STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157541	A. BUILDING B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPOINTS HOME HEALTH CARE INC	9801 PRAIRIE AVE, HIGHLAND, IN, 46322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey dates: 9/13/2024, 9/16/2024-9/20/2024 Unduplicated Skilled Census for the Past 12 Months: 73 At this Emergency Preparedness survey, Allpoints Home Health Care, Inc. was found to not be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E0000	An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102	

E0001	Establishment of the Emergency Program (EP) 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E0001	At the time of the Survey Agency failed to provide Surveyor with the Agency's Emergency Preparedness binder, later the binder was found and is now located in a secure designated place within the office. Agency will develop a community based and facility based all hazards assessment. Agency will commit to collaborate with District 1 Emergency Preparedness officials. Agency will develop a form to use with all patients to develop individual patient emergency plans and include in the comprehensive assessment. Agency will develop a policy with procedures to inform state and local officials of on-duty staff and patients that are unable to be reached. Agency will develop a communication plan that will include the contact information for patients, all staff, entities providing services under arrangement, and physicians as well as state and federal emergency preparedness officials. Agency will develop a process for emergency staffing. Our software provider, Axxess,	2024-10-20

	CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: Based on record review and interview, the agency failed to the emergency preparedness plan was developed by utilizing a facility-based and community-based risk assessment utilizing an all hazards approach; failed to include a process for cooperation and collaboration with local, state, and federal emergency preparedness officials; failed to include individual patient emergency plans in the comprehensive assessment; failed to include in the policy and procedures the process for informing state and local officials of on-duty staff and patients that are unable to be reached; failed to address process for emergency staffing; failed to include a communication plan that included the contact information for patients, all staff, entities providing services under arrangement, physicians, and state and federal emergency preparedness officials; failed to evidence emergency preparedness training at time of hire and every 2 years for all staff; and failed to conduct a community based exercise. The findings include:		provides a list of available staff who have signed up to provide service in our service are. Agency will incorporate emergency preparedness training in it's onboarding training and at least every 2 years for all staff. Agency will conduct a community based exercise. Agency has enrolled in the nation wide earthquake emergency drill planned for 10/17/2024 at 10:17am, all staff notified and will be participating in this nationwide drill. Agency Administrator is registered to attend the District 1 HealthCare Preparedness Coalition on Wednesday, October 16, 2024. Administrator is responsible for the ongoing monitoring of the deficiency to maintain compliance.	

	The emergency preparedness plan dated 8/15/2018 failed to evidence a all-hazards risk assessment, failed to include the collaboration and communication with local, state, and federal emergency preparedness officials, failed to include in the policy the process for informing state and local emergency preparedness officials of on-duty staff and patients unable to be reached, failed to evidence a communication plan that included the contact information for patients, all staff, entities providing services under contract, physicians, and state and federal emergency preparedness officials, and failed to evidence a community-based exercise. The emergency preparedness plan indicated the agency would educate all staff on the plan annually but failed to evidence any education for any contracted staff. A clinical record review for Patient #3 evidenced the start of care comprehensive assessment dated 9/5/2024 which indicated the emergency preparedness plan was developed but failed to			

	evidence what the plan was for the patient. On 9/18/2024, beginning at 9:30 AM, RN 1 indicated there was nowhere to document in the new electronic health record the emergency preparedness plan for the patient. On 9/18/2024, at 4:19 PM, the Alternate Administrator indicated she oversaw the emergency preparedness plan. The Alternate Administrator indicated there was no communication or collaboration with the local, regional, and state emergency preparedness officials. On 9/19/2024, at 3:49 PM, the Alternate Administrator indicated there was no additional documentation for the emergency preparedness plan. The Alternate Administrator indicated the agency has tried to participate in a community-wide exercise in the past and were considered too small of an agency to participate. On 9/20/2024, at 12:58 PM, the Administrator indicated the agency did not provide			

	and indicated the staff should receive inservices from their contracted agency. The Administrator indicated the agency did not have documentation of inservice training for the contracted staff from their contracted agency.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Agency. Survey dates: 9/13/2024, 9/16/2024-9/20/2024 12 Month Unduplicated Skilled Census: 73 During this Federal Recertification Survey, Allpoints Home Health Care, Inc., was found to be out of compliance with Conditions of Participation 484.55 Comprehensive Assessment of Patients; 42 CFR 484.58 Discharge Planning; 42 CFR 484.60 Care Planning, Coordination of Care and Quality of Care; 42 CFR 484.65 Condition: Quality Assessment/Performance Improvement; 42 CFR 484.70	G0000	All matters referenced by this Tag have been included in the responses that follow.	

	Control; and 42 CFR 484.105 Organization and Administration of Services. Based on the Condition-level deficiencies during the 9/20/2024 survey, your HHA was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 9/16/2024. 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 programs for a period of two years beginning 9/20/2024 and continuing through 9/19/2026. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. **QR:** 10/02/2024			
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the	G0434	Clinical Manager to educate all clinicians on the need to include all disciplines and frequency of visits on the service agreement and to also inform patients and their representatives. Clinical Manager is responsible for the ongoing monitoring of this deficiency to ensure compliance. Clinical Manager to audit 100% of admission documentation to ensure service agreement was correctly filled out and verify with patient that clinician has provided	2024-10-20

	comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the agency failed to ensure the patient was informed of and consented to in advance of care the disciplines that were to furnish care and the frequency of visits in 1 of 1 clinical record reviewed with a start of care after 9/1/2024. (Patient #3) The findings include: A review of a policy dated 12/20/2016 titled "Service Agreement" indicated the agency would provide and explain the service agreement to the patient upon admission before care was provided and the form should include the disciplines and frequency of the visits to be provided. A clinical record for Patient #3, start of care 9/5/2024, indicated physical therapy (PT) services		him/her a signed copy of the service agreement. Administrator responsible for ensuring that this deficiency does not reoccur.	

	9/5/2024, 9/9/2024, and 9/11/2024. On 9/18/2024, at 3:38 PM, Physical Therapy Assistant (PTA) 1 indicated he made a visit on 9/16/2024 but had not yet documented the visit. The service agreement signed by the patient and Registered Nurse (RN) 1 on 9/5/2024 failed to evidence the PT services and frequency were included when reviewed on 9/17/2024. On 9/17/2024, at 9:30 AM, RN 1 indicated she did not indicate the PT services and frequency at time of admission, because the agency was awaiting authorization. On 9/18/2024, at 10:45 AM, when clinical record copies were received, the PT frequency was added. The Office Manager indicated she added the PT frequency and did not know she could not amend the documents prior to copying per surveyor's request. 410 IAC 17-12-3(b)(2)(D)(ii)(AA)			
G0458	Outcomes/goals have been achieved	G0458	Agency will update its Transfer/Discharge policy to include the transfer or discharge is appropriate because the physician or allowed	2024-10-20

	484.50(d)(3) The transfer or discharge is appropriate because the physician or allowed practitioner, who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with §484.60(a)(2)(xiv) have been achieved, and the HHA and the physician or allowed practitioner, who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services; Based on record review and interview, the agency failed to discharge the patient from home health services only if the physician agreed the measurable outcomes and goals set forth in the plan of care had been achieved in 2 of 2 closed records reviewed. (Patient #6, #7) The findings include: 1. A review of a policy revised 1/2/2017 titled "Client Discharge Planning" indicated the agency would discharge from home health services if the patient had reached defined goals and was no longer in need of home care. 2. A clinical record for Patient #6 evidenced a plan of care for the initial certification period of 7/12/2024-9/9/2024 which		practitioner, who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care have been achieved and/or the patient no longer need hoe health services. Copies of the revised policy will be given to all current patients and placed in all new admission packets. Agency will make sure physician is contacted prior to discharge to make sure they are agreeable with discharge. A verbal order will be placed in chart to document that agreement. Clinical Manager will be responsible for the ongoing monitoring of this deficiency. Administrator to be responsible for ensuring that this deficiency does not reoccur.	

	receive skilled nursing services 2 times a week for 1 week and then 1 time a week for 8 weeks for wound care. The primary diagnosis was osteomyelitis (infection of the bone) of the ankle and foot patient's goals included optimal wound healing. The plan of care evidenced the patient received intravenous (IV, administered directly into the bloodstream through the vein) antibiotic. The start of care comprehensive assessment dated 7/12/2024 indicated the patient had a wound to the right medial (side close to the middle of the body) great toe measuring 1.3 centimeters (cm) in length, 1.3 cm in width, and 0.3 cm in depth; right third toe measuring 1.9 cm in length, 2.0 cm in width; and 0.3 cm in depth, and left calf measuring 12.7 cm in length, 10.1 cm in width, and 0.1 cm in width. The last skilled nursing visit prior to discharge dated 8/15/2024 completed by Registered Nurse (RN) 1 indicated the wound to the right medial great toe measured 1.0 cm in length, 1.0 cm in width, and 0.2 cm in depth; the wound to the right 3rd toe measured 1.0 cm in length, 2.0			

	cm in width, and 0.2 cm in depth; and the wound to the left calf measured 9.0 cm in length, 9.0 cm in width, and 0.1 cm in depth. The skilled nurse visit on 8/15/2024 failed to evidence any discharge planning and indicated a plan of treatment for the next visit to include wound care and assess efficacy of the IV antibiotics for osteomyelitis. A non-visit discharge assessment dated 8/19/2024 completed by RN 1 indicated the patient's goals were met and the patient was discharged from the agency. On 9/19/2024, at 2:05 PM, RN 1 indicated the patient's wounds were still present at time of discharge, and the patient was discharged because the patient was being seen at an outpatient lymphedema (chronic condition of fluid retention in the tissues under the skin causing swelling and skin changes, most common in the legs) clinic. On 9/19/2024, at 2:45 PM, the Clinical Manager indicated the patient's insurance would not pay for home care services if the patient was being treated at an			

	outpatient facility and indicated the agency did not verify a denial of payment from the insurance company prior to discharge. The Clinical Manager indicated optimal wound healing meant that wounds would be healed or healing and indicated there was not much change to the wounds based on the assessment of the wound size. 3. A clinical record review for Patient #7 evidenced a plan of care for the recertification period of 6/17/2024-8/15/2024 which indicated the patient was to receive skilled nursing services 1 time every other week and physical therapy 2 times a week for 6 weeks. The physical therapy (PT) plan of care indicated the patient's goals included an increase in upper and lower extremity strength to a 4 out of 5, a decrease in the TUG assessment (a timed test to determine mobility, balance, and walking ability) to 12 seconds, ambulate 150 feet 2 times with a rolling walker with stand-by assistance, and no falls. A physical therapy note dated			

	7/23/2024 indicated the patient had a fall. The physical therapy discharge dated 7/25/2024 and completed by PT 3 failed to evidence the patient met goals by indicating the patient's strength to the shoulders, hips, knees and ankles were a 3 out of 5, patient walked 40 feet 3 times with contact guard assistance, and the TUG score was 16 seconds. The reason for PT discharge indicated was goals met. The discharge assessment completed by RN 1 and dated 8/12/2024 indicated the patient was discharged from the agency due to goals met. On 9/19/2024, at 2:24 PM, PT 3 indicated the patient was unable to meet all of the goals, but the PT felt the patient was safe to discharge. PT 3 indicated not all goals were able to be met with chronic conditions. On 9/19/2024, beginning at 2:09 PM, RN 1 indicated the patient was discharged, because the patient had 2 full certification periods. RN 1 indicated it was the decision of			

	continue getting home care services. RN 1 indicated she assumed the PT discharge was accurate for the patient meeting goals and indicated she was not aware the patient had a fall prior to discharge.			
G0510	Comprehensive Assessment of Patients 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessment: was completed withing 48 hours of referral (See tag G0514); included the physical and psychosocial status (See tag G0528); included the measurable outcomes and goals (See tag G0530); included a medication review of all patient medications (See tag G0536); included the willingness, availability, and ability of the primary caregiver (See tag G0538); and was completed at time of discharge (See tag G0550).	G0510	Agency will assure that all comprehensive assessments are completed within 48 hours of a referral or physician will be contacted. The comprehensive assessment will include the physical and psychosocial status, measurable outcomes and goals , a medication review of all patient medications, and the willingness, availability, and ability of the primary caregiver. Agency will all assure that the comprehensive assessment and caregiver assessment is completed at time of discharge. Clinical Manager will educate all clinicians on this correction and will be responsible for the ongoing monitoring of this deficiency to assure compliance. Administrator will be responsible for ensuring that this deficiency does not reoccur.	2024-10-20

	The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.55 Comprehensive Assessment of Patients.			
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 home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the agency failed to conduct an initial visit within 48 hours from the time of referral in 2 of 4 active clinical records reviewed with starts of care since 8/1/2024. (Patient #1 and 3) The findings include: *The record reviewed for Patient #1 evidenced a referral document from Entity 2 dated 8/15/24. The start of care	G0514	Agency will assure that all comprehensive assessments are completed within 48 hours of a referral or physician will be contacted. Patient and/or patient representative will be contacted for any delay and documentation of that communication will be in the clinical record. 1. Patient #3 hospital faxed referral on Friday August 30,2024, social worker indicated patient should be going home over the weekend, said someone from the hospital will contact agency once patient is discharged, however no call was received. Proactively AllPoints nurse reached out to patient on Saturday August 31, 2024 and Sunday September 1, 2024 no answer, Finally when nurse made contact with patient #3, she was unsure and confused on what she was going to do. Patient request that nurse give her a few days and she can come on Thursday September 5, 2024. Clinical Manager reached out to hospital social worker who had given the original referral to notify doctor of patient decision. Pt#3 oncologist gave verbal order for home health services to begin 9/5/24. Documentation issues occurred as a result of staff not able to navigate the new Synergy Software. This issue rectified, all patient #3 clinical records have been transferred to the Axxess software. 2. Patient #2 original soc order received from physician was dated 8/15/24, but was not received until 8/18/24, SN SOC was on the next day 8/19/2024. Patient #2 clinical records	2024-10-20

	dated 8/19/24 completed by Registered Nurse 1 (RN 1), failed to evidence the initial visit was conducted within 48 hours. On 9/18/24, in an interview beginning at 3:15 PM, RN 1 indicated provider wanted the agency to provide Vitamin B12 injections and the injections were not included on the original referral dated 8/15/24 and that the Clinical Manager (CM) had to contact Entity 2 to obtain the order for the B12 injections. On 9/18/24, in an interview beginning at, the Clinical manager indicated the original referral was on 8/15/24 but it did not include the order for Vitamin B12 injections, and they contacted Entity 2 to obtain a referral that included the Vitamin B12 injections. CM indicated they were waiting for order for Vitamin B12 referral, and there practice is to not complete an initial assessment. The CM further indicated there was no documented communication with the patient or provider regarding the delay in the initial visit.		reflects this information. Clinical Manager will educate all clinicians on this correction and will be responsible for the ongoing monitoring of this deficiency to assure compliance.	

	A clinical record review for Patient #3 evidenced a referral document from Entity 1 dated 8/30/2024. The start of care comprehensive assessment dated 9/5/2024 and completed by Registered Nurse (RN) 1 failed to evidence the initial visit was conducted within 48 hours of referral. On 9/18/2024, at 9:30 AM, RN 1 indicated she was unsure why the initial visit was more than 48 hours after the referral. On 9/18/2024, at 1:35 PM, the Clinical Manager indicated the patient did not discharge from the hospital until 8/31/2024 and indicated there was no documented communication with the patient regarding the delay in the initial visit.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: (1) The patient's current health, psychosocial,	G0528	Agency will assure that the content of all comprehensive assessments will include the patient's current health, psychosocial, functional, and cognitive status. This will include but not be limited to Foley catheter type, size of the catheter, the size of the inflated balloon, and the appearance and amount of urine collected in the drainage bag; depression screening; psychosocial and rehab potential. All clinicians will be in-serviced on the need to include this information.	2024-10-20

	functional, and cognitive status; Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment included a complete physical assessment in 4 of 5 active clinical records reviewed. (Patient #1, 2, 3 and 4) The findings include: *On 9/16/24, during an interview beginning at 3:20 PM, the Clinical Manager (CM) indicated the agency has been using a new Electronic Medical Record (EMR) for approximately a month and have not had training nor provided training on the EMR. *The comprehensive assessment completed on 8/19/24 by Registered Nurse 1 (RN 1) for Patient #1 failed to evidence assessment of spiritual needs and rehabilitation potential. On 9/18/24, in an interview beginning at 3:15 PM, RN 1 indicated they are using a new electronic medical record system that they had not received training on and was not familiar with how to		1. Patient #2 Physician order received indicating giving specific Foley catheter instructions regarding pts#2. Plan of Care has been updated to reflect specific instructions. Pts #2 nurse re-educated on complete and accurate documentation on visit notes to include type of catheter, size, size of inflated balloon and amount of saline to inject into balloon, urine assessment. 2. Patient #3 startof care documentation has been corrected, physicianorders completed, including communicationnotes. This deficiency occurred as aresult of staff not fully being trained and unable to navigate the new Synergysoftware. This issue has been resolved, Agency administrationdecided to no longer use the new Synergy software, all patients records have sincebeen transferred back to the Axxess Software. 3. Patient #1 comprehensive assessment documentation was not fully completed at time of survey. This deficiency occurred as a result of staff unable to navigate the new Synergy software. This issue has been resolved, Agency administration decided to no longer use the new Synergy software, all patients records have since been transferred back to the Axxess Software. 4. Patient #4 comprehensive assessment documentation was not fully completed at time of survey. This deficiency occurred as a result of staff unable to navigate the new Synergy software. This issue has been resolved, Agency administration decided to no longer use the new Synergy software, all patients records have since been transferred back to the Axxess Software. The QA Team and Clinical Manager is responsible for the ongoing monitoring of this deficiency to assure compliance. Administrator will be responsible for ensuring that this deficiency does not occur again	

EMR.

*The comprehensive assessment completed on 8/28/24 by Physical Therapist 2 (PT 2) for Patient #4 failed to evidence assessment of spiritual needs.

On 9/20/24, in an interview beginning at 10:20 AM, PT 2 indicated they are using a new electronic medical record system that they had not received training on and was not familiar with how to complete the assessment in this EMR.

1. During an observation of care at the home of Patient #2 on 9/16/2024 from 12:00 PM to 12:40 PM, the patient was observed to have tube inserted into the penis with a drainage bag attached at the other end of the tube with a dark yellow liquid collected in the bag.

The recertification assessment completed by the Clinical Manager and dated 8/2/2024 indicated the patient had a foley catheter (a tube inserted into the bladder to drain urine and held in place by an inflated balloon). The assessment failed

	the catheter, the size of the inflated balloon, and the appearance and amount of urine collected in the drainage bag. On 9/18/2024, at 2:59 PM, the Clinical Manager indicated the assessment did not include the size and type of the catheter, the size of the inflated balloon, and the urine assessment. 2. A clinical record review for Patient #3 indicated a referral document from Entity 1 dated 8/30/2024 which indicated the patient's primary diagnosis was metastatic basal cell carcinoma to the abdominal wall (skin cancer that has spread to other parts of the body) for which the patient was receiving oral chemotherapy (a medication to treat cancer) and included additional diagnoses of intractable low back pain, anxiety about health, and metastasis to bone and lungs. The start of care comprehensive assessment completed by Registered Nurse (RN) 1 on 9/5/2024 indicated the patient was depressed and had difficulty coping. The comprehensive assessment			

	failed to include a depression screening. On 9/18/2024, beginning at 9:30 AM, RN 1 indicated there was no depression screening in the new electronic health record program that was used to document the comprehensive assessment so a depression screening was not completed.			
G0530	Strengths, goals, and care preferences 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA;	G0530	**These multiple deficiencies occurred as a result of staff not fully being trained and unable to navigate the new Synergy software. This issue has been resolved, Agency administration decided to no longer use the new Synergy software, all patients records have since been transferred back to the Axxess Software. All clinicians notified of this decision and instructed to return to using Axxess Software or paper notes for all future clinical documentation.** Agency will assure that the comprehensive assessments will include assessment of the patient's strengths, goals, and care preferences as identified by the patient. The comprehensive assessment will also include measurable outcomes that are identified by the clinician during the comprehensive assessment. All clinicians will be educated on this correction by the Clinical Manager who will be responsible for the ongoing monitoring of this deficiency. Administrator will be responsible for ensuring that this deficiency does not occur again.	2024-10-20

Based on record review and interview, the agency failed to ensure the comprehensive assessment included an assessment of the patient's strengths, goals, and care preferences identified by the patient and the measurable outcomes identified by the agency in 2 of 3 active clinical records reviewed in the agency's new electronic medical record (Patient #1 and 4).

The Findings Include:

1. On 9/16/24, during an interview beginning at 3:20 PM, the Clinical Manager (CM) indicated the agency has been using a new Electronic Medical Record (EMR) for approximately a month and have not had training nor provided training on the EMR.

2. The start of care comprehensive assessment completed on 8/19/24 by Registered Nurse 1 (RN 1) for Patient #1 failed to evidence an assessment was completed of the patient's strengths, goals, and care preferences as identified by the patient. The

	failed to evidence measurable outcomes were identified by the clinician during the comprehensive assessment. On 9/18/24, at 3:15 PM, RN 1 indicated they are using a new electronic medical record system that they had not received training on and was not familiar with how to complete the assessment in this EMR. 3. The start of care comprehensive assessment completed on 8/28/24 by Physical Therapist 2 (PT 2) for Patient #4 failed to evidence an assessment was completed of the patient's strengths, goals, and care preferences as identified by the patient. The comprehensive assessment failed to evidence measurable outcomes were identified by the clinician during the comprehensive assessment. On 9/20/24, at 10:20 AM, PT 2 indicated they are using a new electronic medical record system that they had not received training on and was not familiar with how to complete the assessment in this			

	EMR.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the agency failed to ensure all medications were reviewed for potential adverse effects and drug reactions in 4 of 5 active clinical records reviewed. (Patient #1, 3, 4, 5) The findings include: *The referral for Patent #1 included a medication list which included the medications Fish Oil (a vitamin supplement) and Zolpidem (to treat insomnia). The plan of care for the initial certification period 8/19/24 – 10/17/24 for Patient #1 failed to evidence the inclusion of fish oil or zolpidem. The plan of care indicated the patient's medications included: cyanocoboalamin injection (to treat vitamin B12 deficiency), duloxetine (to treat depression),	G0536	Agency will assure that a review of all medications the patient is currently using is completed in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. All therapists will be educated to contact the nurse case manager or the clinical manager if there are any medications the patient is found to be using that are not on the patient's medication list. All clinicians will be educated to question patients on any OTC medications they use as well as if there are any other medications they may keep in a bedroom or bathroom drawer that they may not take on a regular basis. All clinicians will be educated on the need to contact physician for any discrepancies found in home medications and the physician or facility medication list. All clinicians will be educated on how to run a drug to drug interaction report with the EMR software. All major drug to drug interactions will be reported to the physician. Physical Therapist and Nursing Field Staff to be in-serviced oncorrect documentation for medications,documenting that physician has been notified of all possible major "Drug toDrug" interactions that could occur, and documenting any changes requiringphysicians order. 1. Patient #3 start ofcare documentation has been	2024-10-20

	latanoprost ophthalmic solution (to treat increased pressure in the eye), rivastigmine (to treat dementia), tamsulosin (to treat enlarged prostate) and thera-m (a vitamin supplement). The start of care comprehensive assessment completed on 8/19/24 by Registered Nurse 1 (RN 1) indicated issues were found during medication review, the record failed to evidence which medications interacted or notification to the referring provider. On 9/18/24, beginning at 3:15 PM, RN 1 indicated she referenced the medication list on the referral for 8/15/24 to develop the medication profile for Patient #1 and if they discovered medication interactions they would contact the provider office via an electronic app and would have documented the notification on the comprehensive assessment but they did not know how to complete documentation in the electronic medical record (EMR). On 9/19/24, at 2:00 PM, the Clinical Manager (CM) indicated RN 1 has not been trained on		updated, physician ordersclarifying medications issues have been completed, including communicationnotes. This deficiency occurred as aresult of staff not fully being trained and unable to navigate the new Synergysoftware. This issue has been resolved, Agency administrationdecided to no longer use the new Synergy software, all patients records have sincebeen transferred back to the Axxess Software. All clinicians notified of this decision andinstructed to return to using Axxess Software or paper notes for all future clinicaldocumentation. 2. During the surveyor observation visit ofpatient #5, on 9/17/24, surveyor questioned patient about a bottle of Rolaidsthat was sitting on the table in her living room, where her and her husband eattheir meals together, patient indicated to surveyor that “they take 3 tabletsafter dinner”. On 9/25/24 at the nextnurse visit, patient indicated to the nurse, the reason she never mentioned theRolaids, was because it was not hers, husband takes them with his meals. Noaction taken.	

	the new EMR and may not know how to document in the record. The CM further indicated the record did not indicate what medications had interactions. *The record reviewed for Patient #4 evidenced a plan of care for the initial certification period 8/28/24 – 10/26/24 which indicated the patient's medications included: Amlodipine besylate (to treat high blood pressure), Eliquis (to prevent blood clots), metformin (to treat high blood sugar), Metoprolol Tartate (to treat high blood pressure), Pantoprazole sodium (to treat acid reflux), Robitussin (to loosen chest congestion), simvastatin (to treat high cholesterol), Vitamin B12 (a vitamin supplement), and Vitamin D3 (a vitamin supplement). The start of care comprehensive assessment completed on 8/28/24 by Physical Therapist 2 (PT 2) indicated there were no issues found during medication review. An internet-based drug		3. Patient #1 was theAgency's first patient to be entered into the new Synergy Software System, multipleissues were identified, and since then rectified. Moving forward all patient information hasbeen transferred to Axxess Software, medication issues for patient #1 have beencorrected, with communication documentation, physician orders and amended planof care. 4. Physician forpatient #4 was notified of potential major drug to drug interaction that couldoccur from amlodipine and simvastatin. Physical Therapist and Nursing Field Staff in serviced on how to use theEMR to correctly identify potential adverse effects and drug to druginteractions. Instructed on how toidentify ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy. Instructed on correct documentation formedications, including documenting that physician has been notified of allpossible "major Drug to Drug	

	interaction program revealed 1 major interaction drug interaction between amlodipine and simvastatin, 4 moderate interactions and 1 minor interaction. On 9/20/24, in an interview beginning at 10:20 AM, PT 2 indicated hey run a drug interactions report in the EMR to verify drug interactions. They further indicated they would contact the clinical manager if there were interactions. On 9/20/24, during an interview beginning at 11:40 AM, the clinical manager (CM) indicated the record should have gone through a quality check by the office manager, but they were not familiar with how to complete that in the new EMR. The CM further indicated the documentation was not in the record. 1. A clinical record review for Patient #3 evidenced a plan of care for the initial certification		interactions" that could occur, and documentingany changes requiring physicians' order. QA Team will review all patients medication profiles atstart of care, recertifications, and with every medication change to identify significant drug to druginteraction and ensure documentation that patients physician has been notifiedand patient/patient's caregiver is aware of the signs and symptoms of thepossible adverse effects to monitor for and report. Director of Nursing will beresponsible for ensuring this deficiency does not reoccur.	

	which indicated the patient's medications included: ondansetron (to treat nausea/vomiting), fentanyl (to treat severe pain), Senna (to treat constipation), Miralax (to treat constipation), cyclobenzaprine (muscle relaxer), and alprazolam (to treat anxiety). The drug interactions dated 9/18/2024 indicated 3 moderate drug interactions between ondansetron and fentanyl, Senna and Miralax, and alprazolam and cyclobenzaprine and 2 major drug interactions between fentanyl and cyclobenzaprine and between fentanyl and alprazolam. The start of care comprehensive assessment dated 9/5/2024 and completed by Registered Nurse (RN) 1 indicated there were significant drug interactions but failed to evidence which drugs interacted. On 9/18/2024, beginning at 9:30 AM, RN 1 indicated she did not include the medications that interacted on the start of care assessment. Physical therapy (PT) notes dated 9/9/2024 and 9/11/2024 completed by Physical Therapy			

	Assistant (PTA) 1 indicated the patient had a lidocaine patch (a medicated topical patch to relieve pain). On 9/18/2024, at 3:27 PM, PTA 1 indicated the lidocaine patch was applied to the patient's back. The undated medication profile and plan of care both for the initial certification period 9/5/2024-11/3/2024 failed to evidence the lidocaine patch was included in the patient's medications. On 9/18/2024, at 3:31 PM, RN 1 (patient's nurse case manager) indicated the lidocaine patch was not included in the drug review. 2. During an observation of care at the home of Patient #5 on 9/17/2024, at 3:53 PM, with the Clinical Manager, a bottle labeled "Rolaids" (medication used to control stomach acid) was observed on the patient's bedside table which the patient indicated they take 3 tabs after dinner. The medication profile dated 8/17/2024 and signed by the Clinical Manager failed to evidence the review of the			

	medication profile was noted. A clinical record review on 9/19/2024, at 2:50 PM, the Clinical Manager indicated she missed the bottle of Rolaids and she did not include the Rolaids in the medication review.			
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on record review and interview, the agency failed to ensure the comprehensive assessment included the assessment of the primary caregiver and their ability, availability, and willingness to provide care in 1 of 1 active clinical record reviewed with a primary diagnosis of carcinoma (skin cancer). (Patient #3) The findings include: A clinical record review for	G0538	Agency will assure that all comprehensive/OASIS assessments include assessment of the primary caregiver and their ability, availability, and willingness to provide care. All staff will be educated on this correction and the clinical manager will be responsible for the ongoing monitoring of this deficiency. Clinical staff will be In-Serviced by clinical manager onOctober 25, 2024 regarding assessment of primary caregiver, any assistancepatient receives in the home, identify who is the patient's primary caregiver(if any), assess primary caregivers ability, availability and willingness toprovide patient care. Clinicians will beinstructed to document this information on patients' comprehensive plan ofcare. Primary Caregiver for patient #3 is her husband, who hasbeen observed and assessed to be	2024-10-20

	Patient #3 evidenced a start of care comprehensive assessment completed by Registered Nurse (RN) 1 on 9/5/2024 which indicated the patient had an abdominal wound that required wound treatment 2 times a day. The comprehensive assessment failed to include who was the primary caregiver and their willingness, availability, and ability to provide wound care. On 9/18/2024, at 1:47 PM, the Clinical Manager indicated the comprehensive assessment did not include the assessment of the primary caregiver.		willing, able and independent in providing patientcare. Failure to include caregiver informationcomprehensive assessment was a result of the recent software change. Our agencytransferred from Axxess Software to Synergy Software, and with staff not beingfully training, it was a struggle to navigate through the Software, and as aresult, Pts #3 Clinician did not know how to document this informationcorrectly. Due to multiple issues that have occurred during this softwaretransition, and to resolve this deficiency from ever occurring again, it hasbeen decided by the administration that it is in the best interest of ourpatients, our staff and the agency as a whole, to not move forward with the useof Synergy software. Moving forward the agency has returned to using Axxess Softwarefor all its clinical documentation. All Staff including contracted staff have been instructedto use Axxess Software for all their clinical documentation. Director of Nursing will beresponsible for ensuring this	

			deficiency does not reoccur.	
G0550	At discharge 484.55(d)(3) At discharge. Based on record review and interview, the agency failed to ensure a comprehensive assessment was completed at the time of discharge in 1 of 2 closed records reviewed. (Patient #6) The findings include: A clinical record review for Patient #6 evidenced a discharge assessment dated 8/19/2024 completed by Registered Nurse (RN) 1 which indicated the assessment was a non-visit. On 9/19/2024, beginning at 2:04 PM, RN 1indicated the patient had wounds to both legs at time of discharge, but the wounds were not assessed because the nurse did not conduct an in-person assessment. RN 1indicated an in-person assessment at time of discharge was not completed because Patient was being seen	G0550	Patient #6 was discharged due patient receiving outpatient physical therapy for Lymphedema treatment. Our Agency services patient's who arehomebound, and are not physically able to leave the home for outpatient therapy. Agency will ensure a comprehensive assessment is completed at the time of discharge. If a comprehensive assessment cannot be completed, the physician and patient will be notified, and an order will be written to document that notification. All nursing and therapy field staff to be re-educated on this. Clinical Manager will be responsible for this ongoing monitoring of this deficiency. Director of nursing to ensure this deficiency does not reoccur.	2024-10-20

	fluid under the skin causing swelling and skin changes typically to the legs) clinic and Patient's insurance would not pay for home health services, if seen by an outpatient clinic. RN 1 indicated she did not verify denial of coverage for home health services.			
G0560	Discharge Planning 484.58 Condition of Participation: Discharge planning. Based on record review and interview, the agency failed to follow agency policy regarding the discharge planning process to include communicating with the physician to determine the physician was in agreement with the measurable outcomes have been achieved, providing the physician the discharge summary with all required elements within 5 business days of discharge, and providing a 15 day discharge notice to the patient in 2 of 2 closed records reviewed. (Patient #6, 7) The findings include: 1. A review of a policy revised 1/2/2017 titled "Client Discharge Planning" indicated	G0560	Agency will follow our policy regarding the discharge planning process to include communicating with the physician to determine the physician was in agreement with the measurable outcomes that have been achieved, providing the physician the discharge summary with all required elements within 5 business days of discharge, and providing a 15 day discharge notice to the patient. Agency will assure that patients have information for continued care upon discharge and the discharge summary will include instructions given to patients. Coordination of care will be provided to any agencies or post discharge care clinics that patient will be following up with. All clinicians will be educated on the policy Client Discharge Planning and Discharge Summary. All discharge summaries will be sent to the physician within 5 business days. All therapists will be educated on the need to make sure goals are met prior to discharge and to document the results of any standardized tests such as TUG and Tinetti on the discharge summary. If goals are not met, therapists will call the physician to make sure the physician is agreeable to discharge. If physician is not agreeable, then a new order to continue will be obtained. Patient and any patient representative will be informed of the physician's decision.	2024-10-20

	physician in the decision to discharge the patient and would provide the patient a 15 day written notice prior to discharge. The agency would ensure treatment goals were met, and if unmet needs are present, the agency would provide appropriate referrals to agencies to meet the patient's needs. The agency would document all communication with the patient related to discharge and send to the physician. 2. A review of a policy dated 1/20/2017 titled "Discharge Summary" indicated the summary would include the discharge date and instructions provided to the patient. 3. A clinical record for Patient #6 evidenced a plan of care for the initial certification period of 7/12/2024-9/9/2024 which indicated the patient was to receive skilled nursing services 2 times a week for 1 week and then 1 time a week for 8 weeks for wound care. The primary diagnosis was osteomyelitis (infection of the bone) of the ankle and foot patient's goals included optimal wound		1. Allnurses and therapist to be re-educated on agency policy "client dischargeplanning", patient must be given a 15 day written notice prior to discharge, ifgoals have not been met, agency would provide appropriate referrals to another provider. All communication must be documented and included indischarge summary and to be sent to physician within 5 days after discharge. 2. Allnurses and therapist to be re-educated on agency policy, "Discharge Summary" Dischargeinstructions that were provided to patient must be included on the "dischargesummary" indicating date patient was discharged. 3. Allnurses and therapist to be re-educated on discharge planning to includecommunication with physician, document on patient's condition at discharge,indicate reason for discharge, indicate what goals have been met or unmet,insure all verbal orders and case communication notes are	

	evidenced the patient received intravenous (IV, administered directly into the bloodstream through the vein) antibiotic. The last skilled nursing visit prior to discharge dated 8/15/2024 completed by Registered Nurse (RN) 1 indicated the wound to the right medial great toe measured 1.0 cm in length, 1.0 cm in width and 0.2 cm in depth with a small amount of serous (clear) drainage; the wound to the right 3rd toe measured 1.0 cm in length, 2.0 cm in width, and 0.2 cm in depth; and the wound to the left calf measured 9.0 cm in length, 9.0 cm in width, and 0.1 cm in depth with a large amount of serous drainage. The skilled visit note dated 8/15/2024 failed to evidence any discharge planning and indicated a plan of treatment for the next visit to include wound care and assess efficacy of the IV antibiotics for osteomyelitis. A non-visit discharge assessment dated 8/19/2024 completed by RN 1 indicated the patient had completed the IV antibiotics, the patient began treatment at a lymphedema		completed. 4. Allnurses and therapist to be re-educated on Agency policy regarding "clientdischarge planning". Clinicians will be instructed that discharge planningshould be discussed with patient at start of care, communication/caseconference between nurse, therapist and director of nursing must bedocumented. Patient must be informed ofupcoming discharge 15 days prior to discharge. Physician must be contacted prior to discharge and be in agreement. Discharge summary to be sent to physicianwith verbal order for discharge within 5 days of discharge. Field clinician must notify office manageronce discharge notice is given to patient so that all other disciplinesproviding patient care can be notified. Cliniciansto be instructed that if patient is unable to meet goals, have discussion withpatient regarding more attainable goals, clinician must revise the plan of carereflecting any changes, patient must be provided a copy of revised plan of carewithin a week after	

	(retention of fluid in the tissues under the skin causing swelling and changes in the skin typically affecting the legs), the patient's legs were wrapped, goals were met, and the patient was discharged from the agency. The clinical record failed to evidence any communication with the physician prior to discharge to discuss if the physician agreed with the discharge from home health services and to inform the physician of the treatment at the lymphedema clinic and failed to evidence communication with the lymphedema clinic to confirm the services provided. The clinical record failed to evidence an order to discharge prior to the end of the certification period as ordered by the physician on the plan of care and failed to evidence the patient was provided a discharge notice. On 9/19/2024, beginning at 2:02 PM, RN 1 indicated the patient's wounds were still present at time of discharge and indicated the patient was discharged, because the patient was being seen at an outpatient lymphedema (chronic condition		changes have been made. Director of Nursing will audit all charts two weeks priorto discharge, to review for accuracy, that necessary communication had beendocumented, and that physician was notified. Director of Nursing will be responsible for ensuring thatthis deficiency does not reoccur	

	of fluid retention in the tissues under the skin, most common in the legs) clinic. RN 1 indicated she did not discuss the patient's discharge with the physician responsible for the plan of care and did not obtain an order for discharge. RN 1 indicated the patient was not provided a 15 day discharge notice because the patient began receiving treatment from the lymphedema clinic, and the patient's insurance would not cover home care services if receiving outpatient treatment. RN 1 indicated she did not confirm if the insurance would cover outpatient treatment and home health. The discharge summary signed by RN 1 and dated 8/28/2024 failed to indicate the discharge date and instructions provided to the patient. The clinical record indicated the discharge summary was sent to the physician on 8/30/2024 and failed to evidence it was sent to the physician within 5 days of discharge. On 9/19/2024, at 2:38 PM, the Administrator indicated the discharge summary was not			

	8/30/2024 per the electronic health record and indicated the discharge date and instructions to the patient were not included. 4. A clinical record review for Patient #7 evidenced a plan of care for the recertification period of 6/17/2024-8/15/2024 which indicated the patient was to receive skilled nursing services 1 time every other week and physical therapy 2 times a week for 6 weeks. The physical therapy (PT) plan of care indicated the patient's goals included an increase in upper and lower extremity strength to a 4 out of 5, a decrease in the TUG assessment (a timed test to determine mobility, balance, and walking ability) to 12 seconds, ambulate 150 feet 2 times with a rolling walker with stand-by assistance, and no falls. A physical therapy note dated 7/23/2024 indicated the patient had a fall. The physical therapy discharge dated 7/25/2024 and completed by PT 3 failed to evidence the patient met goals			

	strength to the shoulders, hips, knees and ankles were a 3 out of 5, patient walked 40 feet 3 times with contact guard assistance, and the TUG score was 16 seconds. The reason for PT discharge indicated was goals met and failed to evidence the PT communicated with the physician to ensure the physician agreed to the discharge of PT services. The discharge assessment completed by RN 1 and dated 8/12/2024 indicated the patient was discharged from the agency due to goals met. The clinical record failed to evidence the patient was provided discharge notice prior to 8/5/2024 which was less than 15 days and failed to evidence communication with the physician to ensure the physician agreed with discharge for goals met. On 9/19/2024, at 2:24 PM, PT 3 indicated the patient was unable to meet all of the goals but the PT felt the patient was safe to discharge. PT 3 indicated not all goals were able to be met with chronic conditions. PT 3 indicated there was no communication documented with the physician or the RN			

	case manager regarding the patient's discharge. On 9/19/2024, beginning at 2:09 PM, RN 1 indicated the patient was discharged, because the patient had 2 full certification periods. RN 1 indicated it was the decision of the physical therapist (PT) if the patient was to continue getting home care services and indicated she assumed the PT discharge was accurate for the patient meeting goals. RN 1 indicated the PT would not inform her if the patient was still not meeting their goals but was going to discharge anyways. RN 1 indicated she was not aware the patient had a fall prior to discharge. RN 1 indicated she was unsure if she spoke with the physician prior to discharge to ensure the physician agreed and indicated the checked box indicated care was coordinated with the physician was because the discharge summary was going to be sent to the physician. RN 1 indicated the agency did not provide a 15 day discharge notice to the patient and indicated the discharge came to a surprise to 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. 410 IAC 17-12-2(i) 410 IAC 17-13-2(a)(b)(9)			
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 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 observation, record review, and interview, the home health agency failed to ensure: the needs of the patient were met (See	G0570	The Clinical Manager will review all comprehensive/OASISassessments for psychosocial deficits. The RN case manager will notify thephysician if any signs and symptoms of depression are identified, or patienthas a positive PSQ2 assessment. A request for MSW evaluation will be made tophysician and interventions and goals will be added to the patient’s plan ofcare to address the issue. Clinical manager will be responsible for the ongoingmonitoring of this deficiency. Director of Nursing will beresponsible for ensuring this	2024-10-20

	tag G0570); the plan of care was reviewed by the physician, individualized and followed by all agency staff (See tag G0572); the plan of care included all required information / elements for the treatment of the patient (See tag G0574); all treatments provided by agency staff were ordered by a physician (See tag G0580); physicians were promptly notified of a change in the patient's condition (See tag G0590); the plan of care was revised to reflect current health status and nursing needs (See tag G0592); coordination of care for all services provided to the patient (See tag G0606); the written visit schedule was provided to patients (See tag G0614); and the treatments to be administered by agency personnel were provided to the patient and caregiver in writing (See tag G0618). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination of Care and Quality of Care. A deficient practice citation was also evidenced at this standard as follows: Based on record review and		deficiency does not reoccur.	

	interview, the agency failed to provide services to meet the patient's needs in 1 of 1 active record review with a primary diagnosis of carcinoma (skin cancer). (Patient #3) The findings include: A clinical record review for Patient #3 indicated a referral document from Entity 1 dated 8/30/2024 which indicated the patient's primary diagnosis was metastatic basal cell carcinoma to the abdominal wall (skin cancer that has spread to other parts of the body) for which the patient was receiving oral chemotherapy (a medication to treat cancer) and included additional diagnoses of intractable low back pain, anxiety about health, and metastasis to bone and lungs. The start of care comprehensive assessment completed by Registered Nurse (RN) 1 on 9/5/2024 indicated the patient had sharp, continuous, and chronic severe pain rated 8/10 on a scale of 0-10 that interfered with ambulation, activities of daily living, sleep, and appetite and the pain regimen was less than 50%			

indicated the patient was depressed and had difficulty coping.

The plan of care for the initial certification period of 9/5/2024-11/3/2024 signed by RN 1 failed to include interventions and goals related to the depression.

The nurse visit notes completed by RN 1 and dated 9/6/2024 and 9/9/2024 indicated the patient was fearful and had poor coping skills. No additional nursing notes were available for review.

An occupational therapy (OT) visit note completed by OT 1 and dated 9/12/2024 indicated the patient was tearful and felt discouraged.

Review of Form CMS (Centers for Medicare and Medicaid) 1572 completed by the Alternate Administrator dated 9/16/2024 indicated the agency provided medical social work (MSW) services under contract.

On 9/13/2024, at 3:32 PM, the Administrator indicated the agency does have a contract with an agency to provide MSW

	agency does not use the contracted MSW services. On 9/17/2024, at 6:04 PM, OT 1 indicated she was unsure if the agency offered MSW services. OT 1 indicated the patient was going through a lot and needed another outlet. On 9/18/2024, beginning at 9:30 AM, RN 1 indicated the patient was going to start palliative care through the oncologist in October. RN 1 indicated the patient was not referred for MSW services, because she did not think the agency had a social worker but the agency could discuss it. RN 1 indicated since the patient was going to receive palliative care in October, the patient could receive social work services then through palliative care. RN 1 indicated had she reviewed the referral before admitting the patient, she would not have admitted the patient, because she was not appropriate for home care. On 9/18/2024, at 3:04 PM, the Clinical Manager indicated the agency did not offer MSW services to the patient probably because the patient may get			

	palliative care. The Clinical Manager indicated there was no start date for palliative care yet.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review, and interview, the agency failed to ensure services were provided as directed in the plan of care in 4 of 5 active clinical records reviewed. (Patient #2, 3, and 5) The findings include: *The record reviewed on 9/19/24 for Patient #4 included an occupational therapy plan of care dated 9/5/24 which indicated a visit frequency of 1 time weekly for 5 weeks. During an interview on 9/20/24 beginning at 11:40 AM, the Clinical Manager indicated they had spoken to a person at the ordering provider office, Entity 2; there was no documentation of the conversation. 1. A clinical record review for	G0572	Clinical Manager in-serviced all nurses on 9/23/204, regardinghow to complete a patient assessment, medications review and reconciliation and theneed to follow the patient's plan of care each visit and to call the physicianfor any changes in patients' condition or values outside ordered parameters. Inaddition, all clinicians educated on the need to follow the ordered frequencyand to notify the physician if any visits are missed. The physician will benotified of any missed visits and visits will be rescheduled the same week if thepatient is agreeable and available. Field staff will notify office manager when unable to makevisit so visit can be rescheduled. Office manager will audit schedules weeklyof patients with multiple disciplines to ensure that scheduled visits do notoverlap. The Clinical Manager is responsible for the	2024-10-20

	Patient #5 indicated a plan of care for the recertification period of 8/13/2024-10/22/2024 which indicated the skilled nurse was to provide services 2 times a week to include perform a complete physical assessment and review the medications at every visit. The clinical record failed to evidence a 2nd skilled nursing visit was provided during the week of 9/8/2024. During an observation of care at the patient's home on 9/17/2024 beginning when entering the home with the Clinical Manager at 3:33PM and when the Clinical Manager left the home at 3:53 PM, the Clinical Manager failed to place the stethoscope on the abdomen to assess for bowel sounds, failed to touch the patient's abdomen to assess for distention and tenderness, failed to assess the patient's last bowel movement, failed to assess the patient's pain, and failed to review the patient's medications. On 9/19/2024, beginning at 2:59 PM, the Clinical Manager indicated she tried to complete		ongoingmonitoring of this deficiency. Director of Nursing will beresponsible for ensuring this deficiency does not reoccur.	

	per the patient's request and did not review the medications, assess the patient's pain, assess the abdomen and bowel sounds, and assess the last bowel movement at the time of the visit. The Clinical Manager indicated she called the patient later in the evening to assess the patient's pain and last bowel movement and review the medications over the phone. The Clinical Manger indicated a 2nd skilled nursing visit was not provided to the patient during the week of 9/8/2024 because she was behind in her schedule for nurse visits. 2. A clinical record review for Patient #2 indicated a plan of care for the recertification period of 8/6/2024-10/4/2024 which indicated the nurse was to flush the foley catheter (a tube inserted into the bladder to drain urine and held in place with an inflated balloon) every 2 weeks with 180 milliliters (ml) of normal saline (flush solution) and was to inflate the balloon with 10 ml of normal saline. Nurse visit notes completed by the Clinical Manager and dated 8/16/2024, 8/28/2024,			

changed the patient's foley catheter and inflated the balloon with 15 ml of normal saline. The plan of care indicated the agency would notify the physician if the patient's heart rate was less than 60 beats per minute (bpm). The skilled nurse visit notes indicated the patient's pulse was 50 bpm on 8/16/2024, 56 bpm on 8/28/2024, and 53 bpm on 9/12/2024.

On 9/18/2024, beginning at 2:17 PM, the Clinical Manager indicated she flushed with 120 ml of normal saline instead of 180 ml as directed by the plan of care since the patient bought their own normal saline. The Clinical Manager indicated she did not call the physician regarding the pulse because she thought the plan of care changed to contact the physician if less than 50 bpm.

3. A clinical record review for Patient #3 evidenced a plan of care for the initial certification period of 9/5/2024-11/3/2024 which indicated the agency would provide skilled nursing visits 2 times a week. The clinical record failed to review a 2nd nurse visit was provided

	during the week of 9/8/2024. On 9/18/2024, beginning at 9:30 AM, Registered Nurse (RN) 1 indicated she missed a nurse visit on 9/12/2024 because she was sick. On 9/18/2024, at 1:52 PM, the Clinical Manager was unaware RN 1 was unable to complete the 2nd visit for the week of 9/8/2024 and indicated a 2nd skilled nurse visit was not provided. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 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;	G0574	All clinicians will be educated on SMART (Specific, Measurable, Achievable, Relevant, Time-bound) goals. All clinicians will be educated on the need to follow the orders on the plan of care or to obtain new orders if indicated. Clinical Manager will educate all clinicians on the need to include all supplies and DME used for patient care and to obtain an order for the use. The Clinical Manager will educate all clinicians on the need to include frequency and duration of services, patient specific interventions, education and measurable goals identified during the comprehensive assessment on all patients. The Clinical Manager is responsible for the ongoing monitoring of this deficiency.	2024-10-20

	(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 evidence the plan of care was individualized to the needs of the patient to include the medications, treatments, measurable goals, and medical equipment in 4 of 5 active clinical records reviewed. (Patient #1, 2, 3 and 5) The findings include: * The record reviewed on 9/16/24 for Patient #1 included an initial plan of care for the certification period 8/19/24 – 10/17/24 which failed to evidence the frequency and duration of services, patient specific interventions, education or measurable goals identified		Agency will make sure that documentation exists about goals and that all measurable goals are met if Discharge OASIS reason is goals met. If patient is discharged for another reason, the discharge oasis reason will reflect that reason. All clinicians notified that moving forward AllPoints willno longer be using Synergy Software, and all visit notes, physician orders, communicationnotes and any documentation related to patients will be done through our previous software, Axxess. The Clinical Manager and QA Team are responsible for theongoing review and monitoring of active patients plan of care. QA and officemanager will audit all SOC’s to ensure documentation of all disciplines,frequencies, medications, including any changes requiring physician order is complete. Director of Nursing will beresponsible for ensuring this deficiency does not reoccur.	

assessment.

On 9/19/24, in an interview beginning at 1:30 PM, the clinical manager (CM) indicated the plan of care did not include the frequency and duration of services, patient specific interventions, education or measurable goals because the agency was using a new electronic medical record system, and they did not know how to complete the documentation.

1. A clinical record review for Patient #3 indicated a referral document from Entity 1 dated 8/30/2024 which indicated the patient's primary diagnosis was metastatic basal cell carcinoma to the abdominal wall (skin cancer that has spread to other parts of the body) for which the patient was receiving oral chemotherapy (a medication to treat cancer) and included additional diagnoses of intractable low back pain, anxiety about health, and metastasis to bone and lungs. The referral indicated the patient had a pulmonary embolism (blood clot) in the left lung, a fracture of the right sacrum (the bone that forms the

	lower spine and the pelvis) due to the cancer in the bone, and had a neoplastic (tumor) wound to the abdomen requiring dressing changes 2 times a day. The start of care comprehensive assessment completed by Registered Nurse (RN) 1 on 9/5/2024 indicated the patient had sharp, continuous, and chronic severe pain rated 8/10 on a scale of 0-10 that interfered with ambulation, activities of daily living, sleep, and appetite and the pain regimen was less than 50% effective. The assessment indicated the patient was depressed, had difficulty coping, had nausea, had a pulmonary embolism to the left lung. The abdominal wound was assessed to have a large amount of serosanguinous (a mixture of clear and bloody) drainage. The plan of care for the initial certification period of 9/5/2024-11/3/2024 signed by RN 1 failed to include interventions and goals related to the pulmonary embolism, depression, and nausea. The plan of care indicated the patient's goals included pain			

	would be within comfort level and failed to be individualized with the patient's preferred comfort level and measurable, and the goals failed to include a measurable goal related to the wound. The intervention for pain was to teach the patient on pain management techniques but failed to include what the techniques were. The parameters for diastolic blood pressure (the pressure against the walls of the arteries when the heart is at rest; noted by the bottom number of the blood pressure reading) was to be above and below 90, and the parameter of the pulse was to be greater than 56 beats per minute (bpm) or lower than 30 respirations per minute (rpm) and failed to evidence accurate parameters. The medications included Tylenol (pain reliever) and Miralax (to treat constipation) as needed and failed to be individualized with indications for use as needed and the Tylenol failed to evidence the frequency of medication administration. On 9/18/2024, beginning at 9:30 AM, RN 1 indicated the patient's goal for pain was to be			

	scale of 0-10 and the goal for the wound was for it to be 10% healed as evidenced by a decrease in measurements. RN 1 indicated she was unsure why the parameters in the plan of care were incorrect and indicated there were no interventions or goals related to the depression and nausea. RN 1 indicated the electronic health record program used to create the plan of care was new and she was unsure how to use the program to complete the plan of care. On 9/18/2024, at 1:50 PM, the Clinical Manager indicated there were no interventions on the plan of care related to the pulmonary embolism. 2. A clinical record review for Patient #2 indicated a plan of care for the recertification period of 8/6/2024-10/4/2024 which indicated the nurse was to change the foley catheter (a tube inserted into the bladder to drain urine and held in place with an inflated balloon) every 2 weeks. Nurse visit notes completed by the Clinical Manager and dated 8/16/2024, 8/28/2024, 9/12/2024 indicated			

	foley catheter with a coude catheter (a type of catheter with a curved tip to help with insertion) and the plan of care failed to include the type of catheter to be used was a coude catheter. The plan of care indicated a physical therapy evaluation was completed and there was a need for further visits. The plan of care indicated the nurse was to assist the patient with bowel regimen and the patient's goals included the patient would have optimal bowel evacuation. The plan of care failed to indicate how the goal would be measured and what was optimal for the patient. On 9/17/2024, beginning at 2:23 PM, the Clinical Manager indicated the patient had been discharged from physical therapy during the previous certification period and should not have been included on the plan of care, but it was carried over from the previous plan of care. The Clinical Manager indicated the coude catheter was not included on the plan of care but should be. The Clinical Manager indicated optimal bowel evacuation was for the			

	movements 3 times a week without difficulty and indicated it was not included in the plan of care. 3. During an observation of care at the home of Patient #5 on 9/17/2024, at 3:33 PM, the patient was observed with a heel protector to the left heel. A clinical record review indicated a plan of care for the recertification period of 8/13/2024-10/11/2024 which indicated the patient had a wound to the left heel and failed to include the heel protector interventions to include the frequency and duration of when to wear it. On 9/19/2024, at 3:02 PM, the Clinical Manager indicated the heel boot was not included in the plan of care and indicated the patient wore the heel boot 24 hours a day, 7 days a week. 410 IAC 17-13-1(a)(1)(D)(iii, v, viii, ix, x, xiii)			
G0580	Only as ordered by a physician	G0580	Clinical Manager will educate all clinicians on the need to obtain an order upon admission, recertification, and resumption for all services. The Clinical Manager is responsible for the	2024-10-20

	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 provide services as directed only by the physician in 1 of 1 active clinical records reviewed receiving care from an oncologist. (Patient #3) The findings include: A clinical record review for Patient #3 evidenced a referral document from Entity 1 dated 8/30/2024 from Person 3 (referring physician) for home health services and the face to face signed by Person 3 indicated skilled nursing, physical therapy (PT), and occupational therapy (OT) were necessary. There were no additional orders from Person 3. The plan of care for the initial certification period of 9/5/2024-11/3/2024 indicated Person 3 was the physician responsible for the plan of care and indicated skilled nursing for wound care, PT, and OT services were to be provided. The plan of care failed to be reviewed and signed by the physician.		ongoing monitoring of this deficiency.	

	The clinical record evidenced the agency provided skilled nursing services to include wound care on 9/5/2024, 9/6/2024, and 9/9/2024; provided PT services on 9/5/2024, 9/9/2024, and 9/11/2924; and provided OT services on 9/6/2024, 9/10/2024, and 9/12/2024 without an order. On 9/18/2024, beginning at 9:30 AM, Registered Nurse (RN, patient's nurse case manager) 1 indicated she had not spoken with Person 3 for home health orders. RN 1 indicated she did speak to the medical assistant at the office of Person 4 (patient's oncologist) but did not hear back from the physician's office and did not send a start of care order. On 9/18/2024, at 3:04 PM, the Clinical Manager indicated the plan of care had not yet been sent to the physician and indicated there was no start of care orders or communication with Person 3 regarding the plan of care. 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 observation, record review, and interview, the agency failed to notify the physician of changes in patient's condition or a need to change the plan of care in 2 of 5 active clinical records reviewed. (Patient #3, 5) The findings include: 1. A clinical record review for Patient #3 indicated a referral document from Entity 1 dated 8/30/2024 which indicated the patient's primary diagnosis was metastatic basal cell carcinoma to the abdominal wall (skin cancer that has spread to other parts of the body) for which the patient was receiving oral chemotherapy (a medication to treat cancer) and included additional diagnoses of intractable low back pain, anxiety about health, and metastasis to bone and lungs.	G0590	Agency will assure that all clinicians are educated on the need to notify the physician responsible for the plan of care of any changes in patient's condition including but not limited to pain, vital signs outside of parameters, major drug to drug interactions, and new wounds. Administrator in-serviced all nurses on 9/23/24 and contracted staff on 10/8/24 that theymust immediately notify the physician, who is following patients' care, of any changesin patients' condition... skin breakdown, non blanching areas, decline inpatients' health status, increased pain, whenever vital signs are out of normalranges or values outside ordered parameters, when patient reports a fall orinjury, all instances must to be reported to patients physician and nurse casemanager. In addition, all clinicians instructed to notify patients' physician ofall major drug to drug interactions that could potentially occur at start ofcare, and then any time there is a medication change, new medication ordiscontinued medication, all relevant physicians' must be notified. QA Team and Clinical Manager are responsible for the ongoingcontinuous monitoring of this deficiency,by reviewing each clinician visit notefor any	2024-10-20

	The start of care comprehensive assessment completed by Registered Nurse (RN) 1 on 9/5/2024 indicated the patient had sharp, continuous, and chronic severe pain rated 8/10 on a scale of 0-10 that interfered with ambulation, activities of daily living, sleep, and appetite and the pain regimen was less than 50% effective. Nurse visit note completed by RN 1 indicated the patient's pain was 8/10 on 9/6/2024 and the pain regimen was less than 50% effective. The occupational therapy (OT) evaluation dated 9/6/2024 indicated the patient's pain was 8/10 and the OT visit note dated 9/12/2024 completed by OT 1 indicated the patient's pain was 9/10. The clinical record failed to evidence the agency notified the physician regarding the patient's severe pain and ineffective pain regimen. On 9/17/2024, at 6:06 PM, OT 1 indicated she had not communicated the pain to the physician. On 9/18/2024, beginning at 9:30 AM, RN 1 indicated she had not communicated with the		changes, and documentation as to who was notified. Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur.	

physician regarding the patient's pain and need for additional pain interventions, because the patient's son was a pharmacist.

OT visit notes completed by OT 1 indicated the patient's had a radial (wrist) pulse of 115 beats per minute (bpm) on 9/10/2024 and a radial pulse of 157 bpm. The clinical record failed to evidence the agency notified the physician of the pulse rate.

On 9/17/2024, at 6:06 PM, OT 1 indicated she did not notify the physician of the patient's heart rate.

On 9/18/2024, at 3:05 PM, the Clinical Manager indicated a pulse greater than 110 bpm should be reported to the physician.

The plan of care for the initial certification period of 9/5/2024-11/3/2024 signed by RN 1 indicated the patient's physician responsible for the plan of care was Person 3. The plan of care indicated the patient's medications included: ondansetron (to treat nausea/vomiting), fentanyl (to treat severe pain),

	relaxer), and alprazolam (to treat anxiety). The drug interactions dated 9/18/2024 indicated 2 major drug interactions between fentanyl and cyclobenzaprine and between fentanyl and alprazolam. The clinical record failed to evidence the agency notified a physician of the major drug interactions. An OT visit note dated 9/12/2024 and completed by OT 1 indicated the patient's pain medication dosage was increased, the patient was started on an antibiotic for an infection, and the chemotherapy medication was on hold. The clinical record failed to evidence the agency notified the physician responsible for the plan of care regarding the new orders for the antibiotic, the increased pain medication, and the discontinuation of the chemotherapy. On 9/18/2024, beginning at 9:30 AM, RN 1 indicated the patient had an appointment with Person 4 (patient's oncologist) on 9/10/2024 who ordered the oral chemotherapy			

	ordered the antibiotic for a wound infection, and ordered an increase in oxycodone for pain. RN 1 indicated she had never spoken to Person 3 (physician responsible for the plan of care). 2. During an observation of care at the home of Patient #5 on 9/17/2024, at 3:38 PM, a reddened area to the left lateral (side) heel was noted to be a half of a pinky finger in length and the width of a pinky finger wide. The Clinical Manager indicated the area was new and not blanching (skin turns white when pressed on). The clinical record review failed to evidence the agency notified the physician of the new area to the left lateral heel. On 9/19/2024, at 3:01 PM, the Clinical Manager indicated the area to the left lateral heel was not blanching and indicated the area was probably a Stage I pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin; superficial injury to the skin noted by red, nonblanching skin). The Clinical Manager indicated she had not			

	notified the physician of the nonblanching area but would keep an eye on it. 410 IAC 17-13-1(a)(2)			
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 observation, record review, and interview, the agency failed to ensure the plan of care was revised as necessary in 3 of 5 active clinical records reviewed. (Patient #2, 3, 5) The findings include: 1. A clinical record review for Patient #2 evidenced a plan of care for certification period 8/6/2024-10/4/2024 which indicated the goals included the patient would remain free from signs and symptoms of urinary tract infection.	G0592	Clinical Manager in-serviced all nurses on 9/23/94 andcontracted staff on 10/8/24 that patients' plan of care must reflect currentinformation from updated comprehensive assessments, to include measurableoutcomes with goals identified. Plan ofcare must be revised anytime there is a medication change, to reflect the newmedication, any medication dose changes, with revised interventions and goals. Planof care must be revised anytime patient develops a new infection or new wound,revised plan of care must reflect interventions with measurable goals relatedto each problem. QA Team and Clinical Manager is responsible for on goingmonitoring of this deficiency, and will check each clinician's visit notes andcommunication notes, continually, for	2024-10-20

	A physician order dated 9/12/2024 indicated the patient started on an antibiotic 2 times a day for 14 days for a urinary tract infection. The plan of care failed to be revised to include the antibiotic and the revised interventions and goals for the infection. On 9/18/2024, at 2:47 PM, the Clinical Manager indicated the plan of care had not been revised related to the urinary tract infection. 2. An occupational therapy (OT) visit note dated 9/12/2024 and completed by OT 1 indicated the patient's pain medication dosage was increased, the patient was started on an antibiotic for an infection, and the chemotherapy medication was on hold. The plan of care for the initial certification period 9/5/2024-11/3/2024 signed by Registered Nurse (RN) 1 on 9/9/2024 indicated the patient's medications included oxycodone (for severe pain) 5 milligrams (mg) every 4 hours and Odomzo (oral chemotherapy medication to treat cancer). The plan of care failed to evidence any revisions.		documentedchanges, and insure plan of care has been revised to reflect any new changes,interventions corresponding to each change, with measurable goals. Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur.	

	On 9/18/2024, beginning at 9:30 AM, RN 1 indicated the oral chemotherapy medication was discontinued on 9/10/2024 by the oncologist, the antibiotic began on 9/11/2024, and oxycodone was increased to 10 mg every 4 hours. RN 1 indicated she had not yet revised the plan of care with the discontinued chemotherapy medication, the new antibiotic, and the increased pain medication because she had not yet documented her visit note from 9/16/2024. 3. During an observation of care at the home of Patient #5 on 9/17/2024, at 3:38 PM, a reddened area to the left lateral (side) heel was noted to be a half of a pinky finger in length and the width of a pinky finger wide. The Clinical Manager indicated the area was new and not blanching (skin turns white when pressed on). A clinical record review evidenced a plan of care for the recertificaion period of 8/13/2024-10/11/2024 which failed to be revised to include the new area on the left lateral heel.			

	On 9/19/2024, at 3:01 PM, the Clinical Manager indicated the area to the left lateral heel was not blanching and indicated the area was probably a Stage I pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin; superficial injury to the skin noted by red, nonblanching skin). The Clinical Manager indicated the plan of care was not revised to include the new area to the right lateral heel and the monitoring of the area.			
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 observation, record review, and interview, the agency failed to coordinate care in 1 of 1 active clinical record reviewed with home health aide services. (Patient #2) The findings include:	G0606	Administrator in-serviced nurses on 9/23/24 and contractedstaff 10/8/2024 of the need to identify patients' needs, and any factors thatcould affect patients' safety or outcome of treatment and coordinate patients'needs with all pertinent staff providing patient care. Documentation of care coordination will be placed in the EMR. Nurse coordinated with HHA on 9/17/24 regarding pt #2 HHAto encourage patient to increase fluid intake due to recurrent urinary tractinfections. Nurse instructed Patient #2 of the need to increase fluid	2024-10-20

	A clinical record review for Patient #2 evidenced the agency provided skilled nursing services 1 time every other week and home health aide (HHA) services 3 times a week. A skilled nurse visit note completed by the Clinical Manager dated 9/12/2024 indicated the patient had foley catheter (a tube inserted into the bladder to drain urine and held in place by an inflated balloon) and had a urinary tract infection. The nurse visit note indicated the nurse instructed the patient to push fluids and failed to evidence the nurse coordinated care with the HHA regarding with what symptoms or concerns to notify the nurse and to instruct the HHA to encourage the patient to increase fluid intake. During an observation of care at the patient's home on 9/16/2024, from 12:00 PM to 12:40 PM, HHA 1 failed to encourage fluid intake, and no fluid was observed at the patient's bedside. On 9/18/2024, at 2:27 PM, the		intake,patient #2 replied "I always keep apitcher of water at my bedside," nurse alsoinstructed patients granddaughter make sure to keep patients water pitcher fullwith water and encourage patient to drink his water. The Clinical Manager willbe responsible for the ongoing monitoring of this deficiency. Administrator will be responsible forensuring this deficiency does not reoccur	

	HHA should know to push fluid as this was not the first urinary tract infection for the patient and indicated the patient drinks beer and gets dehydrated. The Clinical Manager indicated there was no documentation care was coordinated with the HHA regarding the urinary tract infection and the need to push fluids. 410 IAC 17-12-2(g)			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on record review and interview, the agency failed to evidence they provided the patient and caregiver in writing with a copy of the visit schedule in 3 of 3 home visits conducted. (Patient #1, 2, 5) The findings include: *During an observation of care at the home of Patient #1 on 9/16/2024, at 12:00 PM, the agency folder was reviewed and	G0614	Clinical Manager in-service all nurses on 9/23/24 andcontracted staff on 10/8/24 on visit schedule, it is required that eachdiscipline discuss with patient their visit schedule, and mark it on patientsmonthly calendar. Patients' monthlycalendar located in the Agency's folder that is given to the patient at startof care, and must be updated monthly, or as needed to reflect any changes. Clinical Manager is responsible for ongoing monitoring ofthis deficiency by contacting 100% of newly admitted patients by week 2 afterstart of care to verify that monthly calendar had been filled out by eachdiscipline providing care to	2024-10-20

	blank calendars were found inside the folder. No written visit schedule was found in the patient's home. On 9/16/2024, Patient #1 indicated the agency staff discuss visits and call before they visit but the schedule changes and they did not have a written visit schedule. On 9/18/2024, at 2:42 PM, the Clinical Manager indicated providing the plan of care was how the agency informed the patient in writing of the plan for visits to be provided. The clinical manager further indicated the plan of care for Patient #1 did not have a plan for visits because the agency had a new electronic medical record and did not know how to complete the plan of care. The clinical manager indicated that the patient would not have a copy of the plan of care if it had not been completed. 1. During an observation of care		that patient. Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur.	

	9/16/2024, at 12:00 PM, the agency folder was reviewed and blank calendars were found inside the folder. No written visit schedule was found in the patient's home. On 9/16/2024, at 12:33 PM, Patient #2 indicated the agency did not provide a written visit schedule. 2. During an observation of care at the home of Patient #5 on 9/17/2024, at 3:58 PM, the agency folder was reviewed and blank calendars were found inside the folder. No written visit schedule was found in the patient's home. On 9/17/2024, at 3:59 PM, Patient #5 indicated the agency did not send a visit schedule but called before visits. 3. On 9/18/2024, at 2:43 PM, the Clinical Manager indicated calendars were provided at the start of care for patients but had not been updated since.			
G0616	Patient medication schedule/instructions 484.60(e)(2)	G0616	Administrator in-serviced nursing staff on 9/23/24 and in-servicedcontracted staff on 10/8/2024 regarding patient Plan of Care and	2024-10-20

	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 and interview, the agency failed to provide the patient and caregiver in writing with a copy of the medication list in 1 of 1 home visits conducted with an Occupational Therapist. (Patient #1) The Findings Include: During an observation of care at the home of Patient #1 on 9/16/2024, beginning at 12:00 PM, there was no written instructions of the treatments to be provided in the patient's home. On 9/19/2024, at 1:30 PM, the Clinical Manager indicated providing the plan of care was how the agency informed the patient in writing of the current medication list, however because they did not know how to finalize the document in the new electronic medical record they have not provided it to the patient.		Medicationschedule and instructions. Re-educated field staff that Patient mustbe provided a written copy of their treatment Plan of Care and comprehensive medicationlist to include name of medication, dosage, frequency and who will beresponsible for administering medications to patient. Patient must be provideda current plan of care and medication list at start of care, at recertifications, resumptions and whenever treatment plan has changed. Clinical Manager is responsible for the ongoing monitoringof this deficiency contacting 100% of newly admitted patients by week 2 after homehealth services have begun to verify that a current medication list and plan ofcare has been provided. Clinical Managerwill continue to monitor and track this documentation for two quarters,followed by this, Clinical Manager will continue to contact 10% of all activepatients each quarter to verify that required documents regarding current planof care and current medication list have been provided to patient until 100%compliance is achieved.	

			Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur.	
G0618	Treatments and therapy services 484.60(e)(3) 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 provide the patient and caregiver in writing with the treatments to be administered by agency personnel in 2 of 3 home visits observations (Patient # 2 and 5). The findings include: *During an observation of care at the home of Patient #1 on 9/16/2024, beginning at 12:00 PM, the agency's folder was reviewed and there was no written instructions of treatments to be provided found in the patient's home. During an interview on 9/16/24, Patient 1 indicated the agency staff discuss the treatment plan discuss visits and call before they visit but the schedule changes. On 9/19/2024, at 1:30 PM, the	G0618	Agency will immediately provide all patients and caregivers a written plan of care that will include all treatments to be administered by agency personnel. All new patients and their caregivers will be provided with this plan of care upon completion and confirmation of approval from physician. The Clinical Manager will be responsible for this ongoing monitoring of this deficiency to assure compliance. Administrator in-serviced nursing staff on 9/23/24 andin-serviced contracted therapy staff on 10/8/2024 regarding patients TreatmentPlan/ Plan of Care. Once assessments are performed and documentation iscompeted with QA approval, written plan of care must be provided to patient andleft at patient's home inside agency's folder. Plan of care to include treatment plan, servicesto be provided, interventions with measurable goals, list of patient's medication. Patient must be provided witha copy of a current plan of care at start of care, for re-certifications, for resumption of care andwhenever treatment plan has changed. Clinician who performed initial admissionassessment is the required staff to provide written revised copy of treatmentplan	2024-10-20

	Clinical Manager indicated providing the plan of care was how the agency informed the patient in writing of the treatments to be provided, however because they did not know how to finalize the document in the new electronic medical record they have not provided it to the patient. 1. During an observation of care at the home of Patient #2 on 9/16/2024, at 12:00 PM, the agency's folder was reviewed and there was no written instructions of treatments to be provided found in the patient's home. On 9/18/2024, at 2:42 PM, the Clinical Manager indicated the patient would not read the plan of care, so it had not been provided to the patient. 2. During an observation of care at the home of Patient #5 on 9/17/2024, at 3:58 PM, the agency's folder was reviewed and there was no written instructions on treatments to be provided found in the patient's home. 3. On 9/18/2024, at 2:42 PM, the Clinical Manager indicated providing the plan of care was		to patient. Clinical Manager will contact every new patient admitted byweek two after admission for twoquarters to verify that clinician had provided them written instructions regardingtreatment plan/plan of care. Clinical Manager will continue to contact 10% ofall active patients each quarter to verify that required documents regardingcurrent plan of care/treatment plan have been provided to patient until 100%compliance is achieved. Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur.	

	how the agency informed the patient in writing of the treatments to be provided and sometimes they provide it to patients.			
G0640	Quality assessment/performance improvement 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview, the agency failed to: ensure the governing body approved the frequency of the data collection (G0644), the QAPI program focused on high risk areas (G0646),the quality assessment and performance improvement (QAPI) program utilized quality indicator data to include OASIS (Outcome and Assessment	G0640	Governing body will immediately approve the frequency and detail of the data collection for the QAPI program. The QAPI program will include performance improvement activities to address the areas not meeting benchmarks, infections, and hospitalizations. The agency will create a performance improvement project based on a high risk area identified from agency data. The agency will revise its QAPI program to focus on high risk areas to include but not limited to incidents such as falls, infections and hospitalizations; and utilize quality indicator data to include OASIS Outcome and Assessment Information Set data to identify opportunities for improvement. Any deficient areas identified in quarterly reports will be addressed through a plan of action initiated by the QAPI committee. The Administrator is responsible for this ongoing monitoring of this deficiency to assure compliance. All clinical field staff be be in-serviced on performanceimprovement and risk management. All clinical field staff to be instructed on the necessity ofdocumenting and reporting any patient falls, attended or unattended, injury orno injury, hospitalized or not, all falls must	2024-10-20

	Information Set) data to identify opportunities for improvement (G0656), and the agency implemented performance improvement actions and documented the reason the performance improvement project was chosen (G0658). The findings include: A review of a policy revised 12/12/2016 titled "Incident Reporting" indicated staff members were to document attended and unattended patient falls on an incident report within 1 day of notification of the incident. All incident report data was to be reviewed and included in the agency's QAPI program. The review of QAPI binder and the governing body meeting minutes dated 4/11/2022, 7/11/2022, 10/5/20222, 1/9/2023, 4/10/2023, 7/12/2023, 10/22/2023, 1/10/2024, 4/10/2024, and 7/10/2024 failed to evidence the governing body approved the frequency and detail of the data collection. The Performance Report dated July		topatient's physician, nurse case manager, and home health agency. An incidentreport must be completed within 24 hours from the time field staff was madeaware of fall or injury. QA team will review all clinic notes for any indication thata fall had occurred, and follow up with staff to insure incident report ha been completed and physician was notified. Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur. Clinicians instructed to complete "Infection riskassessment form" (which is included in Agency's SOC Folders), form must becompleted and returned to home health agency. This will allow agency toidentify patients at risk for infection, identify patients' needs and theirrisk for hospitalization. The Clinical Manager will be responsible for the ongoingmonitoring of this deficiency. Director of Nursing will be	

	2024 indicated the agency did not meet the benchmark for patients discharged to the community, improvement in dyspnea (difficulty breathing), improvement in oral medication management, acute care hospitalization, and emergency department use. The infection log dated 9/18/2024 and clinical record review evidenced 11 infections with a reported average census of 7 since 1/1/2024 and the hospitalization log dated 9/18/2024 evidenced 19 hospitalizations with a reported average monthly census of 7 since 1/1/2024. The infection and hospitalization logs failed to evidence the data was assessed to identify current level of performance and areas to be improved, and the hospitalization log failed to include data such as length of stay and reason for hospitalization. The QAPI binder failed to evidence performance improvement activities to address the areas not meeting benchmarks, infections, and hospitalizations. The QAPI program failed to evidence a performance improvement project.		responsible for ensuring thisdeficiency does not reoccur.	

	A clinical record review for Patient #7 evidenced a physical therapy note dated 7/23/2024 which indicated the patient had a fall. The incident log dated 1/1/2024-9/30/2024 failed to evidence the patient's fall. On 9/19/2024, at 2:33 PM, the Clinical Manager indicated there was not an incident report for the patient's fall. On 9/19/2024, beginning at 3:39 PM, the Alternate Administrator indicated the agency's QAPI process consisted of receiving the CMS (Centers for Medicare and Medicaid) reports and sharing the results with everyone. The Alternate Administrator indicated the agency was working on a plan for improvement but was worried about skewed data since their census was so low. The Alternate Clinical Manager indicated the agency tried to use hypertension (high blood pressure) as their performance improvement project and indicated all the patient's blood pressure was controlled. The Alternate Administrator indicated the agency had a lot of patients with urinary tract			

	infections and thought there might be more information on her computer, but no additional information was provided. The Alternate Administrator indicated the agency had not addressed the hospitalization rate and did not think the frequency and detail of data collection was discussed for approval by the governing body. The Alternate Administrator indicated it was her fault that things were not written out in the QAPI program. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 42 CFR §484.65 Quality Assessment/Performance Improvement. 410 IAC 17-12-2(a)			
G0680	Infection prevention and control 484.70	G0680	Agency will educate all clinicians on standard/universal precautions to prevent the transmission of infections as well as infection prevention and control. Agency will develop a program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases.	2024-10-20

	Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. Based on observation, record review, and interview, the home health agency failed to ensure: all employees practiced standard/universal precautions to prevent the transmission of infections (See tag G0682); to maintain an agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases (See tag G0684); and failed to ensure the staff was educated on infection prevention and control (See tag G0686). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.70 Infection Prevention and Control.		Infections will be tracked through the QAPI program and any trends will be addressed through a plan of action to correct. Administrator In-Serviced all Field Staff providing educationmaterial regarding Infection control and Prevention, Blood Borne Pathogens,Communicable Diseases, Universal Precautions, Bag Technique and proper hand hygiene Administrator to provide annual competency assessmentsto nursing field staff. Qualified contracted staff will observe, evaluate and educate all home health aide staff whoprovide direct patient care to ensure that home health aides can independently and safelyprovide quality patient care in a safe environment. Quarterly audits of all personnel files will be performed toensure that annual competency assessments have been performed. Target thresholdis 100% compliance. The Clinical Manager will be responsible for the ongoingmonitoring of this deficiency. Administrator will be	

			responsible for ensuring thisdeficiency does not reoccur.	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure all employees practiced standard/universal precautions to prevent the transmission of infections and failed to follow agency infection control policies and procedures in 3 of 3 home visits. (#1, 2, 5) The findings include: 5. During an observation of care at the home of Patient #1 on 9/16/2024, at 12:00 PM, the Occupational Therapist 1 (OT1) was observed to have entered the patient's home, place newspaper on the kitchen table. OT placed clinical bag on the newspaper. OT 1 performed hand hygiene and donned gloves. OT obtained vital signs and placed equipment on the newspaper. OT applied gait belt to patient and assisted patient to stand with walker. OT assisted patient with ambulation to the bathroom. OT educated and assisted with proper toileting transfer technique to toilet.	G0682	Administrator will review the policy titled "Standard Precautions for Home Care" and reviewed to make sure it is updated to the current CDC guidelines. All clinicians will be educated on infection control practices and Clinical Manager will observe all clinicians during a home visit to assure they are following the accepted standards. All aides will be in-serviced on giving baths to assure they are following accepted infection control standards. Comprehensive corrective action plan developed for eachidentified deficiency, implemented staff re-training programs for InfectionControl and Prevention Administrator In-serviced Home Health Aide staff on9/27/24 and nursing staff on 9/23/24 regarding company policies regarding StandardPrecautions and Bag Technique.	2024-10-20

	wheelchair from study and assisted patient with transfer technique from toilet to wheelchair. Patient ambulated per self in wheelchair to living room. OT returned to table to document on paper notepad. OT returned to patient and assisted patient with exercises. OT returned to table to document on notepad. OT offered visit form and pen to patient for signature. OT removed gloves and performed hand hygiene. OT cleaned vital sign equipment and set aside. OT planned for next visit, placed vital sign equipment in clinical bag. OT disposed of gloves and newspaper in patient trash receptacle. During an after-visit interview on 9/16/24, OT 1 indicated it is their practice to wear the same gloves through the entirety of the home visit. 1. Review of a policy revised 12/12/2016 titled "Standard Precautions for Home Care" indicated clinicians should wash their hands with soap and water after removing gloves. 2. Review of a policy revised 12/20/2016 titled "Bag Technique" indicated after cleaning the used equipment, clinicians should wash their hands before replacing equipment in the bag and should never re-enter the bag unless the clinicians washed their hands. 3. Review of foley catheter (a tube inserted into the bladder to drain urine and held in place with an inflated balloon) care procedures at https://www.utoledo.edu/policies/utmc/nursin		HHA staffand nursing staff educated on Catheter care. CNA Training Video for Catheter Care provided, HHA tested on information provided, Infection control and Prevention, properhand hygiene, Blood Borne Pathogens, Communicable Diseases, UniversalPrecautions and Bag Technique. 1. Review of Home healthpolicy for standard precautions, indicates clinicians should wash their handswith soap and water after removing gloves. Thispolicy was reviewed by all field staff. 2. Review of home health policy for Bag Technique indicatesthat after cleaning used equipment, clinicians should wash their hands beforereplacing equipment into the bag and should never re-enter the bag unless clinicianwashed their hands. This Policy reviewed by all field staff. 3. Review of nursing guidelines for foley catheter care andprocedures, it indicates that clinicians should clean the catheter away fromurinary tract opening and not towards in	

	guidelines.pdf indicated the clinicians should clean the catheter away from the urinary tract opening and not towards in order to avoid contamination of the urinary tract. 4. During an observation of care at the home of Patient #2 on 9/16/2024, at 12:10 PM, Home Health Aide (HHA) 1 was observed wearing gloves on both hands and washing the catheter tubing from the tip of the penis and down the tubing away from the body. HHA 1 was then observed washing the patient's scrotum and surrounding area before washing the catheter tubing again from the tip of the penis down the tubing away from the body. HHA 1 was then observed to wash the top of the patient's legs and feet before applying lotion to the patient's chest and arms before the patient rolled to their stomach. At 12:14 PM, HHA 1 was observed changing the water in the wash basin but the washcloth was not changed. HHA 1 was observed washing the patient's back, shoulders, back of the legs, and buttocks. HHA 1 did not change the wash cloth or change gloves and perform hand hygiene during		order to avoid contamination of theurinary track. Nurses and HHA werein-serviced and re-trained on Foley catheter care. Administrator will perform monthly homevisits for two quarters to observe field staff providing patient care to insurecompany policies are being followed and quality and safe care provided until100% compliance is achieved. 4. Based onobservation of clinician during home visit, the home health aide failed insurepatients safety during patient care. HHAdid not follow company policy regarding standard precautions during bathing, didnot wash hands in between glove changes and incorrectly performed catheter care,cleaning catheter towards the body instead of away.	

	the bath. HHA 1 was observed wearing the same gloves worn during the bath and began opening the patient's dresser drawers and removing clothes to dress the patient. On 9/17/2024, at 12:46 PM, HHA 1 indicated she typically only uses 1 wash cloth for bathing patients and indicated she washes her hands after entering the patient's home and after performing the bath. On 9/18/2024, beginning at 2:37 PM, the Clinical Manager indicated a new wash cloth should be used after washing the genital area before washing other parts of the body and should not wash the catheter after washing the genital area. The Clinical Manager indicated gloves should be changed and hand hygiene should be performed after washing the genital area before moving to other parts of the body. 5. During an observation of care at the home of Patient #5 on 9/17/2024, at 3:36 PM, the Clinical Manager was observed cleansing the wound to the patient's left heel with gloved hands. The Clinical Manager		HHA was immediately in-serviced andre-training provided to HHA staff. Administrator will perform monthly homevisits for two quarters to observe field staff providing patient care to insurecompany policies are being followed and quality and safe care provided until 100%compliance is achieved. 5. Based on observationof clinician during home visit, the home health nurse failed to insure patientssafety during patient care. SN did notfollow company policy regarding standard precautions while performing woundcare, did not perform proper hand washing and also failed to follow companypolicy regarding proper Bag Technique. Administrator will perform monthly homevisits for two quarters to observe field staff providing patient care to insurecompany policies are being followed and quality and safe care provided until100% compliance is achieved. Administrator In-serviced skilled	

	removed the glove from her right hand and applied a new glove without performing hand hygiene after the removal of the glove and before applying the new glove. The Clinical Manager then washed the wound to the left heel again, removed gloves from both hands, and retrieved new gloves from the main compartment of the nurse bag before applying new gloves. The Clinical Manager did not perform hand hygiene after the removal of the gloves and before entering the nurse bag and before applying new gloves. At 3:45 PM, the Clinical Manager was observed cleaning the blood pressure cuff, thermometer, and pulse oximeter (medical device that measures oxygen saturation and pulse rate) and then entered the main compartment of the nurse bag to place equipment into the bag. The Clinical Manager did not perform hand hygiene after cleansing equipment and before entering the visit bag to return equipment. On 9/19/2024, at 2:56 PM, the Clinical Manager indicated she did not perform hand hygiene		policiesregarding Standard Precautions, Infection control, Bag Technique, proper hand washing. Administrator will be responsible for the ongoingmonitoring and establish a quality assurance process to prevent recurrence ofthese deficiencies. Administrator will be responsible for the ongoing monitoring to ensure that this deficiency does not occur again.	

	before applying new gloves because she was in a hurry. The Clinical Manager indicated she was not aware of the policy to perform hand hygiene prior to re-entry of the nurse bag. 410 IAC 17-12-1(m)			
G0684	Infection control 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on record review and interview, the agency failed to follow its policy to maintain an agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases in 2 of 3 active clinical records reviewed	G0684	Agency will develop a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program will include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. All patient infections will be documented through an infection log. The logs will be reviewed quarterly by the QAPI committee for any trends. All trends will have a plan of action to prevent further infections. 1. QAPI protocolmodified to include a comprehensive review of patient care, frequency ofinfections, methods to decrease patient infections and to have improvedoutcomes for patient care Clinicians will be In-serviced regarding QAPI protocolmodifications, to include “UTI Infection risk assessment form” (which will beincluded in Agency’s SOC	2024-10-20

	therapy. (Patient #3, 5) The findings include: 1. A review of a policy dated 12/14/2016 titled "Infection Control" indicated the agency was to monitor incidents of infection in patients and complete incident reports and infection control logs to document all evidence of infection. The agency was to ensure adequate data collection, analysis, and interpretation of findings using collection and documentation of infection control data and measuring and assessing infection data to identify opportunities for improving the infection control program. 2. A clinical record review for Patient #3 evidenced an occupational therapy (OT) visit note dated 9/12/2024 and completed by OT 1 indicated the patient was started on an antibiotic for an infection. The clinical record failed to evidence an infection report was completed. On 9/18/2024, beginning at 9:30 AM, Registered Nurse (RN)		Folders), form must be completed by admittingclinician and returned to home health agency. This will allow agency toidentify patients at risk for infection, identify patients' needs and theirrisk for hospitalization. 2. Improvement of medication management practicespertaining to infection, clinician communication and documentation All field staff In-Serviced regarding Infection control managementprotocol. At the time a clinician learns of a patient starting of anew medication to treat infection, it is imperative that the nurse case manager benotified. This communication should be documented in patient's chart. Nursecase manager in turn will verify the medication, contact physician, completephysician order and start infection log which will be completed when antibiotictherapy is completed Clinical Manager is responsible for tracking infections viainfection logs received from clinicians, and provide ongoing	

	1 indicated the patient had an appointment with the oncologist on 9/10/2024 who ordered the antibiotic for a wound infection. On 9/18/2024, at 1:48 PM, the Clinical Manager indicated there was not an infection report for the wound infection. 3. A clinical record review for Patient #5 evidenced a physician order dated 8/17/2024 for Cefdinir (an antibiotic to treat infection) twice daily for 10 days. The clinical record failed to evidence an infection report. On 9/19/2024, at 3:03 PM, the Clinical Manager indicated an infection report was not completed because she called the physician to report the patient had a cough and the physician ordered an antibiotic for an upper respiratory infection, but the Clinical Manager did not believe there was an infection. 4. Review of the Infection Log dated 9/18/2024 failed to evidence the data included the patient infections for Patient #3 and Patient #5 and failed to evidence the analysis and		needed. QA team will review every clinician note forany indication of infection risk. Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur	

	interpretation of data to identify opportunities for infection prevention. On 9/19/2024, at 3:56 PM, the Administrator indicated all patient infections should be included on the infection log, and she indicated Patient #3 and Patient #5 were not included on the infection log.			

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 observation, record review, and interview, the agency failed to ensure the home health aide (HHA) had complete, patient-specific written patient care instructions to be performed by the home health aides in 1 of 1 active clinical record reviewed with home health aide services. (Patient #2) The findings include: A clinical record review for Patient #2 evidenced a HHA Care Plan dated 8/2/2024 which indicated the HHA was to assist with a chair bath and meal set-up. The HHA Care Plan indicated the patient's diet was heart healthy. The plan of care	G0798	On 9/16/24 at noon, State surveyor made home visit to observedHHA provide care to patient #2. Surveyorobserved HHA giving patient a "bed bath", according to the HHA Care Plan date8/2/2024, HHA should have provided "assist with chair bath". Thisclerical oversite was brought to the attention of patient's nurse on 9/17/2024,and immediately patient's nurse created an amended HHA Care plan to include the"Bed Bath" option. The Agency tries to accommodateour services to our patients' needs and request, and patient #2 does not alwayswant to get up out of bed for a chair bath, at times he requests to be bathedin bed. Upon review of patients #2 HHA Care Plan, "Heart Healthy"diet was noted, but patient is on a regular diet. On 9/17/2024 when nurse casemanager created an amended HHA Care Plan, correction was made to reflect"Regular diet" Home health aides in serviced on 9/27/24 regarding HHA assignments andduties, and instructed to notify nurse case manager if patient request a	2024-10-20

	8/6/2024-10/4/2024 indicated the patient's diet was regular. During an observation of care at the patient's home on 9/16/2024 from 12:00 PM to 12:40 PM, HHA 1 was observed bathing the patient in the bed. On 9/17/2024, at 12:46 PM, HHA 1 indicated she typically bathed the patient in the bed and sometimes gave the patient a shower. On 9/18/2024, at 2:47 PM, the Clinical Manager indicated the diet on the HHA Care Plan was not correct and should say regular diet. The Clinical Manager indicated the patient can either do a bed bath or a shower and chair bath should be removed from the plan of care. 410 IAC 17-14-1(m)		changein task or if patient continues to refuse the same task. HHA instructed that if patient refuses atask, HHA must check the box "refused" and note the reason why patient refused thatspecific task. Administrator will be responsible for the ongoingmonitoring of this deficiency. Administrator will beresponsible for ensuring this deficiency does not reoccur	
G0800	Services provided by HH aide 484.80(g)(2)	G0800	On 9/16/24 at noon, State surveyor made home visit toobserved HHA provide care to patient #2. Patient has a daily morning routine he follows,	2024-10-20

	A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on observation, record review, and interview, the home health aide (HHA) failed to provide services as directed in the care plan in 1 of 1 active clinical records reviewed with HHA services. (Patient #2) The findings include: A clinical record review for Patient #2 evidenced a HHA Care Plan dated 8/2/2024 which indicated the HHA was to assist with: a chair bath, shampoo hair, hair care, oral care, shave, empty drainage bag, record bowel movement, and assist with transfer. During an observation of care at the patient's home on 9/16/2024 from 12:00 PM to 12:40 PM, the patient was observed to have tube inserted into the penis with a drainage bag attached at the other end of the tube. The patient was not observed to have left the bed		bathes, gets dressed,brushes his teeth, transfers to his wheelchair, and eats breakfast so he cantake his morning medications, unfortunately, the State Surveyor did not arriveat the patient's home until noon, and patient needed to eat breakfast so hecould take his medications. Patient'sgranddaughter assisted patient with most of his morning task prior to HHA andState Surveyors arrival. The Axxess software we use, has the ability to copyinformation from a previous visit note, it's a convenient option that saves ourstaff time on their charting. When the HHAdid her visit note she repopulated information from a previous visit note withoutindicating which task she performed herself and which task were performed bypatient's granddaughter before her arrival. Upon QA review the visit note was returned to HHA, and the HHA correctedher visit note to reflect only the task that she performed and the reason she did not perform all task listed on HHA care plan. On 9/17/24 the State Surveyor	

	for the observation of care. HHA 1 was observed bathing the patient in the bed and did not perform the tasks to include a shampoo, hair care, oral care, shave, empty drainage bag, inquire about the patient's last bowel movement, and assist with transfer. The HHA visit note completed by HHA 1 and dated 9/16/2024 indicated the patient completed a chair bath, shampoo, hair care, oral care, shave, empty drainage bag, record last bowel movement, and assist with transfer. On 9/17/2024, at 12:46 PM, HHA 1 indicated she typically bathed the patient in the bed and indicated the care she provided to the patient during the observation of care was the typical care she provided to the patient. HHA 1 indicated she was not sure if any personal care was provided to the patient by a caregiver prior to the HHA's arrival. HHA 1 indicated she documented on the visit notes the tasks that are marked on the HHA care plan. On 9/18/2024, at 2:41 PM, the Clinical Manager indicated the		reviewed the HHA visit notefrom 9/16/24 prior to its approval from QA. The corrected note was approved by QA on 9/18/24. Administrator in-serviced HHAs 9/27/24 regarding servicespermitted under state law that HHA can provide, that the home health aide mustdo only the task that are on the HHA Care Plan, HHAs instructed to review thecurrent HHA Care Plan before providing patient care and to review HHA Care Planbefore completing their visit note. Home health aides instructed, that if they did not perform a task or if patient refused atask from being provided, that HHA must document on visit note the reason why taskwas not performed. When a patientcontinues to refuse the same task, or if patient request HHA to do a task thatis not included on the HHA Care Plan, HHA must notify the nurse case manager topossibly revise the HHA Care Plan, HHA must document in her visit note that shecommunicated with the nurse. Administrator In-serviced	

	HHA should not document the tasks not performed.		Clinical field staff on how tocorrectly complete a HHA Care Plan, and to regularly review it with the patientand the HHA to determine if any revisions need to be made. QA team will be responsible for the ongoing monitoring ofthis deficiency, reviewing clinicians notes daily for potential issues. Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur.	
G0813	Basis and Scope §484.80(h)(1)(iv) A registered nurse or other appropriate skilled professional must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care. Based on record review and interview, the agency failed to ensure the Registered Nurse (RN) observed and assessed the home health aide (HHA) while providing care in 3 of 3 HHA personnel files reviewed. (HHA 1, HHA 2, HHA 3) The findings include:	G0813	Home health aides are observed monthly (by a qualifiedclinician) in the patients home performing the assigned task for the patientsthat they have been assigned to. This isdocumented in our software as “HHA supervisory visit”, which is a generic documentprovided in the Axxess software. However,the document format for the “HHA Annual Supervisory Visit” form is the sameformat as the standard form used for the monthly onsite HHA supervisory visits, unfortunately the form does not include a section to indicate specific task that the home healthaide was observed	2024-10-20

	The personnel records for HHA 1, HHA 2, and HHA 3 were reviewed on 9/18/2024. Each record failed to evidence documentation by an appropriate skilled professional, on site visit to observe the aide during the provision direct patient care, annually at minimum. Each record failed to evidence an on site visit occurred during the provision of care for more than 2 years. On 9/18/2024, beginning at 3:30 PM, the administrator relayed they did not have documentary evidence that these on site observations occurred, within the past 2 years for HHA 1, HHA 2, and HHA 3. 1. A clinical record review for Patient #2 evidenced a HHA supervisory visit dated 9/11/2024 signed by the Administrator/RN which indicated HHA was present for the annual supervisory visit. The supervisory visit failed to evidence what care was observed and assessed by the RN. 2. A clinical record review for Patient #8 evidenced a HHA supervisory visit dated		performing. Moving forward AllPoints Home Health Care hasadopted a new paper based "HHA Annual Supervisory Visit" form which includes asection to indicate specific task the HHA was observed performing, thecompleted forms will be filed in the HHA's HR file. Administrator In-serviced skilled nurseson 9/23/24 of the requirement for HHAs to be observed and assessed annually, bya qualified clinician, performing task included on their assigned patients HHACare Plan. The assessment and observation must bedocumented on the newly adopted form titled, "Annual HHA Supervisory Visit", theblank form is available at AllPoints office 1. HHA observed on 10/4/24, by nurse case manager,in the home of pt#2 providing patient care for annual supervisory visit,assessment and observation documented on newly adopted form titled, "Annual HHASupervisory Visit" 2. Patient #8 has been discharged from agency atthe	

	8/26/2024 signed by the Clinical Manager/RN which indicated HHA 2 was present for the annual supervisory visit. The supervisory visit failed to evidence what care was observed and assessed by the RN. 3. A clinical record review for Patient #9 evidenced a HHA supervisory visit dated 9/25/2023 signed by the Clinical Manager/RN which indicated HHA 3 was present for the annual supervisory visit. The supervisory visit failed to evidence what care was observed and assessed by the RN. 4. On 9/19/2024, at 4:22 PM, the Clinical Manager indicated the supervisory visits did not indicate any care that was observed.		time of survey. 3. Patient #9 has been discharged from agency atthe time of survey 4. New form adopted includes section to notespecific task observed during HHA annual supervisory visits, nurses instructedon how to complete the forms and return completed form to administrator. 5. HHA 1, HHA 2, and HHA 3 have each had an onsiteHHA annual supervisory visit since the exist day of the surveyors, assessmentand observation documented on newly adopted “HHA Annual Supervisory Visit” formand updated in HHA’s personnel file 6. New form adopted includes section to notespecific task observed during HHA annual supervisory visits, nurses instructedon how to complete the forms and return completed form to administrator. Administrator will be responsible for the ongoingmonitoring of this deficiency, reviewing all HHA personnel files quarterly, notifyingqualified clinicians of	

			any upcoming HHA annual supervisory visits that aredue. Director of Nursing will be responsible for ensuring thisdeficiency does not reoccur.	
G0940	Organization and administration of services 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished.	G0940	Agency updated its Organization Chart to reflect the Agency'sstructure including lines of authority and services furnished. All Staff to be informed of the agency's organizationalstructure, lines of authority, and be provided a current written copy of theorganizational chart. All staff and contracted staff to beinstructed on the responsibilities of the Administrator, Clinical Manager andOffice Manager. From mid-August 2024 to September 2024 the Agency was in theprocess of switching over to a new software provider. Staff were struggling tonavigate the new software and complete their documentation. Multiple system failures occurred as a resultof this, the failures have been recognized and since rectified, with measuresput in	2024-10-20

	Based on record review and interview, the administrator failed to: ensure the organizational structure was readily identifiable and included the lines of authority and services provided (G0940); ensure the Administrator was responsible for the day-to-day operations (G0948); and ensure the Clinical Manager was coordinating the assignment of personnel and patients (G0960). The findings include: During an interview on 9/16/24 beginning at 12:50 PM Occupational Therapist 1 indicated the Office Manager was the Administrator. 1. A review of a policy revised 1/22/2019 titled "Administration" indicated the administrator was responsible for directing the agency's ongoing functions. 2. A review of a policy revised 1/22/2016 titled "Administrative Staff" indicated the administrator was 3. During the entrance conference on 9/13/2024, beginning at 12:36 PM, the Administrator indicated the current census was 7. On 9/13/2024, at 3:15 PM, the Clinical Manager indicated the active patient census was 11 but 4 patients were listed in the new		place to ensure that this deficiency does not reoccur. The Administratorwill be responsible for the ongoing monitoring of these deficiencies tomaintain compliance.	

	electronic health record (EHR) so the census was reported incorrectly. The Clinical Manager provided the visit schedule and indicated only 4 patient schedules were visible at that time. On 9/16/2024, beginning at 10:35 AM, the Alternate Administrator indicated the occupational therapist (OT) was only available on Mondays. The visit schedule revised on 9/16/2024 failed to evidence any visits by the OT for Monday, 9/16/2024. The Alternate Administrator indicated the patients were scheduled for the ordered frequency and the staff picked when they did their visits. The Alternate Administrator indicated staff was supposed to report their visit schedule to administration. On 9/16/2024, at 10:55 AM, the Clinical Manger indicated OT 1 had a visit with Patient #1 for Monday, 9/16/2024 which was not on the visit schedule. 4. During the entrance conference on 9/13/2024, beginning at 12:36 PM, the Administrator indicated the agency provided services by			

	physical therapy assistants (PTA) and occupational therapy assistants (OTA). The organizational chart revised 11/1/2020 failed to evidence the services provided by the PTA and OTA and the lines of authority. On 9/13/2024, at 3:32 PM, the Administrator indicated the PTA and OTA were not listed on the organizational chart but would be a good idea to add. On 9/17/2024, at 12:46 PM, Home Health Aide (HHA) 1 indicated the Clinical Manager was the Alternate Administrator. 5. On 9/13/2024, beginning at 12:32 PM, the Administrator indicated the agency had switched from one EHR to another EHR and there were 97 visit notes in the new EHR that needed to be reviewed but the agency was unable to access them for review. On 9/16/2024, at3:24 PM, the Clinical Manager indicated she called the EHR company and left a message requesting a call back so the agency could find			

	out how to print a plan of care for Patient #1. The Clinical Manager indicated the agency missed the training for the new EHR and no one knew how to use it. The Clinical Manager indicated the plans of care in the new EHR had not yet been sent to the physician because no one knew how to change it from a draft to the final plan of care to include the plans of care for Patients #1, #3, and #4. On 9/18/2024, at 10:27 AM, the Office Manager indicated the agency had to call the new EHR company in order to find out how to add the physician's name and visit frequency for the plans of care for Patients #1, #3, and #4. On 9/20/2024, at 12:35 PM, the Administrator indicated she informed the Alternate Administrator she did not know how to use the new EHR and indicated the Alternate Administrator informed the Administrator the agency was switching to the new EHR anyways. The cumulative effect of these			

	in the home health agency's inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.105 Organization and Administration of Services. 410 IAC 17-12-1(a)(2) 410 IAC 17-12-1(c)(1)			
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 and interview, the agency failed to ensure the clinicians accurately and timely documented in the clinical record in 4 of 5 active clinical records reviewed. (Patient #1, 2, 3, 5) The findings include: *The record reviewed on 9/16/24 for Patient	G1024	All clinical staff to be in-serviced on Agency's Policy regarding "Clinical Documentation", all staff to be instructed on accurate and complete documentation. All entries must be legible, clear, complete, appropriately authenticated, dated and timed. Authentication must include a signature and a title, or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. 1. All field Staff to be instructed that documentation must be completed within 24 hours of services provided, electronic or paper note; SOC/ROC/Recertification Oasis must be submitted within 7 days. 2. Clinical error for patient #2 has since been rectified, new physician order obtained to clarify specific Foley catheter care, nursing staff was re-educated by Administrator on how to correctly and clearly document. *A Clinical record review by surveyor on Patient #2, surveyor observed a note dated 9/18/24 that had been opened and repopulated in error by home health aide, the note had not been completed nor signed, the home health aide indicated she opened the wrong note, once she realized her mistake she closed the note and reopened the correct note and completed her visit documentation. 3. From mid-August 2024 to September 2024	2024-10-20

	assessment dated 8/19/24 which indicated Registered Nurse 1 (RN 1) opened the visit note and performed the initial assessment. The document included an electronic signature which indicated the comprehensive assessment was completed by the Alternate Administrator. On 9/19/24, during an interview beginning at 1:30 PM the Clinical Manager indicated the Alternate Administrator completed the documentation for RN 1 because RN 1 did not know how to complete the documentation. 1. A policy revised 1/20/2016 titled "Clinical Documentation" indicated all documentation was to be completed the day service was rendered. 2. A clinical record review on 9/17/2024 for Patient #2 evidenced a home health aide (HHA) visit note indicating a visit was made on 9/18/2024 from 9:00 AM to 10:00 AM indicating personal care was completed to include bathing, oral care, assist with dressing, catheter (a tube inserted into the bladder to drain urine from the body) care, and record last bowel movement which was documented to be 9/18/2024. The visit note showed to be last saved by HHA 1 on 9/16/2024 at 2:30 PM. On 9/17/2024, beginning at 12:46 PM, HHA 1 indicated she		the Agency was in theprocess of switching over to a new software provider. Staff were struggling tonavigate the new software and complete their documentation. **Multiple system failures occurred as a resultof this, including late documentation, these failures have been recognized and since rectified, with measuresput in place to ensure that this deficiency does not reoccur. All staff instructed that clinical documentation must be completed within 24 hours of patient visit.** The Administratorwill be responsible for the ongoing monitoring of these deficiencies tomaintain compliance.	

	was not sure why the clinical record indicated a visit note documented for 9/18/2024 and indicated maybe she did not have her glasses on when she was documenting. On 9/17/2024, at 11:13 AM, the Clinical Manager indicated staff should not document visit notes prior to making the visit. The plan of care for the certification period of 8/6/2024-10/4/2024 indicated the nurse was to flush the foley catheter (a tube inserted into the bladder to drain urine and held in place with an inflated balloon) every 2 weeks with 180 milliliters (ml) of normal saline (flush solution). A nurse visit note completed by the Clinical Manager and dated 9/12/2024 failed to evidence the nurse flushed the foley catheter. Skilled nurse visit notes completed by the Clinical Manager and dated 8/16/2024 and 8/24/2024 indicated the nurse flushed the foley catheter but failed to evidence the nurse documented with how much. On 9/18/2024, beginning at 2:17 PM, the Clinical Manager indicated she flushed the foley			

	catheter every 2 weeks with 120 ml but must have forgotten to document the flush on 9/12/2024. The Clinical Manager indicated she should document with how much she flushed the foley catheter. 3. A clinical record review on 9/18/2024 for Patient #3 indicated skilled nursing and physical therapy (PT) services would each be provided 2 times a week failed to evidence a nurse visit note was documented since 9/9/2924 and a PT visit was documented since 9/11/2024. On 9/18/2024, at 9:30 AM, Registered Nurse (RN) 1 indicated she made a visit on 9/16/2024 but had not yet documented the visit. On 9/18/2024, at 3:38 PM, Physical Therapy Assistant (PTA) 1 indicated he made a visit on 9/16/2024 but had not yet documented the visit. The start of care comprehensive assessment dated 9/5/2024 and completed by RN 1 failed to evidence the diastolic blood pressure (the pressure against the walls of the arteries when			

bottom number of the blood pressure reading). The start of care comprehensive assessment for the heart sounds and peripheral pulses was left blank.

On 9/18/2024, beginning at 9:30 AM, RN 1 indicated the blood pressure documented at the start of care assessment was an error. RN 1 indicated she always assessed the heart sounds and peripheral pulses, and it was left blank in error.

A skilled nurse visit note dated 9/6/2024 was marked as "in progress" by RN 1 during review on 9/17/2024 and failed to evidence any documentation of the visit other than the visit date and time.

On 9/18/2024, beginning at 9:30 AM, RN 1 indicated she completed the documentation that morning (9/18/2024) for the visit note dated 9/6/2024.

4. A clinical record review for Patient #5 evidenced skilled nursing visit notes completed by the Clinical Manager dated 8/17/2024, 8/21/2024, and 8/24/2024 indicated the size of the wound to the left heel under the integumentary (skin)

	(cm) in length, 1.0 cm in width, and 0.05 cm in depth and indicated the size of the wound to the left heel under the visit narrative was 1.0 cm in length, 0.5 cm in width, and 0.05 cm in depth. On 9/19/2024, at 3:07 PM, the Clinical Manager indicated the documentation of the wound size was not accurate under the integumentary section and must have been a carry-over in the documentation. 410 IAC 17-15-1(b)			
N0000	Initial Comments This visit was for a State Re-Licensure survey of a Home Health Agency. Survey dates: 9/13/2024, 9/16/2024-9/20/2024 12 Month Unduplicated Skilled Census: 73	N0000	This visit was for a State Re-Licensure survey of a Home Health Agency.	

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
Helena Black	Assistant Administrator	10/13/2024 8:21:48 PM