DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC accepted on 10-19-2022
Deborah Franco, RN

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157692	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elite Home Rehab And Healthcare Corp	580 EAST CARMEL DRIVE, SUITE 208, CARMEL, IN, 46032

(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
N0000	Initial Comments This visit was for a State Re-licensure survey of a Deemed Home Health Provider. Survey Dates: 09-12, 09-13, 09-14 and 09-15-2022. Census: 411	N0000		2022-10-14

	QR by Area 3 on 9-27-2022			
N0486	Q A and performance improvement 410 IAC 17-12-2(h) Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review and interview, the agency failed to ensure all services were coordinated with other health service providers that provided care to their patients in 7 of 7 active patients who received services from other health care providers. (Patients #1, 2, 3, 4, 5, 9, and 11) Findings Include: 7. A review of the clinical record of Patient #5, with a start of care date of 2-18-22 and a recertification period of 8-17-22 through 10-15-22, evidenced a document titled "Home Health Certification and Plan of Care." The recertification plan of care	N0486	The Administrator, Director of Nursing and staff have all been reoriented and re-educated regarding Coordination of Services Policy 2.86 and Care Plan Policy 2.8 including but not limited to ensuring coordinating of care is performed with all health or social service providers serving the patient and is reflected in the clinical record and plan of care. These policies will also continue to be discussed at monthly staff meetings for the next six months. The Director of Nursing has ensured Coordination of Care has been performed with all 7 active patients and is now reflected in the clinical record. The Director of Nursing will audit 100% of Care Plans and Coordination Notes for all patients at Admissions and Recertification to ensure coordination of care has been performed and the record accurately reflects all coordination performed with all health and social service	2022-10-14

	evidence any documentation of coordination of care with Entity #5, a dialysis facility from whom Patient #5 received health care services. A review of agency documents titled "Communication Notes, dated 2-18-22 through 8-16-22, failed to evidence any documentation of coordination of care with Entity #5 to include dietary and fluid restrictions, maintenance of Patient #5's dialysis access site, and any medications received at the dialysis center A review of a document titled, "Limited Encounter," received from Entity #5 on 9-13-22, indicated but not limited to, "...encouraged to limit sodium and fluid intake...patient to meet with home HD (hemodialysis)nurse next week..." During an interview on 9-13-22 at 2:30 PM with the Administrator, she indicated		providers servicing patients of the Agency, until there is 100% compliance. Audits will be performed for a minimum of one month if the threshold is met sooner. Thereafter 10% of records will be will continue to be audited quarterly.	

receives dialysis but, "...we don't talk to them."

During a home visit to Patient # 5's residence on 9-14-22 at 12:30 PM, Patient #5 indicated they receive dialysis 3 times per week and is currently on a 24-ounce fluid restriction, low sodium diet, and diabetic diet. Patient #5 reported they are currently training to do dialysis at home.

During an interview on 9-14-22 at 12:30 PM with Employee #1, Physical Therapist for Patient #5, they reported not sure where Patient #5 gets dialysis treatment, but the patient updates them.

8. A review of the clinical record for Patient #9 with a start of care date of 5-20-22 and certification period of 7-19-22 through 9-16-22, evidenced a document titled "Home Health Certification and Plan of Care (Recertification of Continuing Need for Care)." A section titled "Other Physicians

On the Case" was left blank.
The recertification plan of care failed to evidence coordination of care with Entity 9, a personal service agency, and Entity 10, Neurology Physician for Patient #9.

During a home visit for Patient #9 on 9-14-22 at 10:50 AM, Patient #9's family member reported that Patient #9 had recently received a Botox injection related to the patient's diagnosis of Spastic Hemiplegia (a neurological condition that causes muscles on one side of the body to be in a state of contraction) of the left side.

9. A review of the clinical record for Patient #11 indicated a start of care of 2-24-22 and a recertification period of 8-24-22 through 10-22-22, evidenced a document titled "Home Health Certification and Plan of Care." The clinical record indicated the patient had multiple health providers but failed to evidence coordination of care with providers.

1. A review of an undated agency policy, titled "Coordination of Services,"

	policy number 2.36, stated, “Purpose: 1. To coordinate services to provide comprehensive home care and assure continuity of care. 2. All personnel involved in the patient’s care are responsible for coordinating care effectively… b. Integrating orders from all physicians … c. Integrating services, whether services are provided directly or under arrangement, to ensure the identification of patient needs and factors that could affect patient safety and treatment effectiveness….” 2. A review of an undated agency policy, titled “Care Plan” policy number 2.8, stated, “… 1. Collection of baseline data including all pertinent diagnoses, including mental status, identification of any services furnished by other providers and how those services are coordinated ….” 3. A review of the clinical record of Patient #1, with a start of care date of 06-22-22 and an initial care period of 06-22-22 to 08-20-22, evidenced by an			

	agency document titled “Home Health Certification and Plan of Care.” The initial plan of care and the clinical record failed to evidence any documentation of coordination of care with Entity 2, a county home facility, that Patient #1 resided and received health services. A review of an agency document titled “Home Health Certification and Plan of Care” for the recertification period of 08-21-22 to 10-19-22 failed to evidence documentation of care coordination with Entity 2. A review of agency documents titled “Communication Note,” dated 06-22-22 through 09-13-22, failed to evidence any documentation of coordination of care with Entity 2, to include whom they spoke to, what services were provided, any medications received by Entity 2, or changes in those medications. During a home visit to Patient #1’s residence on 09-14-22 at			

	12:15 PM, I observed Physical Therapist (PT) #2 assist Patient #1 with ambulation with their walker instructing them on safe techniques as they ambulated in the hallway of Entity 2. The PT indicated Patient #1 had impulsive behaviors, which due to their diagnosis as mentally disabled, impacted their safety issues as Patient #1 let go of their walker and shook their legs, dancing and smiling. Further observed upon ambulation to the facility dining area, Person 4 introduced themselves as the Director of Entity 2. During an interview on 09-14-22 at 12:15 PM, PT #2 confirmed they did not document care coordination with Entity 2 regarding the care of Patient #1.			

	During the Entrance Conference on 09-12-22, at 9:56 AM, the Administrator confirmed that the coordination of care documentation should be in the agency documents titled "Communication Notes/Case Conference Notes." During an interview on 09-13-22 at 12:21 PM, Person 4, the Director of Entity 2, confirmed that Patient #1 resides at the county home facility. 4. A review of the clinical record of Patient #2, with a start of care date of 02-01-22 and an initial care period of 02-01-22 to 04-01-22, evidenced by an agency document titled "Home Health Certification and Plan of Care." The initial plan of care and the clinical record failed to evidence any documentation of coordination of care with Entity 12, the assisted living facility that Patient #2 resided and received health services. A review of the plan of care for			

	the recertification period 04-02-22 to 05-31-22 and the clinical record failed to evidence any documentation of coordination of care with Entity 12, the assisted living facility that Patient #2 resided and received health services. A review of the plan of care for the recertification period 06-01-22 to 07-30-22 and the clinical record failed to evidence any coordination of care with Entity 12, the assisted living facility where Patient #2 resided and received health services. A review of the plan of care for the recertification period 07-31-22 to 09-28-22 and the clinical record failed to evidence any coordination of care with Entity 12, the assisted living facility where Patient #2 resided and received health services. A review of agency documents titled "Communication Note," dated 02-01-22 through 09-13-22, failed to evidence any			

	of care with Entity 12, including whom they spoke to, what services were provided, and any received by Entity 12, or changes in those medications. During an interview on 09-13-22 at 2:38 PM, Person 14, the physician for Patient #2, confirmed that Patient #2 was treated by them at Entity 12, the assisted living facility, and their medical records were there. During an interview on 09-13-22 at 2:52 PM, Person 13, the Executive Director of Entity 12, confirmed Patient #2, who resided at the facility. 5. A review of the clinical record of Patient #3, with a start of care date of 02-17-22 and an initial care period of 02-17-22 to 04-17-22, evidenced by an agency document titled “Home Health Certification and Plan of Care.” The initial plan of care and the clinical record failed to evidence any documentation of coordination of care with Entity 12, the assisted living facility			

	that Patient #3 resided and received health services. A review of the plan of care for the recertification period 04-18-22 to 06-16-22 and the clinical record failed to evidence any documentation of coordination of care with Entity 12, the assisted living facility that Patient #3 resided and received health services. A review of the plan of care for the recertification period 06-17-22 to 08-15-22 and the clinical record failed to evidence any documentation of coordination of care with Entity 12, the assisted living facility that Patient #3 resided and received health services. A review of the plan of care for the recertification period 08-16-22 to 10-14-22 and the clinical record failed to evidence any coordination of care with Entity 12, the assisted living facility where Patient #3 resided and received health services.			

A review of agency documents titled “Communication Note,” dated 02-17-22 through 09-13-22, failed to evidence any documentation of coordination of care with Entity 12, to include whom they spoke to, what services were provided, any medications received by Entity 12, or changes in those medications.

During an interview on 09-13-22 at 2:38 PM, Person 14, the physician for Patient #2, confirmed that Patient #3 was treated by them at Entity 12, the assisted living facility, and their medical records were there.

During an interview on 09-13-22 at 2:52 PM, Person 13, the Executive Director of Entity 12, confirmed Patient #3, who resided at the facility.

6. A review of the clinical record of Patient #4, with a start of care date of 05-25-22 and an

	to 07-23-22, evidenced by an agency document titled “Home Health Certification and Plan of Care.” The initial plan of care and the clinical record failed to evidence any documentation of coordination of care with Entity 12, the assisted living facility that Patient #4 resided and received health services. A review of the plan of care for the recertification period 07-24-22 to 09-21-22 and the clinical record failed to evidence any documentation of coordination of care with Entity 12, the assisted living facility that Patient #4 resided and received health services. A review of agency documents titled “Communication Note,” dated 05-23-22 through 09-13-22, failed to evidence any documentation of coordination of care with Entity 12, including whom they spoke to, what services were provided, and any received by Entity 12, or changes in those medications.			

	During an interview on 09-13-22 at 2:38 PM, Person 14, the physician for Patient #2, confirmed that Patient #4 was treated by them at Entity 12, the assisted living facility, and their medical records were there. During an interview on 09-13-22 at 2:52 PM, Person 13, the Executive Director of Entity 12, confirmed Patient #4, who resided at the facility. During an interview on 09-14-22 at 4:00 PM, Patient #4 confirmed he was blind and could not give their insulin anymore after giving the incorrect doses related to their vision loss. Patient #4 further confirmed they received their insulin injections from the staff of Entity 12, the assisted living facility they resided. During an interview on 09-13-2022 at 2:36 PM, when queried about the case conference notes and communication notes containing coordination of care			

	with the other healthcare providers, the Administrator and Clinical Manager were unable to provide them. The administrator stated, "Yes, we need to fix it."			
N0524	Patient Care 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral.	N0524	The Administrator, Director of Nursing and staff have all been reoriented and re-educated regarding Care Plan Policy 2.8 including but not limited to ensuring all medical supplies are listed on the plan of care, all ordering physicians are listed on the plan of care, and all nutritional requirements are listed on the plan of care. This policy will also continue to be discussed at monthly staff meetings for the next six months. The Director of Nursing has ensured addendums have been created for all Plan of Cares for all 10 of the active patients and now accurately reflect all medical supplies, ordering physicians on the case and all nutritional requirements for each of the patients. The Director of Nursing will audit 100% of Care Plans for all the Agency's patients at Admissions	2022-10-14

(xii) Therapy modalities specifying length of treatment.

(xiii) Any other appropriate items.

Based on record review and interview, the agency failed to ensure all medical supplies were listed on the plan of care; all ordering physicians were listed on the plan of care, and failed to ensure all nutritional requirements were listed on the plan of care for 10 of 12 active clinical records reviewed. (Patients #1, 2, 3, 4, 5, 6, 7, 8, 9, and 11)

Findings Include:

9. A review of the clinical record for Patient #5, with a start of care date of 2-18-22, a recertification period of 8-17-22 to 10-15-22, evidenced an agency document titled, "Home Health Certification and Plan of Care," dated and signed by the physician on 9-9-22. The plan of care evidenced diagnoses including but not limited to; Hypertensive Heart and Chronic Kidney Disease with heart failure, Stage 5 end stage renal disease, Type 2 diabetes, and Long term use of insulin. The section titled "DME and

the Care Plans accurately follow this policy, until there is 100% compliance. Audits will be performed for a minimum of one month if the threshold is met sooner. Thereafter 10% of records will be continue to be audited quarterly.

Supplies" was left blank. The plan of care failed to evidence diabetic supplies: insulin injection supplies, glucometer strips, and lancets. The plan of care evidenced a section titled, "Nutritional Requirements: No concentrated Sweets." The plan of care failed to evidence the patient had a fluid restriction of 24 ounces per day, low sodium, and a low phosphorous diet.

During a home observation on 9-14-22 at 12:30 PM, Patient #5 indicated they check their blood sugar 4 times a day. They also reported they have a fluid restriction of 24 ounces per day, a low sodium diet, and a low phosphorous diet.

10. A review of the clinical record for Patient #9, with a start of care date of 5-20-22 and a recertification period of 7-19-22 to 9-16-22, evidenced a document titled, "Home Health Certification and Plan of Care." The plan of care evidenced diagnoses including but not limited to; Parkinson's Disease, Unspecified diastolic

Dysphagia (swallowing dysfunction), and Spastic hemiplegia affecting the left side." The section titled, "DME and Supplies," listed grab bars, walker, wheelchair, Hoyer lift." Durable Medical EQUIPMENT Provider: Name: Phone: were left blank. The section titled " Nutritional Requirements," listed "Heart Healthy, No Added Salt." The nutritional requirements failed to address dietary needs related to dysphagia.

During a home observation on 9-14-22 at 11:00 AM patient #9's family member reported the patient was to receive an injection of Botox in the throat to assist with speech and that at this time they had no swallowing issues.

11. A review of the clinical record for Patient #11, with a start of care date of 2-25-22 and a recertification period of 8-24-22 to 10-22-22, evidenced a document titled, " Home Health Certification and Plan of Care." The plan of care evidenced diagnoses of but not

limited to; Parkinson's Disease, History of falling, and Anxiety disorder. The section titled DME and Supplies listed;" Wheelchair, Grab bar, Walker, Cane, Tub/Shower Bench." Durable Medical Equipment Provider, Name: Phone: were left blank.

1. A review of an undated agency policy, titled "Care Plan" policy number 2.8, stated, "Development of Care Plan. In order to ensure that a patient's needs are being met... within an individual patient situation as needed...1. Collection of baseline data including all pertinent diagnoses, including mental status, types of services, identification of any services furnished by other providers and how those services are coordinated, equipment required, frequency and duration of visits, prognosis, rehabilitation potential, functional limitations...."

2. A review of the clinical record for Patient #1, with a start of care date of 06-22-22, with a recertification care period of 08-21-22 to 10-19-22,

	evidenced an agency document titled "Home Health Certification and Plan of Care," dated 08-16-22, and electronically signed by the Clinical Manager. The plan of care evidenced diagnoses, including but not limited to; Epilepsy, unspecified vitamin D deficiency, unspecified osteoarthritis, generalized anxiety disorder, unspecified protein-calorie malnutrition, personal history of pulmonary embolism, personal history of COVID-19, personal history of pneumonia, and history of falling. The section subtitled "Orders For Disciplines and Treatment" indicated, "… Using aseptic technique, SN (skilled nurse) to administer vitamin B 12, 1 ml (milliliter) sub-Q (subcutaneously) due to diagnosis of pernicious anemia …." The section subtitled "DME and Supplies" indicated that "DME: Walker, Wheelchair, Tub/Shower Bench Durable Medical Equipment Provider: Name: Phone: were left blank. DME/Supplies provided: were left blank." The plan of care failed to evidence syringes, needles, and supplies used to administer the B 12 injections.			

During a phone interview on 09-13-22 at 12:23 PM, the Director, Person #4, of Entity #2, the county home facility where Patient #1 resides, confirmed the skilled nurse from Elite Home Rehab and Healthcare sets up Patient #1's meds and administers their B-12 injections.

3. A review of the clinical record for Patient #2, with a start of care date of 02-01-22, with a recertification care period of 07-17-22 to 09-14-22, evidenced an agency document titled "Home Health Certification and Plan of Care," dated 07-27-22, and electronically signed by the Registered Nurse (RN) #2. The plan of care evidenced diagnoses, including but not limited to; Multiple sclerosis, Vitamin B12 deficiency, Muscle weakness, other secondary hypertension, Major depressive disorder, Iron deficiency anemia, overactive bladder, Gastro-esophageal reflux disease, other constipation, personal history of COVID-19,

personal history of urinary (tract) infections, mild cognitive impairment, and history of falling. The section subtitled "Orders For Disciplines and Treatment" indicated, "... Using aseptic technique, SN (skilled nurse) to administer vitamin B 12, 1 ml (milliliter) sub-Q (subcutaneously) due to diagnosis of pernicious anemia ...." The section subtitled "DME and Supplies" indicated, "DME: Tub/Shower Bench, Wheelchair, Grab bars, Hospital bed Durable Medical Equipment Provider: Name: Phone: were left blank. DME/Supplies provided: were left blank." The plan of care failed to evidence syringes, needles, and supplies used to administer the B 12 injections.

4. A review of the clinical record for Patient #3, with a start of care date of 02-17-22, with a recertification care period of 08-16-22 to 10-14-22, evidenced an agency document titled "Home Health Certification and Plan of Care," dated 08-12-22, and electronically signed by the Registered Nurse (RN) #2. The

diagnoses, including but not limited to; Complete traumatic amputation of one right lesser toe, Encounter for orthopedic aftercare following surgical amputation, Type 2 diabetes mellitus with diabetic neuropathy, Essential hypertension, Chronic obstructive pulmonary disease, unspecified dementia, Schizophrenia, Long term (current) use of aspirin, Long term (current) use of insulin, Acquired absence of right great toe, and history of falling. The section subtitled "Wound Care Orders" indicated, "... SN (skilled nurse) to perform wound care to R (right) hallux. Cleanse wound with NS (normal saline), apply iodoflex to open area cover foam, and secure with three flex, wrap foot "football style" cover tetranet, using aseptic technique. SN may teach patient/caregiver to perform wound care ...." The section subtitled "DME and Supplies" indicated, "DME: Tub/Shower Bench, Wheelchair, Grab bars, DME/Supplies provided: hearing aides, w/c, diabetic meter" The plan of care failed to evidence insulin syringes, needles, normal saline, iodoflex, foam dressing, three

flex wrap dressing, tetranet cover dressing specific wound care supplies used for wound care.

5. A review of the clinical record for Patient #4, with a start of care date of 05-25-22, with a recertification care period of 07-24-22 to 09-21-22, evidenced an agency document titled "Home Health Certification and Plan of Care," dated 07-20-22, and electronically signed by the Registered Nurse (RN) #2. The plan of care evidenced diagnoses, including but not limited to; Type 2 diabetes with diabetic peripheral angiopathy without gangrene, Legal blindness, Hypertensive chronic kidney disease, chronic kidney disease, muscle weakness, Chronic obstructive pulmonary disease, Kidney transplant, Long term (current) use of aspirin, Long term (current) use of insulin, and history of falling. The section subtitled "Orders For Discipline and Treatment" indicated, "...SN may obtain blood sugar level via fingerstick as needed...." The section subtitled "DME and Supplies"

	indicated, "DME: Tub/Shower Bench, Wheelchair, Grab bars, Durable Medical Equipment Provider: Name: Phone: were left blank. DME/Supplies provided: were left blank." The plan of care failed to evidence insulin syringes, needles, lancets, and testing strips for the glucometer. The plan of care failed to list all the healthcare providers providing orders for Patient #4, including Person #17, with Entity #18, who provided diabetic treatment orders and medical monitoring, and Person #19, with Entity #20, who provided renal treatment orders and medical monitoring. During a phone interview on 09-14-22 at 4:00 PM, Patient #4 confirmed they received blood sugar monitoring via fingerstick and insulin injections by staff due to blindness. Patient #4 indicated they had just seen Person #17 at Entity #18, the provider that monitored and treated their blood sugar. The patient further indicated they had seen Person #19 at Entity #20 last month to monitor their			

function.

6. A review of the clinical record for Patient #6, with a start of care date of 06-22-21, with a recertification care period of 08-16-22 to 10-14-22, evidenced an agency document titled "Home Health Certification and Plan of Care," dated 08-15-22, and electronically signed by RN #1. The plan of care evidenced diagnoses, including but not limited to; Pressure ulcer of sacral region, unstageable, Hypertensive chronic kidney disease, Type 2 diabetes with diabetic chronic kidney disease, Hemiplegia following cerebral infarction affecting left non-dominant side, Anemia, Malignant neoplasm of prostate, Multiple myeloma, Lymphedema, Long term (current) use of aspirin, Long term (current) use of insulin, and history of falling. The section subtitled "Wound Care Orders" indicated, "SN to perform pressure ulcer care to sacrococcygeal wound 3x a week. Cleanse/irrigate wound with sterile water, apply Prisma in wound bed, cover with silver

alginate as a primary dressing, use ABD (abdominal) pad and medipore tape as a secondary dressing, using aseptic technique....” The section subtitled “DME and Supplies” indicated, “DME: Other (Hoyer, trapeze, bedside commode, bedpan, diabetic supplies, glucometer, wound care supplies), Hospital bed, Wheelchair Durable Medical Equipment Provider: Name: Phone: were left blank. DME/Supplies provided: were left blank.” The plan of care failed to evidence insulin syringes, needles, lancets, and testing strips for the glucometer, sterile water, failed to list Prisma wound dressings, silver alginate wound dressings, abdominal pads, and medipore tape used for Patient #6’s wound care.

During a home visit on 09-15-22 at 11:00 AM, observed RN #1 perform wound care to Patient #6. The RN then reviewed the blood sugar log that the family member provided. During an interview, RN #1 indicated that the family provided 24-hour care,

monitored the patient's blood sugar, and administered insulin.

7. A review of the clinical record for Patient #7, with a start of care date of 06-27-22, with a recertification care period of 08-26-22 to 10-24-22, evidenced an agency document titled "Home Health Certification and Plan of Care," dated 08-24-22, and electronically signed by RN #4. The plan of care evidenced diagnoses, including but not limited to; Non-pressure chronic ulcer unspecified right lower leg limited to breakdown skin, Unspecified open wound, right foot, Type 2 diabetes, Edema, Unspecified atrial fibrillation, Major depressive disorder, Acquired absence of left leg below the knee, Anemia, Sleep Apnea, Chronic obstructive pulmonary disease, Benign prostatic hyperplasia with lower urinary tract symptoms, Long term (current) use of insulin, Pressure ulcer of right buttock, stage 2, and history of falling. The section subtitled "Wound Care Orders" indicated, "SN to perform wound care to Multiple wound

	areas: Cleanse with normal saline or wound cleanser, pat dry....Right/ 5th toe and Left stump wound apply skin prep to peri-wound skin. Paint both with betadine and allow to dry. Cover 5th toe with 2x2 gauze secured with medipore tape. Cover Left stump wound with softened sorbion pad, then heel Mepilex. Right dorsal wrist: apply a fitted piece of xerofoam cover and secure with mepilex border dressing. Sacrum/buttocks: Apply generous amount of sensicare to affected tissues. RLE (Right lower extremity) Apply kerlex and figure 8 from toe to knee cover with tetranet #7 using aseptic technique...SN to perform wound care to R (Right) -Lateral Lower Leg: Cleanse wound with Wound cleanser, apply calcium alginate/ABD (Abdominal) cover, and secure with kerlix/ACE wrap secured, using aseptic technique...." The section subtitled "DME and Supplies" indicated, "DME: Wheelchair, Walker, Tub/Shower Bench, Hospital bed, OTHER (Wound supplies, compression wraps, diabetic supplies) Durable Medical Equipment Provider: Name: Phone: were left blank.			

DME/Supplies provided: were left blank.” The plan of care failed to evidence glucometer, glucometer testing strips, lancets, insulin needles, syringes, normal saline, wound cleanser, skin prep, sorbion pads, Mepilex dressings, 2x2 gauze, xerofoam dressings, kerlex, stranet #7 dressings, calcium alginate, abdominal pads, ace wraps.

During a phone interview on 09-15-22 at 9:30 AM, the family member who cared for Patient #7 confirmed the patient received wound care supplies from Entity #15, from the orders of Person #16, the health care provider, at Entity #15.

8. A review of the clinical record for Patient #8, with a start of care date of 06-25-21, with a recertification care period of 08-19-22 to 10-17-22, evidenced an agency document titled “Home Health Certification and Plan of Care,” dated 08-15-22, and electronically signed by RN #3. The plan of care evidenced

	limited to; Pressure ulcer of left buttock, stage 2, Essential (primary) hypertension, Hereditary ataxia, Major depressive disorder, Iron deficiency anemia, Diverticulosis of intestinal, Chronic viral hepatitis C, Alcoholic neuropathy, Tremor, Long term (current) use of aspirin, and history of falling. The section subtitled “Wound Care Orders” indicated, “SN to perform wound care to left buttocks wound Cleanse with wound wash, pat dry. Apply sorbact ribbon moistened with blast X to wound bed. Cover with dry gauze. Apply skin prep to peri-wound, cover and secure with sacral Mepilex dressing, using aseptic technique....” The section subtitled “DME and Supplies” indicated, “DME: Wheelchair, Grab bars, Other (Wound Care Supplies; Colostomy Supplies), Bedside Commode Durable Medical Equipment Provider: Name: Phone: were left blank. DME/Supplies provided: were left blank.” The plan of care failed to evidence wound wash, skin prep, sorbact ribbon, gauze, sacral Mepilex dressings, and blast X.			

During a home visit on 09-14-22 at 10:05 AM, Patient #8 confirmed they received all their colostomy and wound care supplies from Entity #15. The Licensed Practical Nurse (LPN) #1 was observed to perform wound care on Patient #8's left buttock. LPN #1 confirmed with the patient that they had called Entity #15 and ordered medication refills and supplies needed.

During an interview on 09-13-22 at 3:57 PM, the Administrator and Clinical Manager confirmed that all DME and supplies should be listed on the patient's plan of care.

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