05-22-2024. The record failed to evidence a patient's rights and responsibilities form and admission to service forms were provided and signed by the patient or their legal representative upon start of care. 3. A review of Patient #2's clinical record evidenced a Plan of Care (POC) with a start of care date of 05-22-2024. The record failed to evidence a patient's rights and responsibilities form and admission to service forms were provided and signed by the patient or their legal representative upon start of care. 4. A review of Patient #1's clinical record evidenced a Plan of Care (POC) with a start of care date of 05-23-2024. The record failed to evidence a patient's rights and responsibilities form and admission to service forms were provided and signed by the patient or their legal representative upon start of care. 5. During an interview with the Administrator (Admin 1) and Director of Nursing (DON, Admin 2) on 06-13-2024 at	G0000 G0412		

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G0412	Continued from page 2 3:43 PM, they indicated when they readmitted Patients #1, 2, and 3, they had not had the patients or their legal representatives sign any consent forms. They explained they were in the process of having the forms resigned to reflect the patients' new admission dates. 410 IAC 17-12-3(a)1(A) and (B)	G0412		
G0528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the content of the comprehensive assessment was complete and accurately reflected the patients' condition including relevant medical history and diagnoses in 3 of 3 active clinical records reviewed. (Patients #1, 2, and 3) Findings Include: 1. A review of a D-Best Home Care policy with a revised date of 04-11-2016 and titled "Completion of the Comprehensive Assessment" indicated but was not limited to, " … The comprehensive assessment shall reflect the patient's current health status and include information to establish and monitor a plan of care. …" 2. A review of Patient #1's clinical record evidenced a document titled "OASIS-E (sic Outcome Assessment Information Set) Start of Care" with a Start of Care (SOC) date of 05-22-2024. The comprehensive assessment evidenced a primary diagnosis of Vascular Dementia (a decline in memory, thinking, and behavior due to reduced blood flow to the brain), Hemiplegia affecting the right side of the body (paralysis affecting the right side of the body), Type 2 Diabetes Mellitus (the body does not regulate and use sugar appropriately) with Diabetic Polyneuropathy (a condition where multiple nerves are injured due to high sugar levels in the blood), and Hypertension (high blood pressure). The sub-section titled "Mouth" indicated the patient's mouth was within normal limits. During a home visit on 06-13-2024 at 8:30 AM, a Home Health Aide (HHA) was observed performing a bed bath on the patient. It was observed during the home visit, the patient had a set of dentures. The section titled "Client Strengths" was left blank. During the home visit Person 1, Patient #1's caregiver, confirmed they checked in with the	G0528		05/22/2024

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G0528	Continued from page 3 patient often and ensured the patient received what they needed. The section titled “Behavioral Status” was left blank. The section titled “PHQ-2” (the depression screening) was left blank. The section titled “Fall Assessment” was left blank. The section titled “Supplies/DME (sic Durable Medical Supplies)” included chux/underpads, alcohol pads, and exam gloves; but failed to list Diabetic supplies. During an interview with Admin 2 on 06-14-2024 at 3:10 PM, they confirmed the patient had dentures at the time of discharge. They indicated Person 1 was a strong support system for the patient. They indicated the patient’s diabetic supplies were to be listed on the patient’s DME. They explained the assessment was not completed and had not accurately reflected the patient at the time of admission. A review of Patient #1’s clinical record with a Start of Care (SOC) date of 05-19-2021 and a discharge date of 05-21-2024 failed to reflect the patient’s current condition. The clinical record evidenced a document titled “OASIS-E Discharge” dated 05-21-2024 by the Director of Nursing (DON, Admin 2). The comprehensive assessment evidenced a primary diagnosis of Vascular Dementia (a decline in memory, thinking, and behavior due to reduced blood flow to the brain), Hemiplegia affecting the right side of the body (paralysis affecting the right side of the body), Type 2 Diabetes Mellitus (the body does not regulate and use sugar appropriately) with Diabetic Polyneuropathy (a condition where multiple nerves are injured due to high sugar levels in the blood), and Hypertension (high blood pressure). The section titled “Sensory status” evidenced the patient’s eyes were within normal limits and the patient was hearing impaired in both ears. During a home visit on 06-13-2024 at 8:30 AM, it was evidenced the patient had glasses and hearing aids. A document titled “OASIS-E Start of Care” dated 05-22-2024 evidenced the patient had glasses and hearing aids for both ears. The sub-section titled “Hearing” was left blank. The section titled “Neuro/Emotional/Behavioral” indicated the patient had no cognitive, behavioral, or psychiatric symptoms demonstrated once a week. The section titled “Narrative” evidenced the patient had a diagnosis of Dementia (an impaired ability to think, recall information, and make decisions) with behavioral issues and intermittent confusion. The section titled “Fall Assessment” listed the patient was over 65 years old, had cognitive impairment, 3 or more diagnoses, 4 or more prescriptions, history of falls in the last 3 months, and impaired functional mobility; but failed to list the patient’s incontinence and visual impairment.	G0528		

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G0528	Continued from page 4 The OASIS Discharge assessment failed to evidence it was completed and accurately reflected the condition of the patient at discharge. During an interview with Admin 2 on 06-14-2024 at 3:10 PM, they confirmed the patient had glasses, hearing aids, was incontinent, and was cognitively impaired at the time of discharge. They explained the assessment was not completed and had not accurately reflected the patient at the time of discharge. 3. A review of Patient #2's clinical record evidenced a document titled "OASIS-E Start of Care" with a SOC date of 05-22-2024. The comprehensive assessment evidenced a primary diagnosis of Rheumatoid lung disease (a group of lung problems because of Rheumatoid Arthritis) with Rheumatoid arthritis of left shoulder (a chronic inflammatory disease causing pain in joints and issues in organs of the body), Hyperlipidemia (high level of lipids in the blood), Delirium (altered thinking and confusion), Major Depressive disorder, and Chronic kidney disease (loss of the kidney's function to filter out waste and excess fluids). The section titled "Dialysis" indicated the patient was not on dialysis; but the section titled "Narrative" evidenced the patient received dialysis Tuesdays, Thursdays, and Saturdays at Entity 5, a Dialysis center. The sub-sections titled "Neurological", "Behavioral Status", "PHQ-2" (a depression screening), and "Fall Assessment" were left blank. The section titled "Activities Permitted" evidenced the patient had "No Restrictions". During the home visit on 06-14-2024 at 6:05 AM, an HHA was observed transferring the patient and assisting the patient with a shower. During the visit, it was observed, Patient #2 was completely dependent on the HHA to transfer the patient from the bed to the patient's wheelchair, and the wheelchair to the shower chair. The assessment evidenced the DME the patient needed included a wheelchair, alcohol pads, chux/underpads, and exam gloves; but failed to list a shower chair, diapers, gait belt, rollator walker, elevated toilet seat, and 2-wheeled walker as evidenced in the patient's residence during a home visit. During an interview with Admin 1 on 06-14-2024 at 11:41 AM, they confirmed the patient was a fall risk and received dialysis on Tuesdays, Thursdays, and Saturdays. They evidenced they had not performed a depression screening and fall assessment on the patient. They affirmed DME was missing from the assessment and the patient required assistance for activities. They evidenced the assessment was not complete and had not accurately reflected the patient at the time of admission.	G0528		

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G0528	Continued from page 5 A review of Patient #2's clinical record with a SOC date of 03-01-2024 and a discharge date of 05-22-2024 failed to reflect the patient's current condition. The clinical record evidenced a document titled "OASIS-E Discharge" dated 05-22-2024 by the Administrator (Admin 1). The document titled "OASIS-E Start of Care" dated 05-22-2024 evidenced a primary diagnosis of Rheumatoid lung disease (a group of lung problems because of Rheumatoid Arthritis) with Rheumatoid arthritis of left shoulder (a chronic inflammatory disease causing pain in joints and issues in organs of the body), Hyperlipidemia (high level of lipids in the blood), Delirium (altered thinking and confusion), Major Depressive disorder, and Chronic kidney disease (loss of the kidney's function to filter out waste and excess fluids). The OASIS discharge failed to include a list of the patient's pertinent diagnoses. The section titled "Vital Signs" evidenced the patient's temperature and their heart rate; but failed to include the patient's oxygen saturation and blood pressure. In the section titled "Special Treatments, Procedures, and Programs", the box for "None of the above" was selected. The sub-section titled "Dialysis" indicated the patient had not received dialysis. The comprehensive assessment failed to evidence the patient received dialysis from Entity 5, a Dialysis center, and the days and times the patient went to dialysis. The sub-section titled "Hearing" was left blank. Under the section "Integumentary" the question regarding the oldest stage 2 pressure ulcer present at discharge was left blank. The Fall Assessment was left blank. "N/A" was checked regarding whether the patient had fall prevention and depression interventions in place. The assessment failed to evidence whether a reconciled medication list was provided to the patient or caregiver. During an interview with Admin 1 on 06-14-2024 at 11:41 AM, they confirmed the patient was a fall risk and received dialysis on Tuesdays, Thursdays, and Saturdays. They evidenced they had not performed a depression screening, fall assessment, or hearing test on the patient. They evidenced the assessment was not complete and had not accurately reflected the patient at the time of discharge. 4. A review of Patient #3's clinical record evidenced a document titled "OASIS-E Start of Care" with a SOC date of 05-23-2024. The assessment evidenced a primary diagnosis of Multiple Sclerosis (a chronic disease where the body attacks itself causing spasms, incontinence, and walking difficulties). The sub-sections titled "Psychosocial", "Behavioral	G0528		

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G0528	Continued from page 6 Status", and "PHQ-2" (a depression screening) were left blank. A review of Patient 3's clinical record with a Start of Care (SOC) date of 08-13-2019 and a discharge date of 05-22-2024 failed to reflect the patient's current condition. The clinical record evidenced a document titled "OASIS-E Discharge" dated 05-21-2024 by the Director of Nursing (DON, Admin 2). The sub-section titled "Hearing" was left blank. The assessment evidenced the patient's disposition at discharge was unknown. During an interview with Admin 2 on 06-14-2024 at 3:10 PM, they confirmed all information on the assessment was to be completed. They indicated the patient at discharge had remained in their home with assistance because they discharged the patient to correct the clinical record and readmitted the patient the next day. 410 IAC 17-14-1(a)(1)(A)	G0528		
G0570	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of 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. This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview the agency failed to individualize the plan of care to meet all required elements (G574), failed to ensure treatments were followed according to physician orders (G580), and failed to ensure the coordination of care	G0570		05/04/2024

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G0570	Continued from page 7 delivery (G608) for 3 of 3 active clinical records reviewed. (Patients #1, 2, and 3) The cumulative effect of this systemic problem resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for 42 CoP 484.60 Care Planning, Coordination of Services, and Quality of Care. Findings Include: 410 IAC 17-13-1(a)	G0570		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and	G0574		05/22/2024

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G0574	Continued from page 8 the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the Plan of Care (POC) was individualized and included all the required elements in 3 of 3 active clinical records reviewed. (Patients #1, 2, and 3) Findings include: 1. A review of D-Best Home Care policy revised 04-11-2016 and titled “Care Planning” indicated but was not limited to, “ … The plan of care covers the following … required equipment … Medications and treatments … other items as appropriate …” 2. A review of a D-Best Home Care policy revised on 05-20-2024 and titled “Coordination of Patient Services” indicated but was not limited to, “ … The plan of care will list all other organizations/providers involved in the patient’s care. …” 3. A review of Patient #1’s clinical record evidenced a Plan of Care (POC) with a Start of Care date of 05-22-2024 and a certification period from 05-22-2024 to 07-20-2024. The POC evidenced a primary diagnosis of Vascular Dementia (a decline in memory, thinking, and behavior due to reduced blood flow to the brain), Hemiplegia affecting the right side of the body (paralysis affecting the right side of the body), Type 2 Diabetes Mellitus (the body does not regulate and use sugar appropriately) with Diabetic Polyneuropathy (a condition where multiple nerves are injured due to high sugar levels in the blood), and Hypertension (high blood pressure). The POC evidenced a section titled “DME (sic Durable Medical Equipment) and Supplies” and failed to include the supplies observed in the patient’s home during a home visit of a Home Health Aide (HHA) on 05-13-2024 at 8:30 AM. The patient had lancets for blood checks, test strips, a quad cane, and a walker. Blood sugar parameters were not included in the POC for a patient diagnosed with Type 2 Diabetes Mellitus. The "Medications" section indicated “There is no data for this section”. During the home visit at Patient #1’s residence, the Director of Nursing (DON,	G0574		

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G0574	Continued from page 9 Admin 2) explained their process for medication setup, they expressed they looked over the medication list on their electronic medical record. The medications in the patient's home and verified on the medication profile in the patient's home evidenced the patient took the following medications: Fluticasone 50mcg (micrograms), Januvia 25 mg (milligrams) daily, Levetiracetam 500mg 1 by mouth 2 times a day, Duloxetine 30mg 2 times a day, Amlodipine 10mg daily, Atorvastatin 40mg daily, and Losartan 50mg daily. The goals were not patient-specific and measurable as evidenced by, " … Client's strength, endurance and mobility will be improved. … The Caregiver will verbalize understanding of medication regimen, dose, route, frequency, indications and side effects by 60. The Caregiver will demonstrate understanding of flushing peripheral IV (sic intravenous) line. …". During the home visit and observation of the HHA performing a bed bath on the patient, a peripheral IV line was not observed on the patient. Entity 3, a Home Health Agency who provided patient care from 4:00 PM to 9:00 PM, failed to be included on the POC. The POC failed to be patient-specific and listed all the required elements on the POC. During an interview with Admin 2 on 06-14-2024 at 10:18 AM, they explained Patient #1's POC was to include all DME, medications, other providers in the home, and goals pertaining to the patient's care. They indicated the patient had no IV and was not on insulin. 4. A review of Patient #2's clinical record evidenced a POC with a SOC date of 05-22-2024 and a certification period from 05-22-2024 to 07-20-2024. The POC evidenced a primary diagnosis of Rheumatoid lung disease (a group of lung problems because of Rheumatoid Arthritis) with Rheumatoid arthritis of left shoulder (a chronic inflammatory disease causing pain in joints and issues in organs of the body), Hyperlipidemia (high level of lipids in the blood), Delirium (altered thinking and confusion), Major Depressive disorder, and Chronic kidney disease (loss of the kidney's function to filter out waste and excess fluids). The POC indicated the patient's caregiver was available, but failed to indicate the caregiver's availability and willingness. The POC evidenced the DME the patient needed included a wheelchair, alcohol pads, chux/underpads, and exam gloves; but failed to list a shower chair, diapers, gait belt, rollator walker, elevated toilet seat, and 2-wheeled walker as evidenced in the patient's residence during a home visit. The section titled "Activities Permitted" evidenced the patient had "No Restrictions". During the home visit on 06-14-2024 at 6:05 AM, an HHA was observed transferring the patient	G0574		

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G0574	Continued from page 10 and assisting the patient with a shower. During the visit, it was observed, Patient #2 was completely dependent on the HHA to transfer the patient from the bed to the patient's wheelchair, and the wheelchair to the shower chair. The patient provided minimal assistance during transfers and required a wheelchair to move around their residence. The section titled "Goals/Rehabilitation Potential/Discharge Plans" evidenced but was not limited to, " … The Client/Caregiver will verbalize understanding of medication regimen, dose, route, indications, and side effects by . The Client/Caregiver will demonstrate understanding of flushing peripheral IV line. 1. Patient will compile with medication regime … 2. Patient be able to verbize any reactions . …". During the home visit, a peripheral IV line was not observed on the patient. Upon exit of the home visit an aide from Entity 6 (a Personal Service Agency), indicated they provided care for the patient from 7 AM to 7 PM on Mondays, Wednesdays, and Fridays. The aide, Person 8, with Entity 6, explained the patient received dialysis (a procedure used to remove the waste and excess fluids in place of the kidneys) on Tuesdays, Thursdays, and Saturdays and they provided care for the patient before and after dialysis. The POC failed to include Entity 6 provided care for the patient during the day. The POC failed to evidence the patient received dialysis from Entity 5 and the days and times they received dialysis. The POC failed to be patient-specific and listed all the required elements on the POC. During an interview with the Administrator, Admin 1 on 06-14-2024 at 11:41 AM, they indicated the POC was supposed to be complete and accurate according to the needs of the patient. They confirmed all DME, goals, the patient's caregiver and their availability, activities permitted and other providers in the home were supposed to be included in the POC. They confirmed the patient had no IV. 5. A review of Patient #3's clinical record evidenced a POC with a SOC of 05-23-2024 and a certification period from 05-23-2024 to 07-21-2024. The POC indicated a primary diagnosis of Multiple Sclerosis (a chronic disease where the body attacks itself causing spasms, incontinence, and walking difficulties). The section titled "Caregiver Status" evidenced "No family caregiver available." The section titled "Goals/Rehabilitation Potential/Discharge Plans" evidenced but was not limited to, " … Client's strength, endurance and mobility will be improved. The Client/Caregiver will demonstrate proper ROM (Range-of-motion) exercise and body alignment techniques. … The Client/Caregiver will verbalize	G0574		

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G0574	Continued from page 11 understanding of medication regimen, dose, route, frequency, indications, and side effects by . …". The POC failed to evidence the patient had Entity 7, a personal service agency, provided care for the patient from 4:00 PM to 8:00 AM. The POC failed to be patient-specific and listed all the required elements on the POC. During an interview with Admin 2, on 06-14-2024 at 10:18 AM, they indicated the goals listed on the POC were supposed to be complete and reflect the patient's needs. Admin 2 confirmed Patient #3 had Entity 7 provided care for the patient and the patient lived with their caregiver, Person 11 who was there for the patient during the night, but worked during the day. They indicated Entity 7 and Person 11 were to be included on the POC. 410 IAC 17-13-1(a)(D)(ii, vii, ix, and xiii)	G0574		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure orders were received from a physician before providing care for 1 of 1 active patient receiving skilled nursing services. (Patient #1) Findings Include: 1. A review of a D-Best Home Care policy revised on 05-20-2024 and titled "Plan of Care" indicated but was not limited to, " … All clinical services shall be implemented only in accordance with a plan of care established by a physician's written orders. …" 2. A review of Patient #1's clinical record evidenced an "OASIS-E Discharge" document dated 05-21-2024 by the Director of Nursing (DON, Admin 2) at 10:00 AM. The document indicated the patient was discharged from the agency on 05-21-2024. The clinical record evidenced an "OASIS-E Start of Care" dated 05-22-2024 at 1:00 PM by Admin 2 for the patient's start of care. The clinical record revealed an "HHA (sic Home Health Aide) Visit" note dated 05-22-2024 and confirmed the HHA started the visit on 05-22-2024 at 8:28 AM. The agency failed to ensure a Registered Nurse (RN) started care and received orders from the physician before an HHA	G0580		05/22/2024

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G0580	Continued from page 12 provided care. 3. During an interview with Admin 2 on 06-14-2024 at 10:18 AM, they confirmed a Registered Nurse was to perform the start of care and was the first person the patient was to see upon admission to the agency before the HHA. 410 IAC 17-13-1(a)	G0580		
G0608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure they coordinated care with all providers and entities providing care for patients in 1 of 2 active clinical records reviewed with Home Health Aide services only. (Patient #2) Findings Include: 1. A review of a D-Best Home Care policy revised on 05-20-2024 and titled “Coordination of Patient Services” indicated but was not limited to, “ … When the patient is receiving care, treatment and/or services from other organizations/providers, D-Best Home Care ensures that the responsibilities of the HHA (sic Home Health Agency) and other organizations/providers are collaborative and exclusive. Communication is maintained between those providing services regarding changes in the patient’s needs, services or care … The Director of Nursing will document all coordination of care activities with outside organizations or providers in the patient’s medical record, including names of persons spoken to. …” 2. During the entrance conference on 06-12-2024 at 9:43 AM, the Administrator (Admin 1) and Director of Nursing (DON, Admin 2) indicated they would contact the other providers providing care for the patients and include the agencies in the patients’ charts. They explained they would inform the other agencies of any changes in the patient’s care. 3. During a home visit at Patient #2’s residence on	G0608		05/22/2024

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G0608	Continued from page 13 06-14-2024 at 6:05 AM, an aide, Person 8, with Entity 6, a home health agency, indicated their agency provided care for the patient from 7:00 AM to 7:00 PM every day of the week for the patient. A review of agency documents titled “Care Coordination” dated 05-22-2024 to 05-29-2024 failed to evidence coordination of care with Entity 6 and Entity 5, a dialysis (a procedure used to remove the waste and excess fluids when the kidneys are unable to function appropriately) facility. During a phone interview with Person 9, the Coordinator of Clinical Services, from Entity 6, on 06-14-2024 at 2:12 PM, they indicated they had been unaware D-Best Home Care provided care for Patient #2 and had not been contacted by D-Best Home Care. They explained they provided care for Patient #2 on Mondays, Wednesdays, and Fridays from 7:00 AM to 7:00 PM. They confirmed they provided care for the patient on Tuesdays, Thursdays, and Saturdays before the patient received dialysis and after the patient received dialysis from 2:00 PM to 7:00 PM. During an interview with Person 10, Nurse Manager, from Entity 5 on 06-13-2024 at 2:40 PM, they indicated they had not heard from D-Best Home Care regarding Patient #2’s care. The agency failed to evidence documentation of coordination of care with the dialysis center. 410 IAC 17-14-1(a)(1)(F)	G0608		
G1022	Discharge and transfer summaries CFR(s): 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.	G1022		

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G1022	Continued from page 14 This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure all elements of a discharge summary were sent to the physician for 3 of 3 clinical records reviewed. (Patients #1, 2, and 3) Findings Include: 1. A review of a D-Best Home Care policy with a revised date of 05-22-2024 and titled “Discharge/Transfer Summary” indicated but was not limited to, “ … Discharge summary information includes, but is not limited to: date of discharge, patient identifying information … diagnosis, a brief description of the care provided, patient’s medical and health status at the time of discharge …” 2. A review of Patient #1’s clinical record evidenced a document titled “RN (sic Registered Nurse) Discharge Summary” dated 05-21-2024 by the Director of Nursing (DON, Admin 2). The Discharge summary failed to evidence the patient's admission date, the frequencies of the services provided, medications at the time of discharge, the patient’s outcomes toward the goals in the plan of care, and the reason for the patient’s discharge. 3. A review of Patient #2’s clinical record evidenced a document titled “RN (sic Registered Nurse) Discharge Summary” dated 05-22-2024 by the Administrator (Admin 1). The Discharge summary failed to evidence the patient's admission date, the reason for the patient’s admission, types of services provided and their frequencies, medications at the time of discharge, the patient’s outcomes toward the goals in the plan of care, and the reason for the patient’s discharge. During an interview with Admin 1 on 06-14-2024 at 11:41 AM, they evidenced the discharge summary was to include why the patient was discharged, their condition, and the services they provided for the patient. They confirmed they sent the plan of care to the physician. 4. A review of Patient #3’s clinical record evidenced a document titled “RN (sic Registered Nurse) Discharge Summary” dated 05-22-2024 by Admin 2. The Discharge summary failed to evidence the patient's admission date, reason for admission to home health, medications at the time of discharge, and the patient’s outcomes toward the goals in the plan of care. The summary indicated the reason for discharge was because the patient was no longer homebound; but the care summary evidenced the patient was discharged and readmitted to	G1022		

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G1022	Continued from page 15 the agency for the purpose of correcting their clinical records. 5. During an interview with Admin 1 and Admin 2 on 06-12-2024 at 12:50 PM, they confirmed they had readmitted all patients to the agency, excluding the 2 new admissions. 6. During an interview with Admin 1 and Admin 2 on 06-13-2024 at 3:43 PM, they indicated the discharge summary had to have the reason for discharge listed and had to send it to the patient's physician. 7. During an interview with Admin 2 on 06-14-2024 at 3:10 PM, they indicated the discharge summary was to include all pertinent information affecting the patient's care and their condition at discharge. They indicated they had not sent a plan of care or a medication list with the discharge summary. 410 IAC 17-15-1(a)(6)	G1022		