STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157633	A. BUILDING B. WING	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOME HEALTH CARE INC	3800 W 80TH LN, MERRILLVILLE, IN, 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 6/18/2024 to 6/21/2024 and 6/24/2024 to 6/25/2024 Active Census: 69 At this Emergency Preparedness survey, Hope Home Health, Inc., was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR: 7/05/24, A1	E0000	t this Emergency Preparedness survey, Hope Home Health, Inc., was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	
G0000	INITIAL COMMENTS This visit was for a Federal and State Complaint survey of a	G0000	Hope Home Health has contracted with an outside RN contractor to provide all aide	

	deemed Home Health Provider. Survey Dates: 6/18/2024 to 6/21/2024 and 6/24/2024 to 6/25/2024 Complaint #: 106920 was investigated and found not to be in compliance with 42CFR 484.58. Federal and state deficiencies were cited related to the complaint. 12-Month Unduplicated Skilled Admissions: 368 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. During this Federal Complaint Survey, Hope Home Health, Inc. was found to be out of compliance with Conditions of Participation 42 CFR 484.58 Discharge Planning and 484.60 Care planning, coordination of services, and quality of care. Based on the Condition-level deficiencies during the 6/25/2024 survey, Hope Home Health Care Inc. was subject to an extended survey pursuant to section 1891(c)(2)(D) of the		in-services, training, skills competency and competency evaluations beginning 6-25-24 to 6-24-26.	

	Social Security Act on 6/20/2024. 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 program for a period of two years beginning 6/25/2024 and continuing through 6/24/2026. QR: A1 7/05/24			
G0374	Accuracy of encoded OASIS data 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on record review and interview, the agency failed to ensure the accuracy of OASIS data collected in 1 of 1 record reviewed of a discharge per patient request (Patient #2). The findings include: In the Discharge OASIS (Outcome and Assessment Information Set) (a group of standard data elements used to assess home health care patients) completed by PT	G0374	By 7-19-24 Agency will: *Review with all staff and educate how to answer OASIS question "Reason for Discharge" *Review with all staff agency policy Discharge Criteria and Planning *Review with all staff CFR: 484.45(b) *Clinical Manager will review all Discharge OASIS for accuracy in answering Reason for Discharge Monitoring: Clinical manager will audit 100% of all Reason for Discharge answers on Discharge OASIS for accuracy for a period 1 month.	2024-07-19

	(Physical Therapist) 1 indicated Patient #2 was discharged due to goals met. A clinical record review evidenced a physician order dated 4/19/2024 which indicated the Patient was being discharged from home care due to patient requesting discharge. During an interview on 6/24/2024 at 3:40 PM, the Administrator indicated Patient #2 was discharged due to patient request to go to outpatient therapy, and the Discharge OASIS failed to evidence this.		If 100% accuracy is not achieved in 1 month, Clinical Manager will continue to audit Discharge OASIS monthly until 100% accuracy has been achieved. Once 100% accuracy has been achieved for 3 consecutive months, then Reason for Discharge will be added to quarterly chart audits for a period of 1 year. If 100% accuracy has been achieved after 1 year, monitoring may be stopped and quarterly random monitoring of accuracy will be on-going.	
G0430	Be free from abuse 484.50(c)(2) Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property; Based on record review and interview, the agency failed to provide the patient right to be free from verbal abuse in 1 of 1 clinical record reviewed with a complaint investigation of abuse. (Patient #6) The findings include:	G0430	All staff have reviewed agency policy "Identifying and Reporting Possible Victims of Alleged/Suspected Abuse, Neglect or Exploitation." Administrator reviewed CFR 484.50(c)(2) and 410 IAC 17-12-3(b)(4)(A) with all staff. Administrator educated all staff on the appropriateness of text messaging. Administrator educated all staff of consequences of a patient right's violation that may	2024-07-19

	A review of a policy titled "Identifying and Reporting Possible Victims of Alleged/Suspected Abuse, Neglect or Exploitation" indicated the patient had a right to be free of abuse from agency staff and indicated verbal abuse referred to any use of insulting, demeaning, disrespectful written language directed toward the patient. A review of the agency's complaint binder on 6/18/2024 evidenced a complaint dated 2/14/2024 which indicated the caregiver for Patient #6 called to discuss a complaint of Registered Nurse (RN) 2 sending an inappropriate text to the caregiver. A copy of the texts between the caregiver and RN 2 were included and a text from RN 2 stated, "This girl is as crazy as her mom." On 6/20/2024, at 2:10 PM, the Clinical Manager indicated RN 2 accidentally sent a text to the patient's caregiver about the caregiver and the patient but meant for the text to go to someone else. On 6/20/2024, at 5:07 PM, RN 2		include suspension or termination. Administrator will monitor all patient rights complaints on-going. Administrator will educate all staff on "Identifying and Reporting Possible Victims of Alleged/Suspected Abuse, Neglect or Exploitation" during on-boarding and at least annually.	

	indicated she was indicating the text to be about the patient and the caregiver but did not intend to send the text message to the caregiver but to someone else. 410 IAC 17-12-3(b)(4)(A)			
G0458	Outcomes/goals have been achieved 484.50(d)(3) The transfer or discharge is appropriate because the physician or allowed practitioner, who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with §484.60(a)(2)(xiv) have been achieved, and the HHA and the physician or allowed practitioner, who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services; Based on record review and interview, the agency failed to ensure patient goals were met by the time of discharge in 4 of 4 records reviewed discharged due to “goals met” (Patient #1, 3, 4, 5). The findings include: 1. A review of the plan of care for Patient #3, certification period 4/11/2024 to 6/9/2024, evidenced the following physical therapy goal: the Patient will demonstrate a	G0458	Agency will: *Review with all staff agency policy Discharge Criteria and Planning *Review with all staff CFR: 484.50(D)(3) *Clinical Manager will conference with all clinicians at least 1 week prior to each patient's scheduled discharge to review and discuss if goals are met and appropriateness for discharge. *Clinical manager will educate all clinical staff on the need to contact the physician or ordering practitioner prior to discharge to make sure they agree with the patient's discharge from home care services. Clinical Manager educated all clinicians on goal attainment and appropriateness of	2024-07-19

	Tinetti (a test of balance and stability) score of 22 or higher within 5 weeks. A clinical record review failed to evidence a Tinetti score at the discharge visit by PT (Physical Therapist) 1 on 5/14/2024. The last Tinetti score, documented on 5/7/2024, was 19. When informed of the findings on 6/24/2024 at 4:20 PM, the Administrator indicated she was aware of the problem, and offered no further information. 2. A clinical record review for Patient #5 evidenced a plan of care for certification period 3/7/2024-5/5/2024 which indicated the patient would be discharged when the skin was intact and indicated the patient's goals included, but were not limited to, the patient/caregiver would demonstrate competence with self-management of venous insufficiency (improper functioning of the veins in the legs causing swelling and skin changes) as evidenced by symptom management. The discharge comprehensive assessment dated 5/1/2024 and completed by Registered Nurse		discharge based on established goals. Education will continue to be provided during on-boarding and yearly to clinical staff. Monitoring: Monitoring will be on-going by Administrator	

	(RN) 1 indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) to the right heel and a stasis ulcer (wounds caused by abnormal or damaged veins typically to the feet and legs) to the right 4th toe at time of discharge. The recertification comprehensive assessment on 3/4/2024 indicated the right heel was 100% granulated tissues (new tissue growth) and the right 4th toe had 80% slough (white/yellow material consisting of dead skin cells and mixed with wound drainage) and 20% granulated tissue. The skilled nurse visit note dated 3/11/2024 indicated the right heel and right 4th toe were 100% necrotic (dead tissue). The recertification comprehensive assessment dated 3/4/2024 indicated the left calf measured 23 centimeters (cm) and the right calf measured 22.5 cm. The skilled nurse visit note on 4/22/2024 indicated the left calf circumference was 26 cm and the right calf circumference was 23.5 cm. Review failed to evidence the patient's goals were met prior to discharge.			

	On 6/21/2024, beginning at 2:55 PM, the Clinical Manager indicated the patient should be discharged when the goals were met and indicated most of the goals were met. The Clinical Manager indicated she was unsure why the patient was discharged if the patient was not stable and indicated the symptoms were not managed at time of discharge. On 6/21/2024, at 2:55 PM, the Alternate Administrator indicated the goals were not met. 3. A clinical record review for Patient #1 evidenced a physical therapy (PT) plan of care for certification period 2/15/2024-4/14/2024 which indicated the patient's goals included, but were not limited to, patient will demonstrate improved muscle function to 4/5 and will improve bed mobility to supervision. The PT discharge assessment on 3/20/2024 and completed by PT 1 indicated the patient's strength to both knees and hips were 3/5 and required minimal assistance with bed mobility. The discharge assessment completed by the RN and dated			

	4/12/2024 indicated the patient was discharged for goals met and failed to include an assessment of muscle strength to indicate the patient's goal of improved muscle strength to 4/5 was met. On 6/24/2024, at 2:18 PM, the Clinical Manager indicated the PT should have called the physician if the patient was not meeting goals rather than discharging the patient and indicated the patient should not be discharged if the goals were not met. 4. A clinical record review for Patient #4 indicated the agency discharged the patient from services on 6/5/2024 due to goals met. The plan of care for certification period 4/10/2024-6/8/2024 indicated the patient's goals included, but were not limited to, the patient's pain would be less than 3 on a scale of 0-10 (10 being most severe). The discharge assessment dated 6/5/2024 and completed by RN 1 indicated the patient's pain was rated 8 on a scale of 0-10 to both legs. On 6/20/2024, beginning at			

	1:20 PM, the Clinical Manager indicated the agency should not have discharged the patient if the pain was not controlled.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure the comprehensive assessment included the status of the intravenous catheter (IV, a tube inserted into the bloodstream to deliver medications) in 1 of 1 clinical record review with an IV. (Patient #4) The findings include: A clinical record review for Patient #4 evidenced a start of care comprehensive assessment dated 4/10/2024 that indicated the patient had a port-a-cath (a medical device installed under the skin with a plastic tube that connects to the vein to deliver medication into the bloodstream) to the right side of the chest for antibiotic administration every 24 hours.	G0528	Clinical Manager educated all nurses on the need to include the insertion date and the last dressing change on all comprehensive assessments when patients have a port a cath. Clnical Manager will review all comprehensive assessments on patients with port a cath access to assure that the insertion date and last dressing date change has been included. Monitoring will be on-going by Clinical Manager to assure the agency remains in compliance.	2024-07-19

	The assessment failed to indicate the insertion and last dressing change date. On 6/24/2024, at 2:01 PM, the Clinical Manager indicated the date of the last dressing change and the insertion date should be included in the comprehensive assessment but it was not. 410 IAC 17-14-1(a)(1)(A)			
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on record review and interview, the agency failed to ensure the comprehensive assessment included the ability, willingness, and availability of the primary caregiver is 3 of 5 clinical records reviewed. (Patient #1, 4, 5) The findings included: 1. A clinical record review for Patient #5 evidenced a start of care comprehensive assessment	G0538	Clinical Manager has educated all staff on the need to perform a complete caregiver assessment that includes the caregiver's willingness, ability, and availability and schedule to provide care for the patient. Monitoring will be ongoing by the Clinical Manager. Any caregiver assessments that are not complete will be returned to the assessing clinician to include deficient information. Any clinician found to still be deficient in their caregiver assessments will be educated individually.	2024-07-19

	dated 11/8/2023, which indicated the patient had limited range of motion to the lower extremities, muscle weakness, joint stiffness and pain, and was at a high risk of falls. The assessment indicated the patient was dependent for personal care, mobility, activities of daily living, and feeding and was chairfast. The assessment indicted the patient had a stasis ulcer (wounds caused by abnormal or damaged veins typically to the feet and legs) to the right 4th toe and indicated the patient lived alone with one family member checking on him frequently and another family member who stayed with the patient at night. Review failed to evidence the assessment included the willingness, ability, and availability and schedule of the primary caregiver. On 6/21/2024, at 3:06 PM, the Clinical Manager indicated the assessment did not include the assessment of the caregiver to include who was providing wound care. 2. A clinical record review for Patient #1 evidenced a comprehensive start of care			

	and a comprehensive discharge assessment dated 4/12/2024, which indicated the patient required assistance for dressing, bathing, transferring, and toileting. The comprehensive assessments indicated the patient had a caregiver but failed to evidence the assessments included the willingness, ability, and availability and schedule of the primary caregiver. On 6/24/2024, at 2:22 PM, the Clinical Manager indicated there was no assessment of the primary caregiver in the comprehensive assessments. 3. A clinical record review for Patient #4 evidenced a start of care comprehensive assessment dated 4/10/2024 that indicated the patient needed assistance with grooming, dressing, toilet hygiene, and ambulation. The assessment indicated the patient lived with another person around the clock and failed to evidence the assessment included the willingness and ability of the caregiver to assist with personal care. On 6/24/2024, at 2:01 PM, the			

	Clinical Manager indicated the comprehensive assessment did not include the willingness and ability of the caregiver to assist with personal care.			
G0550	At discharge 484.55(d)(3) At discharge. Based on record review and interview, the agency failed to conduct a comprehensive assessment at time of discharge in 1 of 4 records reviewed for discharge due to goals met. (Patient #5) The findings include: A review of a policy titled "Initial Assessments/Comprehensive Assessments" revised February 2024 indicated the comprehensive assessment would include a physical assessment and a review of systems, a review of all medications, and the assessment of the primary caregiver's willingness and	G0550	Clinical Manager has educated all staff on the need to complete a comprehensive and Discharge OASIS on all patients except in rare circumstances. If there is a reason to complete a Discharge OASIS without a visit, the clinician will contact the Clinical Manager for approval and then contact the physician for approval. A verbal order will be written after physician has approved the non-visit discharge of the patient. Monitoring will be on-going by the Administrator.	2024-07-19

availability and schedule.

A review of a policy titled "Reassessment/Update of the Comprehensive Assessment" revised February 2024 indicated audio only or two-way audio-video telecommunication can be used for updates to the comprehensive assessment if it is part of the patient's plan of care.

A clinical record review for Patient #5 evidenced a discharge comprehensive assessment dated 5/1/2024 completed by Registered Nurse (RN) 1 which indicated the assessment was a non-visit and failed to evidence the reason why the comprehensive assessment was not completed. The assessment indicated the patient was dependent for personal care and activities of daily living (ADLs), was chairfast, and required maximal assistance with rolling from side to side. The assessment indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) to the right heel and a stasis ulcer (wounds caused by abnormal or

	damaged veins typically to the feet and legs) to the right 4th toe at time of discharge. The discharge assessment failed to evidence an assessment of the wounds to include size, wound bed and surrounding skin assessment, and any noted drainage and odor. The assessment failed to evidence the willingness, ability, and availability of the caregiver to provide care to the patient at time of discharge. On 6/20/2024, at 5:27 PM, RN 1 indicated she could not complete the discharge assessment in person because the nurse could not meet the patient's caregiver at the home early in the morning and had patients late into the evening which did not agree with the caregiver, so the discharge assessment was a non-visit. RN 1 indicated she was not at the patient's home at time of discharge so did not reconcile medications that day. On 6/22/2024, beginning at 11:01 AM, the patient's caregiver indicated RN 1 told the caregiver she had other patients to see that day and could not make it until later in			

	the evening for a discharge assessment but could discharge the patient without coming to the home. On 6/21/2024, beginning at 2:37 PM, the Clinical Manager indicated there was no documentation on why a comprehensive assessment was not completed in-person with the patient at time of discharge. The Clinical Manager indicated there was not an assessment of the primary caregiver at time of discharge since the discharge assessment was a non-visit.			
G0560	Discharge Planning 484.58 Condition of Participation: Discharge planning. Based on record review and interview, the agency failed to follow agency policy regarding the discharge planning process to include communicating with the physician to determine the physician was in agreement with the measurable outcomes have been achieved, providing the physician the discharge summary within 5 business days of discharge, and providing a 15 day discharge notice to the patient as required by the State of Indiana in	G0560	Clinical Manager has re-educated all clinicians on the agency's discharge policy entitled "Discharge Planning and Criteria: to include "The discharge is appropriate because the physician/practitioner who is responsible for the home health plan of care and the Agency agree that measurable outcomes and goals set forth in the plan of care have been achieved and the Agency and physician/practitioner responsible for the home health plan of care agree that the patient no longer needs the Agency's services." A verbal order will be written after physician has approved the discharge of the patient. Hope Home Health has revised it's Discharge policy entitled "Discharge Criteria and Planning" to include the 15 day notice to be given to each	2024-07-19

	5 of 5 clinical records reviewed. (Patient #1, 2, 3, 4, 5) The findings include: 1. A review of a policy titled "Discharge Criteria and Planning" revised February 2024 indicated the discharge planning process was to include communicating with the physician who is in agreement that measurable outcomes have been achieved and patient no longer needs agency's services, patient to be informed of the plan to discharge in a timely manner, the documented evaluation of the patient's discharge needs and plan and the documented discussion with the patient/patient representative, the assessment of the continuing care needs at time of discharge, and provision of verbal or written discharge instructions to the patient to include a list of medications. 2. A review of a policy titled "Discharge Summary" revised February 2024 indicated the discharge summary would include, but not limited to, patient's outcomes to goals as listed in the plan of care, patient/family post-discharge instructions, and medications at		patient, patient legal representative or other individual responsible for patient care. Clinical Manager educated all staff on the revised policy Clinical Manager had the new policy placed in all admission packets Clinical Manager gave copies to all staff to give to current patients and instructed them to educate the patients or their representative on the change. Clinical Manager has created a "Discharge Form" task. During scheduling, the Clinical Manager will schedule this task 15 days prior to patient's planned discharge date to the appropriate clinician. This task serves as a cue to the clinician to inform the patient and any representatives of the upcoming discharge and to explain and complete the NOMNC form. Administrator will educate all staff on "Discharge Planning and Criteria" during on-boarding and at least annually.	

	time of discharge and indicated the agency would provide the discharge summary to the physician within 5 business days of discharge. 3. A clinical record review for Patient #5 failed to evidence a notice of discharge was provided to the patient/patient representative prior to discharge and failed to evidence the agency communicated with the physician prior to discharge regarding the physician in agreement the measurable outcomes were met and the patient no longer needed the agency's services. The plan of care for certification period 3/7/2024-5/5/2024 indicated the patient would be discharged when the skin was intact and indicated the patient's goals included, but were not limited to, the patient/caregiver would demonstrate competence with self-management of venous insufficiency (improper functioning of the veins in the legs causing swelling and skin changes) as evidenced by symptom management. The discharge comprehensive assessment dated 5/1/2024 and completed by Registered Nurse		Monitoring of the above processes will be on-going by the Administrator.	

	(RN) 1 indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) to the right heel and a stasis ulcer (wounds caused by abnormal or damaged veins typically to the feet and legs) to the right 4th toe at time of discharge. The recertification comprehensive assessment on 3/4/2024 indicated the right heel was 100% granulated tissues (new tissue growth) and the right 4th toe had 80% slough (white/yellow material consisting of dead skin cells and mixed with wound drainage) and 20% granulated tissue. The skilled nurse visit note dated 3/11/2024 indicated the right heel and right 4th toe were 100% necrotic (dead tissue). The recertification comprehensive assessment dated 3/4/2024 indicated the left calf measured 23 centimeters (cm) and the right calf measured 22.5 cm. The skilled nurse visit note on 4/22/2024 indicated the left calf circumference was 26 cm and the right calf circumference was 23.5 cm. Review failed to evidence the physician was notified of the change in symptoms prior to discharge			

	and the provision of instructions for continued care needs to the patient's caregiver. The discharge summary dated 5/1/2024 noted the agency sent it to the physician on 5/1/2024 and failed to include the discharge instructions for wound care and leg swelling. The discharge summary failed to include each goal as listed in the plan of care and indicated "all goals met". The patient's discharge condition was noted to be "improved" and failed to evidence the wounds to the right heel and right 4th toe and failed to evidence the increased swelling to both calves. On 6/22/2024, at 11:01 AM, the patient's caregiver indicated RN 1 informed the caregiver the "patient's time was up" and the agency couldn't provide services any longer just a few days or the week before services stopped. The patient's caregiver indicated wounds were present to the patient's feet at time of discharge. On 6/21/2024, at 2:50 PM, the Alternate Administrator indicated the more			

summary from the electronic health record was not sent to the physician until 5/16/2024 and indicated the written discharge summary sent to the physician on 5/1/2024 was sent while waiting for the discharge paperwork to be turned in to create the more comprehensive discharge summary in the electronic health record.

4. A clinical record review for Patient #1 evidenced a physical therapy (PT) plan of care for certification period 2/15/2024-4/14/2024 which indicated the therapy diagnosis was muscle weakness and the patient's goals included, but were not limited to, patient will demonstrate improved muscle function to 4/5 and will improve bed mobility to supervision. The PT discharge assessment on 3/20/2024 and completed by PT 1 indicated the patient's strength to both knees and hips were 3/5 and required minimal assistance with bed mobility. The discharge assessment completed by the RN and dated 4/12/2024 indicated the patient was discharged for goals met and failed to include an assessment of muscle strength to indicate the patient's goal of

	improved muscle strength to 4/5 was met. The previous skilled nurse visit prior to discharge dated 4/1/2024 failed to evidence notice of discharge was provided to the patient and no evidence of notice of discharge was evidenced in the clinical record. Review failed to evidence the agency communicated with the physician prior to discharge to ensure the physician agreed the patient's measurable outcomes were met and the patient no longer required home health services. The discharge summary dated 4/14/2024 failed to include the status to goals for the first 6 listed goals on the summary. On 6/25/2024, at 12:52 PM, the patient and caregiver indicated they were not provided discharge notice prior to the day of discharge and were not provided discharge instructions. On 6/24/2024, beginning at 2:18 PM, the Clinical Manager indicated she did not see the patient was provided a notice of discharge in the clinical record and did not see any communication with the			

	physician prior to discharge regarding the physician in agreement that the goals were met. The Clinical Manager indicated she was unsure why the status for the goals were not included in the discharge summary but indicated they should be included. 5. A clinical record review for Patient #4 indicated the agency discharged the patient from services on 6/5/2024 due to goals met. The plan of care for certification period 4/10/2024-6/8/2024 indicated the patient's goals included, but were not limited to, the patient's pain would be less than 3 on a scale of 0-10 (10 being most severe). The discharge assessment dated 6/5/2024 and completed by RN 1 indicated the patient's pain was rated 8 on a scale of 0-10 to both legs. The discharge assessment indicated the RN checked the box that the physician agreed with the plan to discharge for the reason of goals met and failed to evidence the RN communicated with the physician at time of the discharge assessment to communicate the patient's pain level greater than 3 and if the			

	physician was still in agreement that the measurable outcomes were met. A skilled nurse visit note dated 5/30/2024 indicated the RN provided the patient notice of discharge and failed to evidence the agency provided a 15 day discharge notice. On 6/20/2024, at 1:51 PM, the patient indicated the agency staff told them at a visit that the agency would stop coming at the end of the week. The patient indicated they feel about the same after home health services as they did before home health services started. The patient indicated they have shoulder pain on and off and they don't move very well. On 6/20/2024, beginning at 1:20 PM, the Clinical Manager indicated the agency did not provide a notice of discharge prior to 5/30/2024. The Clinical Manager indicated the discharge assessment did not indicate who the nurse spoke to regarding the communication with the physician for the agreement that goals were met and patient no longer in need of agency services and the date			

	Manager indicated there was no documentation the RN informed the physician of the patient's pain at time of discharge and if the physician was still in agreement to discharge even though measurable outcomes were not met. 6. A clinical record review for Patient #2 evidenced a plan of care for certification period 4/9/2024-6/7/2024 which indicated the patient's goals included, but were not limited to, a Tinetti score (a test to assess the patient's perception of balance and stability) of 22 or higher. The discharge assessment completed by PT 1 dated 4/19/2024 failed to evidence a Tinetti score. The clinical record failed to evidence the agency communicated with the physician prior to discharge to ensure the physician agreed the measurable outcomes were met and the patient did not need agency services. Review failed to evidence a notice of discharge was provided prior to the day of discharge to the patient. The discharge summary failed to be sent to the physician until 4/25/2024.			

	On 6/24/2024, at 2:09 PM, the Clinical Manager indicated the comprehensive discharge assessment did not include a prompt for the Tinetti score and indicated the discharge summary was not sent to the physician prior to 4/25/2024. The Clinical Manager indicated she could not find a notice of discharge provided to the patient prior to the day of discharge. The Clinical Manager indicated the plan of care was specific for how long the services were to be provided to the patient as the reason why the physician was not contacted prior to discharge to ensure the physician agreed with the measurable outcomes and that agency services were no longer needed. 7. A clinical record review for Patient #3 evidenced a plan of care for certification period 4/11/2024-6/9/2024 which indicated the patient's goals included, but were not limited to, a Tinetti score of 22. Review of the discharge comprehensive assessment completed by the PT 1 dated 5/14/2024 indicated the patient was discharged for goals met and failed to evidence a Tinetti score. The			

	previous PT visit prior to discharge dated 5/7/2024 indicated the Tinetti score was 19. The record failed to evidence the physician was notified about the goal not met related to the Tinetti score and the physician agreed to discharge despite outcome to goal not met. On 6/20/2024, at 1:43 PM, the Clinical Manager indicated the discharge comprehensive assessment did not include a Tinetti score. The Clinical Manager indicated there was no notice of discharge provided to the patient prior to 5/7/2024. The Clinical Manager indicated there was no documentation the physician was informed of the progress to goals related to no Tinetti score prior to discharge.			

	8. On 6/20/2024, at 5:16 PM, PT 1 indicated he only called the physician in special circumstances such as a joint replacement to be sure he wanted the patient to discharge and otherwise he did not call the physician to ensure the physician agreed with discharge and just followed the ordered frequency on the plan of care. 9. On 6/20/2024, at 5:27 PM, RN 1 indicated most communication was done with the physicians via text and not documented in the notes. RN 1 indicated she could not remember which doctors she communicated with and indicated sometimes it is just the physician's representative she speaks to and indicated she should document exactly who she communicates with but checks the box that the physician was notified since "one way or the other, the doctor is contacted." 410 IAC 17-12-2(i) 410 IAC 17-15-1(a)(6) 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.			
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 record review and interview, the agency failed to ensure services were provided as directed in the plan of care in 2 of 5 clinical records reviewed. (Patient #4, 5) The findings include: 1. A clinical record review for Patient #5 evidenced a plan of care for certification period 3/7/2024-5/5/2024 which indicated the skilled nurse was	G0572	Clinical Manager has educated all staff on the need to follow the plan of care including ordered frequency and assessment of each system to include pain on each nursing or therapy visit. Any missed visits will be reviewed by Clinical Manager to see if the patient wants a visit rescheduled to meet the ordered frequency. All nursing notes will be reviewed by Clincical Manager to make sure all ordered interventions on the plan of care are completed by the nurse. Monitoring is on-going by the Administrator.	2024-07-19

	week to provide wound care and assess patient's pain. A skilled nurse visit note dated 3/11/2024 failed to evidence the nurse assessed the patient's pain as directed in the plan of care. Review failed to evidence the agency provided skilled nurse services the week of 3/17/2024. A missed visit form dated 3/19/2024 indicated the patient's caregiver cancelled services and agreed to be seen the following week. Review failed to evidence the agency attempted to reschedule the skilled nursing services for the week of 3/17/2024 and failed to evidence the patient's caregiver refused any attempts to reschedule the skilled nursing services during the week of 3/17/2024. Review indicated the home health aide provided services 2 times a week during the week of 3/17/2024 on 3/18/2024 and 3/23/2024. On 3/21/2024, beginning at 3:42 PM, the Clinical Manager indicated the nurse did not assess the patient's pain. The Clinical Manager indicated there were no documented attempts to reschedule the skilled nursing visit during the week of 3/17/2024 to meet the ordered			

	visit frequency for the skilled nurse. 2. A clinical record review evidenced a plan of care for certification period 4/10/2024-6/8/2024 which indicated the agency would provide home health aide (HHA) services 2 times a week for 8 weeks. Review failed to evidence the agency provided HHA services 2 times a week as directed in the plan of care during the weeks 4/28/2024, 5/5/2024, and 5/26/2024. The missed visit notes indicated the caregiver cancelled the visits on 4/30/2024, 5/9/2024, and 5/28/2024 and wanted to reschedule, and the record failed to evidence the agency offered to reschedule the visits for the week to meet the ordered frequency. On 6/24/2024, at 1:57 PM, the Clinical Manager indicated there was no documentation the visits were rescheduled and no other visits provided for the week to meet the ordered frequency. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following	G0574	Clinical Manager has educated	2024-07-19

	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 (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 included all necessary components in 5 of 5 clinical records reviewed		all clinicians on SMART goals specific, measureable, attainable, relevant and time bound. The Clinical Manager will review all plans of care to assure that SMART goals are established. Clinical Manager has educated all clincians on patient specific interventions to include DME such as ice machines as well as the DME provider and an end date for antibiotics or an indication that they are for prophylaxis. Clinical Manager has educated all clinicians on the need to assess and document who is performing glucometer checks and how often for all diabetic patients. Clinical Manager will review all comprehensive assessments on diabetic patients to assure that this information has been documented. Clinical Manager educated all clinicians on a complete medication order/profile to include locations for topical applications and indications for PRN medications. Clinical Manager will review all medication profiles for accuracy.	

	(Patient #1, 2, 3, 4, 5). The findings include: 1. A review of the plan of care for certification period 4/9/2024 to 6/7/2024 evidenced the following non-measurable and/or not individualized goals for Patient #2: patient / caregiver will adapt optimally and develop effective coping skills related to change in body image or limitations, patient's activity level will improve, and patient will attain optimal effectiveness of pain management regimen. The plan of care failed to evidence measurable short term physical therapy goals. The plan of care indicated the Patient was taking Cephalexin (an antibiotic) starting 4/8/2024 but failed to evidence an end date. The Admission Narrative on the Plan of Care indicated the Patient had an ice machine in the home but failed to evidence orders for instruction on use of the ice machine. During an interview on 6/24/2024 at 3:40, the Administrator indicated the plan		Monitoring will be on-going by administrator.	

	individualized, measurable goals for both nursing and physical therapy. The Administrator indicated the Cephalexin order should have had an end date, but it did not. The Administrator indicated the pain control section of the plan of care should have evidenced use of the ice machine, but it did not. 2. A review of the plan of care for certification period 4/11/2024 to 6/9/2024 evidenced the following non-measurable and/or not individualized goals for Patient #3: patient will demonstrate return to stable cardiovascular status regarding congestive heart failure and verbalize improvement to symptoms, patient / caregiver will verbalize understanding and demonstrate compliance with prescribed care to improve health status and minimize long-term debilitating diabetes complications, and patient will attain optimal effectiveness of pain management regimen. The plan of care indicated the Patient was diabetic, and gave parameters for patient blood sugars, but failed to evidence			

	who was checking the patient's blood sugar and at what frequency. During an interview on 6/24/2024 at 4:20 PM, the Administrator indicated the goals should be individualized and measurable, but they were not. The Administrator indicated the plan of care should include treatments needed by the patient, but the nurse might not have added it to the plan of care because it was not the Patient's primary diagnosis. 3. A clinical record review for Patient #5 evidenced a swallow study from Entity 2 dated 2/22/24, which indicated the patient's diet order was pureed with honey thick liquid. The plan of care for certification period 3/7/2024-5/5/2024 evidenced the patient's nutritional requirements included a mechanical soft diet and a pureed diet and failed to evidence the plan of care was patient specific. The plan of care indicated the patient's goals included the patient would attain optimal effectiveness of pain management and failed to			

	measurable. On 6/21/2024, at 3:08 PM, the Clinical Manager indicated she was unsure which diet order was correct and the plan of care should be patient specific. The Clinical Manager indicated she was unsure what the patient's optimal level of pain was and should be assessed and included in the plan of care. 4. A clinical record review for Patient #1 evidenced a start of care comprehensive assessment dated 2/15/2024 which indicated the patient had constipation. The plan of care for certification period 2/15/2024-4/14/2024 which indicated the patient's goals included, but were not limited to, the patient will achieve optimal bowel evacuation and failed to evidence the goal was measurable. The medications in the plan of care included, but were not limited to, cyclobenzaprine (muscle relaxer) as needed, Lidoderm patch (a topical patch for pain relief) to applied to painful site, and nystatin powder applied to affected areas. The plan of care failed to be individualized to include the indications for use			

	for the cyclobenzaprine and to what area of the body the Lidoderm and nystatin should be applied. On 6//24/2024, beginning at 2:32 PM, the Clinical Manager indicated the patient's optimal bowel evacuation would have been the frequency of bowel movements from the comprehensive assessment and indicated the plan of care did not document the patient-specific frequency. The Clinical Manager indicated the indications for use for cyclobenzaprine and the parts of the body for the Lidoderm and nystatin were not included in the plan of care. 5. A clinical record review for Patient #4 evidenced a start of care comprehensive assessment dated 4/10/2024 that indicated the patient had a port-a-cath (a medical device installed under the skin with a plastic tube that connects to the vein to deliver medication into the bloodstream) to the right side of the chest for antibiotic administration every 24 hours. The comprehensive assessment indicated the IV (intravenous; port-a-cath is a type of IV)			

	supplies were supplied by Entity 4. The plan of care for the certification period 4/10/2024-6/8/2024 failed to evidence how often the port-a-cath dressing was to be changed and failed to evidence the company supplying the IV supplies. On 6/24/2024, at 1:59 PM, the Clinical Manager indicated the frequency of the port-a-cath dressing change and the company supplying the IV supplies were not included in the plan of care. 410 IAC 17-13-1(a)(1)(D)(viii, ix, x, xiii)			
G0584	Verbal orders 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and	G0584	Clinical Manager has educated all clinicians to obtain and write a verbal order for all admissions to include plan of care, interventions, goals and medication profile. Education will also be provided on the need to include signature, date and time on all verbal orders. Administrator is responsible for on going monitoring to assure we remain in compliance.	2024-07-19

time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies.

Based on record review and interview, the agency failed to ensure clinicians signed, dated and timed the verbal orders received and failed to ensure the verbal orders were authenticated and dated by the physician in 2 of 5 clinical records reviewed. (Patient # 4 and 5)

The findings include:

XX. In a visit note dated 4/26/2024, RN (Registered Nurse) 4 indicated Patient #3 was started on 3 new medications: potassium chloride, furosemide (a water pill), and metolazone (a water pill). A clinical record review failed to evidence physician orders for the new medications.

During an interview on 6/24/2024 at 4:20 PM, the Administrator indicated the nurse should have written a verbal order for the new medications.

17-14-1(a)(H)

1. A review of a policy titled "Physician/Practitioner Orders – Verbal Orders" revised February

	2024 indicated a verbal order must be written down on a supplemental order form to include the physician's name, date and time the order is taken, the signature of the person taking the order, and the specific order within 3 days of receipt of the order. The policy indicated the order would be sent to the physician for signature and authentication. 2. A clinical record review for Patient #5 evidenced a start of care comprehensive assessment completed by Registered Nurse (RN) 1 and dated 11/8/2024 which indicated the nurse coordinated care with the physician responsible for the plan of care to include the start of care and the plan of care. Review failed to evidence the nurse wrote the verbal order, signed, dated and timed the order. Review failed to evidence the physician authenticated and dated the order. On 6/21/2024, at 3:23 PM, the Clinical Manager indicated the verbal order for the start of care was obtained by RN 1 and documented in the comprehensive assessment and			

	indicated the nurse did not write the verbal order and send to the physician for signature. 3. A clinical record review for Patient #4 evidenced a plan of care for certification period 4/10/2024-6/8/2024 which indicated the agency would provide physical therapy (PT) services 1 time a week for 1 week and then 2 times a week for 5 weeks. A PT reassessment dated 5/10/2024 indicated the PT would continue services 1 time a week for 4 weeks effective 5/10/2024 and indicated the PT confirmed the orders with the physician. Review failed to evidence the PT wrote the verbal order, signed, dated and timed the order. Review failed to evidence the physician authenticated and dated the order. On 6/20/2024, at 1:38 PM, the Clinical Manager indicated the verbal order was not written as a supplemental order but the agency used the PT Plan of Care for the continuation order of PT services which was not yet signed by the physician. 410 IAC 17-14-1(a)(H)			

G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Based on record review and interview, the agency failed to ensure the physician reviewed the plan of care no less than every 60 days in 1 of 1 clinical record reviewed with more than 1 certification period. (Patient #5) The findings include: A clinical record review for Patient #5 evidenced a plan of care for the initial certification period 11/8/2023-1/6/2024 was signed by the physician on 2/22/2024. Review failed to evidence the physician reviewed the plan of care no less than every 60 days. On 6/21/2024, at 3:15 PM, the Clinical Manager indicated the plan of care was not reviewed by the physician within 60 days.	G0588	Clincial Manager educated office manager on need to obtain all orders including plans of care in a timely manner. The Administrator will run a report each week to identify any un-signed orders and discuss with Office Manager what steps have been taken to get the orders signed. Unsigned orders may be taken to physician or practitioner's office for signature if not signed in a timely manner and returned to agency via fax or US mail. The Administrator is responsible for on-going monitoring of this process to assure we remain in compliance	2024-07-19

	410 IAC 17-13-1(a)(2)			
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 promptly alert the physician to changes in the patient's condition or needs in 2 of 5 clinical records reviewed. (Patient #3, 5). The findings include: 1. In a skilled nurse visit note dated 4/17/2024, Patient #3 reported a new onset of shortness of breath with minimal exertion to RN (Registered Nurse) 4. A clinical record review failed to evidence the nurse alerted the physician of the Patient's condition. During an interview on 6/24/2024 at 4:20 PM, the Administrator indicated it was	G0590	Clincial Manager educated all clinical staff on the need to promptly alert the relevan 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. The Administrator is responsible for on-going monitoring of this process to assure we remain in compliance	2024-07-19

notify the physician of the Patient's shortness of breath with minimal exertion.

During an interview on 6/25/2024 at 12:10 PM, RN 4 indicated they did not notify the physician of the patient's condition because the Patient said they would follow up with the doctor at their appointment.

2. A clinical record review for Patient #5 evidenced a recertification comprehensive assessment completed by Registered Nurse (RN) 1 and dated 3/4/2024 which indicated the patient's primary diagnosis was venous insufficiency (improper functioning of the veins in the leg causing swelling and skin changes) and indicated the stasis ulcer (wounds caused by abnormal or damaged veins typically to the feet and legs) to the right heel was 100% granulated tissues (new tissue growth) and the right 4th toe had 80% slough (white/yellow material consisting of dead skin cells and mixed with wound drainage) and 20% granulated tissue. The skilled nurse visit note dated 3/11/2024 indicated the right heel and right 4th toe

	were 100% necrotic (dead tissue). The recertification comprehensive assessment dated 3/4/2024 indicated the left calf measured 23 centimeters (cm) and the right calf measured 22.5 cm. The skilled nurse visit note on 3/25/2024 indicated the left calf circumference increased to 24.5 cm and visit note on 4/1/2024 indicated the left calf circumference increased to 26 cm. The visit note on 3/25/2024 indicated the right calf circumference increased to 23.5 cm. Review failed to evidence the agency notified the physician of the changes in the wounds and the increased calf circumference measurements. On 3/21/2024, at 3:50 PM, the Clinical Manager indicated she did not see any communication with the physician regarding the wound and calf measurement changes. 410 IAC 17-13-1(a)(2)			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are	G0606	The Clinical Manager has educated all clinical staff on the need to 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. This includes but is not limited to	2024-07-19

	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 between all entities and disciplines providing care to the patient in 3 of 5 closed clinical records reviewed. (Patient #3, 4, 5) The findings include: 1. A clinical record review for Patient #5 evidenced a wound care note from Entity 2 dated 2/23/2024 which indicated the wound care to the right heel was to apply betadine (an anti-infective solution) and leave open to air. The medication list from Entity 2 dated 2/27/2024 indicated the patient's medications included, but were not limited to, amlodipine (a medication to treat high blood pressure) and enoxaparin (a medication used to thin the blood to prevent/treat blood clots). A review of the plans of care for certification period 1/6/2024-3/6/2024 and 3/6/2024-5/5/2024 failed to evidence betadine for wound care and failed to evidence		all medications. The Clinical Manager instructed all clinicians to use the software communication system to document coordination of care between all disciplines and to write verbal orders for all communication with physician or allowed practitioners to document notification and the physician or allowed practitioner's order or response. The Administrator is responsible for the ongoing monitoring of this process to assure continued compliance.	

	amlodipine and enoxaparin in the patient's medications. Review failed to evidence the agency coordinated care with Entity 2 and with the physician responsible for the plan of care regarding the wound care and medication order discrepancies. On 6/21/2024, at 3:31 PM, the Clinical Manager indicated the agency should document any changes and was looking for discharge orders from Entity 2 and any documentation of coordination of care with Entity 2 and the physician regarding wound care and medication discrepancies. No additional documentation or information was provided before exit on 6/25/2024. 2. A clinical record review for Patient #4 evidenced a skilled nurse visit note dated 4/17/2024 which indicated the patient had muscle weakness and felt like "legs were dead". Review failed to evidence the skilled nurse coordinated care with the physical therapist (PT) who was providing care to the patient 2 times a week. On 6/20/2024, at 1:25 PM, the			

	was no documentation the skilled nurse communicated the patient's complaint to the physical therapist. 3. A clinical record review for Patient #3 evidenced a skilled nurse discharge visit dated 5/7/2024 which failed to evidence the nurse coordinated care with the PT, who was providing care to the patient 1 time a week, regarding the discontinuation of nursing services. On 6/20/2024, at 2:03 PM, the Clinical Manager indicated there was no documentation of care coordination between the nurse and PT regarding the discontinuation of nursing services. 410 IAC 17-12-2(g) 410 IAC 17-12-2(h)			
G0620	Other pertinent instructions 484.60(e)(4) Any other pertinent instruction related to the patient's care and treatments that the HHA will provide, specific to the patient's care needs. Based on record review and	G0620	The Clinical Manager educated all clinical staff on the need to include all other pertinent instruction related to the patient's care and treatments that the agency will provide specific to the patient's care needs. This will include but is not limited to instructions for showering when patient's have a surgical incision. The Administrator is responsible for the ongoing monitoring of this process to assure	2024-07-19

	interview, the agency failed to provide the patient pertinent instruction related to care and treatments in 1 of 1 post-surgical patients (Patient #2). The findings include: A review of the plan of care for certification period 4/9/2024 to 6/7/2024 indicated Patient #2's surgical incision should remain covered by the waterproof bandage for 7 days, then removed and covered with Primapore (a dry gauze dressing). The plan of care indicated the Patient could shower, but failed to evidence what should be done with the surgical incision while showering. During an interview on 6/24/2024 at 3:40 PM, the Administrator indicated the plan of care should include instructions the Patient would need to care for their wound, but it did not.		continued compliance.	
G0644	Program data 484.65(b)(1),(2),(3)	G0644	The Governing Board met on 7-19-2024 to approve the frequency and detail of data collection for the QAPI program. The Administrator along with the Governing	2024-07-19

	Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. Based on record review and interview, the agency failed to ensure the governing body approved the frequency and detail of the data collection for the quality assurance and performance improvement (QAPI) program. The findings include: A review of the agency's QAPI program and governing body meeting minutes from 10/20/2022 to 2/1/2024 failed to evidence the governing body approved the frequency and detail of the data collection. On 6/25/2024, at 1:15 PM, the Clinical Manager indicated there was no documentation of the approval from the governing body for the data collection. The Clinical Manager indicated		Board is responsible for the on-going monitoring of the process to assure continued compliance.	

	governing body meeting notes. 410 IAC 17-12-2(a)			
G0646	Program activities 484.65(c) (1) The HHA's performance improvement activities must (i) Focus on high risk, high volume, or problem-prone areas; (ii) Consider incidence, prevalence, and severity of problems in those areas; and (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Based on record review and interview, the agency failed to ensure the performance improvement activities led to an immediate correction of identified problem that threatened the health and safety of patients. The findings include: A review of the quality assurance performance improvement (QAPI) report from Quarter 1 2024 evidenced 34 patient hospitalizations for a total of 19.2% and the total from Quarter 4 2023 was 19.1%. Review indicated the agency did not meet their goal of 15% and	G0646	Administrator has reviewed all QAPI data. Goal was unmet. However, there was information in the report about PI activities to address any failures. Leading cause of hospitalizations in Q1 2024: Neuro and other. No real trend identifiedZERO hospitalizations r/t CHF. Hospitalization subset goal MET:Q1 2023, the agency established a goal to reduce hospitalizations related to falls to 10% or less. This goal has been met: in Q1 2024, there were only two patients hospitalizeddue to a fall (5.9%) Hospitalization subset goal MET:Q4 2023, the agency established a goal to reduce hospitalizations related to CHF to 10% or less. This goal has been met: in Q1 2024, there were zero patients hospitalized due CHF (0%) Hospitalization subset goal MET:Q4 2023, the agency established a goal to reduce hospitalizations related to wounds to 10% or less. This goal has been met: in Q1 2024, there was only 1 patient hospitalized due to wound deterioration (2.9%) Performance Improvement Action Plan was listed on the data as: 1) Maintain wound protocol for all patients with any type of wound a) This would include additional printed information regarding signs andsymptoms to report, prevention, handwashing, wound care b) Reporting of nonhealing/declining wounds	2024-07-19

	failed to evidence any change or new performance improvement activities to address the failure to reduce the hospitalization rate from Quarter 4 2023 to Quarter 1 2024. On 6/25/2024, at 1:15 PM, the Clinical Manager indicated the agency's action plan was the same as last year for the hospitalization rate and no new performance improvement activities had been added.		to MDwith carecoordination and new orders clearly documented c) Perhaps implement chlorhexidine wipes protocol for all woundcarepatients d) Implement wound monitoring protocol from the office and caseconference weekly on wounds that show little to no improvement 2) Continue protocol for potentially avoidable hospitalizations a) 14.7% of this quarter's hospitalizations are considered potentiallyavoidablei) Down 22% from last quarter (was 36.7%) b) Create, implement and/or maintain Fall, DM, COPD, UTI andHTNprotocols c) Maintain CHF protocol 3) Implement (reasonable and necessary) front loading efforts a) 64.7% of this quarter's hospitalizations occurred within 30 days of thepatient being discharged from the hospital (SOC/ROC)Q1 2024 QAPI Report - Hope Home Health Care, Inc. b) Increasing the # of visits the first 1-4 weeks post hospitalizationcanpotentially reduce the # of hospitalizations that occur within the first 30days after dischargei) Recommendation: SN visits 2-3x weekly for weeks 1-2; 2x weeklyweeks 3-4; reduce only if progression towards establishedgoals isobserved/documented c) Additionally, identifying and addressing barriers to noncompliance such as transportation, knowledge deficits, poor coping skills, cognitive deficits, unwilling/unable caregivers, etc. can potentially reduce ERvisits and/or hospitalizationsi) Recommendation: Identify all compliance barriers at SOC, ROCand/or Recert. Establish patient specific goals and orders forcompliance with POC, medications, MD followup, etc. ii) Involve MSW as applicable/appropriate	

			Administrator will continue to review all QAPI data, and implement strategies for any failures or identified problem areas.	
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the agency failed to document a performance improvement project (PIP) undertaken and failed to document the reason for considering the project and the measurable progress achieved. The findings include: A review of the quality assurance performance	G0658	Administrator has written up the PIP for 2024. This was based on 2023 trended data. Administrator is responsible for creating the PIP with input and participation by the PIP team and all clinicians. Monitoring will be on-going	2024-07-19

	from Quarter 1 2024 evidenced suggestions for performance improvement projects. The report failed to identify a project that was chosen to be undertaken by the agency, and the reason for considering the project and the measurable progress achieved. On 6/25/2024, at 1:15 PM, the Clinical Manager indicated she was not sure if the former alternate clinical manager had a performance improvement project before she left at the end of January and indicated there was nothing documented about a PIP.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the skilled professional failed to document complete and clear clinical notes in 1 of 5 clinical records reviewed (Patient #5). The findings include: 1. A skilled nurse visit note	G0716	Clinical Manager educated all clinicians on preparing clinical notes for accuracy. Any time the Administrator identifies inaccurate documentation from a clinician, that clinician will be provided one-on-one education. Additionally, the requirement of accurate and comprehensive documentation on all visit notes will be part of all onboarding education as well as annual education. Administrator is responsible for on-going monitoring of this process to assure continued compliance.	2024-07-19

	dated 4/15/2024 evidenced the nurse removed Patient #2's original surgical dressing and covered the incision with a dry dressing. A clinical record review failed to evidence a measurement of the surgical wound. A review of physical therapy visit notes dated 4/10/2024, 4/12/2024, 4/15/2024 and 4/17/2024 failed to evidence documentation of the surgical wound or presence of a dressing. During an interview on 6/24/2024 at 3:40 PM, the Administrator indicated the nurse should have documented a measurement of the wound when it was first visible (4/15/2024) but they did not. The Administrator indicated the physical therapist should observe the surgical site / dressing at each visit and document their findings, but they did not. 2. A clinical record review for Patient #5 evidenced a plan of care for certification period 3/7/2024-5/5/2024 and a recertifcation comprehensive assessment dated 3/4/2024,			

	both signed by Registered Nurse (RN) 1, which indicated the nutritional requirements included TPN (total parental nutrition, the administration of nutrition into the blood stream). Review failed to evidence an assessment of TPN and TPN orders. On 6/21/2024, at 3:08 PM, the Clinical Manager indicated the completion of the documents to include TPN was a mistake. 410 IAC 17-14-1(a)(1)(E)			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the agency failed to provide written patient care instructions in 1 of 1 clinical record reviewed with thickened liquid orders. (Patient #5)	G0798	Clinical Manager educated all clinicians on preparing written patient care instructions for the aide care plan. Emphasized that all diet orders and precautions need to be included. Administrator is responsible for the on-going monitoring of this process to assure continued compliance.	2024-07-19

	The findings include: Review of the policy titled "Care Planning Process" revised February 2024 indicated the home health aide care plan will include, but not be limited to, nutritional requirements and safety measures. The clinical record review for Patient #5 evidenced plans of care for certification period 1/7/2024-3/6/2024 and 3/7/2024-5/5/2024 which indicated the patient was to receive honey thick liquids. Review of the home health aide care plan dated 3/4/2024 failed to evidence the home health aide was provided written instructions to include the patient's honey thick liquid orders and aspiration precautions. On 6/21/2024, at 3:34 PM, the Clinical Manager indicated honey thick liquids and aspiration precautions were not listed on the aide care plan. 410 IAC 17-14-1(m)			
G0818	HH aide supervision elements	G0818	Clinical Manager educated all clinicians on aide superviory visits and what is needed to include: Review if aide is following plan of care, Maintain open communication, Demonstrates	2024-07-19

	484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. Based on record review and interview, the agency failed to ensure the registered nurse (RN) provided supervision of the home health aide (HHA) in 3 of 3 clinical records reviewed with HHA services. (Patient #1, 4, 5) The findings include: 1. A clinical record review for Patient #5 evidenced HHA visit notes completed by HHA 2 and dated 3/9/2024, 3/11/2024, 3/16/2024, 3/18/2024, 3/23/2024, 3/25/2024, 3/30/2024, 4/6/2024, 4/8/2024, 4/13/2024, 4/15/2024,		competency, Complies with infection control, Reports changes in patient condition, and honors patient rights. Instructed RNs, PTs and OTs that they must review aide notes also for accuracy in following the plan of care. Administrator is responsible for on-going monitoring to assure continued compliance	

	4/20/2024, and 4/22/2024 which indicated the HHA documented the patient's temperature to be 97.4 degrees Fahrenheit. The HHA supervisory visit note completed by RN 1 and dated 4/22/2024 failed to evidence supervision of the HHA to address the repetitive patient temperatures. 2. A clinical record for Patient #1 evidenced HHA visit notes completed by HHA 2 and dated 3/6/2024, 3/8/2024, 3/13/2024, 3/16/2024, 3/20/2024, 3/22/2024, 3/27/2024, 3/29/2024, 4/3/2024, 4/6/2024, 4/8/2024, and 4/11/2024 which indicated the HHA documented the patient's temperature to be 96.5 degrees Fahrenheit. The HHA supervisory visit notes completed by RN 1 and dated 3/18/2024, 3/25/2024, 4/1/2024, and 4/12/2024 failed to evidence supervision of the HHA to address the repetitive patient temperatures. 3. A clinical record review for Patient #4 evidenced HHA visit notes completed by HHA 2 and dated 4/15/2024, 4/19/2024, 4/22/2024, 4/25/2024, 5/2/2024, 5/6/2024, 5/13/2024,			

	5/16/2024, 5/21/2024, 5/23/2024, 5/30/2024, and 6/4/2024 which indicated the HHA documented the patient's temperature to be 97.5 degrees Fahrenheit. The HHA supervisory visit notes completed by RN 1 and dated 4/17/2024, 4/25/2024, 5/1/2024, 5/10/2024, 5/15/2024, 5/22/2024, 5/30/2024, and 6/5/2024 failed to evidence supervision of the HHA to address the repetitive patient temperatures. 4. On 6/21/2024, at 3:40 PM, the Clinical Manager indicated the RN should have provided supervision to the HHA by asking the HHA why the temperature was the same at every visit and provide observation of the HHA to ensure temperature was being obtained accurately. The Clinical Manager indicated she did not believe the RN reviewed the HHA visit notes. 410 IAC 17-14-1(n)			
G1024	Authentication 484.110(b)	G1024	Clinical Manager educated all clinicians on legible, clear, complete and appropriatel authenticated, dated and timed entries and notes. Educated all clinicians that sometimes a computer cache may auto-fill certain boxes and to review all documentation prior to	2024-07-19

	Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure the home health aide (HHA) accurately documented in the clinical record in 3 of 3 clinical records reviewed with HHA services. (Patient #1, 4, 5) The findings include: 1. A clinical record review for Patient #5 evidenced HHA visit notes completed by HHA 2 and dated 3/9/2024, 3/11/2024, 3/16/2024, 3/18/2024, 3/23/2024, 3/25/2024, 3/30/2024, 4/6/2024, 4/8/2024, 4/13/2024, 4/15/2024, 4/20/2024, 4/22/2024, 4/26/2024, and 4/29/2024 which indicated the HHA documented the patient's temperature to be 97.4 degrees Fahrenheit. 2. A clinical record for Patient #1 evidenced HHA visit notes completed by HHA 2 and dated 3/6/2024, 3/8/2024, 3/13/2024,		signing. Administrator is responsible for the on-going monitoring of this process to assure continued compliance.	

	3/16/2024, 3/20/2024, 3/22/2024, 3/27/2024, 3/29/2024, 4/3/2024, 4/6/2024, 4/8/2024, and 4/11/2024 which indicated the HHA documented the patient's temperature to be 96.5 degrees Fahrenheit. 3. A clinical record review for Patient #4 evidenced HHA visit notes completed by HHA 2 and dated 4/15/2024, 4/19/2024, 4/22/2024, 4/25/2024, 5/2/2024, 5/6/2024, 5/13/2024, 5/16/2024, 5/21/2024, 5/23/2024, 5/30/2024, and 6/4/2024 which indicated the HHA documented the patient's temperature to be 97.5 degrees Fahrenheit. 4. On 6/21/2024, at 12:45 PM, HHA 2 indicated the electronic health record must not have updated the correct temperature and indicated the patients' temperatures varied at each visit and were not the same at every visit. 5. On 6/21/2024, at 3:40 PM, the Clinical Manager indicated maybe the temperature was pre-filled from the visit before and was carried over on the subsequent visit notes. 6. On 6/24/2024, at 1:57 PM,			

	the Clinical Manager indicated the HHA was sloppy and carrying over the temperature onto each subsequent visit notes or the HHA was not taking the temperature every visit. 410 IAC 17-15-1(b)			
N0000	Initial Comments This visit was for a State Complaint survey of a Home Health Provider. Survey Dates: 6/18/2024 to 6/21/2024 and 6/24/2024 to 6/25/2024 Complaint #: 106920 was investigated, federal and state deficiencies were cited related to the complaint. 12-Month Unduplicated Skilled Admissions: 368 QR: A1 7/05/24	N0000	This visit was for a State Complaint survey of a Home Health Provider. Survey Dates: 6/18/2024 to 6/21/2024 and 6/24/2024 to 6/25/2024 Complaint #: 106920 was investigated, federal and state deficiencies were cited related to the complaint.	
N0488	Q A and performance improvement	N0488	Hope Home Health has revised it's Discharge policy entitled "Discharge Criteria and	2024-07-19

	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 least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (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. (2) The patient refuses the home health agency's services. (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 (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.		Planning" to include the 15 day notice to be given to each patient, patient legal representative or other individual responsible for patient care. Clinical Manager educated all staff on the revised policy Clinical Manager had the new policy placed in all admission packets Clinical Manager gave copies to all staff to give to current patients and instructed them to educate the patients or their representative on the change. The Administrator is responsible for ongoing monitoring of this correction	

Based on record review and interview, the agency failed to ensure their discharge policy included the Indiana 15 day discharge notice and affected all current patients.

Findings include:

A review of a policy titled "Discharge Criteria and Planning" revised February 2024 and received from the Clinical Manager on 6/18/2024 indicated the patient would be informed of the discharge plan in a timely manner and failed to evidence the policy included a 15 day discharge notice.

On 6/18/2024, at 11:30 AM, the Clinical Manager indicated the agency's discharge policy did not include a 15 day discharge notice provided to the patient.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Krull	RN Administrator/Clinical Director	7/19/2024 4:04:49 PM