STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157571	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARETENDERS	**1724 STATE STREET , NEW ALBANY, Indiana, 47150**

(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 Federal and State complaint survey of a Home Health Provider. Survey Dates: 07/29/2024 - 07/31/2024 Complaint: IN00108350 with related deficiencies cited. Complaint: IN00108374 with related deficiencies cited. 12 Month Unduplicated Skilled Admissions: 1,732 This survey was partially extended on 07/30/2024 at 2:14 PM. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. QR Completed by A4 on 08/09/2024	G0000		
G0520	5 calendar days after start of care CFR(s): 484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure an order for Registered Nurse (RN) evaluation was completed in a timely manner for 1 of 5 active patient records reviewed (Patient #5) and 1 of 1 discharged patient records reviewed (Patient #3).	G0520		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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G0520	Continued from page 1 Findings include: Based on record review and interview, the agency failed to ensure an order for Registered Nurse (RN) evaluation was completed in a timely manner for 1 of 5 active patient records reviewed (Patient #5) and 1 of 1 discharged patient records reviewed (Patient #3). Findings include: 1. A policy titled "Physician Orders" indicated but was not limited to: "To outline the process of receiving and documenting physician or authorized practitioner orders…Services are provided according to the most recent orders updating the patient's Plan of Care…All care and services are provided within acceptable standards of practice…" 2. The clinical record for Patient #3, certification period 06/14/2024 - 08/12/2024, included a Physician's Order dated 06/17/2024. The order indicated verbal orders received on 06/17/2024 for continuation of PT (Physical Therapy) and Nursing evaluation. The clinical record included a Client Coordination Note dated 06/24/2024. The note indicated a Team Case Conference for Start of Care Conference and Patient #3 needed additional disciplines or care. The clinical record included a Client Coordination Note dated 06/26/2024. The note indicated a missed visit on 06/21/2024 by the Skilled Nurse. The reason the visit was missed was documented as an add-on evaluation. The clinical record included a Physician's Order dated 06/26/2024. The note indicated to discontinue Registered Nurse (RN) evaluation the week of 06/16/2024; Skilled Nurse to evaluate week of 06/23/2024. The clinical record included a Client Coordination Note dated 07/05/2024. The note indicated a missed visit on 06/28/2024 by the Skilled Nurse. The reason the visit was missed was documented as a staff emergency/illness. The clinical record included a Physician's Order dated 07/10/2024 to reschedule Skilled Nurse assessment to the week of 7/14/2024 per patient request. 3. The clinical record for Patient #5, certification period 06/11/2024 - 08/09/2024, included a physician's order dated 07/11/2024 for a nursing evaluation to be completed to assess the patient's right heel wounds and	G0520		

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G0520	Continued from page 2 bilateral pinky toes. The clinical record failed to evidence a nursing assessment had been completed for Patient #5. The clinical record included a client coordination note dated 07/22/2024, documented by PT 2 that indicated but was not limited to the: Patient has still not seen nursing for evaluation, they report that they have not had anybody call to schedule, and that they did not request that the evaluation be moved to this week…" The clinical record included a Physician's Order dated 07/16/2024 to reschedule the skilled nursing evaluation to the week of 07/21/2024 per the patient request. 4. During an interview on 07/29/2024 at 10:12 AM, Patient #3's spouse indicated the agency never came to provide nursing services to Patient #3 during his time as a patient. She indicated the patient had a wound that needed cared for by a nurse. The spouse indicated a continued need for nursing services up until the patient died at home. 5. During a phone interview on 07/29/2024 at 10:47 AM, Physical Therapist (PT) 1 indicated Patient #3 was admitted to the agency for Arteriovenous (AV) fistula (a connection that's made between an artery and a vein for dialysis access) malfunction and based on the initial/comprehensive assessment, would need nursing services to manage wound and medications. PT 1 indicated she obtained a verbal order on 06/17/2024 from the physician for the patient to have an evaluation for skilled nursing services. She indicated as far as she knows, Patient #3 never received skilled nursing services from the agency before he died. She indicated that Patient #3's spouse was overwhelmed and needed as much help as possible for patient care. 6. During a phone interview on 07/29/2024 at 11:15 AM, PT 2 indicated she never met Patient #3 but did speak to the spouse on the phone after the patient's death and the spouse indicated nobody from the agency contacted her about starting nursing services after the order was obtained on 6/17/2024 and that she never requested the nursing evaluation visit to be moved. PT 2 indicated office staff were putting orders into clinical records when an evaluation was late or missing, saying the patient or family had requested the visit dates changed, but the patient/family did not request those changes. PT 2 indicated that recently PT was expected to complete Resumption of Care, Start of Care, and Recertification for patients in cases where skilled nursing services were ordered due to a shortage	G0520		

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G0520	Continued from page 3 of nursing staff. 7. During an interview on 07/29/2024 at 11:32 AM, the Administrator acknowledged Patient #3 never received skilled nursing services as ordered and indicated being unsure why Patient #3 never received nursing services and that a new process had been implemented for documenting when a patient or family requests a change in visit date. The Administrator indicated the nurse who had entered the order in Patient #3's clinical record to change the visit date per the patient request was a Patient Care Manager (PCM) from Branch Office #1 who was remotely filling in for Branch Office #2 at the time and was helping with documentation and workflow. 8. During a phone interview on 07/29/2024 at 12:11 PM, RN 1 indicated she works for Entity #2. She indicated she was previously performing remote work for the agency office to help process orders and with "workflow". RN 1 indicated when a field clinician would receive an order they could let her know and she would enter it into the Electronic Medical Record (EMR). RN 1 indicated she was told to write the order for Patient #3 to reschedule skilled nursing evaluation to the week of 07/21/2024 per the patient's request. She indicated she couldn't remember who gave her the order information documented in Patient #3's clinical record. 9. During an interview on 07/30/2024 at 2:50 PM, the Alternate Administrator acknowledged a skilled nurse evaluation was ordered on 07/11/2024, and documentation of a skilled nurse evaluation was not present in the clinical record for Patient #5. The Alternate Administrator indicated she completed Patient #5's Skilled Nurse evaluation on 07/22/2024 after learning in a case conference that it had not been completed. She indicated the visit was documented on paper and not yet completed.	G0520		
G0522	Eligibility for Medicare home health benefit CFR(s): 484.55(b)(2) Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure that patient comprehensive assessments were completed by the appropriate skilled professional for 1	G0522		

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G0522	Continued from page 4 of 1 therapy patient records reviewed (Patient #4). Findings include: A policy titled "Patient Assessment, Initial and Reassessment" indicated but was not limited to: "To describe the process of patient assessments…All patients receive ongoing and periodic reassessments. Comprehensive OASIS reassessments are made prior to patient recertification for all adult patients receiving skilled care…Physical Therapists, Speech Therapists, and Occupational Therapists may perform initial/admission comprehensive assessment visits in cased where there are no nursing services ordered or known at the time of referral…A qualified clinician performs a comprehensive assessment or reassessment visit in the following situations: A resumption of care assessment within 48 hours following post-hospitalization discharge notification or on physician-ordered resumption date…" The Clinical Record for Patient #4, Certification Period 05/08/2024 - 07/06/2024, indicated the patient was admitted to the hospital on 06/02/2024 and discharged to home on 06/21/2024 with orders for Physical Therapy, Occupational Therapy, Speech Therapy, and Nursing services. Patient #4 agreed to Resumption of Care (ROC) visit from the agency on 06/28/2024. The Clinical Record included a Client Coordination Note dated 07/10/2024 which indicated Physical Therapy completed the ROC on 06/28/2024 after hospitalization. Prior to hospitalization Patient #4 had skilled nursing, physical therapy (PT), occupational therapy (OT), and speech therapy (SLP) ordered. During chart review, it was found that hospital physician was recommending discharging patient home with PT, OT, SLP, as well as Nursing per Face-to-Face dated 06/24/2024. The patient's recertification was scheduled to physical therapy however was not placed on therapists tablet until after episode had ended and this therapist was on vacation the last week of the patient's episode. PT spoke with NP on 07/10/2024 at 12:15 PM and received verbal order to continue Nursing, PT, OT, and SLP services for this patient. During a phone interview on 07/29/2024 at 11:15 AM, PT 2 indicated recently Physical Therapy was expected to complete Resumption of Care (ROC) for patients in cases where skilled nursing services were ordered due to a	G0522		

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G0522	Continued from page 5 shortage of nursing staff. During an interview on 07/30/2024 at 1:05 PM, the Administrator acknowledged Physical Therapy completed the ROC after hospitalization on 06/28/2024 for Patient #4. She indicated the patient was ordered nursing services on the hospital discharge instructions and prior to hospitalization. She indicated a Skilled Nurse should have completed the ROC. During an interview on 07/30/2024 at 1:14 PM, the Primary Caregiver for Patient #4 indicated nobody from the agency had been out to see the patient in about 2 or so weeks. They indicated being unsure if therapy or a nurse came for the last visit received. They indicated a continued need and want for home health services through the agency. They indicated patient was getting stronger now than in the past and no current issues at this time.	G0522		
G0546	Last 5 days of every 60 days unless: CFR(s): 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure an update of the comprehensive assessment was completed within the last 5 days of every 60 days beginning with the start-of-care date for 3 of 5 active patient records reviewed (Patient #4, #6, #7). Findings include: A policy titled "Patient Assessment, Initial, and Reassessment" indicated but was not limited to: "To describe the process of patient assessments…All patients receive ongoing and periodic reassessments. Comprehensive OASIS reassessments are made prior to patient recertification for all adult patients receiving skilled care…A qualified clinician performs a	G0546		

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G0546	Continued from page 6 comprehensive assessment or reassessment visit in the following situations: …Periodic reassessment during the last 5 days of the re-certification, or at least every 60 days…" 2. The Clinical Record for Patient #4, Certification Period 07/07/2024 - 09/04/2024, indicated no documentation present for the certification period, including a Recertification Comprehensive Assessment. 3. The Clinical Record for Patient #6, Certification Period 07/14/2024 - 09/11/2024, indicated a late Recertification date of 07/20/2024. 4. The Clinical Record for Patient #7, Certification Period 07/07/2024 - 09/04/2024, indicated a late Recertification date of 07/10/2024. 5. During an interview on 07/30/2024 at 1:05 PM, the Administrator indicated having no prior knowledge of there being no visits or documentation of Recertification for Patient #4 under the current certification period in the EMR (Electronic Medical Record). She indicated she would need to go ask the Quality Assurance Registered Nurse (RN) what happened. 6. During an interview on 07/30/2024 at 1:14 PM, the Primary Caregiver for Patient #4 indicated nobody from the agency had been out to see the patient in about 2 or so weeks. He indicated being unsure if it was therapy or a nurse who last provided a visit. He indicated a continued need and want for home health services through the agency . He indicated the patient was getting stronger now than in the past and had no current issues at this time. 7. During an interview on 07/30/2024 at 1:30 PM, the Administrator indicated she was not sure why there was no documentation at all for Patient #4 for Certification Period 07/07/2024 - 09/04/2024. The Administrator indicated the Alternate Administrator is the Clinical Director at Branch office #2 and the Administrator sits at Branch office #3 usually. She indicated being unaware the Recertification for Patient #4 was not completed. 8. During an interview on 07/30/2024 at 1:38 PM, the	G0546		

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G0546	Continued from page 7 Alternate Administrator indicated Patient #4 was discharged on 07/19/2024. She indicated she was instructed to discharge the patient and do a restart of care because the Recertification was late. The Alternate Administrator indicated she completed the discharge visit on paper and it was incomplete at this time. She indicated the Administrator was aware of the situation. 9. During an interview on 07/31/2024, the Quality Assurance RN indicated that 100% of chart audits were completed last evening to identify missing elements in patients' records. She indicated the agency has known about the patients' late recertification for a couple of weeks. 10. During an interview on 07/31/2024, the Administrator indicated Patient #4 was seen either yesterday or this morning for official discharge from the agency since the agency dropped the ball when the Alternate Administrator went to complete the discharge visit on 07/19/2024 on paper. The Administrator indicated late recertification was discovered a week or 2 ago and corporate held a meeting to discuss the plan moving forward. She indicated being aware that a Home Health Administrator is ultimately responsible for monitoring the functions of both offices under the provider license. 410 IAC 17-14-1(a)(1)(B)	G0546		