| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/22/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ANGELS OF MERCY HOMECARE | 1140 W JEFFERSON STREET STE B, FRANKLIN, IN, 46131 |

| (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 |
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| E0000 | Initial Comments<br><br>An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102.<br><br>Survey Dates: 08-20, 08-21, 08-22-2024<br><br>Census: 26<br><br>At this Emergency Preparedness survey, Angels of Mercy Homecare was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.<br><br>QR by Area 3 on 8-30-2024. | E0000 | | |
| G0000 | INITIAL COMMENTS<br><br>This visit was for a Federal Recertification and State | G0000 | | |

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| | Re-Licensure survey of a Home Health Provider.<br><br>Survey Dates: 08-20-2024, 08-21-2024, 08-22-2024<br><br>12-Month Unduplicated Skilled Admissions: 74<br><br>QR by Area 3 on 8-30-2024. | | | |
| G0572 | Plan of care<br><br>484.60(a)(1)<br><br>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.<br><br>Based on record review and interview, the agency failed to individualize a plan of care for 5 of 5 active clinical records reviewed (Patients #1, #2, #3, #4, and #5) and 2 of 3 inactive clinical records reviewed (Patients #7 and #8)<br><br>Findings Include:<br><br>1. A policy titled "Plan of Care | G0572 | **Immediate actionimplemented to correct specific deficiency:**<br><br>Patient # 4, 7, and 8 have been discharged from homehealth services.<br><br>Patient # 1 plan of care (POC) was updated to includecapillary blood glucose parameters.<br><br>Patient # 1, 2,3, and 5 POC were updated,discontinuing interventions for Urinary Tract Infection (UTI) and Constipation protocols.<br><br>During a mandatory TEAMS call on 9/17/24, theExecutive Director (ED) instructed all clinical and Quality Review staff on a completingan | 2024-09-20 |

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| | revised on 12-01-2021 indicated but was not limited to, " ... Policy: Each patient has an individualized Plan of Care (POC) developed ... that integrates comprehensive assessment findings to address patient problems, needs, and goals, as well as to address specific services being provided ..."<br><br>2. A review of Patient #1's active clinical record evidenced a POC with a Start of Care date of 07-05-2024 and a certification period from 07-05-2024 to 09-02-2024. The POC evidenced the following diagnoses: An open wound of the left lower leg, Atrial Fibrillation (a condition where the heart beats fast and irregularly), Acute on Chronic Diastolic Heart Failure (when the heart attempts to compensate for the loss of function over a period causing a decreased ability to contract and relax), Benign Prostatic Hyperplasia with lower urinary tract symptoms (an enlarged prostate causes weak urine stream and difficulty in making a stream), long term use of Anticoagulants (medicine which assists in preventing blood clots), and a history of falling. | | individualized POC, with emphasis on UTI and constipation protocols usingpolicy 2.1.007 Plan of Care.<br><br>The UTI and Constipation protocols will only beconsidered for those patients having a history of UTI (non-colonized) orconstipation with physician agreement.<br><br>**New process that willbe implemented to prevent deficiency from re-occurring:**<br><br>Each patient has an individualized Plan of Care (POC)developed in consultation with the patient, physician or authorizedpractitioner, and staff that integrates comprehensive assessment findings toaddress patient problems, needs, and goals, as well as to address specificservices being provided.<br><br>The POC includes, but is not | |

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| | The POC evidenced a section titled "Orders of Discipline and Treatments" included a standing protocol for for a bowel regimen if the patient was constipated. The bowel regimen indicated but was not limited to, the clinician was to instruct the patient to take 17 grams (g) of MiraLAX (used to help constipation) by mouth daily or 15 Milligrams (mg) of Senna (used to help constipation) by mouth daily for up to 2 days. The bowel regimen evidenced the physician was supposed to be contacted after 2 days if a normal bowel movement was not achieved. The section indicated the clinician was able to perform a urine test to assess for a urinary tract infection (UTI) if the patient displayed signs and symptoms of a UTI. The order evidenced the urine was supposed to be sent to the lab if the result of the original test were positive for a UTI. The POC indicated the clinician was to report the findings for a Fasting Blood Sugar less than 70 and greater than 250, and a Random Blood Sugar less than 70 and greater than 350. The POC failed to evidence the patient had a history of constipation, UTI, and a Diabetic (where the | | limited to types,frequency, and duration of services required which may include virtual services;medications and treatments; pertinent diagnosis(es); patient specificinterventions and education; and patient's risk for emergency department visitsand re-hospitalization including interventions that address underlying riskfactors.<br><br>The POC will be individualized, with considerationgiven for the inclusion of the UTI and constipation interventions only if thepatient has a documented history of a UTI (non-colonized) or constipation andthe physician or authorized practitioner is agreeable.<br><br>The Quality Review team will ensure supportingdocumentation is present in the medical record identifying a diagnosis orhistory of UTI or constipation to support the addition of the UTI andConstipation protocols.<br><br>**Title of personresponsible for implementing plan of correction:** | |

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| | body is unable to appropriately produce and use insulin) diagnosis. The POC failed to be individualized to the patient and included standardized order sets for bowel, bladder and blood sugar control.<br><br>A phone interview was conducted with Patient #1's physician's office, Entity 1, on 08-21-2023 at 10:53 AM. Person 15, a nurse for Patient #1's physician (Person 13) evidenced the patient was not on a bowel regimen and there were no standing orders for the patient. The nurse, Person 15, indicated orders were put in only when the patient displayed signs and symptoms of a UTI.<br><br>During an interview with Registered Nurse (RN) 1 on 08-22-2024 at 4:05 PM, they indicated Patient #1 had not had a diagnosis of Diabetes and had not checked their blood sugar. They evidenced the patient had no recent history of a UTI or issues with constipation. RN 1 explained corporate had enforced a new protocol for the POC and they were to include standing orders for urine testing and a bowel regimen to prevent | | Executive Director<br><br>**Date of completion:**<br>**9/20/24**<br><br>**Monitoring proceduresto ensure effectiveness of process improvement and continued compliance:**<br>Beginning 9/23, the Executive Director will review 8Plan of Cares (POC) per month to ensure the POC is individualized to theassessed needs of the patient.<br><br>Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months.<br><br>Once 100% compliant for 2 consecutive months, ongoingmonitoring will continue via monthly Quality Chart Reviews. | |

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| | hospitalizations.<br><br>3. A review of Patient #2's active clinical record evidenced a POC with a Start of Care date of 08-12-2024 and a certification period from 08-12-2024 to 10-10-2024. The POC evidenced the following diagnoses: Polyosteoarthritis (a condition where many of the joints and bones of the body degrade and cause pain and stiffness), Type 2 Diabetes Mellitus (a disease where the body is unable to produce and use insulin and sugar appropriately) with Diabetic Neuropathy (high blood sugar and fat levels cause damage to the nerves in the body), Chronic Kidney Disease, State 3 (a condition where there was damage to the kidney from high blood sugar levels causing the kidneys to be unable to filter waste and fluid out of the blood), Malignant Neoplasm of the rectum (a cancerous tumor formed in the rectum) and a history of falling. The POC evidenced a section titled "Orders of Discipline and Treatments". The section indicated the patient had a standing order for a bowel regimen if the patient was constipated. The bowel regimen | | | |

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| | indicated but was not limited to, the clinician was to instruct the patient to take 17g of MiraLAX by mouth daily or 15mg of Senna by mouth daily for up to 2 days. The bowel regimen evidenced the physician was supposed to be contacted after 2 days if a normal bowel movement was not achieved. The section indicated the clinician was able to perform a urine test to assess for a UTI if the patient displayed signs and symptoms of a UTI. The order evidenced the urine was supposed to be sent to the lab if the result of the original test were positive for a UTI. The POC failed to evidence the patient had a history of constipation and/or UTI. The POC failed to be individualized to the patient and included standardized order sets for bowel, bladder and blood sugar control.<br><br>A phone interview was conducted with Patient #2's physician's office, Entity 17, on 08-21-2024 at 1:25 PM. A nurse, Person 18, for Patient #2's Primary Care Provider, Person 16, evidenced the patient had a stool softener on their medication list but had no | | | |

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| | regimen in case of constipation. The nurse indicated there were no standing orders for UTI testing, orders were based on the situation and the circumstances.<br><br>During an interview with Physical Therapist 1 on 08-21-2024 at 3:38 PM, they indicated if Patient #2 showed signs and symptoms of a UTI they were able to collect a sample of urine and bring it to the lab for testing. They evidenced the bowel regimen and UTI protocol were implemented for all patients.<br><br>4. A review of Patient #5's active clinical record evidenced a POC, unsigned by the physician, with a Start of Care date of 08-14-2024 and a certification period from 08-14-2024 to 10-12-2024. The POC evidenced the following diagnoses: open wound on the left lower leg, Type 2 Diabetes Mellitus, Hypertension (high blood pressure), Fracture of the shaft of the left tibia, and liver cell carcinoma (a tumor that grows on the liver). The POC evidenced a section titled "Orders of Discipline and | | | |

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| | indicated the patient had a standing order for a bowel regimen if the patient was constipated. The bowel regimen indicated but was not limited to, the clinician was to instruct the patient to take 17g of MiraLAX by mouth daily or 15mg of Senna by mouth daily for up to 2 days. The bowel regimen evidenced the physician was supposed to be contacted after 2 days if a normal bowel movement was not achieved. The section indicated the clinician was able to perform a urine test to assess for a UTI if the patient displayed signs and symptoms of a UTI. The order evidenced the urine was supposed to be sent to the lab if the result of the original test were positive for a UTI. The POC failed to evidence the patient had a history of constipation and/or UTI. The POC failed to be individualized to the patient and included standardized order sets for bowel and bladder regimens.<br><br>During an interview with RN 2 on 08-22-2024 at 2:22 PM, they indicated Patient #5 had no issues with having a UTI recently, and had some | | | |

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| | the bowel and UTI regimens were included in the POC because of the new protocol from corporate.<br><br>5. A review of Patient #7's inactive clinical record evidenced a POC with a Start of Care date of 03-25-2024 and a certification period from 03-25-2024 to 05-23-2024. The POC evidenced the following diagnoses: Paroxysmal Atrial Fibrillation (a fast irregular heart rate lasting hours to days), Human Immunodeficiency Virus Disease (HIV, a virus which attacks the body's immune system), Hemiplegia following a cerebral infarction affecting the left side of the body (paralysis on the left side of the body because of a lack of blood to the brain), and a history of falls. The POC evidenced a section titled "Orders of Discipline and Treatments". The section indicated the patient had a standing order for a bowel regimen if the patient was constipated. The bowel regimen indicated but was not limited to, the clinician was to instruct the patient to take 17g of MiraLAX by mouth daily or 15mg of Senna by mouth daily for up to 2 days. The bowel regimen | | | |

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| | evidenced the physician was supposed to be contacted after 2 days if a normal bowel movement was not achieved. The section indicated the clinician was able to perform a urine test to assess for a UTI if the patient displayed signs and symptoms of a UTI. The order evidenced the urine was supposed to be sent to the lab if the result of the original test were positive for a UTI. The POC failed to evidence the patient had a history of constipation and/or UTI. The POC failed to be individualized to the patient and included a standardized bowel and bladder regimen.<br><br>6. During an interview with the Administrator on 08-22-2024 at 3:09 PM, they indicated their corporate office had implemented a new policy and process to reduce UTIs and a bowel regimen protocol for constipation. They evidenced if the clinician suspected the patient had a UTI, they were to obtain a urine sample and test it. They indicated not all of their patients were on the bowel regimen.<br><br>7. Review of clinical record for patient #3 Plan of Care did not | | | |

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| | evidence diagnosis of constipation (having a difficult time passing stool) or diagnosis of a (UTI) urinary tract infection- (an illness in any part of the urinary tract, the system that makes urine). The start of care order set date 07-02-2024, evidenced a skilled nursing order that stated if patient exhibits signs or symptoms of constipation, ensure patient is taking any prescribed medications for conditions if not already prescribed, then instruct to in initiate 17GM of Miralax (a stool softener) daily until normal bowel regime resumes, and/or instruct patient to initiate 15mg of senna ( a stool softener) PO ( orally) BID ( twice a day) until norma bowel regime resumes. If normal bowel movement does not resume in 2 days, contact physician for additional orders. A second order stated for clinician to obtain urine and test via a reagent strip (a test strip that measures components in urine). If results are positive, urine is to be sent to the lab for a UA with culture and sensitivity (a test to determine if urine has an infection) or obtain a PCR swab (a test that identifies more bacteria than a urinalysis with | | | |

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| | culture and sensitivity) PRN (as needed) for signs and symptoms of a UTI. The POC failed to be individualized to the patient and included a standardized bowel and bladder regimen.<br><br>A phone interview on 08-22-2024 at 9:15 A.M. with Person 8 at Entity 7 assisted with phone call and was queried if patient had a diagnosis of constipation or urinary tract infections and person #8 stated no. When queried if a standing order for a bowel regime or a urinary tract infection regime was ordered by patient #3's physician. Nurse 8 stated she did not see any orders for a bowel regimen or urinary tract infection protocol in patient #3's chart and stated no orders were found for PRN medications on patient medication list for Miralax or Senna.<br><br>8. Review of clinical record for patient #4 with a start of care 07-23-2024 did not evidence of diagnosis of a (UTI) urinary tract infection- (an illness in any part of the urinary tract, the system that makes urine). The plan of | | | |

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| | order that stated if patient exhibits signs or symptoms of constipation, ensure patient is taking any prescribed medications for conditions, if not already prescribed, then instruct to in initiate 17GM of Miralax ( a stool softener) daily until normal bowel regime resumes, and/or instruct patient to initiate 15mg of senna (a stool softener) PO (orally) BID ( twice a day) until norma bowel regime resumes. If normal bowel movement does not resume in 2 days, contact physician for additional orders. The medication list reviewed for patient evidenced an active order for Miralax 8.5GM daily PRN. A second order stated for clinician to obtain urine and test via a reagent strip (a test strip that measures components in urine). If results are positive, urine is to be sent to the lab for a UA with culture and sensitivity (a test to determine if urine has an infection) or obtain a PCR swab (a test that identifies more bacteria than a urinalysis with culture and sensitivity) PRN (as needed) for signs and symptoms of a UTI. The POC failed to be individualized to the patient and included a standardized bowel and bladder | | | |

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| | regimen.<br><br>A phone interview on 08-22-2024 at 10:50 A.M., with person 11 at Entity 9, when queried if patient had a bowel regimen or urinary tract infection protocol, person 11 stated patient had a diagnosis of constipation and had a PRN order for Miralax 8.5GM on patient medication list, however no bowel or urinary tract infection regimen physician order was active, nor did patient have an active urinary tract infection. Person 11 had stated usually other facilities/agencies call them to notify of symptoms /signs of a UTI with a patient and will then proceed with an order to collect the urinalysis with culture and sensitivity.<br><br>9. Review of a clinical record for patient #8 with a start of care date 06-19-2024 did evidence a diagnosis of constipation related to a surgical colectomy with ileorectal anastomosis ( a surgical procedure that removes part of the colon and joining the end of the small intestine to the rectum), but did not evidence a diagnosis of a (UTI) urinary tract infection- (an illness in any part of the urinary | | | |

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| | tract, the system that makes urine). The plan of care evidenced a skilled nursing order that stated if patient exhibits signs or symptoms of constipation, ensure patient is taking any prescribed medications for conditions, if not already prescribed, then instruct to in initiate 17GM of Miralax (a stool softener) daily until normal bowel regime resumes, and/or instruct patient to initiate 15mg of senna (a stool softener) PO (orally) BID ( twice a day) until norma bowel regime resumes. If normal bowel movement does not resume in 2 days, contact physician for additional orders. The medication list reviewed for patient evidenced an active order for psyllium oral powder 11gram weekly for constipation. A second order stated for clinician to obtain urine and test via a reagent strip (a test strip that measures components in urine). If results are positive, urine is to be sent to the lab for a UA with culture and sensitivity (a test to determine if urine has an infection) or obtain a PCR swab (a test that identifies more bacteria than a urinalysis with culture and sensitivity) PRN (as needed) for signs and | | | |

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| | symptoms of a UTI. The POC failed to be individualized to the patient and included a standardized bowel and bladder regimen.<br><br>A phone interview on 08-20-20204 with Person 10 at Entity 7, when queried if patient had a bowel regimen or urinary tract infection protocol, person 10 stated she did not see any orders in regard to that regime or protocol by the physician, and the medication list provided a weekly dose of Psyllium 11grams for constipation, no other constipation orders active.<br><br>410 IAC 17-13-1(a) | | | |
| G0574 | Plan of care must include the following<br><br>484.60(a)(2)(i-xvi)<br><br>The individualized plan of care must include the following:<br><br>(i) All pertinent diagnoses;<br><br>(ii) The patient's mental, psychosocial, and cognitive status;<br><br>(iii) The types of services, supplies, and equipment required;<br><br>(iv) The frequency and duration of visits to be made;<br><br>(v) Prognosis; | G0574 | **Immediate action implemented to correct specific deficiency:**<br><br>Patient # 1 Plan of Care updates to reflect proper DMEand Supplies.<br><br>During a mandatory TEAMS call on 8/23/24 and again,during a mandatory team meeting held on 8/29/24, the Executive Director (ED)instructed all clinical staff on a complete Plan of Care (POC), with emphasison | 2024-08-29 |

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| | (vi) Rehabilitation potential;<br><br>(vii) Functional limitations;<br><br>(viii) Activities permitted;<br><br>(ix) Nutritional requirements;<br><br>(x) All medications and treatments;<br><br>(xi) Safety measures to protect against injury;<br><br>(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.<br><br>(xiii) Patient and caregiver education and training to facilitate timely discharge;<br><br>(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;<br><br>(xv) Information related to any advanced directives; and<br><br>(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.<br><br>Based on observation, record review, and interview, the agency failed to ensure the plan of care included all necessary durable medical equipment (DME) for 1 of 1 active record reviewed with a home visit of a nurse providing wound care. (Patient #1)<br><br>Findings Include:<br><br>1. A policy titled "Plan of Care (POC), Policy Number: 2.1.007" revised on 12-01-2021 indicated but was not limited to, " ... 2. The POC includes: ... j. Required equipment and supplies ..."<br><br>2. A review of Patient #1's active | | DME and supplies using policy 2.1.007 Plan of Care.<br><br>**New process that will be implemented to prevent deficiency from re-occurring:**<br><br>Eachpatient has an individualized Plan of Care (POC) developed in consultation withthe patient, physician or authorized practitioner, and staff that integratescomprehensive assessment findings to address patient problems, needs, andgoals, as well as to address specific services being provided.<br><br>ThePOC includes required equipment and supplies.<br><br>ThePatient Care Manager or Quality Review staff will review the POC to ensureincludes appropriate DME and supplies.<br><br>**Title of person responsible for implementing plan of correction:**<br><br>Executive Director<br><br>**Date of completion:**<br><br>8/29/24<br><br>**Monitoring procedures to ensure** | |

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| | clinical record evidenced a POC with a Start of Care date of 07-05-2024 and a certification period from 07-05-2024 to 09-02-2024. The POC evidenced the following diagnoses: An open wound of the left lower leg and a history of falling. The POC evidenced a section titled "DME and Supplies", indicating the patient had a walker. The walker was the only supply listed for Patient #1 on the POC.<br><br>A home visit was conducted at Patient #1's residence on 08-22-2024 at 9:09 AM, Registered Nurse (RN) 1 was observed providing wound care for the patient. During the home visit, it was observed the patient had wound care supplies including Betadine, gauze sponge pads, normal saline, and tape for the patient's wound. The POC failed to evidence all the supplies the patient had in their home and necessary for their care.<br><br>During an interview with RN 1 on 08-22-2024 at 4:05 PM, they evidenced Patient #1's POC was to include all of the DME and supplies the patient used or was needed for the patient's care. | | **effectiveness of process improvement and continued compliance:**<br><br>Beginning 9/1, the Executive Director will review 8Plan of Cares (POC) per month to ensure the POC contains proper DME andSupplies.<br><br>Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months.<br><br>Once 100% compliantfor 2 consecutive months, ongoing monitoring will continue via monthly QualityChart Reviews. | |

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| | 410 IAC 17-13-1(a)(1)(D)(ii) | | | |
| G0598 | Discharge plans communication<br><br>484.60(c)(3)(ii)<br><br>(ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any).<br><br>Based on record review and interview, the agency failed to ensure care was coordinated with the nursing home for 1 of 1 inactive clinical record reviewed who transferred to a nursing home. (Patient #7)<br><br>Findings Include:<br><br>1. A policy titled "Patient Discharge/Transfer Process" revised 10-01-2023 indicated but was not limited to, " ... 16. Transfer Summary is sent to the primary care physician and the facility ... which the patient is transferred within 2 business days of planned transfer or becoming aware of unplanned transfer. ..."<br><br>2. A review of Patient #7's | G0598 | **Immediate action implemented to correct specific deficiency:**<br><br>Patient # 7 has been discharged from home healthservices.<br><br>During a mandatory TEAMScall on 8/23/24 and again, during a mandatory team meeting held on 8/29/24, theExecutive Director (ED) instructed all clinical staff on care coordination,with emphasis on coordinating care with the receiving facility when a patientis transferred to an inpatient facility using policy 2.1.004 PatientDischarge/Transfer Process.<br><br>**New process that will be implemented to prevent deficiency from re-occurring:**<br><br>A Transfer Summary is sent to the facility (if thepatient is still receiving care in the facility at the time the agency becomesaware of the transfer) to which the patient is transferred within 2 businessdays of planned transfer or becoming<br><br>aware of unplanned transfer. This form includes agencyname, transfer date, reason for transfer, patient's condition, summary of caretreatment, services provided to the patient, the patient's progress towardsgoals, patient's | 2024-08-29 |

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| | evidenced a document titled "Visit Note Report" dated 04-15-2024 by Physical Therapist (PT) 3. The document indicated Patient #7 was transferred to a nursing home, Entity 22, on 04-15-2024. The document failed to evidence any coordination with Entity 22.<br><br>The inactive clinical record for Patient #7 evidenced documents titled "Client Coordination Note Report". The document dated 04-22-2024 and signed by the Administrator indicated the patient was transferred to a nursing home and they were "(GETTING NAME FROM FAMILY)". The coordination notes failed to evidence the agency coordinated care with Entity 22.<br><br>During an interview with the Administrator on 08-22-2024 at 1:10 PM, they indicated Patient #7's inactive record's communication notes evidenced the family was supposed to inform the agency to which nursing home the patient was transferred. The Administrator explained the | | discharge goals of care, patient's treatment preferences, alist of community resources or referrals made or provided to patient, any<br><br>information on advance directives or DNR orders,patient name, physician name, diagnoses, current list of medications, and otherorganizations involved in patient care (ex. Pharmacy or DME).<br><br>**Title of person responsible for implementing plan of correction:**<br><br>Executive Director<br><br>**Date of completion:**<br><br>8/29/24<br><br>**Monitoring proceduresto ensure effectiveness of process improvement and continued compliance:**<br><br>Beginning 9/1, the Executive Director will review 8Transfers per month to ensure care coordination occurred with the receivingfacility, as evidenced by a Transfer Summary having been sent to the receiving facility. | |

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| | agency had not attempted to reach out to the patient's family to confirm which nursing home the patient went to and coordinate care with the nursing home regarding the patient's transfer of services. | | Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months.<br><br>Once 100% compliantfor 2 consecutive months, ongoing monitoring will continue monthly via reviewof 2 randomly selected transfers per month. | |
| G0608 | Coordinate care delivery<br><br>484.60(d)(4)<br><br>Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.<br><br>Based on record review and interview, the agency failed to ensure care was coordinated with Assisted Living Facilities for 1 of 1 home visit in an Assisted Living Facility. (Patient #1)<br><br>Findings Include:<br><br>1. A policy titled "Coordination of Care, From Admit through Discharge, Policy Number: 2.1.017" with a revised date of 06-01-2024 indicated but was not limited to, " ... 2. During | G0608 | **Immediate action implemented to correct specific deficiency:**<br><br>Patient # 1 was identified as residing in anIndependent Living Facility and currently receives no services from outsideentities.<br><br>During a mandatory TEAMScall on 8/23/24 and again, during a mandatory team meeting held on 8/29/24, theExecutive Director (ED) instructed all clinical staff on care coordination,with emphasis on coordinating care with community or other organizations usingpolicy 2.1.017 Coordination of Care, From Admit Through Discharge.<br><br>**New process that will be implemented to prevent deficiency from re-occurring:**<br><br>Coordination of services with other organizations andcommunity will occur when the patient receives services | 2024-08-29 |

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| | the course of care and services: a. The Executive Director and Clinical Director coordinate patient care and services ... 6. Coordination of services with other organizations and community: When the patient receives services from other organizations and/or individual's care is coordinated to ensure the patient's needs are met efficiently ..."<br><br>2. A review of Patient #1's active clinical record evidenced a POC with a Start of Care date of 07-05-2024 and a certification period from 07-05-2024 to 09-02-2024. The POC evidenced the following diagnoses: An open wound of the left lower leg, Atrial Fibrillation (a condition where the heart beats fast and irregularly), Acute on Chronic Diastolic Heart Failure (when the heart attempts to compensate for the loss of function over a period causing a decreased ability to contract and relax), Benign Prostatic Hyperplasia with lower urinary tract symptoms (an enlarged prostate causes weak urine stream and difficulty in making a stream), long term use of Anticoagulants (medicine which assists in preventing blood | | from otherorganizations and/or individual's care is coordinated to ensure that patient'sneeds are met efficiently, without duplication of services, including staffunderstanding the role and responsibilities of these other health careproviders; communication with other health care providers when there aresignificant; changes in patient care and/or condition; and if and whenconflicts and/or duplications arise, attempts are made to correct and<br><br>reduce thesesituations<br><br>**Title of person responsible for implementing plan of correction:**<br><br>Executive Director<br><br>**Date of completion:**<br><br>8/29/24<br><br>**Monitoring procedures to ensure effectiveness of process improvement and continued compliance:** | |

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| | clots), and a history of falling.<br><br>A review of Patient #1's clinical record failed to evidence any communication with the patient's Assisted Living Facility, Entity 12.<br><br>3. An interview with Registered Nurse (RN) 1 on 08-22-2024 at 4:05 PM, indicated the only time they ever spoke with the Director of Nursing (DON) of Entity 12 was when the patient first started with the agency on 07-05-2024. RN 1 evidenced they had no further communication with the DON of the Assisted Living Facility.<br><br>410 IAC 17-14-1(a)(1)(F) | | Beginning 9/1, the Executive Director will review 8 medicalrecords per month to ensure care coordination occurred with community or other organizationsproviding services to the patient.<br><br>Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months.<br><br>Once 100% compliantfor 2 consecutive months, ongoing monitoring will continue via monthly QualityChart Reviews. | |
| G0682 | Infection Prevention<br><br>484.70(a)<br><br>Standard: Infection Prevention.<br><br>The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.<br><br>Based on record review and interview, the agency failed to ensure proper infection control practices were followed for 1 of 1 Registered Nurse (RN) observed providing wound care | G0682 | **Immediate action implemented to correct specific deficiency:**<br><br>RN 1 provided 1:1 instruction to employee on properhand hygiene.<br><br>During a mandatory TEAMS call on 8/23/24 and again,during a mandatory team meeting held on 8/29/24, the Executive Director (ED)instructed all clinical staff on hand hygiene, with emphasis on hand | 2024-08-29 |

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| | on a home visit. (RN 1)<br><br>Findings Include:<br><br>1. A policy titled "Hand Hygiene, Policy Number: 8.004" with a revised date of 05-01-2019 indicated but was not limited to, " ... 1. Staff performs hand hygiene by handwashing with soap and water or using an alcohol-based hand sanitizer: ... b. before performing an aseptic task ... wound care). ... f. before and after removal of personal protective equipment ..."<br><br>2. Registered Nurse (RN) 1 was observed providing wound care to Patient #1 at Patient #1's residence on 08-22-2024 at 9:09 AM. RN 1 was observed removing the patient's old wound dressing from their right lower leg and doffed gloves, donned new gloves, and proceeded to clean the wound with normal saline and betadine. RN 1 failed to perform hand hygiene after doffing gloves and before donning new gloves to perform wound care.<br><br>3. An interview with RN 1 on 08-22-2024 at 4:05 PM, indicated hand hygiene was to be performed before going into their bag, before and after | | hygienewith glove changes using policy 8.004 Hand Hygiene.<br><br>**New process that will be implemented to prevent deficiency from re-occurring:**<br><br>Staff performs hand hygiene by handwashing with soap and water or usingan alcohol-based hand sanitizer before and after removal of personal protectiveequipment (PPE), to include glove changes.<br><br>**Title of person responsible for implementing plan of correction:**<br><br>Executive Director<br><br>**Date of completion:**<br><br>8/29/24<br><br>**Monitoring procedures to ensure effectiveness of process improvement and continued compliance:**<br><br>Beginning 9/1, the Executive Director will conduct 6observation visits per month to ensure proper hand hygiene is utilized withglove changes.<br><br>Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months. | |

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| | wound care, and after the visit.<br><br>410 IAC 17-12-1(m) | | Once 100% compliant for 2 consecutive months, ongoingmonitoring will continue via monthly observation / tactical visits. | |
| G1022 | Discharge and transfer summaries<br><br>484.110(a)(6)(i-iii)<br><br>(i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or<br><br>(ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or<br><br>(iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.<br><br>Based on record review and interview, the agency failed to ensure a transfer summary was sent to the physician and the entity assuming care of the patient for 1 of 3 inactive clinical records reviewed. (Patients #7)<br><br>Findings Include:<br><br>1. A policy titled "Patient Discharge/Transfer Process" revised 10-01-2023 indicated but was not limited to, " ... 6. | G1022 | **Immediate action implemented to correct specific deficiency:**<br><br>Patient # 7 has been discharged from home healthservices.<br><br>During a mandatory TEAMScall on 8/23/24 and again, during a mandatory team meeting held on 8/29/24, theExecutive Director (ED) instructed all clinical staff on care coordination,with emphasis on coordinating care with the physician and receiving facility whena patient is transferred to an inpatient facility using policy 2.1.004 PatientDischarge/Transfer Process.<br><br>**New process that will be implemented to prevent deficiency from re-occurring:**<br><br>A Transfer Summary is sent to the primary carephysician and the facility (if the patient is still receiving care in thefacility at the time the agency becomes aware of the transfer) to which thepatient is transferred within 2 business days of planned transfer or becoming<br><br>aware of unplanned transfer. This form includes agencyname, transfer date, reason for transfer, patient's condition, summary of caretreatment, | 2024-08-29 |

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| | Documentation in the medical record will be evident … reason for refusing services, education provided on risks and adverse outcomes associated with refusing services, notification to physician, and measures taken to investigate refusal of services … 16. A Transfer Summary is sent to the primary care physician and the facility … to which the patient is transferred within 2 business days of planned transfer or becoming aware of unplanned transfer …"<br><br>2. A review of Patient #7's inactive clinical record evidenced a POC with a Start of Care date of 03-25-2024 and a certification period from 03-25-2024 to 05-23-2024. The POC evidenced the following diagnoses: Paroxysmal Atrial Fibrillation (a fast irregular heart rate lasting hours to days), Human Immunodeficiency Virus Disease (HIV, a virus which attacks the body's immune system), Hemiplegia following a cerebral infarction affecting the left side of the body (paralysis on the left side of the body because of a lack of blood to the brain), and a history of falls. | | services provided to the patient, the patient's progress towardsgoals, patient's discharge goals of care, patient's treatment preferences, alist of community resources or referrals made or provided to patient, any<br><br>information on advance directives or DNR orders,patient name, physician name, diagnoses, current list of medications, and otherorganizations involved in patient care (ex. Pharmacy or DME).<br><br>**Title of person responsible for implementing plan of correction:**<br><br>Executive Director<br><br>**Date of completion:**<br><br>8/29/24<br><br>**Monitoring procedures to ensure effectiveness of process improvement and continued compliance:**<br><br>Beginning 9/1, the Executive Director will review 8Transfers per month to ensure care coordination occurred with the receivingfacility, as evidenced by a Transfer Summary having been sent to the receivingfacility and physician. | |

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| | A review of Patient #7's inactive clinical record evidenced a document titled "Visit Note Report" dated 04-15-2024 by Physical Therapist (PT) 3. The document indicated Patient #7 was transferred to a nursing home, Entity 22, on 04-15-2024. The document failed to evidence any coordination with Entity 22.<br><br>The inactive clinical record for Patient #7 evidenced documents titled "Client Coordination Note Report". The document dated 04-22-2024 and signed by the Administrator indicated the patient was transferred to a nursing home and they were "(GETTING NAME FROM FAMILY)". The coordination notes failed to evidence the agency sent a transfer summary to Entity 22.<br><br>During an interview with the Administrator on 08-22-2024 at 1:10 PM, they indicated Patient #7's inactive record's communication notes evidenced the family was supposed to inform the agency to which nursing home the patient was transferred. The Administrator explained the | | Monitoring will continue for 3 months and until 100%compliant for 2 consecutive months.<br><br>Once 100% compliantfor 2 consecutive months, ongoing monitoring will continue monthly via reviewof 2 randomly selected transfers per month. | |

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| | reach out to the patient's family to confirm which nursing home the patient went to and ensure a transfer summary was sent.<br><br>410 IAC 17-15-1(a)(7) | | | |
| N0000 | Initial Comments<br><br>This visit was for a State Licensure Survey of a Home Health Provider.<br><br>Survey Dates: 08-20-24, 08-21-24, and 08-22-24<br><br>12-Month Unduplicated Skilled Admissions: 74<br><br>This agency was found to not be in compliance with 410 IAC 17, as related to a home health agency.<br><br>QR completed by Area 3 on 8-30-2024. | N0000 | | |

correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Stephanie Decker | Executive Director | 9/17/2024 11:10:14 AM |