STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K133	A. BUILDING B. WING	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D-BEST HOME CARE	2346 S LYNHURST DRIVE SUITE 600, INDIANAPOLIS, IN, 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
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: 07-22-2024 and 07-23-2024 12-Month Unduplicated Skilled Admissions: 1 During the post-condition revisit survey D-Best Home Care was found to be in compliance with CoP 484.60 Care Planning, Coordination of Services, and Quality of Care. 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,	G0000		

	2026. QR completed by Area 3 on 7-25-2024.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and	G0574	The Administrator and Director ofNursing reviewed CMS COP 484.60(a)(2)(i-xvi) and agency policies 'Plan of Care(Plan of Treatment' and 'Care Planning.' All nurses were inserviced on the individualized plan of care's requiredelements as well as the requirement to accurately document all coordination ofcare activities. All patients' chartswere audited and coordination of care added where missing as well as theservices they provide and frequency provided and the name of the person spokento. To prevent thisdeficiency from recurring, the Director of Nursing will review all activepatients' records to determine if the plan of care is individualized for thepatient and contains all required elements as listed in CMS COP484.60(a)(2)(i-xvi) including all entities providing services to	2024-08-23

	(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure the plan of care was individualized and included all the entities providing services for patients in 1 of 3 active clinical records reviewed. (Patient #3) Findings Include: 1. A review of D-Best Home Care policy revised 05-20-2024 and titled "Plan of Care (Plan of Treatment) indicated but was not limited to, " ... The plan of care must be established ... and if appropriate, other professional staff, shall have a substantial role in ... helping to develop the overall plan of care ..." 2. A review of Patient #3's clinical record evidenced a Plan of Care (POC) with a Start of Care (SOC) date of 04-25-2024 and a certification period from 06-24-2024 to 08-22-2024. The POC evidenced a primary diagnosis of Hypertension (high blood pressure), End Stage Renal Disease (the kidneys are unable to filter out waste and excess fluids requiring a person		their patients.If an omission or error is found, the Director of Nursing or designee will askthe nurse to correct the issue before anything becomes a permanent part of thepatient's record or is sent to the physician for signature. When the Director of Nursing determines theplan of care is correct and contains all required elements, the nurse will signit and it will be sent to the physician for signature. This process will continue indefinitely toensure compliance with this correction. The QAPICommittee will monitor compliance with the requirement that individualized planof care contains all required elements. 100% of plan of cares will be reviewedeach 30 days for 6 months or until 100% compliance has been established and theagency has assurance that plan of cares are complete and contain all requiredelements as listed in CMS COP 484.60(a)(2)(i-xvi). If 100% compliance is not achieved each 30days of the 6 months monitoring period, the monitoring will be extended	

	where a machine replaces the kidneys to remove unnecessary fluid from the body), Atrial Fibrillation (irregular and fast heart rhythm). The POC failed to evidence the patient received services from Entity 3, a dialysis facility, for lab draws and regular check-ins with their nephrologist (a physician specializing in treating kidney diseases). The POC failed to include how often the patient received services from Entity 3. During a phone interview on 07-22-2024 at 11:35 AM, the receptionist, Person 2, for Patient #3's nephrologist, Person 1, evidenced the patient received home peritoneal (the lining of the abdomen is used to drain excess fluid from the body, in place of the kidneys, through a tube) dialysis from Entity 3. During an interview on 07-22-2024 at 12:50 PM, the manager, Person 4, at Entity 3 confirmed Patient #3 received home peritoneal dialysis from their facility. Person 4 indicated they make home visits for the patients upon admission and annually.		another30 days until 100% compliance is achieved. Upon compliance, the QAPI Committee will perform this review quarterlyon a minimum of 10% of patients indefinitely. Staff will bere-inserviced as needed and continued noncompliance with this correction willresult in progressive disciplinary action up to an including termination. The Director ofNursing is responsible for ensuring this correction continues.	

	During an interview with Patient #3 on 07-22-2024 at 3:15 PM, they confirmed they were on peritoneal dialysis with Entity 3 and did their dialysis every evening or night. They indicated they went to Entity 3 every 3 months to have their labs drawn and every 2 months to have a check-up and meet with their nephrologist, Person 1. During an interview with the Administrator (Admin 1) on 07-23-2024 at 9:53 AM, they indicated they were unaware of which dialysis facility Patient #3 received services and went to for labs and follow-up appointments. 410 IAC 17-13-1(a)(D)(xiii)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to ensure the physician was notified of missed visits for 1 of	G0590	TheAdministrator and Director of Nursing reviewed CMS COP 484.60(c)(1) and agencypolicy 'Plan of Care (Plan of Treatment).' All employees were inserviced on required elements of each patient'sindividualized plan of care as well as the need to notify the MD of any changesto the plan of care	2024-08-23

	3 active clinical records reviewed. (Patient #2) Findings Include: 1. A review of D-Best Home Care policy revised 05-20-2024 and titled "Plan of Care (Plan of Treatment)" indicated but was not limited to, " ... HHA professional staff promptly alerts the physician to any changes that suggest a need to alter the plan of care ..." 2. During a review of Patient #2's clinical record, it evidenced a Plan of Care (POC) with a Start of Care (SOC) date of 04-18-2024 and a certification period from 06-17-2024 to 08-15-2024. The POC indicated the patient received Home Health Aide (HHA) services 5 hours a day, 5 days a week for 8 weeks, and 4 days a week for 1 week for assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). The clinical record evidenced the patient had not received services from 07-05-2024 to 07-15-2024. The clinical record failed to evidence the physician was notified of the missed visits. During an interview with the		including a disruption in the MD ordered frequency/durationof visits. To prevent thisdeficiency from recurring, a process was put in place that any employee madeaware of a change to the plan of care must notify the Director of Nursingimmediately. This includes if the MDordered frequency is changed. TheDirector of Nursing will be responsible for notifying the MD of any changes andobtaining orders or adjusting the plan of care If necessary. Visits scheduled will be compared againstvisits documented daily to ensure all visits missed have been reported to theMD appropriately. If any omission isfound, the Director of Nursing will notify the MD of the omission and obtainorders or adjust the plan of care if necessary. The employee responsible for the omission will be re-inserviced andcontinued noncompliance with this correction will result in progressivedisciplinary action up to and including termination.	

	Administrator (Admin 1) on 07-22-2024 at 2:27 PM, they indicated HHA 1 for Patient #2 was gone and had not notified Admin 1 they were gone. Admin 1 confirmed they were unaware the patient was not receiving services at the time. The Office Manager (Admin 4) indicated HHA 1 had informed Admin 4 they were away for testing the week of June 1, 2024 through June 5, 2024. Admin 4 confirmed Patient #2 was made aware the HHA was not going to be there. Admin 1 and Admin 4 evidenced HHA 1 was supposed to be back the next week, but the HHA had not made them aware they had to extend their time off. Admin 1 evidenced the physician was not notified of the missed visits. During an interview with Admin 1 and the Director of Nursing (DON, Admin 2) on 07-23-2024 at 12:00 PM, they indicated HHA 1 was away for a week and had made the office staff aware, but had not returned at the end of the week. They indicated they were unaware the HHA had not returned and was not providing services for Patient #2. They evidenced HHA 1 made them aware a week later, after the		All MDnotifications will be documented in the patient record either as acommunication note including date/time/name of person spoken to or a faxconfirmation of a written notification attached to the notification in themedical record. The QAPICommittee will monitor compliance with the requirement. 100% of patient charts will be reviewed each30 days for 6 months or until 100% compliance has been established and theagency has assurance that all missed visits are reported to the MD. If 100% compliance is not achieved each 30days of the 6 months monitoring period, the monitoring will be extended another30 days until 100% compliance is achieved. Upon compliance, the QAPI Committee will perform this review quarterlyon a minimum of 10% of patients indefinitely. The Director ofNursing is responsible for ensuring this	

	agreed-upon return date. HHA 1 went to see Patient #2 to provide services, the patient refused to receive services from the HHA. Admin 1 confirmed from 07-01-2024 to 07-15-2024, Patient #2 had not received services and the physician was not notified by the agency regarding the missed visits. Admin 2 evidenced their communication with each other was not effective and the physician should have been notified of the missed visits as soon as they were informed by HHA 1 of the missed visits. 410 IAC 17-13-1(a)(2)		correction continues.	
G0608	Coordinate care delivery 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. Based on record review and interview, the agency failed to ensure they coordinated care with other providers and entities providing care for patients in 1 of 2 active clinical records reviewed with Home	G0608	The Administratorand Director of Nursing reviewed agency policy 10021 'Coordination of PatientServices.' All nurses were inserviced on the requirement to coordinate caredelivery with other health providers to meet the patient's needs, and involvethe patient, representative (if any), and caregiver(s), as appropriate, in thecoordination of care activities. This information is to	2024-08-23

	Health Aide (HHA) services only. (Patient #3) Findings Include: 2. During the entrance conference on 07-22-2024 at 9:20 AM, the Administrator (Admin 1) and (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 communicate with other providers at recertification and as needed. 3. A review of Patient #3's clinical record failed to evidence coordination of care with Entity 3, 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 4, the Clinical Manager, from Entity 3, on 07-22-2024 at 12:50 PM, they indicated they had been unaware D-Best Home Care provided care for Patient #3 and had not been contacted by D-Best Home Care. They explained Patient #3 received home peritoneal dialysis (a procedure used to		be documented in themedical record, and if coordination of care is with an agency or company, thename of the person communicated with is to be documented as well. The otherentities involved will be listed on the plan of care and specifics of thecommunication with those entities will be documented in a communication note inthe patient medical record. This is to be completed minimally at admission andevery 60 days. If a patient has no other entities involved to coordinate care,that will be stated in the medical record. To prevent thisdeficiency from recurring, the Director of Nursing or designee will review allactive patients' records for coordination of care documentation. If it ismissing, the nurse will be contacted for clarification and the information willbe added to the medical record. This will be done at minimum every 60 days attime of recertification and documented with each episode of care. This process will continue indefinitely toensure	

	remove the waste and excess fluids when the kidneys are unable to function appropriately) from their facility and they make home visits for patients upon admission and annually. During an interview with the Administrator (Admin 1) on 07-23-2024 at 9:53 AM, they indicated they were unaware of which dialysis facility Patient #3 received services and went to for labs and follow-up appointments. 410 IAC 17-14-1(a)(1)(F) 1. A review of D-Best Home Care policy revised 04-11-2016 and titled "Coordination of Patient Services" indicated but was not limited to, " ... Communication is maintained between those providing services regarding changes in the patient's needs, services or care ... Coordination of service activities is documented in the patient's home care record. Each record shall contain up-to-date information regarding ... Communication between involved parties. ..."		compliance with this correction. The QAPICommittee will monitor compliance with this correction. 100% of patient recordswill be reviewed each 30 days for 6 months or until 100% compliance has beenestablished. If 100% compliance is not achieved each 30 days of the 6 monthsmonitoring period, the monitoring will be extended another 30 days until 100%compliance is achieved. Upon compliance, the QAPI Committee will perform thisreview quarterly on a minimum of 10% of patients indefinitely. Staff will bere-inserviced as needed and continued noncompliance with this correction willresult in progressive disciplinary action up to and including termination. The Director of Nursing is responsible forensuring this correction continues	

G0814	Non-skilled direct observation every 60 days 484.80(h)(2) If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the registered nurse must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in order to observe and assess each aide while he or she is performing care. Based on record review and interview, the agency failed to ensure a Home Health Aide (HHA) supervisory visit was completed every 30 days according to their policy for 1 of 3 active clinical records reviewed. (Patient #2) Findings Include: 1. A review of D-Best Home Care policy revised 04-11-216 and titled "Certified Home Health Aide Supervision" indicated but was not limited to, " ... The Registered Nurse ... evaluates patients receiving only Home health Aide services at least every 30 days with the Home Health Aide present at least once every 60 days ..." 2. A review of Patient #2's	G0814	TheAdministrator and Director of Nursing reviewed CMS COP 484.80(h)(2) and agencypolicy 'Certified Home Health Aide Supervision.' All home health aides and nurses wereinserviced on the requirement of non-skilled patients to have a in personsupervisory visit by a nurse every 30 days with the home health aide present atleast every 60 days. Any scheduleadjustments or coordination that need to be made in order to meet thisrequirement must be reported to the Director of Nursing to ensureadjustments/coordination is followed. All activepatients were audited, and home health aide supervisory visits werepre-scheduled at minimum every 14 days for skilled patients or every 30 daysfor non-skilled patients in their current episodes. The home health aide supervisory visits werepre-assigned to a supervising nurse.	2024-08-23

	of Care with a Start of Care date of 04-18-2024 and a certification period from 06-17-2024 to 08-15-2024. The record evidenced the last HHA supervisory visit note was completed on 05-28-2024. The clinical record failed to evidence an HHA supervisory visit was completed every 30 days. During an interview with the Administrator (Admin 1) and the Director of Nursing (DON, Admin 2) on 07-23-2024 at 12:00 PM, they indicated they were supposed to perform an HHA supervisory visit every 30 days for nonskilled patients. Admin 1 reviewed Patient #2's clinical record and confirmed there were no HHA supervisory visit notes since 05-28-2024. During the Exit Conference on 07-23-2024 at 3:43 PM, Admin 1 and Admin 2 evidenced the HHA they were supposed to supervise for Patient #2 was gone the week they were going to perform the supervisory visit. They indicated they should have done the supervisory the week the aide returned, but planned the next supervisory visit for 07-28-2024.		Thesupervising nurse is to report to the Director of Nursing or Administratorimmediately if a supervisory visit cannot be completed for any reason (patientnot home, weather, etc) so that it can be rescheduled within the requiredtimeframe. The Director of Nursing wasresponsible for ensuring this was completed. To prevent thisdeficiency from recurring, the Director of Nursing will pre-schedule andpre-assign supervisory visits at minimum every 14 days for skilled patients orevery 30 days for non-skilled patients at time of OASIS review for that episodeof care. The supervising nurse will beresponsible to report to the Director of Nursing or Administrator immediatelyif a supervisory visit cannot be completed for any reason so that it can berescheduled within the required timeframe. At time of recertification OASIS review, the Director of Nursing willalso check the previous episode to ensure all supervisory visits were scheduledand completed	

			within the required timeframe. Additionally, the QAPI Committee will audit 100% of patient chartsmonthly for 90 days or until 100% compliance is achieved for home health aidesupervisory visit compliance. Uponcompliance, the QAPI Committee will audit 10% of patient charts quarterly. Failure tofollow this process will result in progressive disciplinary action up to andincluding termination. This process willbe followed indefinitely to ensure compliance with this correction. The Director ofNursing is responsible for ensuring this correction continues.	
N0000	Initial Comments This visit was for a Post Condition Revisit for a State Re-licensure survey of a Home Health Provider. Survey Dates: 07-22-2024 and	N0000		

	07-23-2024 12-Month Unduplicated Skilled Admissions: 1 QR completed by Area 3 on 7-25-2024.			
N0600	Scope of Services 410 IAC 17-14-1(l)(3) Rule 14 Sec. 1(l)(3) If the home health agency issuing the proof of the aide's achievement of successful completion of a competency evaluation program is not the employing agency, the employing agency shall keep a copy of the competency evaluation documentation in the home health aide's employment file. Based on record review and interview, the agency failed to ensure competency evaluations and skills competency were included in the 3 of 3 Home Health Aide (HHA) records reviewed. (Employees: HHA 2, 3, and 4) Findings Include:	N0600	TheAdministrator and Director of Nursing reviewed IAC 17-4-1(l)(3). Competency evaluations were obtained for the3 home health aides in the survey and placed in their files. Remaining home health aide employee fileswere audited to ensure proof of competency were present. To prevent thisdeficiency from recurring, agency Policy 'Certified Home Health Aide CompetencyEvaluation Program' was updated to include: "Home Health Aides who have beencompetency evaluated by an outside agency will provide documentation of thiscompetency. No home health aide will be allowedto provide patient care until the proof of competency is	2024-07-24

	1. A review of the Employee record of HHA 2, with a hire date of 06-18-2024, failed to evidence their competency exam and their skills competency. 2. A review of the Employee record of HHA 3, with a hire date of 06-25-2024, failed to evidence their competency exam and their skills competency. 3. A review of the Employee record of HHA 4, with a hire date of 06-18-2024, failed to evidence their competency exam and their skills competency. 4. During an interview with the Administrator (Admin 1) and the Director of Nursing (DON, Admin 2) on 07-23-2024 at 3:30 PM, they indicated HHAs 2, 3, and 4 had performed the skills and test competency through another agency and confirmed they did not have their competencies in the employees' files.		completeness by the Director of Nursing. Proof will be placed in the employee's file for reference." Additionally, the QAPI Committee will audit100% of new home health aide employee charts monthly for 90 days or until 100%compliance is achieved. Upon compliance,the QAPI Committee will audit 10% of employee charts quarterly indefinitely. The Director ofNursing is responsible for ensuring this correction continues.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joshua Oluwayomi	Administrator	8/5/2024 6:15:07 PM