

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157545	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER PERSONAL TOUCH HOME CARE OF INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 139 W TATE ST STE 1, LAWRENCEBURG, IN, 47025	
(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
N0000	Initial Comments This visit was for a State Re-licensure survey of a Home Health Provider. Survey Dates: April 30th, May 1st, May 2nd, May 3rd of 2024 12-Month Unduplicated Skilled Admissions: 352 QR Completed on 05/08/2024 by A4	N0000	Survey completed. Plan of Correction - note completion dates for each deficiency.	
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at	N0488	Personal Touch Home Care of Indiana and Personal Touch Home Care Inc updated policy to reflect 15 calendar day notice of discharge per Indiana State Regulations. Updated policy was shared with Surveyor while she was on-site. Clinicians were educated on Policy at Mandatory Team Mtg 5/9/2024. All future Clinicians will be educated on policy	2024-05-06

	<p>least fifteen (15) calendar days before the services are stopped.</p> <p>(j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances:</p> <p>(1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient.</p> <p>(2) The patient refuses the home health agency's services.</p> <p>(3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or</p> <p>(4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.</p> <p>Based on record review and interview the agency failed to develop and implement a</p>		<p>at orientation</p> <p>10% of Patient Records will be audited monthly x 3 months for compliance.</p> <p>Then 10% will be audited quarterly for continued compliance.</p> <p>QI team will provide findings at quarterly Meetings</p>	
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	<p>discharge policy ensuring that patients would receive 15-day notice when being discharged from services in 1 of 1 agency review.</p> <p>Findings Include:</p> <p>A policy titled, "Discharge Criteria and Process" indicated but was not limited to, "The organization will verbally notify the patient of the decision to terminate or reduce services within 48 hours prior to the time the change in service is to occur".</p> <p>During an interview on 04/30/2024 at 3:05 PM, the Administrator indicated that the discharge policy and common agency practice is to notify the patient of discharge from services within a 48-hour time frame. She was unaware of the state requirement of a 15-day notice and further indicated the policy would be updated to reflect this state requirement.</p>			
N0522	<p>Patient Care</p> <p>410 IAC 17-13-1(a)</p> <p>Rule 13 Sec. 1(a) Medical care shall follow a</p>	N0522	<p>1. Policy Missed/Unmade Visits was reviewed with all Indiana clinicians. Copy of policy provided and signature for receipt and understanding obtained.</p> <p>2. 10% of Patient Charts will be reviewed weekly for 1 month for compliance; then 10% monthly times 2 months, then quarterly to</p>	2024-05-09

	<p>written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on record review and interview the agency failed to ensure missed visits were attempted to be rescheduled and/or the physician was notified in 2 of 4 records reviewed without home visits. (Patient #4, #5)</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. A policy titled, "Missed/Unmade Visits" indicated the following but was not limited to, "Unmade visits will be moved to another day in that week, if this is not possible then it will be considered a missed visit and the MD will be notified of the missed visit". 2. The POC for Patient #4, certification period, 02/12/2024--04/11/2024 indicated skilled nursing orders starting 02/17/2024 twice weekly x 3 weeks. The clinical record indicated a missed visit by skilled nursing on 02/28/2024 and 03/06/2024. The clinical record failed to 		<p>assure compliance continues per policy.</p> <p>3. Clinicians will continue to be reeducated on this policy at monthly Staff meetings.</p>	
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	<p>evidence attempted rescheduled visits or that the physician was notified.</p> <p>During an interview on 05/02/2024 at 1:00 PM Entity 1 CM indicated the missed visits for Patient #4 were not rescheduled nor was the physician notified. She clarified that if a visit was not completed it would be documented in the EMR (electronic medical record) as either an unmade visit or as a missed visit. An unmade visit indicated that the visit was missed, however, it was completed as a rescheduled visit that same week. A missed visit indicated that the visit was not rescheduled. The expectation is that the physician is to be notified of both, the unmade and missed visits.</p> <p>3. The POC for Patient #5, certification period, 03/23/2024--05/21/2024 indicated skilled nursing orders starting 03/30/2024 once a month x 2 months. The POC indicated the following skilled need: continuing suprapubic catheter changes as ordered. The clinical record indicated a missed visit on 04/19/2024 due</p>			
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	<p>additional follow-up appointments made or scheduled.</p> <p>During an interview on 05/03/2024 at 2:57 PM Entity 1 CM indicated that Patient #5 is to have a Suprapubic catheter (a device used to assist in draining urine from the bladder) change completed every 4-6 weeks. A visit was made on 03/22/2024 by a skilled nurse where the catheter was changed, however, no other visits have been made or are currently scheduled to date. Entity 1 CM is unsure if the patient had the Suprapubic catheter changed by his/her caregiver or physician. No documentation was found in the clinical record. The POC referenced that the patient and caregiver needed more reinforcement of teachings and recommendations.</p>			
<p>N0524</p>	<p>Patient Care</p> <p>410 IAC 17-13-1(a)(1)</p> <p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p>	<p>N0524</p>	<ol style="list-style-type: none"> 1. All Clinicians reeducated on Medication Profile Policy. Copy of Policy provided to Staff, including documentation on plan of care of all DME as well as medications. 2. All SOC, new Plans of care will be reviewed by Clinical Manager and QI for compliance to above for one month. 3. 10% of active patient charts will be reviewed monthly times 3 months, and the quarterly for continued compliance. 	<p>2024-05-09</p>

- (A) Be developed in consultation with the home health agency staff.
- (B) Include all services to be provided if a skilled service is being provided.
- (B) Cover all pertinent diagnoses.
- (C) Include the following:
 - (i) Mental status.
 - (ii) Types of services and equipment required.
 - (iii) Frequency and duration of visits.
 - (iv) Prognosis.
 - (v) Rehabilitation potential.
 - (vi) Functional limitations.
 - (vii) Activities permitted.
 - (viii) Nutritional requirements.
 - (ix) Medications and treatments.
 - (x) Any safety measures to protect against injury.
 - (xi) Instructions for timely discharge or referral.
 - (xii) Therapy modalities specifying length of treatment.
 - (xiii) Any other appropriate items.

Based on record review and interview the agency failed to ensure the medical plan of care included all medications and DME (durable medical equipment) in the home for 3 of 3 patients with a home visit. (Pt #1, #2, #3)

4. Results of all audits per PTHC QI Team will be reported at quarterly meetings for QAPI needs

Findings Include:

1. A policy titled, "Medication Profile" indicated but was not limited to, "All skilled patients will have a current, accurate medication profile in the clinical record to include a drug monitoring review of all medications to identify any potential adverse effects and drug reactions ... Medications profiles will be updated for each medication change to reflect current medications, new, and/or discontinued medications".

2. The POC (Plan of Care) and Medication profile for Patient #1 failed to include the following medications:

Medications: 1. Magnesium Glycinate (magnesium deficiency supplement) 240 mg (milligrams) PO (by mouth) every night, 2. Men's One A Day Complete Multivitamin PO daily, 3. Potassium Chloride (potassium deficiency supplement) 20 mEq (milliequivalents) PO daily, 4. Duloxetine (treats depression/anxiety) 30 mg PO three times a day, Plan of Care

one-time dose, 5. Metoprolol (treats increased blood pressure) 75 mg PO twice daily, 6. B12 (vitamin supplement) 1000 mcg (micrograms) PO daily, 7. Pioglitazone (treats Type 2 diabetes) 15 mg PO daily, and 8. Coenzyme Q10 (CoQ10) (antioxidant used for cell growth/maintenance) 200 mg PO daily.

The POC for Patient #1 failed to include the following medical equipment:

DME: 1. Spirometer (used to improve lung ventilation), 2. Wheelchair, 3. Blood pressure cuff 4. bedside commode, 5. stairlift, 6. shower chair, 7. grab bars located in the bathroom, and 8. Freestyle glucometer (used to measure blood glucose levels).

During an interview on 05/02/2024 at 11:56 PM, LPN 1 indicated that RNs (registered nurses) add DME at the start of care and at each recertification visit. LPN 1 further indicated that she can probably add DME to the POC but has not been trained to do so on the new EMR (electronic medical record). It is her practice to notify the

RN of changes, then the RN updates the POC. LPN 1 indicated that all current medications taken by Patient #1 should be listed on the POC and medication profile and was not aware of the missing and/or incorrect medications noted by the surveyor. It is her practice to ask the patient if there were any changes to his/her medications at each visit, particularly after a known doctor's appointment, and update the POC and medication profile accordingly. Typically, the medications in the home in the original bottles are not compared to the POC or medication profile list unless a discrepancy is found. LPN 1 can and does make changes to the medications in the EMR as needed. The new EMR was implemented in April of 2024 and LPN 1 did complete the EMR training but does not recall being trained on adding/editing DME.

During an interview on 05/02/2024 at 1:39 PM, Entity 1 CM (clinic manager) indicated it the expectation for all current medications and DME to be listed on the POC.

3. The POC and/or Medication

Profile for Patient #2 failed to include and/or failed to discontinue or was incorrect for the following medications:

Medications: 1. Aspirin (used to prevent blood from clotting) 81 mg PO daily (discontinued), 2. Macrobid (used to treat urinary tract infections) 100 mg PO every night (listed on POC/medication profile as twice daily), 3. Cranberry 4200 mg twice a day (listed on POC/medication profile as 1000 mg twice a day), 4. Lidocaine External Gel 2% (treats pain) 1 application daily (discontinued medication), 5. Wound wash Saline External Solution 0.9% 1 Application daily wound cleansing (discontinued) 6. Benadryl Allergy PO 25-50 mg as needed & 50 mg at bedtime as needed for sleep (Discontinued).

The POC for Patient #2 failed to include the following DME:

DME: Hospital bed, Air Mattress, CPAP (continuous positive airway pressure used to keep airways open when sleeping), trapeze (bar over bed to assist in positioning), bedside table, toileting assist bars, and shower

chair.

During an interview on 5/3/2024 at 12:40 PM RN 1 indicated that the above medications and DME are incorrectly listed on the Plan of Care provided to the surveyor. RN 1 indicated not having access to the EMR to update the POC or medication profile as she only utilizes paper charting. Another RN completes home visits at each recertification utilizing the EMR and should be updating this information, unsure why it not happening. RN 1 does not have access to the POC in the EMR and has never been trained to use it. She works with Patient #2 two days a week, working 24-hour shifts, administering all medications, and assisting with home DME use. RN 1 has asked for access to complete EMR documentation for Patient #2 but is unsure why this has not happened. She is unfamiliar with the POC and has never seen one in the home.

4. The POC for Patient #3 failed to include the following DME:

DME: 1. Nebulizer (used to treat

	<p>wheelchair, reacher (used to pick things up from a distance/floor), grab bars, and shower chair.</p> <p>During an interview on 05/02/2024 at 4:20 PM, RN 2 indicated all DME in the home should be listed on the POC and agreed it was not currently all listed. RN 2 plans to add the missing DME.</p>			
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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 Terry Carpenter	TITLE Administrator	(X6) DATE 6/12/2024 9:29:48 AM
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