STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	300010123	A. BUILDING B. WING	11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HOME CARE SERVICES INC	7550 HOHMAN AVENUE, SUITE 1000, MUNSTER, IN, 46321

(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 survey was a re-licensure survey for a home health agency. Survey Dates: 11/7/2022, 11/9/2022, 11/10/2022, and 11/14/2022. Facility ID: 013729 Census: 11 Quality Review Completed 11/21/2022	N0000		2022-11-28
N0408	Licensure 410 IAC 17-10-1(d)	N0408	As of 9/1/2022 Elaine Amescua assumed the role of Alternate Administrator. As of 11/22/2022 Frances Sprouse assumed the role of Alternate Director of Nursing. To prevent the deficiency from occurring in the future, the administrator will update or review our records annually. The letters of updated staff will be	2022-11-23

	Rule 10 Sec. 1(d) Disclosure of ownership and management information must be made to the department at the time of the home health agency's initial request for licensure, for each survey, and at the time of any change in ownership or management. The disclosure must include the names and addresses of the following: (1) All persons having at least five percent (5%) ownership or controlling interest in the home health agency. (2) Each person who is: (A) an officer; (B) a director; (C) a managing agent; or (D) a managing employee; of the home health agency and evidence supporting the qualifications required by this article. (3) The corporation, association, or other company that is responsible for the management of the home health agency. (4) The chief executive officer and the chairman or equivalent position of the governing body of that corporation, association, or other legal entity responsible for the management of the home health agency. Based on record review and interview, the home health agency failed to disclose the names and addresses of the alternate administrator and alternate clinical manager to the Indiana Department of Health at the time of change in management.		mailed to state. All clinical staff was notified of the changes during in-service on 11/23/2022. See document 1 and 8	

The findings include:

Record review on 11/14/2022, evidenced an agency policy revised 05/2009, titled "Home Health Administrator" which stated, "... The home health Executive Director/Administrator position will be responsible for the direction, coordination, and general supervision of all home health services ... Responsibilities of the position will include but not be limited to: ... Complying with applicable law and regulations of operations ...."

Review on 11/7/2022, of the Indiana Department of Health pre-survey notes indicated as of 6/5/2019, the alternate administrator was person #6 and the alternate clinical manager was person #7.

Record review evidenced an employee list obtained 11/14/2022, which indicated clinical manager/director of nursing #2 was the alternate

	administrator. This document failed to identify an alternate clinical manager. This document failed to include person #6 or person #7. Employee record review on 11/14/2022, failed to evidence personnel records for person #6 or person #7. Employee record review on 11/14/2022, for registered nurse #3, evidenced a job description titled "Alternate Director of Patient Services" which was signed by registered nurse #3 on 8/14/2020. This document stated, "... Responsible for managing clinical services and quality improvement in the absence of the Director of Nursing ...." Record review failed to evidence the home health agency had notified the Indiana Department of Health of the change in alternate clinical manager. During an entrance conference on 11/7/2022, at 10:42 AM,			

person #7 was the alternate administrator and the alternate clinical manager. At 2:38 PM, administrator #1 indicated they did not know who the alternate administrator was and would have to check.

During an interview on 11/9/2022, at 4:00 PM, administrator #1 indicated clinical manager #2 was the alternate administrator. Administrator #1 did not know why person #6 was listed as alternate administrator since they had not worked at the home health agency for over 1 year.

During an interview on 11/14/2022, at 10:21 AM, administrator #1 indicated person #7 did not have an employee file because they were on indefinite medical leave and had been for a long time. Administrator #1 indicated person #7 did not perform any alternate clinical manager duties. Administrator #1 indicated registered nurse #3 would probably perform alternate clinical manager

	duties if the clinical manager was unavailable.			
N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the home health agency failed to ensure the governing body members were clearly set forth in writing and readily identifiable. The findings include: Record review on 11/7/2022, evidenced an agency policy revised 05/2009, titled "Governing Body" which stated, "... The Governing Body will assume full legal authority, responsibility and accountability for the operation of Foster Home Care Services, Inc. ... See	N0440	As of 11/22/2022, the Governing Body Members consist of Obiefuna Foster Eze and Terry Sammons. To ensure the deficiency does not occur again, the administrator will annually review the governing body. The clinical staff was updated during an in-service on 11/23/2022. See document 2 and 8	2022-11-23

	Addendum C:1-002.A for a list of names and addresses of the Governing Body ...." Record review evidenced an agency document obtained 11/7/2022, titled "Addendum C:1-002.A List of Names and Addresses of the Governing Body" which indicated person #1 and person #2 were the members of the governing body from 2019 – 2020. Record review evidenced an agency document obtained 11/7/2022, titled "Governing Body Members" which indicated person #2, person #3, and person #4 were the governing body members until 12/21/2022. Record review evidenced an agency document obtained 11/10/2022, titled "Governing Body Members" which indicated person #1 and person #2 were the governing body members until 12/21/2022.			

	During an interview on 11/7/2022 at 10:45 AM, administrator #1 indicated person #1, person #2 and person #5 were the governing body members. During an interview on 11/7/2022 at 3:12 PM, administrator #1 indicated they believed person #1 and person #2 were the governing body members but were unsure if this was correct. During an interview on 11/10/2022, at 12:48 PM, person #5 (chief executive officer) indicated person #1 and person #2 were the governing body members, and the original governing body member list obtained on 11/7/2022, was not accurate and would be updated.			
N0451	Home health agency administration/management 410 IAC 17-12-1(c)(8) Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d),	N0451	As of 9/1/2022 Elaine Amescua assumed the role of Alternate Administrator. To prevent the deficiency from occurring in the future, the administrator will update or review our records annually. See document 3	2022-11-22

	shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence. Based on record review and interview, the administrator failed to ensure that a qualified person was authorized in writing to act in the administrator's absence. The findings include: Record review on 11/14/2022, evidenced an agency job description revised 05/2009, titled "Executive Director/Administrator" which stated, "... Essential Job Functions/Responsibilities ... Appointing a similarly qualified alternate to be available at all times during operating hours in the absence of the administrator ...." Review on 11/7/2022, of the Indiana Department of Health pre-survey notes indicated as of 6/5/2019, the alternate administrator was person #6.			

	Record review on 11/14/2022, evidenced a handwritten employee list which indicated clinical manager #2 was the alternate administrator. Employee record review on 11/9/2022, evidenced a personnel file for clinical manager #2. This file failed to include any documentation authorizing clinical manager #2 in writing to act in the administrator's absence. This file failed to include an alternate administrator job description or letter of appointment to the position of alternate administrator. Employee record review on 11/14/2022, failed to evidence an employee file for person #6. During an interview on 11/7/2022, at 10:42 AM, administrator #1 indicated person #7 was the alternate administrator.			

	During an interview on 11/9/2022, at 4:00 PM, administrator #1 indicated clinical manager #2 should have been listed as the alternate administrator. Administrator #1 indicated they did not know why the State had person #6 as the alternate administrator since they had not worked at the agency for over 1 year.			
N0456	Home health agency administration/management 410 IAC 17-12-1(e) Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based on record review and interview, the administrator failed to be responsible for an ongoing quality assurance program.	N0456	Because QAPI meetings are held every quarter, the QAPI will be updated and reviewed quarterly by the CEO. Administrator will review QAPI guidelines. The CEO performed a one on one teaching and training with the administrator on the agency's QAPI program. The administrator was added to the QAPI committee. The CEO is responsible for ensuring this deficiency does not occur again. See document 4	2022-11-22

The findings include:

Record review on 11/14/2022, evidenced an agency job description revised 05/2009, titled "Executive Director/Administrator" which stated, "... Essential Job Functions/Responsibilities ... Directing and monitoring organizational performance improvement activities ...."

Record review on 11/7/2022, evidenced an agency document titled "Quality Assurance Program" which stated, "... Role of Administrator ... The executive director shall insure that adequate and necessary staffing is provided to carry out the activities described in the Plan ... He/she shall remain apprised of any findings relative to the management and operation of the Corporation ...."

Review of the agency's QAPI (quality assurance performance improvement) plan on 11/14/2022, evidenced QAPI meeting minutes dated

	focus of the QAPI program was decreasing hospitalizations and the number of patients with urinary tract infections and falls. During an interview on 11/7/2022, at 2:25 PM, administrator #1 did not know how often the QAPI committee met. At 3:11 PM, administrator #1 indicated they were not directly involved in QAPI or the QAPI committee. At 3:13 PM, administrator #1 indicated clinical manager #2 and the chief executive officer were responsible for the quality assurance program. When queried what the focus of the quality assurance program was, administrator #1 indicated the chief executive officer or the clinical manager would be the people to ask about that.			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel	N0458	The 2021 Annual Performance Evaluation was completed on 12/18/2021. Unfortunately the binder was not available to the surveyor. Annual Performance Evaluation is completed at the last quarter of every year. Administrator or Clinical Director is responsible in completing such evaluations. The director of nursing will be responsible for ensuring the binder will be available at all times. During in-service on 11/23/2022 staff was reminded of upcoming performance evaluations that will be due in December. . The 2022 Annual Performance Evaluation will be completed in December 2022. 100% of all active personnel	2022-11-23

	records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the home health agency failed to ensure personnel records of employees were kept current and included receipt of job description and/or annual performance evaluations in 5 of 5 personnel records reviewed for direct employees who were employed over 1 year. (#1, 2, 3, 4, 5) The findings include: 1. Record review on 11/14/2022, evidenced an agency job description revised 05/2009, titled "Clinical Director" which stated, "... Conducts clinical performance evaluations annually, or more frequently if indicated ...."		records were reviewed by the director of nursing for this deficient practice. The director of nursing will monitor this monthly until 100% compliance is achieved for three consecutive months. Director of nursing will be responsible for ensuring this deficient practice does not reoccur. See document 5 and 8	

	2. Record review on 11/14/2022, evidenced an agency policy revised 05/2009, titled "Listing of Services Provided" which stated, "... Job descriptions for each position will be maintained by the organization ...." 3. Employee record review on 11/14/2022, evidenced a personnel record for administrator #1, start date 6/17/2019, which failed to include any annual performance evaluations. 4. Employee record review evidenced a personnel record for clinical manager #2, start date 7/25/2019, first patient contact date 8/1/2019, which failed to include any annual performance evaluations. This personnel file failed to include receipt of a signed alternate administrator job description. 5. Employee record review evidenced a personnel record for registered nurse #3, start			

	contact date 8/25/2020, which failed to include any annual performance evaluations. 6. Employee record review evidenced a personnel record for home health aide #4, start date 2/23/2019, first patient contact date 2/27/2019, which failed to include any annual performance evaluations. 7. Employee record review evidenced a personnel record for registered nurse #5, start date 3/31/2021, first patient contact date 4/16/2021, which failed to include any annual performance evaluations. 8. Review on 11/14/2022, of a performance evaluation binder, failed to evidence any annual performance evaluations for 2021 or 2022. 9. During an interview on 11/9/2022, at 4:00 PM, administrator #1 indicated clinical manager #2 was also the			

	should have had a job description in their file for alternate administrator. 10. During an interview on 11/14/2022, at 1:37 PM, administrator #1 indicated performance evaluations were completed annually, and were kept in a binder. At 1:38 PM, clinical manager #2 indicated the evaluations should have been completed yearly, and they were going to complete 2022 evaluations in December.			
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be	N0464	Staff with direct patient care will complete a two step Tuberculin skin test upon hire, and an annual TB questionnaire/screening thereafter. An annual review of employee files will be done to prevent recurring deficiency in the future by the administrator. 100% of all active personnel records were reviewed by the director of nursing for this deficient practice. The director of nursing will monitor this monthly until 100% compliance is achieved for three consecutive months. Administrator will be responsible for ensuring this deficient practice does not reoccur. See document 6.	2022-11-22

	administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on record review and interview, the home health agency failed to ensure all employees with direct patient			

	contact received a baseline tuberculin skin test or chest radiograph upon hire in 1 of 5 employees records reviewed who had direct patient contact (#5) and failed to ensure employees with direct patient contact completed annual tuberculosis screening in 3 of 4 employees with direct patient contact who were employed greater than 1 year. (#2, 3, 4) The findings include: 1. Record review on 11/14/2022, evidenced an agency policy revised 05/2019, titled "Home Health Human Resources" which stated, "... Prior to hire, the organization will secure multiple reference checks, health reports as required by the state or policy ...." 2. Employee record review on 11/14/2022, evidenced a personnel record for clinical manager #2, start date 7/25/2019, first patient contact date 8/1/2019, which failed to include any annual tuberculosis screenings or skin tests.			

	3. Employee record review on 11/14/2022, evidenced a personnel record for registered nurse #3, start date 8/14/2020, first patient contact date 8/25/2020, which failed to include any annual tuberculosis screenings or skin tests. 4. Employee record review on 11/14/2022, evidenced a personnel record for home health aide #4, start date 2/23/2019, first patient contact date 2/27/2019, which failed to include any annual tuberculosis screenings or skin tests. 5. Employee record review on 11/14/2022, evidenced a personnel record for registered nurse #5, start date 3/31/2021, first patient contact date 4/16/2021, which failed to include a baseline tuberculin skin test was completed prior to patient contact. 6. During an interview on 11/14/2022, at 1:36 PM, administrator #1 indicated they			

	required to have had tuberculin skin tests or chest radiographs upon hire and every other year. Administrator #1 then indicated they believed after the baseline tuberculin test was completed, the employees completed screenings, but was unsure of the interval between screenings.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable	N0488	The agency discharge policy was revised on 11/22/2022 to reflect a change that requires a 15 days prior to discharge notice to patient and/or patient representative. Policies and procedure will be reviewed by the administrator annually to prevent recurring deficiency. All clinical staff was updated on DC revision policy during 11/23/2022 in-service. See document 7.	2022-11-23

order, and the home health agency informs the patient of community resources to assist the patient following discharge.

Based on record review and interview, the home health agency failed to develop and implement a policy which required a 15 day prior to discharge notice to the patients in 2 of 2 discharge records reviewed. (#1, 6)

The findings include:

1. Record review on 11/9/2022, evidenced an agency policy revised 12/2010, titled "Discharge Criteria and Process" which stated, "... The organization will verbally notify the patient of the decision to terminate or reduce services within one visit prior to the time

	… Patient, patient's family, legal representative OR significant other will be given at least a five day advance notice of discharge prior to discharge date ….” 2. Clinical record review for Patient #1 was completed on 11/14/2022, for certification period 8/14/2022 – 10/12/2022, discharged 10/12/2022, due to goals being met. Record review evidenced a skilled nurse visit note dated 10/4/2022 (8 days prior to discharge), which indicated discharge planning was discussed with the patient and caregiver. Record review failed to evidence Patient #1 received 15 day prior discharge notice. During an interview on 11/9/2022, at 3:00 PM, clinical manager #2 indicated the discharge policy was to give patient's notice of discharge 1 visit prior, and this was why Patient #1 received notice of discharge 8 days prior to discharging.			

	3. Clinical record review for Patient #6 was completed on 11/14/2022, for certification period 7/21/2022 – 9/18/2022, discharged 9/14/2022, due to goals being met. Record review evidenced skilled nurse visit notes dated 8/30/2022, and 9/6/2022, which failed to evidence the patient received 15-day prior notice of discharge. Record review failed to evidence any notice of discharge was given to the patient. During an interview on 11/14/2022, at 4:00 PM, clinical manager #2 indicated the discharge notice should have been documented in visit notes or a communication note prior to discharge.			
N0520	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.	N0520	Patient #1: patient did not receive physical therapy despite having an order for 3 months of physical therapy. Director of Nursing will ensure therapists are notified properly in regards to physician orders for therapy and therapists will be notified immediately upon receiving physician orders regarding therapy for patients. The administrator will be in charge of monitoring coordination of care upon eval, a week before discharge. and as needed for any patient updates between Director of Nursing, physician, and staff. Patient #2: The patient forgot the nurse's name and what the nurse was doing such as taking vital signs. Director of Nursing had a	2022-11-23

	Based on observation, record review, and interview, the home health agency failed to accept patients for care based on the expectation the patient's health needs could be adequately met by the home health agency in the patient's place of residence in 2 of 5 active clinical records reviewed. (#1, 2) The findings include: 1. Record review on 11/14/2022, evidenced an agency policy revised 10/2011, titled "Admission Criteria and Process" which stated, "... A patient will be accepted for care based on consideration ... Consideration will be given to the adequacy and suitability of organization personnel, resources to provide the required services, and the reasonable expectation that the patient's medical, nursing, rehabilitative, and social needs can be adequately met in the patient's place of residence ...." 2. Clinical record review for Patient #1 was completed on 11/14/2022, for certification periods 8/14/2022 – 10/12/2022, and 10/26/2022 –		one on one teaching and training with nurse 6 regarding medication changes, medication planner, and notifying the physician with any medication discrepancies. on 11/23/2022. In service with staff on 11/23/2022 discussed how to best care for and interact with dementia patients and medication changes. 100% of all active clinical records were reviewed by the director of nursing for this deficient practice. The director of nursing will monitor this monthly until 100% compliance is achieved for three consecutive months. Administrator will be responsible for ensuring this deficient practice does not reoccur. See document 8	

	12/24/2022. Record review evidenced the patient received 1 skilled nurse visit per week and 2 home health aide visits per week for certification period 8/14/2022 – 10/12/2022, and was discharged on 10/12/2022, because goals were met. Record review indicated the patient was re-admitted to home health care on 10/26/2022, and was to receive 1 skilled nurse visit per week and 2 home health aide visits per week for certification period 10/26/2022 – 12/24/2022. Clinical record review evidenced a referral order received 10/24/2022 by the home health agency, which contained a physician order dated 10/11/2022, to continue home health services. This referral indicated the patient was to receive 3 months of physical therapy. Record review failed to evidence a physical therapy evaluation order or any physical therapy visits were conducted during certification period 10/26/2022 – 12/24/2022. During an interview on			

	11/10/2022, at 11:30 AM, person #1 (Patient #1's caregiver), indicated they wanted additional physical therapy, and obtained an order from the physician for therapy, but had not received any visits or heard from the home health agency anything about the physical therapy evaluation.			

	During an interview on 11/14/2022, at 2:13 PM, clinical manager #2 indicated Patient #1 was discharged because they were receiving home health services for so long. Clinical manager #2 indicated they had to discharge patients if they were on service for 3 or more certification periods and re-admit them with a new diagnosis. Clinical manager #2 indicated they were not aware of the physician order to continue home health services. Clinical manager #2 indicated the patient did not receive a physical therapy evaluation or physical therapy services as ordered, but that they would get therapy ordered. Clinical manager #2 did not know why Patient #1 did not receive physical therapy as ordered. 3. Observation of a home visit for Patient #2 was completed on 11/10/2022, at 3:00 PM, to observe a routine skilled nurse visit. Patient #2 was observed to be alert to self and place. The patient appeared to forget the nurse's name and what the nurse was doing, such as taking vital signs. Patient #2 indicated			

	they were married, but did not remember when they were married, or for how long. The patient showed the surveyor all their medication bottles, including tinazidine (muscle relaxer) and amlodipine (to lower blood pressure), which were not included in their plan of care. Patient #2 initially indicated they did not take the tinazidine because it was a pain medication, which they did not want to use. Later, when the nurse was reviewing the patient's medications, Patient #2 indicated they were taking the tinazidine and amlodipine. The nurse instructed Patient #2 not to take the tinazidine or amlodipine because they were not included on the previous medication list, and turned the bottles of medication upside down to remind the patient not to take these medications. After a few minutes, Patient #2 indicated they would take all of the medications, including the tinazidine and amlodipine, and appeared to have forgotten why the bottles had been turned upside down. Patient #2 appeared to be upset because they did not know where their ear medication was located, and repeatedly voiced this concern.			

	Patient #2 appeared to forget the missing ear drops had already been discussed. Patient #2 lived with person #2 (family member). Person #2 arrived home around 3:30 PM. When queried if person #2 knew where Patient #2's ear drops were or what medication they were taking, person #2 indicated they didn't know anything about Patient #2's medication. Person #2 indicated Patient #2 didn't take the medications anyways. Person #2 appeared to be uninterested, irritable, and unwilling to assist with Patient #2's care. Patient #2 appeared increasingly anxious when person #2 arrived home. The nurse did not call the physician or clinical manager during the visit to confirm medication discrepancies, missing ear drop medication, patient's inability to self-manage medications, or need for medication planner. Clinical record review for Patient #2 was completed on 11/14/2022, for certification period 10/21/2022 – 12/19/2022. Record review evidenced a physician referral			

	order dated 10/11/2022, which indicated the patient was to receive home health skilled nursing for medication management. Record review evidenced a history and physical dated 9/28/2022, which stated, "... Daughter states pt [patient] is in need of help w/ [with] managing medications] ...."			

	Clinical record review evidenced a start of care assessment dated 10/21/2022, which indicated the patient was confused, forgetful, and had dementia (disease affecting memory and cognition). This document indicated Patient #2 was able to take medication at the correct times if given reminders by another person at the appropriate time. This document indicated person #2 was Patient #2's caregiver and was currently providing assistance. This document indicated the patient and caregiver demonstrated skills to self-manage disease process, including medication management. Clinical record review evidenced a plan of care for certification period 10/21/2022 – 12/19/2022, which indicated the nurse was to visit 1 time per week, and to complete a medication review each visit and reconcile medications. Record review failed to evidence any communication with the clinical manager or physician after the 11/10/2022, skilled nurse visit regarding			

patient's and caregiver's inability to manage medications and need for medication planner or additional assistance.

During an interview on 11/10/2022, at 3:15 PM, licensed practical nurse #6 indicated Person #2 lived with Patient #2, but was not much help, because they had their own mental and physical health issues like Patient #2.

During an interview on 11/14/2022, at 2:42 PM, clinical manager #2 indicated they had completed the start of care assessment and did not see tinazidine or amlodipine. Clinical manager #2 indicated the pharmacy was supposed to have called the patient if there were new medications. Clinical manager #2 indicated they would order the patient a medication planner and indicated the patient should have received more assistance. Clinical manager #2 indicated the nurse should have called the physician with any medication discrepancies.

N0522	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview, the home health agency failed to ensure a written plan of care was established and/or care followed the plan of care in 3 of 5 active clinical records reviewed. (#1, 3, 4) The findings include: 1. Record review evidenced an agency policy revised 4/2011, titled "Care Planning Process" which stated, "... A written plan of care will be initiated within five days of start of care ... The plan of care will be based upon the physician's orders ...." 2. Clinical record review for	N0522	Patient #1: No written plan of care was established within 5 days of Start of Care, an in-service with staff on 11/23/2022 was held to discuss how to properly document Plan of Care and timeline for completing Plan of Care. Director of Nursing will review new patient charts and referrals to coordinate with visiting nurse to make sure plan of care is completed on time which is within 5 days after start of care. This missing plan of care was completed in the chart. 100% of all active clinical records were reviewed by the director of nursing for this deficient practice. The director of nursing will monitor this monthly until 100% compliance is achieved for three consecutive months. Director of nursing will be responsible for ensuring this deficient practice does not reoccur.	2022-11-23

	11/14/2022, for certification period 10/26/2022 – 12/24/2022. Record review evidenced a start of care assessment was conducted on 10/26/2022. Record review on 11/9/2022, failed to evidence a written plan of care was established. Record review evidenced the patient received skilled nursing visits on 11/1/2022, and 11/8/2022, and home health aide visits on 10/28/2022, 11/2/2022, 11/4/2022, and 11/9/2022, with no written plan of care. During an interview on 11/9/2022, at 10:38 AM, administrator #1 indicated the plan of care should have been completed within 1 week of the initiation of care. At 10:39 AM, clinical manager #2 indicated the plan of care for Patient #1 was not completed, and the nurse and home health aide were probably providing services based on a previous plan of care. Clinical manager #2 indicated they had reached out to the registered nurse responsible for completing the plan of care, and it would be			

	day. 3. Clinical record review for Patient #3 was completed on 11/14/2022. Record review evidenced a plan of care for certification period 11/8/2022 – 1/6/2022, which indicated the patient was to receive physical therapy visits 3 times per week for 2 weeks. Record review evidenced the patient received only 2 physical therapy visits the week of 11/6/2022. During an interview on 11/14/2022, at 2:55 PM, clinical manager #2 indicated they did not know why Patient #3 did not receive 3 physical therapy visits the week of 11/6/2022. 4. Clinical record review for Patient #4 was completed on 11/14/2022. Record review evidenced a plan of care for certification period 10/4/2022 – 12/2/2022, signed by the registered nurse on 10/4/2022, which indicated the patient was to receive 2 home health aide			

	evidenced the patient did not receive any home health aide visits for the week of 10/2/2022. During an interview on 11/14/2022, at 3:10 PM, administrator #1 indicated they did not know why Patient #4 didn't receive any home health aide visits the week of 10/2/2022.			
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.	N0524	Director of Nursing conducted an in-service on 11/23/2022 to all nursing staff regarding medication profile in plan of care, to properly document medications, correct frequency as well as indications. Every 30 days a review of medication profiles will be done by director of nursing to ensure this deficiency does not recur. Patient #1 medication profile was updated, and plan of care was revised to include wheelchair and grab bar. Patient #2 medication profile was updated. Patient #3 medication profile was also updated to include indication for medication and plan of care was updated as to include cane and cooling pad. Patient #4 plan of care was updated to include lymphedema as one of the diagnoses, and medication profile was updated to include dosage of Glipizide.	2022-11-23

	(viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on observation, record review, and interview, the home health agency failed to ensure the medical plan of care included all pertinent diagnoses, types of services and equipment required, and all medications and treatments in 4 of 5 active clinical records reviewed. (#1, 2, 3, 4) The findings include: 1. Record review on 11/9/2022, evidenced an agency policy revised 4/2011, titled "Care Planning Process" which stated, "... The clinical plan of care includes: ... Pertinent primary and secondary diagnoses ... Medications and treatments ... Supplies and equipment required ...."		100% of all active clinical records were reviewed by the director of nursing for this deficient practice. The director of nursing will monitor this monthly until 100% compliance is achieved for three consecutive months. Director of nursing will be responsible for ensuring this deficient practice does not reoccur.	

	2. Observation of a home visit for Patient #1 was conducted on 11/10/2022, at 11:00 AM, to observe a routine home health aide visit. During the home visit a bottle of Desitin (cream for diaper rash, or irritated skin) was observed. During the visit, all of the patient's medication bottles were reviewed. A bottle of glipizide (to lower blood sugar) was observed, which was not included in the plan of care. A bottle of aspirin 325 milligrams prescribed once daily was observed in the home, and metformin (medication to lower blood sugar) 1000 milligrams in the morning and 500 milligrams in the evening. Observation failed to evidence the patient was taking isosorbide (medication to lower blood pressure) or loperamide (to reduce diarrhea). A wheelchair and grab bars were observed during the visit. Clinical record review for Patient #1 was completed on 11/14/2022. Record review evidenced a plan of care for certification period 10/26/2022			

	– 12/24/2022, which included the following medications which the patient was not taking: isosorbide and loperamide, and the following medications with different dosages: aspirin 162 milligrams once daily and metformin 500 milligrams once daily. The plan of care failed to include a wheelchair or grab bars. During an interview on 11/14/2022, at 2:22 PM, clinical manager #2 indicated the plan of care should have included all medication the patient was taking at home. Clinical manager #2 indicated the nurse should have included all the bottles of medication in the home on the plan of care. Clinical manager #2 indicated the plan of care should have included the grab bars and wheelchair. 3. Observation of a home visit for Patient #2 was conducted on 11/10/2022, at 3:00 PM, to observe a routine skilled nurse visit. During the visit, the patient's medication bottles were observed. The following			

	medications were observed which were not included in the plan of care: Biofreeze (ointment for pain), tinazidine (muscle relaxer), and amlodipine (to lower blood pressure). Clinical record review for Patient #2 was completed on 11/14/2022. Record review evidenced a plan of care for certification period 10/21/2022 – 12/19/2022, which indicated the patient was taking rosuvastatin (medication for cholesterol) and failed to include Memantine (medication to improve memory loss and confusion). Record review evidenced a referral/history and physical dated 9/28/2022, which indicated the patient had been prescribed Memantine, and did not take Rosuvastatin. This document indicated the patient was to continue taking amlodipine and tinazidine. During an interview on			

	11/14/2022, at 2:32 PM, clinical manager #2 indicated the nurses should review all the medication bottles in the patient's home, and those medications should have been included in the plan of care. 4. Observation of a home visit for Patient #3 was completed on 11/14/2022, to observe a routine physical therapy visit. During the visit, a cane and a cooling pad/machine was observed in the home. The patient indicated they used the cane for ambulation, and the cooling pad on the left knee, after surgery on 11/7/2022. During the visit, the patient's medications were observed, which included oxycodone 5 milligrams 1 tablet every 4 – 6 hours for pain, and metoprolol 25 milligrams, ½ tablet twice per day. Clinical record review for Patient #3 was completed on 11/14/2022. Record review evidenced a plan of care for certification period 11/8/2022 – 1/6/2022, which indicated the patient was taking losartan (to			

	lower blood pressure) and hydrochlorothiazide (to lower blood pressure). The plan of care failed to include the diagnosis of hypertension (high blood pressure). The plan of care failed to include a cane or cooling pad. The plan of care included an order for oxycodone (medication for pain) 5 milligrams, 1 tablet every 4 – 6 hours as needed. The plan of care failed to include an indication for pain medication. The plan of care included an order for metoprolol (to lower heart rate and blood pressure) 25 milligrams 1 time per day. During an interview on 11/14/2022, at 8:30 AM, Patient #3 indicated they had a diagnoses of high blood pressure. During an interview on 11/14/2022, at 2:57 PM, clinical manager #2 indicated because Patient #3 was receiving home health after a knee replacement surgery, the nurse didn't need to add other diagnoses. Clinical			

	of care should have included the supplies the patient used in the home. At 2:59 PM, clinical manager #2 indicated a complete medication order should have included the indication for an as needed medication. Clinical manager #2 indicated the plan of care should have indicated the oxycodone was for pain. Clinical manager #2 indicated the plan of care should have included metoprolol 25 milligrams, ½ tablet twice daily. 5. Clinical record review for Patient #4 was completed on 11/14/2022, for certification period 10/4/2022 – 12/2/2022. Record review evidenced a referral order/history and physical dated 9/14/2022, which indicated the patient had a diagnosis of lymphedema (swelling caused by lymphatic system blockage). This document indicated the patient had high blood pressure and was to report any sustained blood pressure greater than 140/90. This document indicated the patient was to elevate the lower extremities			

	day to decrease lymphedema and monitor sodium intake, and intake and output. Clinical record review evidenced a plan of care for certification period 10/4/2022 – 12/2/2022, which failed to include diagnoses of lymphedema, orders to elevate legs, or monitor intake and output. This document indicated the clinician was to notify the physician if the blood pressure was greater than 160/90. The plan of care included an order for glipizide (medication to lower blood sugar) but failed to include the dose. During an interview on 11/14/2022, at 3:08 PM, clinical manager #2 indicated maybe the orders from the referral/history and physical were not included in the plan of care because it was what the physician's office was doing, not what the home health agency was supposed to do. Clinical manager #2 indicated the diagnosis of lymphedema should have been included in the plan of care. At 3:28 PM,			

	clinical manager #2 indicated the plan of care should have included a dose of glipizide.			
N0537	Scope of Services 410 IAC 17-14-1(a) Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on observation, record review, and interview, the home health agency failed to ensure nursing services were provided in accordance with the medical plan of care in 4 of 6 clinical records reviewed. (#2, 4, 5, 6) The findings include: 1. Record review on 11/9/2022, evidenced an agency policy revised 4/2011, titled "Care Planning Process" which stated, "... The plan of care will be based upon the physician's orders and will encompass the equipment, supplies, and services required to meet the patient's needs ...."	N0537	Director of nursing completed a one on one with nurse #6 regarding complete physical assessment. Director of nursing conducted an in-service on 11/23/2022 to all nursing staff on proper physical assessment, including mental/neuro assessment especially to patients with dementia. In-service included wound care, assessment, proper documentation, wound care order per physician. In-service also included prompt notification to physician about vital signs outside parameters and proper documentation. To prevent this from happening again, director of nursing will go with nurse #6 once a week for 4 weeks to ensure plan of care is being followed and an assessment is being completed. 100% of all active clinical records were reviewed by the director of nursing for this deficient practice. The director of nursing will monitor this monthly until 100% compliance is achieved for three consecutive months. Director of nursing will be responsible for ensuring this deficient practice does not reoccur. See document 8	2022-11-23

	2. Record review on 11/14/2022, evidenced an agency policy revised 5/2009, titled "Registered Nurse" which stated, "... Initiates the plan of care ...." 3. Record review on 11/14/2022, evidenced an agency policy revised 5/2009, titled "Licensed Practical/Vocational Nurse" which stated, "... Implements the plan of care initiated by the registered nurse ...." 4. Observation of a home visit for Patient #2 was completed on 11/10/2022, at 3:00 PM, to observe a routine skilled nurse visit. During the visit, the nurse failed to perform a complete physical assessment, as ordered in the plan of care, including, skin assessment, peripheral pulse assessment, or assessment of edema. Patient #2 appeared to be alert to person, place, and occasionally situation. The nurse failed to complete an assessment focused on dementia (disease affecting memory and			

	cognition), as ordered in the plan of care, including asking patient questions to confirm orientation level. Clinical record review for Patient #2 was completed on 11/14/2022. Record review evidenced a plan of care for certification period 10/21/2022 – 12/19/2022. The plan of care indicated the skilled nurse was to visit 1 time per week and perform a complete physical assessment each visit, with emphasis on dementia. This document indicated the skilled nurse was to assess cardiovascular status. During an interview on 11/14/2022, at 2:49 PM, clinical manager #2 indicated the nurse maybe didn't assess the patient's skin, peripheral pulse, or edema because the primary diagnosis was dementia. 5. Clinical record review for Patient #4 was completed on 11/14/2022. Record review			

dated 10/4/2022, which indicated the nurse was to apply a mepilex (self-adherent dressing) twice weekly to wounds. Record review evidenced a plan of care for certification period 10/4/2022 – 12/2/2022, which indicated the nurse was to perform the following wound care to gluteal/thigh wounds: cleanse/irrigate with wound cleanser, apply Silvadene (wound topical ointment), cover with large self-adhering dressing.

Clinical record review evidenced skilled nurse visit notes for the following dates, which indicated the nurse applied gauze dressings, instead of self-adherent dressing: 10/8/2022, 10/11/2022, 10/20/2022, 10/24/2022, 11/3/2022, and 11/5/2022.

During an interview on 11/14/2022, at 3:16 PM, clinical manager #2 indicated the nurse should have completed wound care as ordered. Clinical manager #2 did not know why

	applying a self-adherent dressing as ordered. 6. Clinical record review for Patient #5 was completed on 11/14/2022. Record review evidenced a plan of care for certification period 9/28/2022 – 11/26/2022, which indicated the skilled nurse was to visit the patient 2 times per week to assess the surgical site for healing/complications, complete dressing care to abdominal incision, and perform a complete physical assessment every visit. Record review evidenced skilled nursing visit notes dated, 9/30/2022, 10/3/2022, 10/10/2022, 10/13/2022, 10/17/2022, and 10/21/2022, which all failed to include any wound assessment, dressing care completed, or wound measurements. During an interview on 11/14/2022, at 3:41 PM, clinical manager #2 indicated they did			

not documented or performed, or the wound wasn't assessed or measured as ordered on the plan of care. Clinical manager #2 indicated the nurses should have documented every visit on wound measurements, appearance, drainage, and what dressing was applied.

7. Clinical record review for Patient #6 was completed on 11/14/2022. Record review evidenced a plan of care for certification period 7/21/2022 – 9/18/2022, which indicated the clinician was to notify the physician of heart rate less than 60.

Record review evidenced a skilled nurse visit note dated 8/30/2022, which indicated Patient #6's heart rate was 58. Record review failed to evidence the physician was notified as ordered on the plan of care.

Record review evidenced a discharge visit note dated 9/14/2022, which indicated the

	patient's heart rate was 55. Record review failed to evidence the physician was notified of the heart rate outside of plan of care parameters. During an interview on 11/14/2022, at 3:45 PM, clinical manager #2 indicated the physician should have been notified of any vital signs outside of parameters on the plan of care.			
N0541	Scope of Services 410 IAC 17-14-1(a)(1)(B) Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview, the home health agency failed to ensure the registered nurse regularly re-evaluated the patient's nursing needs in 1 of 2 active clinical records reviewed for patients who received only skilled nursing services. (#5)	N0541	Director of nursing conducted an in-service to all nursing staff regarding proper assessment and documentation on wounds (addressing patient #5) Training will be provided to all new hires and also to current staff by the director of nursing to prevent future deficiency. 100% of all active clinical records were reviewed by the director of nursing for this deficient practice. The director of nursing will monitor this monthly until 100% compliance is achieved for three consecutive months. Director of nursing will be responsible for ensuring this deficient practice does not reoccur.	2022-11-25

The findings include:

Record review on 11/14/2022, evidenced an agency policy revised 12/2021, titled "Ongoing Assessments" which stated, "... During each home visit, the appropriate clinical will re-evaluate the patient according to the problems identified during the initial visit and thereafter ... The clinician will reassess the patient for ... Skin integrity ... Progress toward goals and patient needs and problems ...."

Clinical record review for Patient #5 was completed on 11/14/2022, for certification period 9/28/2022 – 11/26/2022. Record review evidenced a skilled nurse visit note signed and dated by licensed practical nurse #6, on 9/26/2022, which indicated the patient's abdominal wound was dry and healed but failed to evidence the supervising nurse was notified of the healed wound.

Record review evidenced a

	recertification assessment signed and dated by registered nurse #5, on 9/27/2022, which failed to evidence the patient's wound was healed. This document indicated the abdominal wound measured 9.5 cm (centimeters) x 1.5 cm x 1 cm. During an interview on 11/14/2022, at 3:42 PM, clinical manager #2 indicated they did not know why the nurse documented wound measurements if the wound was healed. Clinical manager #2 indicated they did not know if the registered nurse assessed the wound or not. Clinical manager #2 indicated the wound may have been healed if the licensed practical nurse documented it was healed the day before the recertification.			
N0542	Scope of Services 410 IAC 17-14-1(a)(1)(C) Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:	N0542	Patient #5 plan of care was updated to reflect healed wound status. In-service on 11/23/2022 by director of nursing was conducted about proper wound assessment, documentation, and importance of notifying patient's physician on wound status. Director of nursing will have weekly case conferences on any wound care patients with staff to ensure proper wound care is being completed and documented. 100% of all active clinical records were reviewed by the	2022-11-23

	(C) Initiate the plan of care and necessary revisions. Based on record review and interview, the home health agency failed to ensure the registered nurse implemented necessary revisions to the plan of care in 1 of 2 active clinical records reviewed for patients receiving only skilled nursing services. (#5) The findings include: Record review on 11/14/2022, evidenced an agency policy revised 12/2010, titled "Continuity of Care" which stated, "... The clinician will be responsible for ... Updating the plan of care ...." Clinical record review for Patient #5 was completed on 11/14/2022, for certification period 9/28/2022 – 11/26/2022. Record review evidenced a skilled nursing visit note dated 9/26/2022, which indicated the patient's wound was healed. Record review evidenced a plan of care for certification period		director of nursing for this deficient practice. The director of nursing will monitor this monthly until 100% compliance is achieved for three consecutive months. Director of nursing will be responsible for ensuring this deficient practice does not reoccur. See document 8	

	9/28/2022 – 11/26/2022, which indicated the patient was to receive skilled nursing visits 2 times per week to complete wound and dressing care to an abdominal surgical wound. This document failed to be revised to reflect the patient's healed wound status. During an interview on 11/14/2022, at 3:50 PM, clinical manager #2 indicated the plan of care should have been updated to reflect the healed wound and removed the wound care orders.			
N0544	Scope of Services 410 IAC 17-14-1(a)(1)(E) Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes.	N0544	Plan of care for patient #1 was updated/revised to reflect the correct start of care date by calling Axxess. Patient #3 plan of care was also updated to reflect integumentary assessment regarding surgical incision. In-service on 11/23/2022 by director of nursing to all nursing staff on proper and accurate assessment and documentation. To prevent this from happening again, director of nursing will have weekly case conferences on any wound care patients with staff to ensure proper wound care is being completed and documented. 100% of all active clinical records were reviewed by the director of nursing for this deficient practice. The director of nursing will monitor this monthly until 100% compliance is achieved for three consecutive months. Director of nursing will be responsible for ensuring this deficient practice does not reoccur. See document 8	2022-11-23

Based on record review and interview, the home health agency failed to ensure the registered nurse prepared accurate and complete clinical notes in 3 of 5 active clinical records reviewed. (#1, 3, 4)

The findings include:

1. Record review on 11/14/2022, evidenced an agency policy revised 05/2009, titled "Registered Nurse" which stated, "... Essential Job Functions/Responsibilities ... Prepares clinical notes ...."

2. Clinical record review for Patient #1 was completed on 11/14/2022. Record review evidenced a plan of care completed by registered nurse #5 on 8/10/2022, for certification period 8/14/2022 – 10/12/2022, which indicated the patient's start of care date was 10/26/2022.

During an interview on 11/14/2022, at 2:03 PM, clinical manager #2 indicated the plan of care included the incorrect start of care date and was not

	sure why. 3. Clinical record review for Patient #3 was completed on 11/14/2022, for certification period 11/8/2022 – 1/6/2022. Record review evidenced a start of care assessment dated and signed by the registered nurse on 11/8/2022, which indicated the patient had an observable surgical wound from a recent left knee replacement surgery, which still had the operative dressing in place, and also indicated the patient had no integumentary problems identified. During an interview on 11/14/2022, at 2:53 PM, clinical manager #2 indicated the documentation that no integumentary issues were identified was incorrect, and the nurse should have noted in integumentary section that patient had an incision. 4. Clinical record review for Patient #4 was completed on 11/14/2022, for certification			

	period 10/4/2022 – 12/2/2022. Record review evidenced skilled nurse visit notes dated and signed by registered nurse #5 on 10/4/2022, 10/8/2022, 10/11/2022, 10/20/2022, 10/24/2022, 11/3/2022, and 11/5/2022, which all stated, "... Awaiting orders from ... NP [nurse practitioner] for further orders; right now we are using Silvadene and covering with gauze ...." During an interview on 11/14/2022, at 3:15 PM, clinical manager #2 indicated the nurse was not documenting accurately.			
N0559	Scope of Services 410 IAC 17-14-1(a)(2)(G) Rule 14 Sec. 1(a) (2) (G) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (G) Inform the physician, dentist, chiropractor, podiatrist, or optometrist of changes in the patient's condition and needs after consulting with the supervising registered nurse. Based on record review and interview, the home health agency failed to ensure	N0559	Director of nursing conducted a one on one with nurse #6 regarding significant changes of patient's condition. An in-service was held on 11/23/2022 to all nursing staff about communication between staff and physician about patient's condition or changes thereof. Director of nursing will ensure this doesn't happen again by having case conferences weekly with staff. 100% of all active clinical records were reviewed by the director of nursing for this deficient practice. The director of nursing will monitor this monthly until 100% compliance is achieved for three consecutive months. Director of nursing will be responsible for ensuring this deficient practice does not reoccur. See document 8	2022-11-23

licensed practical nurses consulted with the supervising registered nurse and informed the physician of changes in patient's condition or needs in 2 of 2 active clinical records reviewed in which the patient only received skilled nursing services. (#2, 5)

The findings include:

1. Record review on 11/14/2022, evidenced an agency policy revised 12/2010, titled "Monitoring Patient's Response/Reporting to Physician" which stated, "... The patient's physician will be contacted on the same day when any of the following occur: ... Significant changes in the patient's condition ... Changes in the patient's expected response to treatment or medications ...."

2. Record review on 11/14/2022, evidenced an agency policy revised 12/2010, titled "Continuity of Care" which stated, "... The clinician will be responsible for: ... Communicating with all personnel caring for the patient

	including the physician … Communicating changes in orders and findings to the Clinical Supervisor or designee, or other team members as necessary ….” 3. Clinical record review for Patient #2 was completed on 11/14/2022, for certification period 10/21/2022 – 12/19/2022. Record review evidenced a start of care assessment dated 10/21/2022, which indicated no respiratory problems were identified. Record review evidenced a licensed practical nurse visit note dated 10/27/2022, which indicated the patient was experiencing dyspnea. Record review failed to evidence the licensed practical nurse communicated with the supervising registered nurse or the physician regarding the change in respiratory status. During an interview on 11/14/2022, at 2:47 PM, clinical			

	physician should have been notified of severe dyspnea. 4. Clinical record review for Patient #5 was completed on 11/14/2022. Record review evidenced a plan of care for certification period 9/28/2022 - 11/26/2022, which indicated the patient was receiving skilled nursing visits 2 times per week for dressing changes to a surgical abdominal wound. Record review evidenced a licensed practical nurse visit note dated 9/26/2022, which indicated the patient's wound was dry and healed. Record review failed to evidence the supervising nurse or physician was notified of the change in wound status. Record review evidenced the patient was recertified on 9/27/2022, for skilled nursing 2 times per week for dressing changes to the abdominal wound. During an interview on 11/14/2022, at 3:42 PM, clinical manager #2 indicated the			

	licensed practical nurse should have notified the clinical manager and the physician if the wound was healed, because maybe the patient wouldn't have needed to be recertified.			
N0608	Clinical Records 410 IAC 17-15-1(a)(1-6) Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the home health agency failed to ensure clinical notes were written the day	N0608	Director of nursing conducted an in-service 11/23/2022 on importance of prompt documentation on all skilled nursing visits and plan of care to be developed within 5 days from start of care. Director of nursing will pull a report off Axxess weekly regarding any visits not completed on time. Director of nursing will review report and notify staff of any visits that are saved an not completed. 100% of all active clinical records were reviewed by the director of nursing for this deficient practice. The director of nursing will monitor this monthly until 100% compliance is achieved for three consecutive months. Director of nursing will be responsible for ensuring this deficient practice does not reoccur. See document 8	2022-11-23

	incorporated into the clinical record within 14 days in 1 of 5 active clinical records reviewed. (#1) The findings include: Record review on 11/14/2022, evidenced an agency policy revised 12/2010, titled "Contents of Clinical Record" which stated, "... The following information will be available in the clinical record for patients receiving skilled care: ... Legible, complete, and individualized diagnostic and therapeutic orders authenticated within the time frame defined by the organization or according to law and regulation ... signed and dated progress notes for each discipline ...." Clinical record review for Patient #1 was completed on 11/14/2022, for certification period 10/26/2022 – 12/24/2022. Record review on 11/9/2022, indicated the patient received skilled nursing visits on 10/26/2022, 11/1/2022, and 11/8/2022, and home health aide visits on 10/28/2022, 11/2/2022, and 11/4/2022.			

	Record review evidenced all the visit notes were blank, not completed, unsigned, and had not been started. Record review failed to evidence any documentation regarding patient assessment, interventions completed, or orders. Record review on 11/9/2022, failed to evidence a plan of care for certification period 10/26/2022 – 12/24/2022. During an interview on 11/7/2022, at 10:50 AM, administrator #1 indicated clinicians were expected to submit all documentation within 24 hours of the visit. Administrator #1 indicated the clinicians documented directly in an electronic medical record. During an interview on 11/9/2022, at 10:38 AM, administrator #1 indicated the visit notes should have been completed and available in the medical record. Administrator #1 indicated the agency knew the nurse and home health aide were completing the scheduled			

	family would have called if the employees were not showing up for visits.			
N0610	Clinical Records 410 IAC 17-15-1(a)(7) Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. Based on record review and interview, the home health agency failed to ensure documentation was appropriately authenticated and dated in 3 of 5 active clinical records reviewed. (#1, 4, 5) The findings include: 1. Record review on 11/14/2022, evidenced an agency policy revised 12/2010, titled "Contents of Clinical Record" which stated, "... The following information will be available in the clinical record for patients receiving skilled care: ... Signed and dated progress notes for each discipline ... Consents for	N0610	Director of nursing conducted in-service on 11/23/2022 to all nursing staff about discharge notice to patients which is 15 days prior to expected date of discharge from agency. Also included in the in-service is Medicare non-coverage or change of care notice forms. Staff should not ask patients to sign such forms without dating the documents. To ensure the consents are up to date, director of nursing will perform weekly audit on patient charts. 100% of all active clinical records were reviewed by the director of nursing for this deficient practice. The director of nursing will monitor this monthly until 100% compliance is achieved for three consecutive months. Director of nursing will be responsible for ensuring this deficient practice does not reoccur. See document 8	2022-11-23

	regulation and organization policy ...." 2. Record review on 11/14/2022, evidenced an agency policy revised 12/2021, titled "Clinical Record Review" which stated, "... Clinical records will be reviewed at least quarterly by qualified organization personnel to assure that documentation entered is reliable, timely, valid, and accurate ...." 3. Record review on 11/14/2022, evidenced an agency policy revised 5/2009, titled "Medicare Written Notices" which stated, "... Patients who incur financial liability must be notified in writing within 30 calendar days from the date the organization is notified of any changes from payers ... Medicare patients must be provided with timely, accurate, and comprehensible written notices in any case where a reduction or termination of services is to occur, or where services are to be denied before being initiated ... When the home health agency plans to stop furnishing all home health services to a			

	patient because it expects that Medicare will not continue to pay for the services, they must provide a completed Generic Expedited Determination Notice entitled 'Notice of Medicare Provider Non-Coverage' … to the patient prior to terminating services … After reading the 'Notice of Medicare Provider Non-Coverage … the patient and his/her representative must sign and date the form indicating they have received the notice and understand they can appeal the decision ….” 4. Clinical record review for Patient #1 was completed on 11/14/2022, for certification period 10/26/2022 – 12/24/2022. Review of the electronic medical record on 11/9/2022, evidenced a skilled nurse visit note dated and electronically signed by registered nurse #5 on 9/27/2022, which failed to include documentation of discharge notice. The surveyor requested this document be printed at 11:45 AM on 11/9/2022, and received the printed visit note at 12:15 PM.			

	note dated 9/27/2022, had been changed to include discharge discussion with the patient. This printed visit note failed to be authenticated with a signature or date. Clinical record review on 11/9/2022, evidenced an activity log printed by administrator #1 for the skilled nurse visit note dated 9/27/2022, which indicated the visit note was submitted with signature by registered nurse #5 on 10/2/2022, and completed by clinical manager #2 on 10/4/2022. This activity log indicated the visit note was reopened on 11/9/2022, at 11:52 AM by clinical manager #2. Clinical record review on 11/14/2022, evidenced a consent form titled "Notice of Medicare Non-Coverage" which was signed by the patient, but not dated, and was blank. This consent failed to be completed to include the date after which insurance would not pay for services.			

Clinical record review on 11/14/2022, evidenced a consent form titled "Home health Change of Care Notice" which was signed by the patient, but not dated, and was blank. This consent failed to be completed to include what home health services were changing.

During an interview on 11/14/2022, at 2:08 PM, clinical manager #2 indicated the visit note should have been signed and dated by the nurse. Clinical manager #2 indicated they had noticed the nurse had not documented a two week discharge notice on the 9/27/2022 visit note, so they told the nurse to update it when the surveyor had inquired about how much discharge notice was required for patients. At 3:05 PM, administrator #1 indicated they did not know why the patients would be given a blank consent form to sign. Administrator #1 indicated they would have to speak to the nurse who was having patients sign them. Clinical manager #2

	indicated the patients should not have signed a blank notice of Medicare non-coverage or change of care notice. Clinical manager #2 indicated these documents should have been dated and completed. 5. Clinical record review for Patient #4 was completed on 11/14/2022, for certification period 10/4/2022 – 12/2/2022. Record review evidenced a consent form titled "Notice of Medicare Non-Coverage" which was signed by the patient, but not dated, and was blank. This consent failed to be completed to include the date after which insurance would not pay for services. Clinical record review evidenced a blank consent form titled "Home health Change of Care Notice" which was signed by the patient, but not dated, and was blank. This consent failed to be completed to include what home health services were changing.			

	6. Clinical record review for Patient #5 was completed on 11/14/2022, for certification period 9/28/2022 – 11/26/2022. Record review evidenced a consent form titled "Notice of Medicare Non-Coverage" which was signed by the patient, but not dated, and was blank. This consent failed to be completed to include the date after which insurance would not pay for services. Clinical record review evidenced a blank consent form titled "Home health Change of Care Notice" which was signed by the patient, but not dated, and was blank. This consent failed to be completed to include what home health services were changing.			
N9999	Final Observations Review of Indiana Code 16-27-2.5 stated "... Section	N9999	Administrator will review employee file annually. Agency has signed up with Working Well and they will be in charge of conducting annual random drug testing on unlicensed employees with direct patient contact. In service on 11/23/2022 for drug screening. To ensure this doesn't happen again administrator will perform annual audits on drug testing for all unlicensed employees. See documents 8 and 9	2022-11-28

2.(b) A home health agency shall randomly test: (1) at least fifty percent (50 %) of the home health agency's employees who: (A) have direct contact with patients; and (B) are not licensed by a board or commission under IC 25; at least annually; or (2) when the home health agency has reasonable suspicion that an employee is engaged in the illegal use of a controlled substance...."

Based on record review and interview, the home health agency failed to perform random, annual drug tests on at least 50% of unlicensed employees with direct patient contact in 1 of 1 home health aides employed by the agency. (#4)

The findings include:

Record review on 11/14/2022, evidenced an undated agency policy titled "Home Health Care Agency Employee Drug Testing

agency must, on an annual basis, randomly test at least 50% of the agency's employees who meet both of the following: ... Provides direct patient care or has direct contact with a patient; AND ... Is NOT licensed by a board or commission under Ind. Code 25 ...."

Employee record review on 11/14/2022, indicated home health aide #4 was the only employee who was unlicensed and provided direct patient care. Record review evidenced a personnel record for home health aide #4, start date 2/23/2019, first patient contact date 2/27/2019, which included 2 drug screens dated 8/29/2019, and 3/11/2020. The personnel file and additional record review failed to evidence annual drug testing was completed for years 7/1/2020 – 6/30/2021, or 7/1/2021 – 6/30/2022.

During an interview on 11/10/2022, at 10:04 AM, administrator #1 indicated the agency only had 1 home health aide and they should have been

	drug tested annually.			

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
Jordan Mora	Administrator	12/5/2022 10:41:05 AM