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	08/13/2024

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
G0000	INITIAL COMMENTS This visit was for a Post Condition Revisit of a Federal and State Complaint survey of a deemed Home Health Provider on 6/25/2024. Survey Dates: 8/5/2024 through 8/9/2024, 8/12/2024, and 8/13/2024 Unduplicated Skilled Admissions for the last 12 Months: 429 During the Post Condition revisit survey, one Condition of Participation at 42 CFR 484.58 Discharge Planning was re-cited and one new condition was cited at 484.60 Care Planning, Coordination of Services, and Quality of Care, 484.105, six [6] standard level deficiencies were determined to be back in compliance, 14 standard level deficiencies were recited, and 7 new standard level deficiencies	G0000		

were cited.

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 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.

An Immediate Jeopardy related to §484.60 Care Planning, Coordination of Care, and Quality of Care was identified on 7/8/2024 when Patient #12, identified to be at a high risk of falls and with a fall history with injuries to include a subdural hematoma (a bruise between the skull and the brain) and pelvic and hip fractures, fell resulting in treatment at the emergency room for a laceration to the head requiring sutures. The nurse practitioner ordered physical therapy (PT)

	evaluations at the time of referral to the agency. The plan of care indicated the agency was to provide skilled nursing and physical therapy services but failed to include an OT evaluation and failed to include individualized interventions and goals related to the patient's risk for falls. The agency failed to notify the physician of the fall and injury after the fall on 7/8/2024. The patient fell again on 7/21/2024 resulting in a bruise to the right side of the torso and again on 7/27/2024. The patient was admitted to the hospital on 7/29/2024 where the patient was identified to have fractured 4 ribs and the right hip. The agency failed to coordinate care between the PT and nurse to develop and revise the plan of care with individualized interventions related to falls. The Administrator and Alternate Administrator were notified of the Immediate Jeopardy on 8/9/2024 at 3:10 PM at the Condition of Participation §484.60 Care Planning, Coordination of Care, and Quality of Care with the likelihood to affect all current patients receiving services by this provider.			

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 with Outcome Assessment and Information Set (OASIS) encoded data reflected the patient's status at the time of assessment in 2 out of 2 active clinical records reviewed with an OASIS transmitted after the date of correction (7/19/24) (Patient #9, 12). Findings include: 1. The agency policy titled "Initial Assessments/Comprehensive Assessments", revised 4/2023, indicated the initial comprehensive assessment would incorporate OASIS (a patient specific standardized assessment) and the skilled health professional determines the immediate support needs of the patient that includes patient history, integumentary status, support assistance, and data items collected from facility discharge. 2. The clinical record of Patient	G0374	Pursuant to the State Operations Manual, Chapter 2, Section 2728B, we are submitting both our objection to this tag and a Plan of correction. For the following reasons, we believe that this tag was cited improperly: M2102- The exact OASIS question at SOC is M2102 F which states, "Supervision and safety due to cognitive impairment" Patient #9 had a BIMS score of 15 at SOC and had no cognitive impairment. Therefore the correct OASIS response should have been 0. Agency had this correct M1340- Patient had healed shoulder incision at time of comprehensive/OASIS assessment on 7-26-24. The assessing nurse clearly documented that the patient had a healed shoulder incision and therefore the answer to M1340 should have been 0. Potential for infection still exists for newly healed incisions so the nurse also correctly answered in the infection risk that he still had a risk for infection. Agency had this correct. Patient #12 did speak English as documented in the NP face to face note. Staff has known this patient for several years and she has always previously spoken English to them. Patient did speak Greek with family members. The hospital record that the surveyor obtained from the hospital after the transfer OASIS was done, stated that the patient did not speak English. That was incorrect and was not available to the clincal manager at the time the transfer OASIS was completed. The agency had this correct. Supporting documentation is uploaded Although we disagree with the cited tag for the foregoing reasons, we are submitting the following plan of correction: Quality Assurance team has been educated on monitoring all OASIS items for accuracy to	2024-09-28

	#9 revealed a start of care comprehensive assessment with OASIS assessment completed on 7/26/24 by Registered Nurse (RN) 2. M2102 of the OASIS assessment evaluated ability and willingness of non-agency caregivers to provide assistance excluding agency staff which indicated "no assistance needed- patient is independent and does not have needs in this area". The comprehensive assessment evidenced Patient needs partial to moderate assistance with showering, dressing, or picking up an object; the assessment revealed supervision or touching assistance is needed for Patient to eat, perform oral hygiene, toileting hygiene, rolling left to right, going from sitting to lying, lying to sitting, going from sitting to standing, chair to chair transfer, walking and medication must be administered by another person. The assessment indicated Patient is vision impaired, hearing impaired, and at a risk for falling. M1340 assessment is for a surgical wound which was charted "no". The comprehensive assessment evidenced a potential risk for infection due to post operative		include M2102F, M1340 and A1110A. Clinical Manager will continue to review 100% of all OASIS for accuracy in answers and monitoring will be ongoing.	

	from surgery. The record failed to evidence assessment of surgical wound. The clinical record indicated the OASIS assessment was exported 8/8/24. During an interview on 8/12/24 beginning at 1:30 PM, Registered Nurse 2 relayed she was unaware if Patient #9 had surgery prior to comprehensive assessment. RN revealed Patient had caregivers in the home a different times to assist Patient with daily activities. During an interview on 8/7/24 beginning at 9:45 AM, Other 9 (an RN at Patient's physician's office) relayed Patient #9 had left shoulder surgery to fix a humerus (upper arm bone) last month. During an interview on 8/7/24 beginning at 9:00 AM, Other E (family member of Patient) relayed he stayed with Patient during the first week of recovery to assist and other family members assist Patient on different days. Other E relayed Patient had should surgery two weeks ago and was unable to lift, push, or pull with his left arm.			

	* A clinical record for Patient #12 evidenced a progress note dated 7/31/2024 from Entity 11 which indicated the patient did not speak English. An OASIS Transfer assessment completed by the Clinical Manager dated 7/30/2024 and transmitted on 7/30/2024 indicated the patient's primary language was English. On 8/7/2024, at 2:32 PM, PT 2 who provided physical therapy services to the patient indicated the patient was mainly nonverbal but indicated "I've never heart the patient speak English. The daughter talks to her in another language other than English." On 8/7/2024, at 4:34 PM, the Clinical Manager she did not provide direct patient care to the patient and indicated she assumed the patient spoke English.			
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	G0458	The Clinical Manager has educated all therapists on the use of standardized testing such as ROM, TUG, and Tinetti scores and the importance of consistent assessment data from SOC through discharge in order to prove that measureable goals have been met. PT3 has received individualized education regarding objective documentation of "goals met" such as reaching goals established for standardized testing. This education regarding	2024-09-28

	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 2 of 2 records reviewed closed clinical records reviewed. (Patient #7, 10). The findings include: 1. A clinical record review for Patient #7, discharged 7/22/2024, evidenced a plan of care for the initial certification period of 7/10/2024-9/7/2024 which indicated the goals included, but were not limited to, a TUG score (an assessment of mobility, balance, walking ability, and fall risk) improvement to 12 seconds. Review of physical therapy (PT) visit notes completed by PT 3 and dated 7/12/2024, 7/13/2024, 7/15/2024, 7/17/2024, 7/19/2024 and review of the discharge assessments completed by PT 3 and RN 5 on 7/22/2024 failed to evidence the assessment of the TUG score.		measureable goals will be provided to all therapists during onboarding and no less than annually. Clinical Manager is responsible for the ongoing monitoring of this deficiency.	

	The discharge summary dated 7/24/2024 indicated the patient was discharged due to goals met and indicated the patient was going to continue with outpatient therapy. The clinical record failed to evidence the patient's TUG score was assessed to determine if the goals were met at time of discharge. 3. A clinical record review for Patient #10, discharged 7/22/2024, evidenced a plan of care for the initial certification period of 7/13/2024-9/10/2024 which indicated the goals included, but were not limited to, increase Tinetti score (an assessment of balance and stability) to 22 or higher, improvement in range of motion to right knee to 98 to 100 degrees, and improvement to 3 out of 5 in muscle strength to the right knee. The PT visit note dated 7/19/2024 and the PT discharge assessment dated 7/22/2024, both completed by PT 3, failed to evidence the assessment of the Tinetti score and right knee range of motion and strength. The discharge summary dated			

	8/1/2024 indicated the patient was discharged due to goals met and indicated the patient was going to continue with outpatient therapy. The clinical record failed to evidence the patient's Tinetti score and right knee range of motion and strength were assessed to determine if goals were met at time of discharge. 4. On 8/5/2024, at 4:30 PM, PT 3 indicated he could not remember the specifics of the discharge assessment and what was documented was assessed. 5. On 8/5/2024, at 3:08 PM, the Administrator indicated if all the goals were not assessed at time of discharge, the patient could not be discharged due to goals met.			
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return	G0514	The Clinical Manager will review 100% of physician orders. If there is a delay in SOC order submitted by a clinician, then Clinical Manager will investigate and confirm the reason for the delay in the SOC to include confirmation with the paient's physician and the patient and/or caregiver(s). The Clincial Manager is responsible for the ongoing monitoring of this deficeincy.	2024-09-28

	home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview the agency failed to ensure the initial assessment completion within 48 hours of receipt of a referral in 1 of 1 active clinical record reviewed with a start of care after the date of correction (7/19/24) (Patient #9). Findings include: 1. The agency policy titled "Initial Assessments/Comprehensive Assessments," revised 4/2023, indicated the initial assessment must be conducted within 48 hours of referral, or patient's return home or on the physician's ordered start of care date.			

	2. The clinical record for Patient #9 revealed a referral for home care for physical therapy, occupational therapy, and wound care, dated 7/22/23, faxed received to the agency on date 7/23/24. The initial comprehensive assessment was completed on 7/26/24. The clinical record included an order dated 7/26/24, signed by Administrator, which stated "ok to admit patient to home care services today per family request." During an interview on 8/5/24 beginning at 3:00 PM, Administrator revealed Patient #9's family requested home care admission to be done on 7/26/24. During an interview on 8/7/24 beginning at 9:00 AM, Other E (family member and initial caregiver for Patient #9) relayed Patient #9 was released from a skilled nursing facility on 7/22/24 with instructions from the facility that an agency home health nurse would be visiting Patient on 7/23/24. Other E revealed Patient #9 and family were awaiting a phone call or visit from an agency nurse on			

	phone call or visit happened by afternoon, he/she called the agency to find out what time a staff member would arrive. Other E relayed he was told by Administrator that Patient #9 was set for a start of care visit on Friday, 7/26. Other E stated the agency's delay "was not our choice." 410 IAC 17-14-1(a)(1)(A)			
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 content of the comprehensive assessment accurately reflected the patient's health and functional status in 1 of 1 active clinical record reviewed with a start of care the correction date (7/19/24) (Patient #9). Findings include: 1. During an interview on 8/7/24 beginning at 9:00 AM, Other E (family member and initial caregiver for Patient #9) relayed Patient must wear a neck brace at all times and he	G0528	During Agency review of the note submitted, RN2 did include the cervical collar in her comprehensive assessment as evidenced by her documentation, "Patient received in recliner, alert, and oriented with cervical collar noted." However, RN2 has received individualized education regarding the need for orders that specifically address any orthopedic device. Additionally, the Clinical Manager has educated all clinical staff on steps to be taken when a patient is utilizing an orthopedic device, including contacting the physician for orders and ensuring the orthopedic device is captured in the patient's treatment plan. Clinical Manager is responsible for the ongoing monitoring of this process.	2024-09-28

	was told if he didn't he could become paralyzed. Other E relayed Patient had surgery to the left shoulder and cannot lift or push/pull with the left arm. During an interview on 8/7/24 beginning at 11:00 AM, Other H (a Registered Nurse at Patient's orthopedic surgeon's office) relayed Patient #9 has a displaced fracture to the second cervical vertebra and Patient must wear a hard collar (rigid neck collar to restrict motion) at all times. Other H revealed Patient is on spinal precautions (no bending or rotating spine). During an interview on 8/12/24 beginning at 1:30 PM, Registered nurse (RN) 2 relayed Patient #9 had a cervical collar (neck collar that restricts motion) on during the start of care comprehensive assessment. RN 2 relayed she was aware of the neck injury. The clinical record for Patient #9 revealed an initial comprehensive assessment start of care completed on 7/26/24 by Registered Nurse (RN) 2. The comprehensive assessment failed to evidence a hard			

	spinal precautions. 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 accurately reflects the patient's primary caregiver(s) willingness, ability, and availability to provide care in 1 of 1 active clinical record with a start of care after the date of correction (7/19/24) (Patient #9) and 1 of 2 closed clinical records reviewed (Patient #7). Findings include: 1. The agency policy titled "Initial Assessment/Comprehensive Assessments", revised 4/2023, indicated the comprehensive assessment includes the patient's primary caregiver(s)	G0538	Clinical Manager educated all staff again on the need to document the caregiver's willingness, ability, and availability and schedule for all patients at the time of the comprehensive assessment. Clinical record of patient #9 did state, " Son (Jay) in home temporarily to provide assistance with all needs until patient recovers. 2 other sons outside the home are also available to assist with care when needed." Son Jay was supposed to stay until patient was recovered. Clinical Manager is responsible for ongoing monitoring to make sure all caregiver assessments are included for all patients at time of each comprehensive assessment and that it includes any caregiver assessment if someone is only a temporary caregiver.	2024-09-28

	including their willingness, ability, and availability to provide care. 2. The clinical record of Patient #9 revealed diagnoses of motor vehicle accident injuries that included a fracture of the left femur (upper leg bone), a fractured humerus (upper arm bone), rib fractures, vertebrae dislocation, an open knee wound and a glass eye. An initial comprehensive assessment completed on 7/26/24 indicated Patient lived alone with short term assistance from Other E, a family member that would assist with activities of daily living, shopping, cooking, medication management, transportation and wound care for Patient until recovery. The clinical record of Patient #9 failed to evidence an evaluation of caregiver past the first week, including the willingness, ability and availability to provide care and assistance to Patient. During an interview on 8/6/24 beginning at 6:15 PM, Other F (family member of Patient #9) relayed Other E (also a family member of Patient #9 and initial			

	assist Patient #9 at home for only one week because he/she lived out of town. Other F revealed the family members who can assist Patient #9 work during the day, therefore Patient #9 was often home alone. During an interview on 8/7/24 beginning at 11:00 AM, Other H relayed Patient #9 had a nondisplaced cervical 2 (second vertebra of spine) fracture and recovery would be at least three months. During an interview on 8/12/24 beginning at 1:30 PM, Registered nurse (RN) 2 relayed Patient #9 had a cervical collar (neck collar that restricts motion) on during the start of care comprehensive assessment. RN 2 relayed she was aware of the neck injury.			
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major	G0544	All Agency staff have been educated on the need for an updated comprehensive assessment anytime there is a significant change in the patient's health status, including declines or improvements. PT2 and RN4 have both received individualized training regarding the availability/requirement of a Significant Change in Condition (SCIC) OASIS anytime there is a significant change in patient's condition. Additionally, the Clincial Manager has educated all clinical staff on the SCIC process. The Quality Assurance team has been educated on the need for alerting the Clinical Manager to any significant changes in the	2024-09-28

	decline or improvement in the patient's health status, but not less frequently than- G544 Based on record review and interview, the agency failed to update the comprehensive assessment after a significant change in 1 of 1 active clinical record reviewed with falls. (Patient #12) The findings include: A clinical record review for Patient #12, start of care 6/25/2024, evidenced a skilled nurse visit note completed by RN 4 dated 7/12/2024 which indicated the patient fell earlier in the week and had a bruise to the right eye and received treatment at the emergency room requiring sutures to a laceration to the forehead. A physical therapy (PT) visit note completed by PT 2 dated 7/15/2024 indicated the patient reported pain 4 out of 10 to the right hip and indicated the patient was moving slower. A PT visit note completed by PT 2 dated 7/17/2024 indicated the patient reported pain 4 out of 10 to the right hip and indicated the patient had a right		paient's condition that are noted during documnetation review. The Clinical Manager is responsible for the ongoing monitoring of this process.	

	foot drag while ambulating. A skilled nurse visit note completed by RN 4 dated 7/22/2024 indicated the patient fell on 7/21/2024 and had a bruise to the right torso measuring 15 centimeters (cm) in length and 10 cm in width. The visit note indicated the patient reported pain 2 out of 10 to the right torso. A PT visit completed by PT 2 dated 7/25/2024 indicated the patient reported pain 4 out of 10 to the right ribs and had a right foot drag while ambulating. Review failed to evidence the agency revised the comprehensive assessment after 2 falls with injuries. On 8/7/2024, at 3:23 PM, the patient's caregiver indicated the patient's right foot drag began in July after the patient fell and indicated the patient began to complain of more pain. On 8/7/2024, at 2:00 PM, RN 4 indicated there was no other comprehensive assessment completed since the start of care.			

	On 8/7/2024, at 3:46 PM, the Administrator indicated a revision to the comprehensive assessment should have been completed due to the new wounds obtained after falls.			
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 measurable outcomes have been achieved, sending all necessary information pertaining to the patient's current course of treatment and progress to goals to the receiving healthcare practitioner, and sending the discharge summary to the physician within 5 business days in 2 of 2 closed records reviewed. (Patient #7, 10) The findings include: 1. A review of a policy titled "Discharge Criteria and Planning" revised 6/18/2024 indicated the discharge	G0560	Clinical Manager is continuing to review all discharges to make sure there is an order in the patient's chart supporting the call to the physician who was in agreement to the discharge. Clinical Manager is responsible for making sure any necessary information pertaining to the patient's current course of treatment is and discharge goals are being sent to any receiving healthcare practitioner. Monitoring will be ongoing by the clinical manager. The need for addressing TUG and Tinetti scores on all PT discharges was again addressed with all therapists by the clinical manager. Clinical Manager will continue to review all discharges to make sure all goals are addressed or if patient is discharged for another reason such as outpatient therapy that the OASIS reason for discharge will reflect that it was a physician request and not because of goals being met. Monitoring will be ongoing by the Clinical Manager Clinical Manager will make sure all discharge summaries are sent to the physician within 5 business days of discharge. Monitoring will be ongoing by the clinical manager.	2024-09-28

	communicating with the physician who is in agreement that measurable outcomes have been achieved and patient no longer needs agency's services and sending all necessary information pertaining to the patient's current course of treatment and discharge goals to the receiving healthcare practitioner. 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 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 #7, discharged 7/22/2024, evidenced a plan of care for the initial certification period of 7/10/2024-9/7/2024 which indicated the goals included, but were not limited to, a TUG score (an assessment of mobility, balance, walking ability, and fall risk)			

improvement to 12 seconds.

Review of physical therapy (PT) visit notes completed by PT 3 and dated 7/12/2024, 7/13/2024, 7/15/2024, 7/17/2024, 7/19/2024 and review of the discharge assessments completed by PT 3 and RN 5 on 7/22/2024 failed to evidence the assessment of the TUG score.

The discharge summary dated 7/24/2024 indicated the patient was discharged due to goals met and indicated the patient was going to continue with outpatient therapy. The discharge summary failed to evidence the goals were not assessed and met for the TUG score.

The clinical record failed to evidence the patient met goals prior to discharge, failed to evidence the agency notified the physician of the goal not met to determine if the physician was in agreement with discharge, and failed to evidence necessary information was provided to the outpatient therapy regarding the patient's current course of treatment and progress to goals.

	3. A clinical record review for Patient #10, discharged 7/22/2024, evidenced a plan of care for the initial certification period of 7/13/2024-9/10/2024 which indicated the goals included, but were not limited to, increase Tinetti score (an assessment of balance and stability) to 22 or higher, improvement in range of motion to right knee to 98 to 100 degrees, and improvement to 3 out of 5 in muscle strength to the right knee. The PT visit note dated 7/19/2024 and the PT discharge assessment dated 7/22/2024, both completed by PT 3, failed to evidence the assessment of the Tinetti score and right knee range of motion and strength. The discharge summary dated 8/1/2024 indicated the patient was discharged due to goals met and indicated the patient was going to continue with outpatient therapy. The discharge summary failed to evidence the goals were not assessed and met for the Tinetti score and right knee range of motion and strength. The electronic health record failed to evidence the discharge			

summary was sent to the physician within 5 business days of discharge.

The clinical record failed to evidence the patient met goals prior to discharge, failed to evidence the agency notified the physician of the goal not met to determine if the physician was in agreement with discharge, and failed to evidence necessary information was provided to the outpatient therapy regarding the patient's current course of treatment and progress to goals.

4. On 8/5/2024, at 4:30 PM, PT 3 indicated he did not communicate with the physician prior to discharge since the patient was going to outpatient therapy. PT 3 indicated he could not remember the specifics of the discharge assessment and what was documented was assessed.

5. On 8/5/2024, at 3:08 PM, the Administrator indicated communication with the physician prior to discharge was probably not done since the agency was still working on correcting the issue. The

	would look for documentation of communication with the physician prior to discharge and no additional information was provided prior to survey exit on 8/13/2024. On 8/6/2024, at 12:07 PM, the Administrator indicated the physician had his own outpatient physical therapy company so she assumed the physician sent his own information and orders to the outpatient therapy regarding the patient. 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.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services	G0570	Clinical Manager will review all patient referrals for appropriateness and ordered services. If an ordered service is refused by the patient or their patient representative, the admitting clinician will contact the physician and write the verbal order that the patient or patient representative is refusing an ordered service. Under patient rights, the patient or their representative have the right to refuse services. This will be monitored by the clinical manager and monitoring will be ongoing. Administrator did provide evidence that RN 4 did know about the OT order and documented in a private EMR message that patient's daughter did not want OT at the time of admission.	2024-09-28

	necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interviews the agency failed to ensure: the plan of care was individualized to meet the patient needs (See G0570), the plan of care was followed by all agency staff as directed by the primary care physician (See G0572), the plan of care contained all required elements (See GO574), services and treatments were provided only as ordered by the physician (See G0580), the plan of care was revised to reflect the current health status and nursing needs of the patient (See G0592), patientcare was coordinated by all disciplines (See G0606), patients / caregivers were provided written medication schedule and instructions (See G0616), patients / caregivers were provided written information about treatments provided (See G0618). The cumulative effect of the systemic problems has resulted in the home health agency inability to ensure provision of quality of health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination, Quality of Care.		If there is a delay in ordered services, patient and their representative will be notified and if agreeable the physician or practitioner will be notified to make sure they are agreeable to the delay. If patient or physician/practitioner is not agreeable to delay, Agency will attempt to transfer patient to another agency that can provide services in a timely manner. Monitoring will be ongoing and Administrator is responsible, All staff have been re-educated on the need to use the EMR communication system to document coordination of care. Clinical Manager is responsible for the ongoing monitoring that all coordination of care is done with all disciplines seeing the patient.	

	A deficient practice citation at this standard as follows: Based on record review and interview the agency failed to provide services to meet the patient's needs in 3 of 4 active clinical records reviewed (Patients #9, 11, 12). Findings include: 1. The agency policy titled "Plan of Care – CMS #485 and Physician/Practitioners Orders", revised 2/2024, indicated patient's orders for treatments and services are the foundation of the plan of care. If the agency missed a visit or treatment or service, the physician/practitioner should be notified and decides whether a treatment or service may be skipped. 2. The agency policy titled "Coordination of Patient Care", revised 2/2024, indicated the agency should assure communication with all physicians/practitioners involved in a patient's plan of care to coordinate services. 3. The clinical record of Patient #9 revealed an initial plan of care for dates 7/26/24 to 9/23/24. The plan of indicated			

	orders for skilled nurse visits with physical therapy to start the week of 7/30/24 and occupational therapy ordered the week of 8/4/24. The clinical record revealed a physician's order entered on 7/26/24 by Registered Nurse (RN) 2 confirming Patient's physician agreeable to admission for home care to include skilled nurse visits, physical therapy services and occupational services. Physical Therapy saw the Patient for an initial evaluation on 7/30/24 and Occupation Therapy saw the Patient for an initial evaluation on 8/6/24. During an interview on 8/7/24 beginning at 3:45 PM, Other I (RN at physician's office of Patient #9) revealed the physician did not order any delays in therapies and physician was not aware Patient had physical therapy start 1 week after the start of care order and had not yet had an occupational therapy evaluation. During an interview on 8/6/24 beginning at 3:00 PM, Occupational Therapist (OT) 1			

	relayed Administrator notified her of Patient #9 needing treatment on an earlier date. OT 1 revealed she notified Administrator that she couldn't see Patient for a couple of weeks because her appointments are being scheduled two weeks out. During an interview on 8/6/24 beginning at 2:00 PM, Physical Therapist (PT) 1 relayed he was told of Patient needing PT services on a Tuesday and he saw the Patient on a Wednesday. During an interview on 8/7/24 beginning at 4:00 PM, Administrator relayed Patient #9 had too many appointments and family wanted to wait to start occupational therapy. Administrator revealed there was no documentation that the physician was notified of the therapy delay but it was added to the plan of care. During an interview on 8/7/24 beginning at 9:00 AM, Other 5 (family member and initial caregiver for Patient #9) relayed he/she was never told Patient was to receive occupational therapy.			

	410 IAC 17-13-1(a) 1. A clinical record review for Patient #12, start of care 6/25/2024, evidenced referral documents to include an order from Person 10 (nurse practitioner) dated 6/21/2024 which indicated the agency was to evaluate for physical therapy (PT) and occupational therapy (OT). The referral documents included a visit note from Person 10 (nurse practitioner) dated 6/21/2024 which indicated the patient's history included a history of falls with injuries to include a subdural hematoma (a bruise between the skull and the brain) and pelvic and hip fractures. The visit note indicated the patient had a fall 3 weeks prior and was evaluated at the emergency room (ER). The start of care comprehensive assessment completed by Registered Nurse (RN) 4 dated 6/25/2024 indicated the patient had decreased cognition, poor mobility, unsteady gait, limited range of motion, poor balance, and required assistance for personal care and activities of			

	daily living (ADLs). The comprehensive assessment indicated the patient was at risk of falls, had a history of falls, and had a traumatic wound to the right elbow due to a fall. The assessment failed to indicate an OT evaluation was to be provided and failed to evidence the patient was offered OT services. The initial plan of care for certification period 6/25/2024-8/23/2024 failed to evidence the agency was to provide an OT evaluation as ordered and the clinical record failed to evidence an order from the physician to discontinue the OT evaluation. A PT visit note completed by PT 2 dated 7/10/2024 indicated the patient had a fall with injury and received treatment at the ER on 7/8/2024. A skilled nurse visit note completed by RN 4 dated 7/12/2024 indicated the patient fell earlier in the week and had sutures to the forehead and a bruise to the right eye. Review failed to evidence the RN coordinated care with PT. The provider notes from the emergency room (ER) at Entity			

	12 dated 7/8/2024 indicated the patient was evaluated and treated after a fall. The ER note indicated the patient had a laceration on the forehead requiring 5 sutures and an abrasion and swelling to the right cheek. The computed tomography (CT) scans of the neck, face, and brain and the X-rays of the right hip, chest, and right shoulder were negative for fractures. A PT visit note completed by PT 2 dated 7/15/2024 indicated the patient reported pain 4 out of 10 to the right hip and indicated the patient was moving slower. A PT visit note completed by PT 2 dated 7/17/2024 indicated the patient reported pain 4 out of 10 to the right hip and indicated the patient had a right foot drag while ambulating. A skilled nurse visit note completed by RN 4 dated 7/22/2024 indicated the patient fell on 7/21/2024 and had a bruise to the right torso measuring 15 centimeters (cm) in length and 10 cm in width. On 8/8/2024, beginning at 12:51 PM, Person 13 (the			

	practice manager at the NP's office) indicated she looked in the telephone log and in the patient's record and there was no notification by the agency that the OT services could not be provided. Person 13 indicated when the agency notified the NP's office on 7/22/2024 of a fall, the NP ordered X-rays to be conducted by a mobile service at the patient's home. On 8/8/2024, at 2:44 PM, RN 4 indicated she did not notify the NP that the agency had not provided OT as ordered, because she was not aware of the OT evaluation order. RN 4 indicated the agency did not typically order PT and OT at the start of care and indicated PT was more important to provide to the patient first because of the patient's falls. On 8/7/2024, at 3:23 PM, the patient's caregiver indicated they never refused OT services for the patient and indicated RN 4 wanted the patient to receive OT services and informed the caregiver she would check into it.			

	On 8/7/2024, at 3:37 PM, the Clinical Manager indicated RN 4 did not inform her that OT was ordered. 2. A clinical record review for Patient #11, start of care 6/18/2024, evidenced an order from the physician responsible for the plan of care dated 6/16/2024 indicating home health for nursing and PT. The start of care comprehensive assessment dated 6/18/2024 the patient had joint stiffness and pain, muscle weakness, poor balance, unsteady gait, was at high risk for falls, and required assistance for transfers and ambulation. Review failed to evidence the patient was offered PT services and failed to evidence a PT evaluation was completed by the agency. Review failed to evidence a physician order discontinuing the PT services. On 8/6/2024, at 3:32 PM, the Patient indicated they needed PT because their neck "was out of whack" and pain was 9 on a scale of 0-10. The Patient indicated they thought there was an order to receive PT.			

	On 8/6/2024, at 2:38 PM, the Administrator indicated the reason PT services were not provided was because during a prior admission the patient received and was discharged from PT services as ordered by the patient's oncologist and not the physician responsible for the current plan of care. The Administrator indicated there was not an order to discontinue PT services.			
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.	G0572	The Quality Assurance team has been educated on monitoring care coordination during documentation review. If a reviewer notes that a patient is receiving dialysis (or another service that may require coordination)the reviewer will then review the patient's chart for approriate coordination of care. If coordination of care is not found in the patient's chart, the clinical manager and field clinician seeing the patient will be alerted. Clinical manager is responsible for the ongoing monitoring of this deficiency.	2024-09-28

	Based on record review and interview, the agency failed to ensure the services were provided as directed in 1 of 2 active clinical record reviewed receiving dialysis (a medical treatment to filter the blood of waste and excess fluid). (Patient #11) The findings include: A clinical record review for Patient #11 evidenced a plan of care for the initial certification period of 6/18/2024-8/16/2024 which indicated the patient received dialysis 3 times a week and indicated the nurse would coordinate care with the dialysis center weekly. Skilled nurse visit notes completed by RN 4 and dated 7/26/2024 and 7/30/2024 failed to evidence the nurse coordinated care with the dialysis center and failed to evidence care was coordinated with the dialysis center weekly as directed by the plan of care for weeks 7/21/2024 and 7/28/2024. On 8/6/2024, at 3:44 PM, RN 4 indicated the last time she spoke to the dialysis center was on 7/24/2024.			
G0574	Plan of care must include the following	G0574	During Agency review of the note submitted, RN2 did include the cervical collar in her comprehensive assessment as evidenced by	2024-09-28

	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 an individualized patient plan of care included necessary components in 3 of 4 active		her documentation, "Patient received in recliner, alert, and oriented with cervical collar noted." However, RN2 has received individualized education regarding the need for orders that specifically address any orthopedic device. Additionally, the Clinical Manager has educated all clinical staff on steps to be taken when a patient is utilizing an orthopedic device, including contacting the physician for orders and ensuring the orthopedic device is captured in the patient's treatment plan. Clinical Manager is responsible for the ongoing monitoring of this process. When patient's have a high risk for falls as evidenced by assessment at SOC, ROC and Recert, individualized interventions will be added to the plan of care. Clinical Manager will be responsible for the ongoing monitoriing of this information. Staff has been re-educated on the need to make sure all services including aide services are on the plan of care and that if a patient is on dialysis that any fluid restrictions are also on the plan of care. Clinical Manager is responsible for the ongoing monitoiring of this information. Clinicians have been re-educated on the need to include any chemotherapy interventions, or pain specialist information on the plan of care. Clinical Manager is responsible for the ongoing monitoring of this information. Clinicians have been re-educated on the need to perform medication reconciliation at time of admission with all physicians/practitioners who are treating the patient. Clinical Manager is responsible for the ongoing monitoring of this deficiency.	

	#9, 11, 12). Findings include: 1. The agency policy titled "Plan of Care – CMS #485 and Physician/Practitioners Orders", revised 2/2024, indicated each patient must receive an individualized written plan of care including additions and revisions that specify the care and services necessary to meet patient specific needs. 2. During an interview on 8/7/24 beginning at 11:00 AM, Other H (an RN at Patient's orthopedic surgeon's office) relayed Patient #9 has a displaced fracture to the second cervical vertebra and Patient must wear a hard collar (rigid neck collar to restrict motion) at all times. Other H revealed Patient is on spinal precautions (no bending or rotating spine). During an interview on 8/12/24 beginning at 1:30 PM, Registered nurse (RN) 2 relayed Patient #9 had a cervical collar (neck collar that restricts motion) on during the start of care comprehensive assessment. RN 2 relayed she was aware of the neck injury but unaware of spinal precaution		All agency clinicians have been educated on the need for developing a comprehensive yet individualized plan of care for each patient that includes all required elements. This education will be provided during onboarding and no less than annually in perpetuity.	

instructions.

During an interview on 8/7/24 beginning at 9:00 AM, Other E (family member and initial caregiver for Patient #9) relayed Patient must wear a neck brace at all times and he was told if he didn't he could become paralyzed. Other E relayed Patient had surgery to the left shoulder and cannot lift or push/pull with the left arm.

The clinical record for Patient #9 revealed an initial plan of care for dates 7/26/24 to 9/23/24 that included nursing, physical therapy, and occupational therapy services. The plan of care failed to include spinal precautions, a cervical collar, nor instructions related to the neck injury. The plan of care failed to evidence limitations for use of left arm.

410 IAC 17-13-1(a)(1)(B), 17-13-1(a)(1)(D)(i-xiii)

* A clinical record review for Patient #12, start of care 6/25/2024, evidenced a visit note from Person 10 (nurse practitioner) dated 6/21/2024 which indicated the patient's history included a history of falls

	subdural hematoma (a bruise between the skull and the brain) and pelvic and hip fractures. The visit note indicated the patient had a fall 3 weeks prior and was evaluated at the emergency room (ER). The start of care comprehensive assessment completed by Registered Nurse (RN) 4 dated 6/25/2024 indicated the patient had decreased cognition, poor mobility, unsteady gait, limited range of motion, poor balance, and required assistance for personal care and activities of daily living (ADLs). The comprehensive assessment indicated the patient was at risk of falls, had a history of falls, and had a traumatic wound to the right elbow due to a fall. The initial plan of care for certification period 6/25/2024-8/23/2024 indicated the agency would provide nursing services physical therapy (PT), and home health aide (HHA) services and indicated the skilled nurse and PT would minimize the risk factors to prevent falls and injuries by educating the patient and caregiver. The plan of care failed to include individualized			

	interventions regarding fall prevention and safety. On 8/7/2024, at 2:00 PM, RN 4 indicated she did not include additional intervention in the plan of care related to the falls because the patient "was mainly getting therapy" from the agency. On 8/7/2024, at 4:59 PM, the Clinical Manager indicated there were no other individualized interventions other than educating the patient and caregiver on fall prevention and indicated education was a standard intervention for fall prevention. * A clinical record review for Patient #11 evidenced a plan of care for the initial certification period of 6/18/2024-8/16/2024 which indicated the agency would provide home health aide (HHA) services 1 time a week for 1 week, 2 times a week for 6 weeks, and then 1 time a week for 1 week. The plan of care failed to evidence interventions and goals related to HHA services. The plan of care indicated the patient received dialysis treatment (a medical treatment that filters			

	the blood to rid the body of waste and excess fluids) 3 times a week and failed to evidence the patient had a fluid restriction. On 8/6/2024, at 2:34 PM, the Administrator indicated the interventions and goals for the HHA services were not included in the plan of care. On 8/6/2024, at 3:01 PM, RN 4 indicated the patient received chemotherapy treatment at Entity 15 as ordered by the oncologist, Person 14, and received treatment by a pain specialist, Person 16. The plan of care failed to include the chemotherapy treatment and orders from Person 14 and the pain specialist. On 8/6/2024, at 2:52 PM, the Clinical Manager indicated the chemotherapy treatment and orders from Person 14 and the pain specialist were not included in the plan of care. The Clinical Manager indicated there was not a fluid restriction included in the plan of care A review of referral documents which included a visit note from			

	the physician dated 5/20/2024 indicated the patient's medications included, but were not limited to, alprazolam (medication to treat anxiety), diclofenac (a medication used to reduce pain and swelling), Tradjenta (a medication to treat high blood sugar), and oxycodone (a medication used to treat severe pain). The plan of care for the initial certification period 6/18/2024-8/16/2024 failed to evidence the alprazolam, diclofenac, Tradjenta, and oxycodone. On 8/6/2024, at 3:32 PM, the Patient indicated their medications included alprazolam, diclofenac, which they indicated they applied to the neck, shoulders, and knees, Tradjenta, and oxycodone. The Patient indicated they had a fluid restriction of 32 ounces per day. On 8/6/2024, at 3:01 PM, Registered Nurse (RN) 4, nurse case manager, indicated she not sure why the medications were not included in the list of patient's medications.			

G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview the agency failed to ensure that drugs, services, and treatments are administered only as ordered by a physician in 1 of 1 active clinical record with a home visit (Patient #8). Findings include: The agency policy titled "Plan of Care – CMS #485 and Physician/Practitioners Orders", revised 2/2024, indicated care, services, drugs, and treatments are provided according to physician/practitioner orders that are current and updated. The clinical record for Patient #8 revealed an initial plan of care for dates 5/15/24 to 7/13/24 which was signed by a physician and a recertification plan of care for dates 7/14/24 to 9/11/24 was signed by a physician on 7/31/24. The clinical record failed to evidence a verbal order for care, services, and	G0580	The Plan of care had always been accepted as the confirmed verbal order from the physician. Clinical Manager has educated all clinicians to write the verbal order out now for all SOC, ROC, and recertifications of patients. Clinical Manager is responsible for the ongoing monitoring of this deficiency.	2024-09-28

	7/31/24. Skilled nurse visits that include wound care were completed 7/19/24, 7/22/24, 7/26/24, and 7/29/22. Home Health Aide visit documentation of care was completed 7/16/24, 7/18/24, 7/23/24, 7/25/24, and 7/30/24. During an interview on 8/5/24 beginning at 4:15 PM, when asked if there was an order for care for 7/13/24 to 7/31/24, Administrator relayed the agency staff were not obtaining a verbal order for care (before the physician signs the plan of care) prior to the date of correction (7/19/24). 410 IAC 17-13-1(a)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview the agency failed to ensure the relevant physician was promptly alerted to any changes in a patient's condition in 2 of 4 active clinical record reviewed.	G0590	Clinical Manager will review all patient referrals for appropriateness and ordered services. If an ordered service is refused by the patient or their patient representative, the admitting clinician will contact the physician and write the verbal order that the patient or patient representative is refusing an ordered service. Under patient rights, the patient or their representative have the right to refuse services. This will be monitored by the clinical manager and monitoring will be ongoing. Administrator did provide evidence that RN 4 did know about the OT order and documented in a private EMR message that patient's daughter did not want OT at the time of admission. If there is a delay in ordered services, patient and their representative will be notified and if	2024-09-28

	(Patient # 9, 12). Findings include: 1. The agency policy titled "Plan of Care – CMS #485 and Physician/Practitioners Orders", revised 2/2024, indicated care and services provided will be according to physician/practitioner's orders and physician/practitioner must be consulted for any modifications to the plan of care. 2. The clinical record of Patient #9 revealed an initial plan of care for dates 7/26/24 to 9/23/24. The plan of indicated orders for skilled nurse visits with physical therapy to start the week of 7/30/24 and occupational therapy ordered the week of 8/4/24. The clinical record revealed a physician's order entered on 7/26/24 by Registered Nurse (RN) 2 confirming Patient's physician agreeable to admission for home care to include skilled nurse visits, physical therapy services and occupational services. Physical Therapy saw the Patient for an initial evaluation on 7/30/24 and Occupation Therapy saw		agreeable the physician or practitioner will be notified to make sure they are agreeable to the delay. If patient or physician/practitioner is not agreeable to delay, Agency will attempt to transfer patient to another agency that can provide services in a timely manner. Monitoring will be ongoing and Administrator is responsible, All staff have been re-educated on the need to use the EMR communication system to document coordination of care. Clinical Manager is responsible for monitoring that all coordination of care is done with all disciplines seeing the patient.	

	the Patient for an initial evaluation on 8/6/24. During an interview on 8/7/24 beginning at 3:45 PM, Other I (RN at physician's office of Patient #9) revealed the physician did not order any delays in therapies and physician was not aware Patient had physical therapy start 1 week after the start of care and had not yet had an occupational therapy evaluation. During a interview on 8/6/24 beginning at 3:00 PM, Occupational Therapist (OT) 1 relayed Administrator notified her of Patient #9 needing treatment on an earlier date. OT 1 revealed she notified Administrator that she couldn't see Patient for a couple of weeks because her appointments are being scheduled two weeks out. During an interview on 8/6/24 beginning at 2:00 PM, Physical Therapist (PT) 1 relayed he was told of Patient needing PT services on a Tuesday and he saw the Patient on a Wednesday. During an interview on 8/7/24 beginning at 4:00 PM,			

	Administrator relayed Patient #9 had too many appointments and family wanted to wait to start occupational therapy. Administrator revealed there was no documentation that the physician was notified of the therapy delay but it was added to the plan of care. During an interview on 8/7/24 beginning at 9:00 AM, Other 5 (family member and initial caregiver for Patient #9) relayed he/she was never told Patient was to receive occupational therapy. 410 IAC 17-13-1(a)(2) * A clinical record review for Patient #12, start of care 6/25/2024, evidenced a referral to include an order from Person 10 (nurse practitioner) dated 6/21/2024 which indicated the agency was to evaluate for physical therapy (PT) and occupational therapy (OT). The start of care comprehensive assessment completed by Registered Nurse (RN) 4 dated 6/25/2024 indicated the patient had decreased cognition, poor mobility, unsteady gait, limited range of motion, poor balance, and required assistance for			

	personal care and activities of daily living (ADLs). The comprehensive assessment indicated the patient was at risk of falls, had a history of falls, and had a traumatic wound to the right elbow due to a fall. The assessment failed to indicate an OT evaluation was to be provided and failed to evidence the patient was offered OT services. The initial plan of care for certification period 6/25/2024-8/23/2024 failed to evidence the agency was to provide an OT evaluation as ordered and the clinical record failed to evidence an order from the physician to discontinue the OT evaluation. A PT visit note completed by PT 2 dated 7/10/2024 indicated the patient had a fall with injury and received treatment at the ER on 7/8/2024. Review failed to evidence the PT notified the NP of the fall. The provider notes from the emergency room (ER) at Entity 12 dated 7/8/2024 indicated the patient was evaluated and treated after a fall. The ER note indicated the patient had a laceration on the forehead			

	abrasion and swelling to the right cheek. The computed tomography (CT) scans of the neck, face, and brain and the X-rays of the right hip, chest, and right shoulder were negative for fractures. A PT visit note completed by PT 2 dated 7/15/2024 indicated the patient reported pain 4 out of 10 to the right hip and indicated the patient was moving slower. A PT visit note completed by PT 2 dated 7/17/2024 indicated the patient reported pain 4 out of 10 to the right hip and indicated the patient had a right foot drag while ambulating. A skilled nurse visit note completed by RN 4 dated 7/22/2024 indicated the patient fell on 7/21/2024 and had a bruise to the right torso measuring 15 centimeters (cm) in length and 10 cm in width. The visit note indicated the patient reported pain 2 out of 10 to the right torso. On 8/8/2024, beginning at 12:51 PM, Person 13 (the practice manager at the NP's office) indicated she looked in the telephone log and in the			

	patient's record and there was no notification of falls by the agency prior to 7/22/2024 and was not notified by the agency of the ER visit and forehead laceration. Person 13 indicated there was no documentation of communication from the agency on the inability to provide OT services as ordered. On 8/7/2024, at 2:00 PM, RN 4 indicated she did not notify the NP until after the patient's 2nd fall on 7/21/2024. RN 4 indicated she documented the physician was notified of the fall on visit note dated 7/12//2024, because she thought the agency had notified the physician. On 8/8/2024, at 2:44 PM, RN 4 indicated she did not notify the NP that the agency had not provided OT as ordered, because she was not aware of the OT evaluation order. RN 4 indicated the agency did not typically order PT and OT at the start of care and indicated PT was more important to provide to the patient first because of the patient's falls. On 8/7/2024, at 2:32 PM, PT 2 indicated she did not notify the NP of the falls, injuries, and the			

	ER visit, because she assumed the agency had notified the physician. On 8/7/2024, at 3:23 PM, the patient's caregiver indicated they never refused OT services for the patient and indicated RN 4 wanted the patient to receive OT services and informed the caregiver she would check into it.			
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Based on record review and interviews the agency failed to ensure a revised a plan of care to reflect the current information concerning the patients progress toward measurable outcomes and goals in two of four active clinical records (Patient #9, 12). Findings include: 1. The agency policy titled "Plan of Care – CMS #485 and Physician/Practitioners Orders", revised 2/2024, indicated each	G0592	The plan of care for Patient #9 was updated on 8-2-24 when the new wound order was received and written. The surveyor wanted to know why a new plan of care wasn't sent to the physician after the SOC POC from 7-26-24 was sent. Our EMR system automatically updates the patient's plan of care when orders are written. A new POC summary is then placed in the patient's home. This will continue to be our process for updating the plan of care. Clinical Manager is responsible for ongoing monitoring. Clinicians will revise the plan of care if a patient experiences a fall to include additional interventions or revised goals related to that fall. Clinical Manager will be responsible for the ongoing monitoring of this deficiency.	2024-09-28

	patient must receive an individualized plan of care, including any revisions or additions, to specify the care and services needed to meet patient needs. 2. The clinical record for Patient #9 revealed a physician's order dated 8/2/24 for skilled nurse to perform wound care to left knee: cleanse wound with normal saline and pat dry, apply Silver Gel (topical antibacterial wound gel), then hydrofera blue (antibacterial wound dressing) dampened with normal saline then cover with foam dressing. The plan of care for Patient #9 for dates 7/26/24 to 9/23/24 included the wound care order: skilled nurse to perform wound care to left knee by cleansing wound with saline, apply venelex (barrier cream for wounds) ointment and cover with non-adhesive dressing. The plan of care failed to evidence the updated wound care order from 8/2/24 that included Silver Gel and hydrofera blue. During an interview on 8/5/25 beginning at 3:00 PM, Administrator revealed the updated wound order was not on the plan of care. She relayed			

	the new wound care order came after the plan of care was created and the plan of care does not need to be revised. * A clinical record review for Patient #12, start of care 6/25/2024, evidenced the initial plan of care for certification period 6/25/2024-8/23/2024 which indicated the agency would provide nursing, physical therapy (PT), and home health aide (HHA) services and indicated the skilled nurse and PT would minimize the risk factors to prevent falls and injuries by educating the patient and caregiver. A PT visit note completed by PT 2 dated 7/10/2024 indicated the patient had a fall with injury and received treatment at the emergency room (ER) on 7/8/2024. A skilled nurse visit note completed by RN 4 dated 7/12/2024 indicated the patient fell earlier in the week and had sutures to the forehead and a bruise to the right eye. The provider notes from the emergency room (ER) at Entity			

	12 dated 7/8/2024 indicated the patient was evaluated and treated after a fall. The ER note indicated the patient had a laceration on the forehead requiring 5 sutures and an abrasion and swelling to the right cheek. A PT visit note completed by PT 2 dated 7/15/2024 indicated the patient reported pain 4 out of 10 to the right hip and indicated the patient was moving slower. A PT visit note completed by PT 2 dated 7/17/2024 indicated the patient reported pain 4 out of 10 to the right hip and indicated the patient had a right foot drag while ambulating. A skilled nurse visit note completed by RN 4 dated 7/22/2024 indicated the patient fell on 7/21/2024 and had a bruise to the right torso measuring 15 centimeters (cm) in length and 10 cm in width. The visit note indicated the patient reported pain 2 out of 10 to the right torso. The Xray report dated 7/23/2024 of the right chest obtained from the NP's office			

	patient had fractures with displacement of the right 9th, 10th, and 11th ribs. A PT re-evaluation visit completed by PT 2 dated 7/25/2024 indicated the patient reported pain 4 out of 10 to the right ribs and had a right foot drag while ambulating. The clinical record failed to evidence the plan of care was revised to include additional interventions and goals related to the patient's falls and injuries. A transfer assessment completed by the Clinical Manager and dated 7/30/2024 indicated the agency was notified by the caregiver that that the patient fell and was transferred to the hospital. The documents from Entity 11 (hospital) indicated the patient was admitted on 7/29/2024 due to right hip pain and unable to bear weight on the right leg after a fall. The X-ray of the right chest dated 8/3/2024 indicated the patient had fractures with displacement of the right 7th, 8th, 9th, and 10th ribs. The MRI of the right hip dated 8/5/2024 indicated the patient had a fracture of the			

	right hip. On 8/7/2024, at 2:00 PM, RN 4 indicated she did not revise the plan of care for additional interventions related to the falls because the patient "was mainly getting therapy" from the agency. RN 4 indicated she was going to talk to the family about the patient needing to use the wheelchair more at the next visit. On 8/7/2024, at 2:32 PM, PT 2 indicated she did not revise the plan of care to include additional interventions or revised goals related to falls. On 8/8/2024, at 1:10 PM, PT 2 indicated the patient's goal was to walk so PT did not introduce the wheelchair. PT 2 indicated the patient had dizziness and got tired after ambulation. On 8/7/2024, at 3:23 PM, the patient's caregiver indicated the patient's right foot drag began in July after the patient fell and indicated the patient began to complain of more pain. The patient's caregiver indicated the agency did not give her any additional instructions to reduce the patient's falls.			

G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the agency failed to coordinate care with all providers involved in the patient's care in 2 of 4 active clinical records reviewed. (Patient #11, 12) The findings include: 1. A clinical record review for Patient #12, start of care 6/25/2024, evidenced the initial plan of care for certification period 6/25/2024-8/23/2024 which indicated the agency would provide nursing, physical therapy (PT), and home health aide (HHA) services. A physical therapy (PT) visit note completed by PT 2 dated 7/10/2024 indicated the patient had a fall with injury and received treatment at the emergency room (ER) on 7/8/2024. Review failed to	G0606	All staff have been re-educated on the need to use the EMR communication system to document coordination of care. Clinical Manager is responsible for ongoing monitoring that all coordination of care is done with all disciplines seeing the patient. PT2 and RN4 have been provided with individualized education on the requirement of alerting the clinical manager, physician, caregiver(s) and all other disciplines of any changes in the patient's condition promptly and then documenting the communication in the patient's EMR. All clinicians will receive this same education during onboarding and no less than annually in perpetuity. Clinical Manager will be responsible for assuring that we are coordinating care with all agencies providing care. Monitoring will be ongoing.	2024-09-28

nurse case manager and the HHA of the fall.

A skilled nurse visit note completed by Registered Nurse (RN) 4 dated 7/22/2024 indicated the patient fell on 7/21/2024 and had a bruise to the right torso measuring 15 centimeters (cm) in length and 10 cm in width. The visit note indicated the patient reported pain 2 out of 10 to the right torso. Review failed to evidence RN 4 coordinated care with PT 2 and the HHA related to the patient's fall.

On 8/7/2024, at 2:00 PM, RN 4 indicated she had not coordinated care with PT 2 regarding the patient's falls because the patient "was mainly getting therapy" from the agency.

On 8/8/2024, at 1:10 PM, PT 2 indicated she never talked to RN 4, because she was not aware the skilled nurse was continuing nursing services after the start of care assessment.

2. A clinical record review for Patient #11 evidenced a plan of care for the initial certification period of 6/18/2024-8/16/2024

which indicated the agency would provide home health aide (HHA) services 1 time a week for 1 week, 2 times a week for 6 weeks, and then 1 time a week for 1 week and skilled nursing services 1 time a week for 9 weeks. The plan of care indicated the patient received homemaker services 14 hours a day, 7 days a week and were provided by a family member. The review indicated the agency had missed visits for the nurse on 7/19/2024 and 7/30/2024 and failed to evidence the home health aide provided services since 7/12/2024.

On 8/6/2024, at 3:01 PM, RN 4 (the nurse providing nursing services to the patient) indicated the patient was hard to contact and schedule visits with and knew the aide had difficulty providing services as well due to difficulty scheduling visits with the patient. RN 4 indicated she had not contacted the agency providing homemaker services in an effort to coordinate contacting the patient to schedule visits.

On 8/6/2024, at 2:57 PM, the Clinical Manager indicated Entity 17 was the agency

	providing the homemaker services and indicated there was no care coordination with the agency regarding the inability to contact patients for visits as ordered. On 8/7/2024, at 3:17 PM, HHA 1 (patient's HHA) indicated she had not received any instructions or notification from the RN or the PT regarding the patient's falls.			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review and interview the agency failed to ensure the Patient medication schedule and instructions were provided to the patient and / or caregiver in 1 of 1 active clinical record with a home visit (Patient #8). Findings include: 1. The agency policy titled "Coordination of Patient Care", revised 2/2024, indicated the agency will coordinate care with	G0616	Clinical Manager has always placed a copy of the patients' plan of care, medication list, aide care plan, and schedule of visits in the nurse or therapist's boxes to take to homes. The nurse seeing patient #8 stated that the information was in the patient's folder. The surveyor even mentioned that there were several different folders in the home. Clinicians have been instructed to check the patient's folder each week to make sure the information is present in the folder and that patient knows where the information can be found. Clinical Manager is responsible for the ongoing monitoring of this deficiency.	2024-09-28

	the patient by providing a copy of written instructions outlining the patient medication schedule and medication instructions. 2. During a home visit observation on 8/6/24 beginning at 10:30 AM, Patient #8's agency folder was at bedside and revealed agency information documents; the folder did not include a medication list nor instructions for Patient #8. During an interview on 8/6/24 beginning at 11:20 AM after the observation, Patient #8 relayed there was no additional paperwork supplied to Patient by the agency staff other than what was in the folder. 3. During an interview on 8/5/24 beginning at 4:25 PM, Administrator relayed staff were told to print patients' medication list and place in agency folder in the home.			
G0618	Treatments and therapy services 484.60(e)(3)	G0618	Clinical Manager has always placed a copy of the patients' plan of care, medication list, aide care plan, and schedule of visits in the nurse or therapist's boxes to take to homes. The nurse seeing patient #8 stated that the information was in the patient's folder. The surveyor even mentioned that there were several different folders in the home. Clinicians have been instructed to check the patient's folder each week to make sure the information is present	2024-09-28

	Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation, record review and interview the agency failed to ensure a copy of written instructions outlining treatments was provided to a patient and caregiver in 1 of 1 active clinical record with a home visit (Patient #8). Findings include: 1. The agency policy titled "Coordination of Patient Care", revised 2/2024, indicated the agency will coordinate care with the patient by providing a copy of written instructions outlining any treatments to be administered by agency personnel and any other pertinent instructions related to the patient's care. 2. During a home visit observation on 8/6/24 beginning at 10:30 AM, an agency folder at the bedside of Patient #8 revealed agency information documents; there were no instructions outlining Patient's care / treatment. During an interview on 8/6/24 beginning at 11:20 AM after the home visit, Patient #8 relayed there was no additional		in the folder and that patient knows where the information can be found. Clinical Manager is responsible for the ongoing monitoring of this deficiency.	

	paperwork supplied to Patient by agency staff, except for the documents that were present in the folder. 3. During an interview on 8/5/24 beginning at 4:25 PM, Administrator relayed staff were told to print patients' instructions for care and place in agency folder in the home.			
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 Quality Assessment and Performance Improvement (QAPI) program activities were measured or tracked. Findings include: 1. The agency policy titled	G0646	Pursuant to the State Operations Manual, chapter 2, Section 2728B, we are submitting both our objection to this tag and a Plan of Correction. For the following reasons, we believe that this tag was cited improperly: Agency was in the process of collecting, reviewing, and processing data from quarter 2 2024 QAPI data during the August 5-13 survey. IQUIES reports from CMS are not always completed by the end of each quarter in order to analyze the data. Q2 2024 is now completed. We are submitting our supporting documentation. Although we disagree with the cited tag for the foregoing reasons, we are submitting the following plan of correction: Governing Board will meet with Administrator to update the policy so it's clear when QAPI reports will be completed and when the QAPI committee will meet.	2024-09-28

	Performance Improvement (QAPI) Plan and Program", revised 4/2023, indicated the agency must measure, analyze, and track quality indicators, including adverse patient events. 2. The QAPI record review revealed quarter one (January, February, and March) of 2024 tracking of patient hospitalization. The record failed to evidence measurement updates since 3/2024. During an interview on 8/7/24 beginning at 4:00 PM, Administrator relayed QAPI was monitored monthly or quarterly with quarter one being the last documentation.			
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.	G0658	Pursuant to the State Operations Manual, chapter 2, Section 2728B, we are submitting both our objection to this tag and a Plan of Correction. For the following reasons, we believe that this tag was cited improperly: At the time of survey, the surveyors were presented with the agency's Performance improvement Project. It clearly stated the the Quarter 4 2023 fall rate was 7% and that the agency wanted to decrease that rate. Supporting data for the reason for the PIP was Quarter 4 2024 fall rate of 7%. The PIP further showed that the Q1 2024 goal was met because the rate now showed 2.8% and the goal was less than 5%. Progress for Q2 2024 was still being analyzed	2024-09-28

	(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 ensure documentation for the reasons the performance improvement project was undertaken and the measurable progress achieved on these projects. Findings include: 1. The agency policy titled "Performance Improvement Projects", revised 3/2018, indicated the agency will conduct performance improvement projects and document the reasons for conducting these projects and the measurable progress achieved on these projects. 2. The review of the quality assurance performance improvement (QAPI) report revealed a performance improvement project (with quarterly updates) based on fall risk identification and fall prevention that involved an informative handout provided to patients. The QAPI report included fall percentage rates for quarter one (January,		at the time of the survey. Supporting documentation is being uploaded. Q2 2024 is now complete. Although we disagree with the cited tag for the foregoing reasons, we are submitting the following plan of correction: Governing Board will meet with Administrator to update the policy so it's clear when QAPI reports will be completed and when the QAPI committee will meet.	

	February, March) of 2024 but failed to evidence means to track patients that receive the handout nor measurable progress since quarter one. During an interview on 8/7/24 beginning at 4:00 PM, Administrator relayed the performance improvement project was monitored monthly or quarterly with quarter one being the last documentation. When asked for documentation for the reasons the project was chosen, none were provided; Administrator relayed falls are always an issue.			
G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on record review and interview, the Registered Nurse (RN) failed to provide ongoing assessment in 1 of 1 active clinical record review with a fall. (Patient #12) The findings include: The policy, revised date October 2017 and titled "Fall Reduction Program" indicated the agency	G0706	All staff has been re-educated on the Agency's Policy of Fall Reduction Plan. All staff will conduct a new fall risk assessment if a patient has a fall during service. Physician will be contacted, all staff will be notified, and additional interventions and goals will be added to the patient's plan of care as appropriate. Clinical Director is responsible for the ongoing monitoring if this deficiency.	2024-09-28

would conduct a reassessment of the fall risk after the patient experienced a fall.

A review of the Incident Log, dated 8/6/2024, indicated Patient #12 had a fall with injury on 7/9/2024, 7/21/2024, and 7/24/2024.

A clinical record review for Patient #12, start of care 6/25/2024, indicated Patient received skilled nursing services 1 time a week and physical therapy (PT) services 2 times a week; the record failed to evidence the agency reassessed Patient's fall risk after each fall.

On 8/7/2024, at 2:00 PM, RN 4 (the nurse assigned to Patient) indicated she was unaware of the agency's policy to reassess the fall risk after each fall and indicated the fall risk was only assessed during a comprehensive assessment, that is where the fall risk tool was located in the electronic medical record.

On 8/7/2024, at 2:32 PM, PT 2 (the PT assigned to the patient) indicated the fall risk was not reassessed because it is only done at the start of care and with the comprehensive

	assessment. On 8/7/2024, at 3:46 PM, the Clinical Manager indicated the fall risk was not reassessed and indicated she was not aware of the agency's policy to reassess the fall risk after each fall. 410 IAC 17-12-2(g)			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview the agency failed to ensure skilled professionals assumes responsibility for preparing clinical notes in 3 of 4 active clinical records (Patients #8, 11, 12) and in 3 of 3 partial clinical record reviews (Patient #13, 14, 15). Findings include: The agency policy "Timely Submission of Patient Documentation", revised 2/2024, indicated visit reports must be submitted the next workday, not exceeding three business days. 1. The agency policy "Home	G0716	All staff has been re-educated in timely submission of clinical notes and incident reports. Clinical notes and incident reports will be completed within 3 business days. RNs have been re-educated to complete aide supervisory visit notes from their EMR visit note if a supervisory visit has not been scheduled or to contact the office to have supervisory visits scheduled. Clinical Manager is responsible for the ongoing monitoring of this deficiency to assure continued compliance. RN 4 was asked to complete multiple fall risk assessment tools for patients so that the agency could have an IJ removed. RN 4 was in a hurry because of the multiple visits she had to make to complete them and inadvertanly marked that 3 patients had a history of falls when they indeed did not. The forms were corrected while the surveyors were at the agency.Clinical Manager will review all fall risk assessments for accuracy and will be responsible for ongoing monitoring.	2024-09-28

	Health Aide Supervision", revised on 2/2023, indicated all home health aide supervisory visits will be made at least every 14 days. 2. The clinical record of Patient #8 revealed a home health aide supervisory visit completed by RN 5 on 7/1/24. The record failed to evidence home health aide supervisory visits from 7/1/24 to 8/5/24. The clinical record of Patient #8 revealed home health aide supervisory visits for dates 7/12/24, 7/15/24, 7/22/24, and 7/29/24 were documented on 8/5/24. During an interview on 8/6/24 beginning at 10:00 AM, RN 5 relayed the home health aide supervisory visits were not documented after 7/1/24 because the visits were not assigned in the electronic medical record. She indicated the Administrator still had not assigned them. During an interview on 8/5/24 beginning at 4:25 PM, Administrator relayed there was not a home health aide supervisory visit completed after 7/1/24 because it's just not documented yet.			

	410 IAC 17-14-1(a)(1)(E) * A clinical a record review for Patient #12 evidenced incident reports completed by RN 4 dated 7/22/2024 and 7/27/2024 which had the same description of the incident to include the patient fell while standing at the bathroom sink and was left alone by the caregiver after which the patient fell backwards and hit their back and right side on the bathtub. On 8/8/2024, at 3:27 PM, the Clinical Manager indicated the incident report dated 7/27/2024 was not correct and had been returned to RN 4 for correction. * A clinical record review for Patient #11 evidenced a Home Health Aide supervisory note completed by RN 4 and dated 7/30/2024. The electronic health record tracking indicated RN 4 did not complete the note until 8/5/2024. On 8/6/2024, at 2:58 PM, the Clinical Manager indicated the supervision note dated 7/30/2024 was not completed by the RN until 8/5/2024. * Review of fall risk assessment			

	#15 dated 8/10/2024 and signed by RN 4 indicated the patients had falls in the last 3 months. During an interview on 8/13/2024, at 1:21 PM, RN 4 indicated she got confused when completing the fall risk assessments and indicated the fall risk assessments were not accurate because the patients did not fall in the last 3 months.			
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 interviews the agency failed to ensure the home health aides are assigned to a specific patient with written patient care instructions prepared by an appropriate skilled professional in 2 of 3 active clinical records with home health aide services	G0798	All RNs have been re-educated on the need to fill out aide care plans completely and to review the plan for accuracy prior to submitting. Clinical Director will be responsible for the ongoing monitoring of this deficiency.	2024-09-28

provided (Patients #8, 11).

Findings include:

The agency policy titled "Nursing Services", revised 2/2021, indicated professional nursing service provided by a registered nurse includes initiating the plan of care and revising as necessary and assigning home health aide to a specific patient.

The clinical record of Patient #8 revealed a home health aide care plan for dates 7/14/24 to 9/11/24 that indicated Patient's diet is "seasonal" and the allergies are "no concentrated sweets, heart healthy."

During an interview on 8/6/24 beginning at 12:00 PM, when asked about the home health aide care plan assignments and information, Registered Nurse (RN) 5 revealed the need to revise the home health aide plan of care.

* A clinical record for Patient #11 evidenced a plan of care for certification period 6/18/2024-28/16/2024 which indicated the agency was to

	home health aide (HHA) services and indicated the patient was allergic to Chantix (a medication used for smoking cessation), Fentanyl (a medication for severe pain), Lyrica (a medication used for nerve pain), and Morphine (a medication for severe pain). The plan of care indicated the patient's diet was heart healthy, no added salt, renal (kidney) diet, no concentrated sweets, low cholesterol and low fat and indicated the safety precautions included seizure and bleeding precautions. The HHA care plan dated 6/18/2024 and signed by the registered nurse (RN) failed to be completed for the sections for diet and allergies and failed to include seizure and bleeding precautions in the safety measures. On 8/6/2024, at 2:40 PM, the Clinical Manager indicated the written instructions for diet, allergies, and bleeding and seizure precautions were not included on the HHA care plan and indicated she had not had time to revise the HHA care plans.			
G0818	HH aide supervision elements	G0818	Home Health aides have all been re-educated on the need to follow the RN plan of Care and	2024-09-28

	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 home health aide furnishes safe and effective care including following the patient's plan of care and reported changes in a patient's condition in 2 of 3 active clinical records reviewed with home health aide services provided (Patient #8, 11). Findings include: 1. The agency policy titled "Home Health Aide Documentation", revised 3/2018, indicated the home health aide will document services rendered to the patient		if there are any changes that the RN needs to be notified so the plan of care can be updated or modified. All RNs have been instructed to try to do visits with the aide at least monthly to assure compliance and the Clinical Director will be responsible for the ongoing monitoring of this deficiency.	

	and report any pertinent observations to the responsible skilled professional. 2. The agency policy titled " Home Health Aide Supervision", revised 4/2023, indicated the appropriate supervising skilled professional must ensure the HHA furnished care in a safe and effective manner that follows the patient's plan of care. 3. The clinical record for Patient #8 revealed a Home Health Aide (HHA) plan of care for dates 7/14/24 to 9/11/24 which planned for care to include a shampoo and oral care every visit with the bed bath and did not include making bed or changing lined. During an observation of a home visit on 8/6/24 beginning at 10:30 AM, HHA 1 provided care to Patient #8 that failed to evidence oral care or a shampoo. HHA 1 changed the bed linens of Patient #8 and made the bed. During an interview on 8/6/24 beginning at 11:15 AM after a home visit, HHA 1 relayed she doesn't wash Patient's hair every visit, rather once a week.			

	She revealed she changed the linen and made the bed at every visit after the bed bath. During an interview on 8/6/24. beginning at 11:20 AM after a home visit, Patient #8 relayed he/she gets a hair shampoo every two weeks and the HHA has never performed oral care. Patient revealed he/she wears dentures often and has a family member assist with denture and oral care. During an interview on 8/6/24 beginning at 3:00 PM, Administrator revealed the possibility that family does not want the linen changed. She relayed that if a service need changed on the HHA plan of care, the HHA should notify her or the case manager. During an interview on 8/6/24 beginning at 12:00 PM, RN 5 revealed she wasn't aware the HHA was not completing the oral care and hair shampoo at every visit. When asked why a linen change was not included in the plan of care, she relayed it wasn't ordered because Patient has multiple animals in the home. RN 5 relayed that			

	tasks specifically on the HHA plan of care and sometimes she doesn't. The clinical record for Patient #8 revealed a HHA visit note for 8/6/24 that indicated the status for tasks shampoo and oral was completed. Tasks to change linen and make bed were not marked completed. 410 IAC 17-14-1(n) 1. The agency policy titled " Home Health Aide Supervision", revised 4/2023, indicated the appropriate supervising skilled professional would provide an on-site, in person supervisory visit every 2 weeks, and indicated the agency could use an interactive telecommunications option for supervisory visits in rare occasions which expired on 12/31/2023. 2. The clinical record for Patient #8 revealed a Home Health Aide (HHA) plan of care for dates 7/14/24 to 9/11/24 which planned for care to include a shampoo and oral care every visit with the bed bath and did not include making bed or changing lined.			

	During an observation of a home visit on 8/6/24 beginning at 10:30 AM, HHA 1 provided care to Patient #8 that failed to evidence oral care or a shampoo. HHA 1 changed the bed linens of Patient #8 and made the bed. During an interview on 8/6/24 beginning at 11:15 AM after a home visit, HHA 1 relayed she doesn't wash Patient's hair every visit, rather once a week. She revealed she changed the linen and made the bed at every visit after the bed bath. During an interview on 8/6/24. beginning at 11:20 AM after a home visit, Patient #8 relayed he/she gets a hair shampoo every two weeks and the HHA has never performed oral care. Patient revealed he/she wears dentures often and has a family member assist with denture and oral care. During an interview on 8/6/24 beginning at 3:00 PM, Administrator revealed the possibility that family does not want the linen changed. She relayed that if a service need changed on the HHA plan of			

	or the case manager. During an interview on 8/6/24 beginning at 12:00 PM, RN 5 revealed she wasn't aware the HHA was not completing the oral care and hair shampoo at every visit. When asked why a linen change was not included in the plan of care, she relayed it wasn't ordered because Patient has multiple animals in the home. RN 5 relayed that sometimes she asked about tasks specifically on the HHA plan of care and sometimes she doesn't. The clinical record for Patient #8 revealed a HHA visit note for 8/6/24 that indicated the status for tasks shampoo and oral was completed. Tasks to change linen and make bed were not marked completed. 410 IAC 17-14-1(n) 4. A clinical record review on 8/6/2024 for Patient #11 evidenced a plan of care for the initial certification period of 6/18/2024-8/16/2024 which indicated the agency would provide home health aide (HHA) services 1 time a week for 1 week, 2 times a week for 6			

for 1 week. The electronic health record evidenced HHA visits scheduled with HHA 2 on 7/1/2024, 7/5/2024, 7/6/2024, 7/15/2024, 7/19/2024, 7/22/2024, 7/26/2024, 7/29/2024, 8/2/2024, and 8/5/2024 which indicated the visits had not yet been started.

On 8/6/2024, at 2:21 PM, HHA 2 indicated she usually provided HHA services to the patient 2 times weekly but at least every Saturday. HHA 2 indicated her phone was broken and she was not able to document her visits.

HHA supervisory visit notes completed by RN 4 and dated 7/19/2024, 7/26/2024, and 7/30/2024 indicated the HHA followed the plan of care and failed to evidence the RN provided HHA supervision to ensure the HHA followed the care plan by providing visits as directed.

On 8/6/2024, at 3:01 PM, RN 4 indicated she knew HHA 2 had difficulty scheduling visits with the patient and was unsure if HHA 2 was providing HHA services per the frequency as directed in the plan of care. RN

	the HHA was not documenting the HHA visits. On 8/7/2024, at 2:00 PM, RN 4 indicated she should not have marked the supervision note for care being performed per the plan of care if it was not being done. 410 IAC 17-14-1(n)			
G1024	Authentication 484.110(b) 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, observation, and interview the agency failed to ensure all entries are complete and appropriately authenticated in 2 of 3 active clinical records with home health aide services provided (Patients #8, 11). Findings include: 1. The agency policy titled "Timely Submission of Patient Documentation", revised 2/2024, indicated the agency	G1024	All staff has been re-educated in timely submission of clinical notes. Clinical notes will be completed within 3 business days. Clinical Manager is responsible for the ongoing monitoring of this deficiency to assure continued compliance.	2024-09-28

	submission of patient documentation. Visit reports should be submitted within three business days. 2. The clinical record review of Patient #8 revealed scheduled home health aide (HHA) visits without documentation, marked "not yet started" on 7/16/24, 7/18/24, 7/23/24, 7/25/24, 7/30/24, and 8/1/24. During the entrance conference on 8/5/25 beginning at 10:40 AM, Administrator revealed the timeframe allowed for clinicians to complete documentation is 48 hours. During an interview on 8/5/24 beginning at 4:25 PM, when asked about the uncharted home health aide documentation on dates 7/16, 7/18, 7/23, 7/25, and 7/30 she relayed they must be missed visits and could not identify any documentation regarding the documentation or visits. interview with on 8/6/24 beginning at 12:20 PM, Alternate Administrator revealed Home Health Aide 2 had her phone stolen and was told to complete the documentation. She relayed			

	complete charting as an alternative method. During an interview on 8/6/24 beginning at 11: 15 AM, HHA 2 revealed she uses her phone to document her visits, and her phone was stolen last month. 410 IAC 17-15-1(b) * A clinical record review on 8/6/2024 for Patient #11 evidenced a plan of care for the initial certification period of 6/18/2024-8/16/2024 which indicated the agency would provide home health aide (HHA) services 1 time a week for 1 week, 2 times a week for 6 weeks, and then 1 time a week for 1 week. The electronic health record evidenced HHA visits scheduled with HHA 2 on 7/1/2024, 7/5/2024, 7/6/2024, 7/15/2024, 7/19/2024, 7/22/2024, 7/26/2024, 7/29/2024, 8/2/2024, and 8/5/2024 which indicated the visits had not yet been started. On 8/6/2024, at 2:21 PM, HHA 2 indicated she usually provided HHA services to the patient 2 times weekly but at least every Saturday. HHA 2 indicated her phone was broken and she was not able to document her visits			

	but would that night. On 8/7/2024, the electronic health record evidenced HHA visit notes completed by HH2 dated 7/1/2024, 7/5/2024, 7/11/2024, 7/12/2024, 7/15/2024, 7/19/2024, 7/22/2024, 7/29/2024, and 8/2/2024 were completed in the evening of 8/6/2024. On 8/6/2024, at 2:34 PM, at 2:44 PM, the Administrator indicated she was not sure why HHA visits were not provided as directed in the plan of care and stated, "That looks horrible." On 8/7/2024, at 11:30 AM, the Alternate Clinical Manager indicated HHA 2 completed the missing HHA visit notes on the night of 8/6/2024.			
N0000	Initial Comments This visit was for a Post Condition Revisit of a State Complaint Survey of a Home Health Provider.	N0000		

	Survey dates: 8/5 to 8/9/24 and 8/13/24 12-Month Unduplicated Skilled Admissions: 429 One tag was found to be in compliance with no new citations.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Krull	RN Administrator/Clinical Director	9/12/2024 11:47:26 AM