STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157034	A. BUILDING B. WING	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HOMECARE NORTHWEST	502 MARQUETTE STREET, VALPARAISO, IN, 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 1/23/2023, 1/24/2023, 1/25/2023, 1/26/2023, 1/27/2023, 1/30/2023, 1/31/2023, 2/1/2023, and 2/2/2023 Facility ID: IN005259	E0000		2023-03-17
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey. Facility ID: IN005259 Survey Dates: 1/23/2023, 1/24/2023, 1/25/2023, 1/26/2023, 1/27/2023, 1/30/2023, 1/31/2023, 2/1/2023, and 2/2/2023. Census: 184 Indiana Homecare Northwest, is precluded from providing its own home health aide training and competency evaluation for a period of two years from 2/2/2023 - 2/1/2024,	G0000		2023-03-17

	due to being found out of compliance with Conditions of Participation: 42 CFR 484.55 Comprehensive assessment of patients and 42 CFR 484.60 Care Planning, Coordination of Care and Quality of Care. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Quality Review Completed 02/16/2023			
N0000	Initial Comments This visit was for a State relicensure survey. Facility ID: IN005259 Survey Dates: 1/23/2023, 1/24/2023, 1/25/2023, 1/26/2023, 1/27/2023, 1/30/2023, 1/31/2023, 2/1/2023, and 2/2/2023. Census: 184	N0000	See following responses	2023-03-17
E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at	E0017	Emergency Preparedness Plan was updated for patients # 1, 2, 4, and 6. Emergency Preparedness Plan was completed for patient # 5. During a mandatory staff meeting held on 2/20/23, the Regional Vice-President (RVP)	2023-03-17

	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. Based on observation, record review, and interview, the home health agency failed to ensure patients received an individualized emergency preparedness plan as part of the comprehensive assessment in 5 of 7 home visits conducted. (#1, 2, 4, 5, 6) The findings include: 1. Record review evidenced an agency policy revised 3/1/2022, titled "Patient Assessment, Initial, and Reassessment" which stated, "... Upon admission and reassessments, the qualified clinician performs the following assessment activities and collects the following data: ... Emergency disaster plan ...."		instructed all clinical staff using Policy # 9.001 Emergency Preparedness / Operations Plan and 2.1.002 Patient Assessment, Initial and Reassessment with emphasis on ensuring all patients have an individualized emergency preparedness plan, and the Patient Disaster Plan Identification Form is completed in its entirety, and a copy is present in each patient's home. For any staff not present, the Vice President of Operations or designee will provide instructions to the individual employees by 2/25/23. All active patients will be evaluated for the presence of a complete Patient Disaster Plan Identification Form. Those found to be incomplete or missing will be completed. Upon admission and reassessments, the qualified clinician evaluates patients according to their care/transport/evacuation needs using the Patient Disaster Plan Identification Form. A copy is maintained in the home and agency. Upon receipt, the Business Manager (BM) or , will review to ensure the Patient Disaster Plan Identification Form is complete. For those found incomplete, the assessing clinician will make the necessary corrections. The BM, or designee, will run a Census Report weekly to ensure all patients have a Patient	

	2. Observation of a home visit for Patient #1 was completed on 1/25/2023, at 8:30 AM, to observe a routine skilled nurse visit. During the visit, the patient's home binder was reviewed. The home binder included an emergency plan which indicated the evacuation location was the nearest hotel, but failed to be individualized to specify which hotel, or include an address. During an interview on 1/31/2023, at 9:48 AM, administrator/clinical manager #1 indicated each patient should have had a personalized plan for where specifically they would evacuate to if they needed to leave their home. 3. Observation of a home visit for Patient #2 was conducted on 1/25/2023, at 10:00 AM, to observe a routine skilled nurse visit. During the visit, the patient's home binder was reveiwed. The home binder included an emergency plan which indicated the evacuation location was the nearest hotel,		Disaster Identification Form completed and will notify the assessing clinician who saw the patient and the Executive Director of the need for the document. The BM will monitor until it is received and is complete. The Executive Director is ultimately responsible for implementing the plan of care. Beginning the week of 3/20/23, the Executive Director or will complete 7 home visits weekly and ensure each patient has a Patient Disaster Plan Identification Form to include addresses and names of the evacuation hotels if applicable. Monitoring will continue weekly for and will continue until 95% compliance is achieved for 3 consecutive weeks. Deficient findings will be addressed immediately, and clinician remediation and disciplinary action will occur as indicated	

	to specify which hotel, or include an address. 4. Observation of a home visit for Patient #4 was conducted on 1/27/2023, at 10:15 AM, to observe a routine skilled nurse visit. During the visit, the patient's home health binder was reviewed. This binder included an emergency plan which indicated the evacuation location was the nearest hotel, but failed to be individualized to specify which hotel, or include an address. 5. Observation of a home visit for Patient #5 was conducted on 1/27/2023, at 8:30 AM, to observe a routine skilled nurse visit. During the visit, the patient's home health binder was reviewed. This binder failed to include an emergency preparedness plan. 6. Observation of a home visit for Patient #6 was conducted on 1/30/2023, at 4:00 PM, to observe a routine physical therapy visit. During the visit,		Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	

	the patient's home health binder was reviewed. This binder included an emergency plan which indicated the evacuation location was the fire department, but failed to be individualized to specify the address of the fire department.			
G0374	Accuracy of encoded OASIS data 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on record review and interview, the OASIS (Outcome and Assessment Information Set) data was inaccurate for 6 of 17 clinical records reviewed (#12, 13, 14, 15, 16, 17). Findings include: 1. An agency policy with revised date 1/01/15, titled "OASIS Accuracy Review", stated, "... Policy ... To enhance and validate accuracy of OASIS ...." 2. Clinical record review for patient #12 was completed on 2/01/23 (start of care date 1/18/23, certification period	G0374	An occurrence report was entered for patients 12, 13, 14, 15, 16, and 17. During a mandatory staff meeting held on 2/22/23, the Regional Vice-President instructed all clinical staff and Patient Care Managers (PCM) using the Clinical Comment Intake Coordination Note Tip Sheet, M0104 Date of Referral Tip Sheet, and M0102 Date of Physician Ordered Start of Care (Resumption of Care) Tip Sheet, with emphasis on proper completion of M0102 and M0104 OASIS items. For any staff not present, the Vice President of Operations or designee will provide instructions to the individual employees by 2/25/23. During a mandatory staff meeting held on 2/22/23, the Regional Vice-President instructed intake staff and PCMs using the Clinical Comment Intake Coordination Note Tip Sheet with emphasis on timely entry, accuracy, and validation of Clinical Comment Intake Coordination Note content. Intake staff will complete the Clinical Comment Intake Coordination Note, which	2023-03-17

	dated and signed by Person #1 on 1/13/23, titled "Referral Order" evidenced the agency received a referral for homecare services on 1/13/23. A document dated 10/04/22, titled "Visit Note Report" (PT start of care comprehensive assessment with OASIS [Outcome and Assessment Information Set]) evidenced the OASIS item M0104 (date of referral) was documented as 1/17/23. The OASIS data was inaccurate. During an interview on 2/01/23 at 11:18 AM, the Administrator confirmed the referral date was 1/13/23, and indicated she didn't know why the PT documented 1/17/23 as the referral date. 3. Clinical record review for patient #13 was completed on 2/02/23 (start of care date 10/04/22, certification period 10/04/22 – 12/02/22). A document dated and signed by Person #28 on 9/29/22, titled "Referral Order" evidenced the agency received a referral for homecare services on 9/29/22. The document failed to evidence the physician ordered		includes the Physician Ordered SOC/ROC date (M0102) and Referral Date (M0104), in Home Care Home Base (HCHB) on all Start of Care (SOC) and Resumption of Care (ROC) assessments upon receipt of a complete referral. A Physician Ordered SOC / ROC date (M0102) will only be entered if the physician/provider provided one specific date for home health to initiate or resume care. Documentation should be present to support the physician ordered SOC/ROC date. The Referral date (M0104) is populated with the original date of the referral. If was received via fax, the fax date is the date the referral was received. The referral date should be updated in instances when a patient has a delayed facility discharge or is requested by a physician and updated information is received. Documentation should include the reason for the updated referral date. The assessing clinician accurately completes the comprehensive assessment / OASIS. The assessing clinician will reference the Clinical Comment Intake Note to aid in accurately answering M0102 and M0104. To enhance and validate the accuracy of OASIS, the Patient Care Manager (PCM) or designee will review the Clinical Comment Intake Note to validate its accuracy and ensure supporting documentation is present, and all comprehensive assessments for OASIS accuracy, including M0102 and M0104.	

	a specific start of care date. A document dated 10/04/22, titled "Visit Note Report" (PT start of care comprehensive assessment with OASIS [Outcome and Assessment Information Set]) evidenced the OASIS item M0104 (date of referral) was documented as 10/03/22. The OASIS data was inaccurate. During an interview on 2/02/23 at 2:33 PM, the Administrator confirmed the referral date was 9/29/22, and indicated she didn't know why the PT documented 10/03/22 as the referral date. 4. Clinical record review for patient #14 was completed on 2/02/23 (start of care date 10/27/22, certification period 10/27/22 – 12/25/22). A document dated 10/17/22, titled "[Entity #25, a skilled nursing facility]" evidenced the agency received a referral for homecare services on 10/17/22. The document failed to evidence the physician ordered a specific start of care date. A document dated 10/27/22, titled "Visit Note Report" (PT start of care comprehensive		The PCM will utilize the PCM Plan of Care (POC) Review Tool to ensure a complete OASIS review is completed, with emphasis on accurate M0102 and M0104 dates. The Executive Director is ultimately responsible for implementing the plan of care. Beginning week of 3/20/23, ED or designee will review the Clinical Comment Intake Notes for proper completion of orders, and M0102 or M0104 are correctly entered in the Clinical Comment Intake Notes note. Once SOC visits occur, the ED or designee will review 100% of Clinical Comment Intake Notes for 3 weeks, and then 50% for to ensure proper completion of the Clinical Comment Intake Notes to reflect all referral orders and timely initial visits occurred. Monitoring will continue until 100% compliance is achieved for 3 consecutive weeks. Any deviation will be addressed up to staff disciplinary action. Discussion of compliance will be discussed with the team during the quarterly Quality	

	assessment with OASIS [Outcome and Assessment Information Set]) evidenced the OASIS item M0102 (date of physician-ordered start of care is known) was documented as "yes", and M0102 (date of physician-ordered start of care) was documented as 10/27/22. The OASIS data was inaccurate. During an interview on 2/02/23 at 3:01 PM, the Administrator indicated there wasn't a specific start of care date ordered by the physician. 5. Clinical record review for patient #15 was completed on 2/02/23. A document titled "[Entity #21, an orthopedic facility] evidenced the agency received a referral for homecare services on 1/11/23. The document failed to evidence the physician ordered a specific start of care date. A document dated 11/13/22, titled "Visit Note Report" (PT start of care comprehensive assessment with OASIS [Outcome and Assessment Information Set]) evidenced the OASIS item M0102 (date of physician-ordered start of care is known) was documented as		Assurance Performance Improvement team meetings until compliance is achieved	

	"yes", and M0102 (date of physician-ordered start of care) was documented as 1/13/23. The OASIS data was inaccurate. During an interview on 2/02/23 at 3:30 PM, the Administrator indicated there was not a specific date ordered by the physician for the start of care. 6. Clinical record review for Patient #16 was completed on 2/01/23 (start of care date 11/20/22). A document dated 11/14/22, titled "[Entity #15, a hospital]" evidenced the agency received a referral for home care services from Entity #15 on 11/14/22. A document dated 11/20/22, titled "Visit Note Report" (PT start of care comprehensive assessment with OASIS [Outcome and Assessment Information Set]) evidenced the OASIS item M0104 (date of referral) was 11/19/22. The OASIS data was inaccurate.			

	During an interview on 2/01/23 at 2:15 PM, the Administrator indicated she didn't know why the physical therapist documented the referral date as 11/19/22 on the comprehensive assessment. 7. Clinical record review for Patient #17 was completed on 2/02/23 (start of care date 7/08/22). A document dated and signed by Person #7 (the patient's certifying physician) on 7/05/22, titled "Referral Order", stated, "... Home Health Referral ... need SN [skilled nurse], PT [physical therapy], and OT [occupational therapy] ...." The referral document was dated 7/05/22 in the patient's EMR. A document dated 7/08/22, titled "Visit Note Report" (PT start of care comprehensive assessment with OASIS [Outcome and Assessment Information Set]) evidenced the OASIS item M0104 (date of referral) was documented as 7/07/22. The OASIS data was inaccurate. During an interview on 2/02/23 at 3:45 PM, the Administrator confirmed the referral date was 7/05/22, indicated she wasn't			

	sure why 7/07/22 was documented as the referral date, it was possibly a documentation error, and the EMR didn't evidence the referral date was changed.			
N0447	Home health agency administration/management 410 IAC 17-12-1(c)(4) Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on record review and interview, the home health agency failed to ensure marketing information was accurate. Findings include: A web base reference was reviewed on 1/24/23 (https://lhcgroup.com/locations/indiana-homecare-northwest/). The site was the agency's marketing website, which included the agency offered home health aide	N0447	The agency's web site (be updated by the Marketing Department to reflect only those services offered. Executive Director, or designee, will monitor the agency's web site quarterly to ensure the accuracy of the information contained. Any discrepancies will be reported to Department for correction. Prior to making changes to web site, the Marketing Department will validate the accuracy with the Executive Director, or . The Executive Director is ultimately responsible for implementing the plan of care. The Executive Director, or designee, will review the agency's web site quarterly on an ongoing basis to ensure the web site accurately reflects services that are provided.	2023-03-17

	services. During an interview on 2/01/23 at 11:13 AM, the Administrator indicated the last regular, full time home health aide quit around 2 years ago, and the agency didn't currently employ any home health aides.			
G0510	Comprehensive Assessment of Patients 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. Based on observation, record review and interview, the home health agency failed to: ensure the initial assessment visit was held within 48 hours of referral, the patient's return home, or on the physician ordered start of care date (see tag G514); ensure the comprehensive assessments included the patient's current health, psychosocial, functional, and/or cognitive status (see tag	G0510	See individual tags: G514, G536, G544, G548	2023-03-17

	medications the patient was currently using in order to identify potential drug interactions, duplicative drug therapy, and/or noncompliance with drug therapy (see tag G536); ensure the comprehensive assessment was updated when there was a major decline in status (see tag G544); and ensure a comprehensive assessment was completed within 48 hours of discharge and return home (see tag G548). This practice had the potential to affect all agency patients. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment and resulted in the agency being found out of compliance with the condition of participation: 42 CFR 484.55 Comprehensive assessment of patients.			
G0514	RN performs assessment 484.55(a)(1)	G0514	For patients #5, 8, 12, 13, 14, 16 &17 on 2/24/23 the ED completed an on-line occurrence report and notified	2023-03-17

A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date.

Based on record review and interview, the home health agency failed to ensure the registered nurse completed the initial assessment visit within 48 hours of referral, within 48 hours of the patient's return home, or on the physician ordered start of care date in 7 of 17 clinical records reviewed. (#5, 8, 12, 13, 14, 16, 17).

The findings include:

4. Clinical record review for patient #12 was completed on 2/01/23 (start of care date 1/18/23, certification period 1/18/23 – 3/18/23). A document dated and signed by Person #1 (the patient's certifying physician) on 1/13/23, titled "Referral Order" evidenced the agency received a referral for homecare services on 1/13/23.

A document dated 1/18/23, titled "Visit Note Report" (PT start of care comprehensive

the physicians of the lack of compliance with completion of initial visits within of the referral.

A meeting hosted by the Quality Coordinator and Regional Vice President (RVP) on 2/20/23 with the Patient Care Managers(PCMs), the ED, scheduler, and intake staff to review the proper process for entering a referral into the HCHB Electronic Medical Record, proper completion of the Clinical Comment Intake (CCI) note, notification of the PCM in workflow of the pending referral, timely PCM verification and approval of the referral in the system, including proper documentation in CCI Note– M0104 and M0102 and scheduler notification to assign the initial visit all to be completed within 48/hours of the referral.

For any staff not present, the Vice President of Operations or designee will provide instructions to the individual employees by 2/25/23.

Beginning on 2/21/23, the ED will verify that PCMs have reviewed all referrals and CCI note documentation to ensure proper documentation exists to support the orders and to ensure timely initiation of care occurs – within of the referral. PCMs will be held responsible to update any referral information including new or revised orders, physician ordered referral dates, and to ensure documentation supports all steps from receipt of the

	assessment), evidenced the initial evaluation was completed on 1/18/23, which was greater than 48 hours (5 days) after the agency received the referral. The EMR failed to evidence why the patient's initial evaluation was delayed. During an interview on 1/26/23, Patient #12 indicated she didn't request a delay in services, and the PT just called her to tell her when he was coming. During an interview on 2/01/23 at 11:18 AM, the Administrator indicated the clinical record didn't show if the patient requested a later start of care date. 5. Clinical record review for patient #13 was completed on 2/02/23 (start of care date 10/04/22, certification period 10/04/22 – 12/02/22). A document dated and signed by Person #28 (the patient's certifying physician) on 9/29/22, titled "Referral Order" evidenced the agency received a referral for homecare services on 9/29/22, and included orders for PT, OT, and skilled nursing. A document dated 10/27/22, titled "Visit Note Report" (PT		initial visit. PRIOR to accepting the referral and signing off as accurate the PCM will verify a complete referral and intake order in the CCI note. ED will ensure schedulers are following the 48-hour initial visit requirement and verify that all visits are and clinicians are aware that these visits cannot be moved from the assigned date to ensure timely visits occur. Beginning week of 3/20/23, ED or designee will review the CCI notes for proper completion of orders, and M0102 or M0104 and to ensure each resumption of care visit to ensure the ROC visit occurred within of referral receipt. Monitoring will occur weekly for and then 50% of the ROC visits will be reviewed weekly for an additional 6 weeks until 100% compliance is achieved for 3 consecutive weeks. Any deviation from the 48-hour will result in staff disciplinary action. Once SOC visits occur, the ED or designee will review 100% of CCI notes for , and then 50% for 6 weeks to ensure proper completion of the CCI note to reflect all referral orders and timely initial visits occurred.	

	start of care comprehensive assessment), evidenced the initial evaluation was completed on 10/04/22, which was greater than 48 hours (5 days) after the agency received the referral. The EMR failed to evidence why the patient's initial evaluation was delayed. During an interview on 2/02/23 at 2:33 PM, the Administrator indicated she didn't know why there was a delay in the start of care. 6. Clinical record review for patient #14 was completed on 2/02/23 (start of care date 10/27/22, certification period 10/27/22 – 12/25/22). A document titled "[Entity #25, a skilled nursing facility] evidenced the agency received a referral for homecare services on 10/17/22. A document dated 10/27/22, titled "Visit Note Report" (PT start of care comprehensive assessment), evidenced the initial evaluation was completed on 10/27/22, which was greater than 48 hours (10 days) after the agency received the referral. The EMR failed to evidence why the patient's initial evaluation		Monitoring will continue until 100% compliance is achieved for 3 consecutive weeks. Any deviation from the 48-hour will result in staff disciplinary action. Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	

was delayed.

During an interview on 2/02/23 at 3:01 PM, the Administrator indicated she didn't know why services were delayed.

7. Clinical record review for Patient #16 was completed on 2/01/23 (start of care date 11/20/22). A document with printed date 11/14/22, titled "History and Physical Report", indicated the patient was admitted at Entity #15 (a hospital) on 11/04/22, and discharged on 11/08/22.

A document dated 11/14/22, titled "[Entity #15]" evidenced the agency received a referral for home care services from Entity #15 on 11/14/22.

A document dated 11/20/22, titled "Visit Note Report" (PT start of care comprehensive assessment) evidenced the initial evaluation was completed on 11/20/22, which was greater than 48 hours (6 days) after the agency received the referral. The EMR failed to evidence why the patient's initial evaluation was delayed.

During an interview on 2/01/23 at 2:15 PM, the Administrator

	stated, "... the patient must have been somewhere between hospital discharge on the 8th [11/08/22] and when we admitted her on the 20th [11/20/22] ...." 8. Clinical record review for Patient #17 was completed on 2/02/23 (start of care date 7/08/22). A document dated and signed by Person #7 (the patient's certifying physician) on 7/05/22, titled "Referral Order", stated, "... Home Health Referral ... need SN [skilled nurse], PT [physical therapy], and OT [occupational therapy] ...." A document dated 7/08/22, titled "Visit Note Report" (PT start of care comprehensive assessment) evidenced the initial evaluation was completed on 7/08/22, which was greater than 48 hours (3 days) after the agency received the referral. The EMR failed to evidence why the patient's initial evaluation was delayed. During an interview on 2/02/23 at 3:45 PM, the Administrator confirmed the referral date was 7/05/22, the initial evaluation occurred greater than 48 hours after the referral was received			

	by the agency, and the EMR didn't evidence the referral date changed. 9. During an interview on 2/01/23 at 11:04 AM, the Administrator indicated the initial evaluation was completed in conjunction with the initial comprehensive assessment. 1. Record review evidenced an agency policy revised 1/1/2023, titled "Admission Process" which stated, "… admission/initial visits are made within 48 hours from referral unless there is a specific physician ordered start of care date which would supersede the state established timeframes …." 2. Clinical record review for Patient #5 was completed on 2/2/2023, for certification period 8/28/2022 – 10/26/2022. Record review evidenced a referral order dated 8/24/2022, which indicated the patient was to receive home health services. Clinical record review evidenced a start of care, initial assessment dated 8/28/2022 (4 days after			

	referral). During an interview on 1/31/2023, at 12:33 PM, administrator/clinical manager #1 indicated they did not know why the start of care was 4 days after the referral order was received. Administrator/clincial manager #1 indciated patients should receive initial assessment visits within 48 hours of referral, unless the physician specified otherwise. 3. Clinical record review for Patient #8 was completed on 2/2/2023, for certification period 1/5/2023 – 3/5/2023. Record review evidenced a referral order dated 12/26/2023, which indicated the patient was to discharge home on 12/26/2023, and receive home health services. Clinical record review evidenced an initial assessment dated 1/5/2023 (10 days after referral). During an interview on			

	1/30/2023, at 2:58 PM, administrator/clinical manager #1 indicated they did not know why the initial assessment was delayed. 410 IAC 17-14-1(a)(1)(A)			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessment included a review of all medications the patient was using to identify potential adverse effects, including ineffective drug therapy, significant side effects, significant drug interactions, duplicative drug therapy, and/or noncompliance with drug therapy; and/or failed to ensure the drug regimen review was conducted by a registered nurse	G0536	For all active patients impacted by these deficient findings 2/24/23 the ED completed an on-line occurrence report and physicians were notified of the lack of a complete and accurate medication review performed by Registered Nurse (RN). By 2/24/23, an accurate medication review was and significant medication interactions, potential adverse reactions and side effects and any medication discrepancies were reported to the applicable physicians for all patients who remain active with the agency. All medications were reviewed by an RN. Medication lists were revised to reflect all current medications taken by the patients. On 2/20/23, ED, Quality Coordinator and RVP conducted a mandatory staff meeting. The staff were instructed on the requirement to provide medication instructions on potential side effects and adverse interactions. is to be notified on all potential drug interactions per HH policy Monitoring Medications and every medication review completed by a therapist must be reviewed by an RN. Home health	2023-03-17

	in 13 of 17 clinical records reviewed. (#1, 2, 3, 4, 5, 6, 8, 12, 13, 14, 15, 16, 17) The findings include: 10. Clinical record review for patient #12 was completed on 2/01/23 (start of care date 1/18/23, certification period 1/18/23 – 3/18/23). A document dated and signed by Person #1 (the patient's certifying physician) on 1/13/23, titled "[Patient's name and identifying information]" evidenced the patient's current medications included calcium citrate 2400 mg twice daily (a supplement), Epipen (for the emergency treatment of life-threatening allergic reactions), fiber capsules (for gut health/soft stools), gas-x (reduce gas), multaq- take twice daily with breakfast and dinner (to treat cardiac arrhythmias) probiotic daily (gut health), Topamax (used to treat epilepsy and prevent migraines), vitamin D3 5000 units daily (supplement), and warfarin (blood thinner) 5 mg daily except Thursday- take 7.5 mg. A document titled "Home		include the requirement to complete a current and accurate medication reconciliation and ensure an accurate med list containing all Over the Counter (OTC) meds including indications. Agency policy "Patient Assessment, Initial, and Reassessment" was reviewed with emphasis that upon admission and reassessments, the qualified clinician performs the following assessment activities and collects the following data: … Review of all medications patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. For any staff not present, the RVP or designee will provide instructions to the individual employees by 2/25/23. Beginning 2/24/23, for any comprehensive assessments completed by a therapist, the medication review will be completed by the PCM of the assigned team. PCMs will verify that High Risk Medications are identified per LHC Policy High Risk Medications and appropriate patient education occurs. For Therapy Only patients, the PCM will provide this education. PCMs will ensure that medication interactions are reported to physicians and orders obtained to address the interactions as indicated for all severe reactions. PCMs will verify that instructions are provided to patients regarding drug interactions as discussed in	

	Care" (for certification period 1/18/23 – 3/23/23), evidenced the patient's medications included diazepam (prescribed to treat insomnia for this patient), calcium citrate plus 250 mg-40 mg-125 Unit-3.75 mg tablet 3 times daily (the current order was calcium citrate 2400 mg twice daily), warfarin 5 mg every morning (the current order was warfarin 5 mg daily except Thursday- take 7.5 mg), and Vitamin D3 2,000 Units every morning (the current order was Vitamin D3 5000 units daily); indicated multaq was a supplement (multaq is used to treat cardiac arrhythmias); failed to evidence the patient's current medications also included fiber capsules, gas-x, a probiotic, and Topamax; and failed to include indication for multaq to be taken twice daily with breakfast and dinner. A document dated 1/17/23, titled "Visit Note Report" (PT start of care comprehensive assessment), evidenced the PT reviewed the patient's medications, and performed a drug regimen review, and stated, "... Was patient instructed on special		Monitoring Medications policy per the identified severity level. Beginning the week of 3/20/23, the Executive Director or designee with complete 7 home visits weekly and will review the medical records of these patients to verify accuracy of the medication lists and to ensure drug interactions were reported and addressed, patients received education on drug educations, and high-risk medications. Monitoring will continue weekly for and will continue until 95% compliance is achieved for 3 consecutive weeks. Deficient findings will be addressed immediately, and clinician remediation and disciplinary action will occur as indicated Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	

	precautions ... Yes ... which medications were instructed on ... Warfarin ....” During an interview on 2/01/23 at 11:18 AM, the Administrator indicated the PT reviewed the medications and performed a drug regimen review. When queried how the PT knew which medications were “high risk”, the Administrator indicated the agency had a “tip list” they could refer to, and there was also patient education access for each medication right in the EMR, and the PT should have addressed the diazepam as a high-risk drug (due to abuse potential and risk for physical and psychological dependence). 11. Clinical record review for patient #13 was completed on 2/02/23 (start of care date 10/04/22). A document titled “Home Health Certification and Plan of Care” (for initial certification period 10/04/22 -), evidenced the patient’s medications included allopurinol (to treat gout), amiodarone (to treat life-threatening heart rhythm problems), carvedilol (to treat high blood pressure and heart failure), Eliquis (a blood thinner),			

	furosemide (a diuretic), and glimepiride (to treat diabetes). The plan of care failed to evidence the indications for use of allopurinol, amiodarone, carvedilol, Eliquis, furosemide, or glimepiride. A document dated 10/04/22, titled "Visit Note Report" (PT comprehensive assessment) evidenced the PT reviewed the patient's medications, performed a drug regimen review, and stated, "... Was patient instructed on special precautions ... Yes ... which medications were instructed on ... Eliquis ...." The document failed to evidence the patient was instructed on the 3 potential major drug interactions between amiodarone and furosemide, allopurinol and lisinopril, an lisinopril and potassium chloride. Review of a web base drug interaction checker on 2/01/23, titled "Drugs.com" (https://www.drugs.com/interactions-check.php?drug_list=127-0,167-0,276-0,1665-16414,531-0,3438-16026,1146-0,1176-0,1476-0,1912-0,3322-15296,1003-5789), evidenced the patient's			

	medications included 3 major drug interactions (highly clinically significant, avoid combinations, and the risk of the interaction outweighs the benefit). Use of amiodarone together with furosemide can increase the risk of an irregular heart rhythm that may be serious. Use of allopurinol together with lisinopril may increase the risk of severe allergic reactions and infections. Use of lisinopril together with potassium chloride may significantly increase potassium levels in the blood, and high levels of potassium can lead to kidney failure, muscle paralysis, irregular heart rhythm, and cardiac arrest. A document titled "Home Health Certification and Plan of Care" (for certification period 12/03/22 – 1/31/23), evidenced the patient's medications included allopurinol, amiodarone, carvedilol, Eliquis, furosemide, and glimepiride. The plan of care failed to evidence the indications for use of allopurinol, amiodarone, carvedilol, Eliquis, furosemide, or glimepiride. During an interview on 2/02/23			

	at 2:33 PM, the Administrator indicated the PT reviewed the patient's medications and performed the drug regimen review. 12. Clinical record review for patient #14 was completed on 2/02/23 (start of care date 10/27/22, certification period 10/27/22 – 12/25/22). A document dated 10/14/22, titled "[Entity #25, a skilled nursing facility] ... Progress Notes", evidenced the patient's lung sounds improved with crackles (sounds heard when the small air sacs in the lungs fill with fluid and there's air movement in the sacs during breathing) since she was started on Lasix (a diuretic). A document titled "Home Health Certification and Plan of Care" (for initial certification period 10/27/22 – 12/25/22) evidenced the patient's medication profile included cephalexin (an antibiotic), colace (docusate) (a stool softener), gabapentin (a controlled substance to treat nerve pain), and continuous oxygen at 4 liters per minute (LPM) via nasal cannula (small			

	to administer oxygen). The plan of care failed to evidence indications for use of cephalexin, colace, or gabapentin; and failed to evidence the patient took Lasix. A document dated 10/27/22, titled "Visit Note Report" (PT start of care comprehensive assessment) evidenced the PT reviewed the patient's medications and performed a drug regimen review, and the patient used oxygen at 2 LPM. The document failed to evidence the patient's correct dose of O2 was 4 LPM. A document dated 11/03/22, titled "Visit Note Report" (PTA routine visit), evidenced the patient used O2 at 3 LPM, the patient used O2 at 6.5 LPM. The document failed to evidence the patient's correct dose of O2 was 4 LPM. An additional document dated 11/03/22, titled "Visit Note Report" (RN add-on evaluation), evidenced the patient's O2 saturation (amount of O2 in the blood) was assessed while the patient wasn't wearing O2, and then indicated the patient used O2 at 3 LPM.			

	A document dated 11/08/22, titled "Visit Note Report" (PTA routine visit), evidenced the patient's O2 saturation (amount of O2 in the blood) was assessed while the patient wasn't wearing O2, and then indicated the patient used O2 at 3 LPM. During an interview on 2/02/23 at 3:01 PM, the Administrator indicated the inaccurate documentation of the patient's oxygen doses were considered medication errors.			

	13. Clinical record review for patient #15 was completed on 2/02/23. A document titled "Home Health Certification and Plan of Care" (for initial certification period 11/20/22 – 1/18/23), evidenced the patient's medication profile included tylenol with codeine (a narcotic/opioid pain medication) amlodipine (to treat high blood pressure), citalopram (an antidepressant), levetiracetam (an anti-seizure medication), and Synthroid (to treat thyroid hormone deficiency). The plan of care failed to evidence indications for use of amlodipine, citalopram, levetiracetam, or Synthroid. A document dated 11/13/22, titled "Visit Note Report" (PT start of care comprehensive assessment), evidenced the PT reviewed the patient's medications, performed a drug regimen review, and stated, "... Was patient instructed on special precautions ... on all high-risk medications ... Yes ... which medications were instructed on ... opioid [a narcotic pain medication] ... constipation risk ...." The document failed to evidence the			

	patient was instructed on the potential for addiction to an opioid medication, or instructed on levetiracetam (a high-risk medication). During an interview on 2/02/23 at 3:30 PM, the Administrator indicated the PT reviewed the patient's medications and performed the drug regimen review, levetiracetam was a high-risk medication, and the PT did not provide instruction on the medication. 14. Clinical record review for Patient #16 was completed on 2/01/23 (start of care date 11/20/22). A document titled "Home Health Certification and Plan of Care" (for initial certification period 11/20/22 – 1/18/23), evidenced the patient's medication profile included allopurinol (to treat gout), amiodarone (to treat life-threatening heart rhythm problems), aspercreme (lidocaine hydrochloride [HCL]) 4% topical patch daily to lower back (pain relief), Eliquis (a blood thinner/anticoagulant), epogen injections 3 times weekly at dialysis (to treat amemia, or low red blood cell count), Jakafi (used for			

	treatment of myelofibrosis, a rare type of blood cancer that causes scar tissue to form in bone marrow), midodrine (to treat orthostatic hypotension, or a sudden drop in blood pressure when changing positions from sitting to standing) as directed/as needed at dialysis, mirtazapine (an antidepressant), ondansetron as needed for nausea, and tramadol (moderate to severe pain relief). The plan of care failed to evidence indications for use of allopurinol, amiodarone, aspercreme (lidocaine HCL) 4% topical patch, Eliquis, epogen injections, Jakafi, midodrine, or mirtazapine. Review of a web base drug interaction checker on 2/01/23, titled "Drugs.com" (https://www.drugs.com/interactions-check.php?drug_list=127-0,167-0,1465-18047,3438-16026,2365-487,998-545,3352-15486,1424-0,1629-0,1640-0,1752-0,1665-16509,1661-19134,2221-0,11-12) evidenced the patient's medications included 7 major drug interactions (highly clinically significant, avoid combinations, and the risk of the interaction outweighs the			

	benefit). Use of amiodarone together with ondansetron can increase the risk of an irregular heart rhythm that may be serious and potentially life-threatening; use of amiodarone together with tramadol can increase the risk of an irregular heart rhythm that may be serious and potentially life-threatening; combined use of ondansetron and tramadol can increase the risk of serotonin syndrome and an irregular heart rhythm, both rare but potentially life-threatening effects of these drugs, and serotonin syndrome may include symptoms such as confusion, hallucination, seizure, extreme changes in blood pressure, increased heart rate, fever, excessive sweating, shivering or shaking, blurred vision, muscle spasm or stiffness, tremor, incoordination, stomach cramp, nausea, vomiting, and diarrhea. Severe cases may result in coma and even death; use of amiodarone together with mirtazapine can increase the risk of an irregular heart rhythm that may be serious and potentially life-threatening; use of ondansetron together with mirtazapine can increase the			

	risk of a rare but serious condition called serotonin syndrome; use of tramadol together with mirtazapine can increase the risk of a rare but serious condition called serotonin syndrome; and use of apixaban (Eliquis) together with ruxolitinib (Jakafi) may increase the risk of bleeding, including severe and sometimes fatal hemorrhage. A document dated 11/20/22, titled "Visit Note Report" (PT start of care comprehensive assessment) evidenced the PT reviewed the patient's medications, performed a drug regimen review, and stated, "... Was patient instructed on special precautions ... Yes ... which medications were instructed on ... Eliquis ...." The document failed to evidence the patient was instructed on the 7 potential major drug interactions between amiodarone and ondansetron, amiodarone and tramadol, ondansetron and tramadol, amiodarone and mirtazapine, ondansetron and mirtazapine, tramadol and mirtazapine, or apixaban (Eliquis) and ruxolitinib (Jakafi).			

	A document received from Entity #16 on 1/27/23, titled "Home Medication", evidenced a list of medications the patient took for date range 10/31/22 – 11/26/22, which included albuterol nebulizer solution to be inhaled every 4 hours as needed for shortness of breath, midodrine 10 mg (milligrams) by mouth twice daily for hypotension (low blood pressure), and mirtazapine (Remeron) was to be taken every night at bedtime. The patient's plan of care/medication profile failed to evidence the patient used albuterol; the patient's medication profile incorrectly indicated midodrine was used only as directed/as needed at dialysis, and the patient's medication profile failed to evidence mirtazapine was to be taken every night at bedtime. During an interview on 2/01/23 at 2:15 PM, the Administrator indicated the PT reviewed the patient's medications and performed the drug regimen review, did not instruct on all high risk medications/ special precautions, and there was no coordination with Entity #16.			

	15. Clinical record review for Patient #17 was completed on 2/02/23 (start of care date 7/08/22). A document titled "Home Health Certification and Plan of Care" (for certification period 7/08/22 – 9/05/22), evidenced the patient's medication profile included atorvastatin (to treat high cholesterol), biotin (a vitamin B supplement), Jakafi (used for treatment of myelofibrosis, a rare type of blood cancer that causes scar tissue to form in bone marrow), magnesium (supplement), pantoprazole (reduces the amount of acid your stomach makes), tolterodine (used treat overactive bladder), topiramate (used to treat epilepsy and prevent migraines), Vitamin B complex and Vitamin D3 (both supplements). The medication profile failed to include indications for use of atorvastatin, biotin, Jakafi, magnesium, pantoprazole, tolterodine, topiramate, Vitamin B complex or Vitamin D3. An untitled document with order date 7/26/22 (a physician's order), evidenced the patient was prescribed metolazone (used to reduce the			

swelling and fluid retention caused by congestive heart failure or kidney disease) to be taken for 3 days. The document failed to indicate why the medication was prescribed.

During an interview on 2/02/23 at 3:45 PM, the Administrator indicated the PT reviewed the patient's medications and performed the drug regimen review, and the patient's medication profile should include indications for use.

1. Record review evidenced an agency policy revised 3/1/2022, titled "Patient Assessment, Initial, and Reassessment" which stated, "... Upon admission and reassessments, the qualified clinician performs the following assessment activities and collects the following data: ... Review of all medications patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy ...."

	2. Record review evidenced an agency policy revised 5/1/2019, titled "Monitoring Medications" which stated, "... For therapy only patients, the Patient Care Manger will review the comprehensive medication list formulated by the therrapist and complete the drug regimen review which is documented in the medical record ...." 3. Observation of a home visit for Patient #1 was conducted on 1/25/2023, at 8:30 AM, to observe a routine skilled nurse visit. During the visit, the patient's medication bottles were reviewed. Review evidenced the following medciations which were not included on the medication profile, or reviewed during the comprehensive assessment: ibuprofen (for fever or pain), topiramate (to prevent seizures), and sertraline 100 milligrams twice daily. Clinical record review for Patient #1 was completed on 2/2/2023, for certification period 1/10/2023 – 3/10/2023. Record review evidenced a medication			

	profile last reviewed on 1/7/2023, which included the following medications the patient was not taking: acetaminophen (for fever/pain), and modafinil (to help stay alert/awake). During an interview on 1/31/2023, at 9:41 AM, administrator/clinical manager #1 indicated the medications profile was completed during the comprehensive assessment, and should have included all medciations the patient was taking. 4. Observation of a home visit for Patient #2 was conducted on 1/25/2023, at 10:00 AM, to observe a routine skilled nurse visit. During the visit, the patient's medication bottles were reviewed. Review evidenced the following medications which were not included on the medication profile, or reviewed during the comprehensive assessment: iron (supplement), vitamin B12, and folic acid (supplement).			

Clinical reccord review for Patient #2 was completed on 2/2/2023, for certification period 11/30/2022 – 1/28/2023. Record review evidenced a medication profile dated 12/28/2023, which included lactase (for lactose intolerance), which the patient was not taking.

5. Observation of a home visit for Patient #3 was conducted on 1/26/2023, at 10:00 AM, to observe a routine occupational therapy visit. During the visit, the patient's medication bottles were reviewed. Review evidenced ciprofloxacin (antibiotic) and tramadol (for pain) 1 time daily as needed for pain, which were not included on the medication profile, or reviewed during the comprehensive assessment.

Record review evidenced a medication profile dated 12/8/2022, which included the following medications the patient was not taking: aspirin

attack), benzonatate (for cough), tizanidine (muscle relaxer), and tramadol 50 milligrams every 4 hours as needed for pain.

6. Observation of a home visit for Patient #4 was conducted on 1/27/2023, at 10:15 AM, to observe a routine skilled nurse visit. During the visit, the patient's medication bottles were reviewed. Review evidenced the following medication bottles which were not included on the medication profile as part of the comprehensive assessment: ipratropium bromide nasal spray (for runny nose) and ibuprofen (for pain).

7. Observation of a home visit for Patient #5 was conducted on 1/27/2023, at 8:30 AM, to observe a routine skilled nurse visit. During the visit, the patient's medication bottles were reviewed. Review evidenced the following medication bottles which were not included on the patient's medication profile as part of the comprehensive assessement:

	oxycodone-acetaminophen (pain medication) 10-325 milligrams every 6 hours as needed for pain, pepcid (antacid), baclofen (muscle relaxer) 10 milligrams twice daily, and probiotic (to improve diarrhea). Clinical record review evidenced a medicatin profile dated 12/16/2022, which included acetaminophen (for pain/fever), which the patient was not taking. 8. Observation of a home visit for Patient #6 was completed on 1/30/2023, at 4:00 PM, to observe a routine physical therarpy visit. During the visit, the patient's medication bottles were reviewed. Review evidenced the patient was taking flomax (for enlarged prostate) 0.4 milligrams twice daily and atorvastatin 10 milligrams twice daily. Clinical record review for Patient #6 was completed on 2/2/2023,			

	1/10/2023 – 3/10/2023. Record review evidenced a medicatin profile, which indicated the patient was taking flomax 0.4 milligrams once daily, and atorvastatin 10 milligrams once daily. Clinical record review evidenced a start of care assessment dated 1/10/2023, which was completed and signed by physical therapist #1. This start of care assessment indicated the physical therapist had reviewed the patients medications for significant side effects, drug interactions, duplicate drug therapy, and compliance with drug therapy. Record review failed to evidence the registered nurse reviewed the patient's medications during the comprehensive assessment. During an interview on 1/23/2023, at 9:49 AM, administrator/clinical manager #1 indicated in therapy only cases, the patient care manager should have completed the drug regimen review, not the therapist.			

	9. Clinical record review for Patient #8 was completed on 2/2/2023, for certification period 1/5/2023 – 3/5/2023. Record review evidenced a start of care assessment completed by a physical therapist on 1/5/2023. This start of care assessment indicated the physical therapist had reviewed the patients medications for significant side effects, drug interactions, duplicate drug therapy, and compliance with drug therapy. Record review failed to evidence the registered nurse reviewed the patient's medications during the comprehensive assessment. 410 IAC 17-14-1(a)(1)(B)			
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment.	G0544	Executive Director, RVP, and Quality Coordinator reviewed home health policy Significant Change in Assessment in a mandatory staff meeting held on 2/22/23. Emphasis was placed on the completion of a comprehensive assessment is done when the agency is made aware of a significant change in	2023-03-17

	The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on record review and interview, the home health agency failed to ensure the comprehensive assessment was updated in 4 of 4 clinical records reviewed where a major decline in the patient's health status occurred (#9, 13, 14, 16). The findings include: 3. Clinical record review for patient #13 was completed on 2/02/23 (start of care date 10/04/22, certification period 12/03/22 – 1/31/23). A document dated 12/06/22, titled "Visit Note Report" (PTA routine visit) evidenced the patient reported no pain. A document dated 12/08/22, titled "Visit Note Report" (PTA routine visit), evidenced the patient had no pain, and no falls occurred since the last routine visit. A document titled "Risk Management Total Incident Summary Report ....", event date		the patient's condition that was not envisioned in the original plan of care during a 60-day episode and when the patient's condition has either severely deteriorated or greatly improved. All patients currently on services will be evaluated by 2/24/23 for the need of an RN assessment. Occurrence reports were entered for active patients identified during the survey process (#9, 13, 14, 16) Physicians were notified that an RN significant change in assessment should have been completed. For any staff not present, the RVP or designee will provide instructions to the individual employees by 2/25/23. Beginning 2/24/23, clinicians will be required to report any changes in patient condition daily to their PCM. The coordination note will also be completed to ensure the concern is included in the medical record. PCMs will ensure physician orders are obtained and schedule an RN visit within 24 hours of the identified patient care change in condition to complete a Significant Change	

	12/07/22, stated, "... Patient fell early last week in bathroom. Patient bruised toes on left foot ... edema and pain ... Emergency services called and patient went to E.R. [emergency room] ... Care Plan [plan of care] reviewed/revised ...." The clinical record failed to evidence a comprehensive assessment with OASIS data occurred after the agency became aware of the fall with injury that required emergent care. A document dated 12/13/22, titled "Visit Note Report" (PT Reassessment without OASIS data set), evidenced the patient reported pain as "5" (on a scale of 0-10, with 0=no pain and 10= worst pain possible), and stated, "... Patient reports she twisted her right knee while getting in and out of a vehicle on Saturday [12/10/22] ... has been experiencing significant pain with the right knee area ever since ... does not want to go to the emergency room ... she is now using the wheelchair for most mobility ... unable to safely use walker ...." The clinical record failed to evidence a comprehensive assessment with OASIS data occurred after the agency became aware of the fall		in Condition assessment as indicated. Beginning 3/20/23, ED or designee will complete 10 record reviews per week to ensure any patient significant changes in condition were reported to the PCM and an RN visit to complete the Significant Change in Assessment visit within 24 hours of the change in condition. Any deviations to this process will be addressed with clinician remediation and disciplinary action as indicated. Monitoring will continue for and will continue until 100% compliance for 3 consecutive weeks. Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	

	with injury that required emergent care. A document dated 12/19/22, titled "Visit Note Report" (PTA routine visit) indicated the patient's right knee remained painful at a "6", and she was going Wednesday (12/21/22) to have it checked out (no further information). The clinical record failed to evidence a comprehensive assessment with OASIS data occurred. A document dated 12/27/22, titled "Visit Note Report" (PT reassessment without OASIS data) indicated the patient used over the counter and prescription medications for pain relief, the patient's fear of falling was a high concern, and stated, "... Patient reports she did have a consult ortho [orthopedic] due to right knee pain ... ortho suspects a fracture ... continued pain ... difficult time getting around ... occasional assistance ...." The clinical record failed to evidence a comprehensive assessment with OASIS data occurred, or what medications the patient took. A document dated 1/02/23,			

	titled "Visit Note Report" (PTA routine visit) stated, "... Patient ... has MRI tomorrow for [right] knee ... mentions ... having an aide come today to help with shower and cleaning of home ... presents [with] right knee brace on ... was not on appropriately ...." The clinical record failed to evidence a comprehensive assessment with OASIS data occurred. A document dated 1/12/23, titled "Visit Note Report" (PTA routine visit) stated, "... Patient had [physician] appointment Tuesday [1/10/23] with [Person #29, an orthopedic physician] ... [patient to] wear [right] knee brace for two weeks then begin [outpatient] therapy ... remain [non-weight bearing right lower leg] ... has a fracture ...." The clinical record failed to evidence a comprehensive assessment with OASIS data occurred. During an interview on 2/02/23 at 2:33 PM, the Administrator indicated the patient should have been reassessed, the aide wasn't from their agency, and she didn't know who it was. 4. Clinical record review for patient #14 was completed on			

	2/02/23 (start of care date 10/27/22, certification period 10/27/22 – 12/25/22). A document dated 10/17/22, titled "... Order Category: Dietary, Pharmacy ... Active Orders As Of ... 10/17/22", evidenced the document originated from Entity #25 (a skilled nursing facility). The document listed the patient's current diagnoses, which included unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), UTI, dysphagia, oropharyngeal phase (difficulty initiating a swallow, and swallowing may be accompanied by regurgitation, aspiration [the drawing in of a foreign substance into the lungs], and a sensation of residual food remaining in the throat), and other symptoms and signs concerning food and fluid intake. A document dated 10/14/22, titled "[Entity #25] ... Progress Notes", evidenced the patient's			

	crackles (sounds heard when the small air sacs in the lungs fill with fluid and there's air movement in the sacs during breathing) since she was started on Lasix (a diuretic), and family had an appointment with Entity #27 (an oxygen and medical equipment company) for training on BiPap (a device that helps with breathing, and forces intermittent air into the lungs). A document titled "Home Health Certification and Plan of Care" (for initial certification period 10/27/22 – 12/25/22), evidenced the patient's primary diagnosis was acute (sudden) and chronic (long standing) respiratory failure with hypoxia (the respiratory system cannot adequately provide oxygen to the body, resulting in an absence of enough oxygen in the tissues to sustain bodily functions), and additional diagnoses included pneumonitis due to inhalation of food and vomit (an infection of the lungs caused by inhaling saliva, food, liquid, vomit and even small foreign objects into the lungs [aspiration]), dementia, and dependence on supplemental oxygen; and medications included oxygen at			

	4 LPM via nasal cannula (tubes inserted into the nose). A document dated 10/27/22, titled "Visit Note Report" (PT start of care comprehensive assessment), evidenced assessment findings, which indicated the patient was alert and oriented to person, place, and time; had no cardiovascular (heart/circulatory) problems, the only respiratory issue was the use of O2 at 2 LPM via nasal cannula, and there were no nutritional risks. A document dated 11/03/22, titled "Visit Note Report" (PTA routine visit), evidenced the patient used O2 at 3 LPM, the patient used O2 at 6.5 LPM, and the patient ambulated with a walker. An additional document dated 11/03/22, titled "Visit Note Report" (RN add-on evaluation), evidenced the patient had difficulty with remembering events, and was alert and oriented to person, place, and time. A document dated 11/08/22, titled "Visit Note Report" (PTA routine visit), evidenced the			

	oxygen, and felt more tired today, was wheezing slightly more than last visit, and now had some non-pitting (no "pit" remains in skin when pressed with fingertip) swelling in her ankles; the caregiver obtained a urine sample for urinalysis due to patient's increased confusion over the past 2 days, and the patient used O2 at 3 LPM via nasal cannula. An additional document dated 11/08/22, titled "Visit Note Report" (LPN routine visit) evidenced the LPN visit occurred 90 minutes after the PTA visit on 11/08/22. The document evidenced the patient was using her O2 at 4 LPM via nasal cannula, had 2+ pitting edema in both lower extremities, the patient was short of breath, and had pronounced expiratory wheezing to both upper portions of the lungs (wheezing indicates partial obstruction of the airway by a foreign substance, such as phlegm or food), and the certifying physician was going to order a chest x-ray and laboratory tests, and was going to contact the caregiver to take the patient for the tests. The document			

	evidenced the LPN notified the Alternate Clinical Manager of the patient's change in condition. The clinical record failed to evidence a RN performed a visit to update/revise the comprehensive assessment.			

	A document dated 11/09/22, titled "Visit Note Report" (OT add-on evaluation), evidenced the patient's breathing was labored, pulse rhythm was irregular, presented also with weakness, severe deconditioning, balance deficits, cognitive deficits, shortness of breath at rest with use of O2 at 4 LPM, both lower legs were swollen, and patient was also found to have a UTI. Additionally, the caregiver reported patient was taken to emergency department last night (11/08/22) for a chest x-ray, was now maximum assist for transfers, dependent for all self-care, and had poor alertness; the OT reported to the therapist (no further information) and the certifying physician. The clinical record failed to evidence a RN performed a visit to update/revise the comprehensive assessment. A document dated 11/16/22, titled "H&P [History and Physical] Note" evidenced the patient became unconscious at home, caregivers indicated she was completely unresponsive, "911" was called, and EMS (emergency medical service)			

	staff was able to provide treatment, and the patient regained consciousness, but was confused. Inpatient diagnoses included syncope (fainting), left lower lobe pneumonia, acute on chronic respiratory failure with hypoxia, congestive heart failure, and dementia. During an interview on 2/02/23 at 3:01 PM, the Administrator indicated the patient had a significant change in condition, confirmed no nursing visits were made after the OT visit on 11/09/22, and no RN visit was made after 11/03/22. 4. Clinical record review for Patient #16 was completed on 2/01/23 (start of care date 11/20/22). A document titled "Home Health Certification and Plan of Care" (for initial certification period 11/20/22 – 1/18/23), evidenced the patient's primary diagnosis was urinary tract infection (UTI), other diagnoses included hypertensive heart (problems with the heart that can develop if you have high blood pressure but don't treat it for years) and chronic kidney disease (long-standing decline of			

	kidney function) with heart failure (the heart's inability to pump blood and oxygen [O2] throughout the body) and stage 5 chronic kidney disease (end stage, requires dialysis to sustain life), sick sinus syndrome (a type of heart rhythm disorder), acute (sudden) and chronic (long standing) respiratory failure with hypoxia (the respiratory system cannot adequately provide oxygen to the body, resulting in an absence of enough oxygen in the tissues to sustain bodily functions), and dependence on supplemental oxygen (O2) (2 liters per minute [LPM] continuous, via nasal cannula [small tubes inserted into the nostrils to administer oxygen]). A document dated 11/20/22, titled "Visit Note Report" (PT start of care comprehensive assessment) evidenced no skin issues/problems were identified, and the patient had 2+ pitting edema (swelling that occurs when excess fluid builds up in the body due to heart, circulatory, and/or kidney problems, and when pressed by the tip of a finger, a "pit" remains; 1+ means the "pit"			

	millimeters [mm] that rebounds immediately; 2+ means the "pit" leaves an indentation of 3–4 mm that rebounds in fewer than 15 seconds; 3+ means the "pit" leaves an indentation of 5–6 mm that takes up to 30 seconds to rebound; and 4+ means the "pit" leaves an indentation of 8 mm or deeper that takes more than 20 seconds to rebound) to both lower extremities. A document dated 11/30/22, titled "Visit Note Report" (Physical Therapy Assistant [PTA] routine visit), indicated the patient sustained a skin tear on the right hip, it was covered with a bandage, and the patient had 3+ bilateral lower extremity edema (worse than previous visit). A document dated 12/07/22, titled "Visit Note Report" (PTA routine visit) evidenced the patient had 3-4+ pitting edema to both lower extremities (worse than last routine visit), and stated, "... [family] reports R [right] buttocks skin tear covered with bandage, reports changed bandage no bleeding noted, patient has bruising at face, UES [upper extremities] that have been long standing			

	...." A document dated 12/15/22, titled "Visit Note Report" (PT reassessment) evidenced an assessment section, which indicated cardiovascular assessment was "NA" (not applicable), post intervention of pain was "NA", and the patient did not have a diagnosis or symptoms indicative of respiratory impairment. The clinical record failed to evidence a comprehensive reassessment was completed for the patient's significant decline in health status. A document dated 12/21/22, titled "Visit Note Report" (PTA routine visit), evidenced new skin tears to the patient's left forearm and right middle finger, the right hip/buttock wound was healing, family addressed the wounds, the patient had 3+ edema to both feet, and used O2 at 2 LPM. A document dated 12/28/22, titled "Visit Note Report" (PTA routine visit), stated, "... [patient/family] mention having a lot [more] fluid due to having to change dialysis routine and patient is a little boated feeling			

	today. Mentions usually [only] wears supplement oxygen at night but has it on today due to mild shortness of breath without supplemental oxygen ... edema in BLE [bilateral lower extremities] being controlled per [family] ....” The clinical record failed to evidence a comprehensive reassessment was completed for the patient’s significant decline in health status. A document dated 1/05/23, titled “Visit Note Report” (transfer data collected, no visit made) evidenced the patient utilized the emergency department and was admitted to the hospital. A document received from Entity #15 (a hospital) on 1/27/23, titled “Emergency Documentation” evidenced the patient was seen at Entity #15’s emergency department, was diagnosed with a UTI, and was admitted for treatment on 12/30/22. During an interview on 2/01/23 at 2:15 PM, the Administrator indicated the patient was declining and a comprehensive reassessment should have been			

done.

1. Record review evidenced an agency policy revised 12/1/2013, titled "Significant Change in Condition [Other Follow-Up] Assessment", which stated, "... A comprehensive assessment is done when the agency is made aware of a significant change in the patient's condition that was not envisioned in the original plan of care during a 60-day episode ... The patient's condition has either severely deteriorated or greatly improved ...."

2. Clinical record review for Patient #9 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 7/24/2022 – 9/21/2022, which indicated the patient needed continued physical therapy and occupational therapy services for strengthening and fall reduction.

Clinical record review evidenced a recertification assessment dated 7/19/2022, which

wounds, or bruises.

Clinical record review evidenced a communication note dated 8/9/2022, which indicated the patient fell 3 times on 8/7/2022, and suffered significant bruising to her face.

Clinical record review evidenced a skilled nurse visit note dated 8/9/2022, which indicated the patient fell on her face on 8/7/2022, and had bruising from eyebrows to chin, a bump above the left eyebrow, bilateral black eyes, and a swollen nose. This document indicated the patient did not go to the emergency room.

Clinical record review evidenced a coordination note dated 8/16/2022, which indicated the patient fell on Sunday 8/14/2022, had a bloody nose, and did not go to the emergency room.

Clinical record review evidenced

	9/7/2022, which indicated the patient fell on 9/5/2022, and died the next day 9/6/2022. Clinical record review failed to evidence the comprehensive assessment was updated after any of the falls, or due to the patient's decreasing mobility, extensive bruising, black eyes, bloody noses, or swollen nose. During an interview on 1/26/2023, at 3:09 PM, administrator/clinical manager #1 indicated the agency should have completed an updated comprehensive assessment when there was change in patient condition. Administrator/clinical manager #1 indicated they were not sure the patient had a change in condition. Administrator/clinical manager #1 indicated the patient was pretty much the same.			
G0548	Within 48 hours of the patient's return 484.55(d)(2)	G0548	ED completed on on-line occurrence on 2/24/23 and notified the physician of the agencies failure to complete a Resumption of Care assessment	2023-03-17

	Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician or allowed practitioner - ordered resumption date; Based on record review and interview, the home health agency failed to ensure a comprehensive assessment occurred within 48 hours, for 1 of 1 clinical record reviewed with a patient who returned home from a hospital admission of 24 hours or more during the certification period (#16). Findings include: An agency policy with revised date 3/01/22, titled "Patient Assessment, Initial and Reassessment", stated, "... A qualified clinician performs a comprehensive ... reassessment visit in the following situations ... within 48 hours following post-hospitalization ...." Clinical record review for Patient #16 was completed on 2/01/23 (start of care date 11/20/22). A document dated 1/05/23, titled “Visit Note Report” evidenced the patient utilized the emergency department and was admitted to the hospital, but failed to evidence why the patient was hospitalized.		within from inpatient facility discharge. On 2/20/23 during a mandatory staff meeting, the ED, RVP, and Quality Coordinator reviewed home health policy "Patient Assessment, Initial and Reassessment" with emphasis on the requirement for a qualified clinician to perform a comprehensive reassessment visit within following post-hospitalization. For any staff not present, the RVP or designee will provide instructions to the individual employees by 2/25/23. Beginning 2/24/23, the Executive Director or will review the Hospital Hold report in HCHB daily and contact each facility in which a patient is an inpatient to confirm any pending discharges. The ED will then complete a hospital hold coordination note to ensure communication is entered into the medical record. PCMs and will be notified of any pending hospital discharges so that a qualified and ordered clinician can be scheduled to complete the Resumption of Care assessment visit within of the hospital discharge. Beginning 3/20/23, the	

	A document received from Entity #15 on 1/27/23, titled "Emergency Documentation" evidenced the patient was seen at Entity #15's emergency department, was diagnosed with a UTI, and was admitted for treatment on 12/30/22. A document received from Entity #15 on 1/27/23, titled "History and Physical Reports", evidenced the patient was discharged from Entity #15 on 1/02/23. An untitled document dated 1/05/23, evidenced the document was a physician's order, which indicated a resumption of care visit was ordered for the week of 1/01/23. During an interview on 2/02/23 at 1:55 PM, the Administrator indicated the family didn't notify the agency the patient was in the hospital until 1/04/23, the agency obtained hospital records on 1/05/23, and she didn't know why the resumption of care didn't occur until 1/09/23.		Executive Director or Designee will audit 100% of patient records of patients weekly who had a resumption of care visit completed within the last 7 days to ensure the comprehensive assessment was completed within of hospital discharge. Any deviation will require physician notification and an occurrence report as well as staff remediation as indicated. Monitoring will continue for a total of and until 100% compliance for 3 consecutive weeks. Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	
G0570	Care planning, coordination, quality of care	G0570	The Patient Care Manager	2023-03-17

	484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review, and interview, the home health agency failed to: ensure patients received the home health services which were written in an individualized plan of care (see tag G572); ensure the plan of care included: all pertinent diagnoses, the patients' mental/psychosocial, and cognitive status, the types of services, supplies and equipment required, the frequency and duration of visits to be made, nutritional requirements, all medications and treatments, safety measures, a description of the		attempted to contact Patient #12's physician on 1/27/23 and was unable to obtain orders for PT/INR until 1/30/23 with follow up and changes in medication. On 2/9/23, a clinician and no signs of potential dehydration or symptoms of IBS identified. Patient #9, 14, 16, and 17 have been discharged and an online occurrence has been completed. A Registered Nurse made a home visit to #2 on 1/25/23 to assess the need for therapy services, Nutritional services, social work services, and aide services. The assessment was communicated to the physician and orders were obtained for therapy services. Social Services and Aide Services are contracted through the VA with another agency. Patient has Meals on Wheels that deliver meals to him. A Physical Therapist made a home visit to patient #3 on 2/16/23 to the bathing services. The patient refused therapist to assist with personal care and shower safety. A social worker order was obtained to assess the needs for aide services. An on-line incident report has been completed. Patient #5 was originally admitted to home health services on 8/28/21. At that time, he received physical therapy services and was discharged from PT with goals met. He had a home exercise program in place at that time, along with caregivers that able to assist with transfers and wheelchair mobility. Contacted physician on 2/23/23 to request an updated PT evaluation order.	

	patient's risk for emergency department visits and hospital re-admission, and interventions to address the underlying risk factors, patient and caregiver education and training, patient-specific interventions and education, measurable outcomes and goals, information related to advanced directives, and/or any additional items (see tag G574); ensure services were provided, only as ordered by the physician (see tag G580); review and revise the plan of care (see tag G586); ensure the physician was promptly notified of any changes in patients' condition which suggested goals were not being achieved (see tag G590); coordinate care delivery (see tag G0608); provide patients with written visit schedules (see tag G614); ensure patients received written medication schedule/instructions including medication name, dose and frequency of medications to be taken (see tag G616); and provide patients with written instructions outlining treatments to be administered by home health personnel or personnel acting on behalf of the home health agency (see tag G618).		Patient #6 has been discharged from services. MD was notified that nursing was not provided and occurrence report entered on 2/24/23. A mandatory in-service was held with all staff on 2/20/23 by the RVP and Quality Coordinator to discuss the findings including assessing the patient's needs for nursing, therapy, nutritional social services, or aide services. If needs are identified the agency will work to meet the patient's needs for changes in the plan of care, increasing frequency, implementation of fall prevention, and physician notification of changes in patient's condition and staff will provide the services timely. If agency staff to provide the services, then the Executive Director or are and the patient will be referred to another entity. All services will be provided within 5 days of referral (SOC/ROC 48 hours) and if there is a delay the physician and Patient Care Manager is notified of the reason for delay. If it is patient/family request the documentation of the conversation and who made the request will be documented. If the agency is unable to provide the services, then the physician is and the patient will be referred to another entity for services. Any staff not present will be by the RVP by 2/25/23 on the above . The agency will have a palliative care organization provide an to the agency staff on what services they can provide by 3/17/23 to ensure knowledge of palliative care referral process. All current patient records will be reviewed by the Executive Director, Patient Care Managers, or Performance Improvement coordinators by 3/4/23 to ensure 100% of services to meet the patients' needs have been identified, ordered, and provided. Upon receiving a referral, the Executive Director or Patient Care Manager will review the services required and will provide approval feedback to the referral source if the services can be provided. All communication will be documented within the medical record.	

G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review, and interview, the agency failed to ensure the patient received all services included in the plan of care, the plan of care was individualized, and/or the patient received all services ordered by the referring physician for 15 of 17 records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17). Findings include: *An agency policy with revised date 1/01/23, titled "Admission Process", stated, "... Patients admitted to home care services ... have reasonable expectations that needs can be safely met ... The agency ... Must be able to meet the patient's needs ...	G0572	The Patient Care Manager contacted Patient #1 and reviewed the new and changed medication including the purpose, side effects, and use of the medications with patient reported comprehension on 2/23/23. The Patient Care Manager contacted the physician for #2 on 2/22/23 to notify of the pulse below parameters. The 12/30/22 visit note indicated that there was no edema. Diet education had previously been provided on 12/21/22. On-line occurrence has been completed. Patient's 3, 4, 6 and 7 unable to correct as no citation was noted. The Patient Care Manager for Patient #5 contacted the physician on 2/24/23 regarding failing to follow wound care orders, no orders for colostomy on the plan of care with orders obtained. An on-line occurrence report has been completed. The Patient Care Manager for Patient #8 contacted the physician on 2/24/23 regarding the lack of goals specific to wound care, and lack of following ordered wound care. No orders were obtained as healed. An on-line occurrence report has been completed. The Patient Care Manager contacted Patient #12's physician on 2/24/23 to obtain modalities and goals for teaching of diagnosis and orders were obtained. The Coumadin clinic was contacted on 2/24/23 and coordination has occurred as well as documentation in the medical record of the clinic. An on-line occurrence has been completed.	2023-03-17

	Admits patients ... according to physician's orders ...." * An agency policy with revised date 12/01/11, titled "Personal Care", stated, "... To promote cleanliness and comfort, it is the policy of the agency to provide/assist patients, as needed, to obtain personal care while maintaining patient safety ...." *Clinical record review for patient #12 was completed on 2/01/23 (start of care date 1/18/23, certification period 1/18/23 – 3/18/23). A document titled "Home Health Certification and Plan of Care" (for certification period 1/18/23 – 3/23/23), evidenced the patient's primary diagnosis was Ehlers Danlos Syndrome (a group of disorders that affect connective tissues supporting the skin, bones, blood vessels, and many other organs and tissues), and secondary diagnosis was atrial fibrillation (an irregular heartbeat which requires regular use of blood thinners), and the patient went to an outpatient coumadin clinic (a clinic that manages therapeutic blood levels for use of anticoagulants). The plan of		Patient #9, 13, 14, 16 and 17 have been discharged. On-line occurrences have been completed related to the individualized plan of care. The Patient Care Manager contacted the physician of #15 to obtain orders for modalities and goals for syncope or seizures on 2/24/23 with orders obtained. On 2/22/23 during a mandatory staff meeting, RVP, and Quality Coordinator provided an to all assessing clinicians on developing a patient specific plan of care. For any staff not present, the RVP or designee will provide instructions to the individual employees by 2/25/23. All Patient Care Reviewers will be by the Quality Coordinator or designee by 2/25/23 to ensure review of the patient individualized plan of care is complete and any recommendations or changes are addressed with the individual clinician and physician. All current patient records will be reviewed by the Executive Director, Patient Care Managers, or Performance Improvement coordinators by 3.4.23 to ensure 100% of all treatments were administered only as ordered by the physician. All assessing clinicians will have a review with the Quality Coordinator or by 3/17/23 to ensure identification and individualized plan of care. The Quality Coordinator or will review with the Patient Care Managers the vital sign workflow which populates when a vital sign is entered that is outside the physician ordered parameters. The Patient Care Manager should review and ensure the clinician notified the	

	care failed to be individualized to include what coumadin clinic the patient went to, which day of the week, or the name and contact information for the clinic and the physician responsible for the care at the clinic; and failed to include interventions/goals specific to the patient's diagnoses of Ehlers Danlos Syndrome or atrial fibrillation. During an interview on 2/01/23 at 11:18 AM, the Administrator indicated information for other physicians who provided treatment to the patient didn't need to be on the plan of care, she thought the interventions/goals for Ehlers Danlos Syndrome were okay because they dealt with mobility, and she didn't know which coumadin clinic the patient went to, or who the physician was. * Clinical record review for patient #13 was completed on 2/02/23 (start of care date 10/04/22, certification period 12/03/22 – 1/31/23). A document dated 11/28/22, titled "Visit Note Report" (PT recertification, comprehensive reassessment), evidenced the		notification to the physician as needed. The agency Patient Care Reviewers will be educated by the Director of Coding or designee to ensure identification and individualized plan of care has been developed to include vital sign parameters, colostomy identification, fall prevention steps including therapy, wound care orders, and telephonic teaching only as ordered by the physician. Beginning 3/5/23 the Executive Director or designee will audit 4 visits notes per clinician per month. For clinicians scoring. All new clinicians will have 2 note audits per week 80% for 4 consecutive weeks then will go into the monthly rotation. The note audit will be a random pull of visits and will focus on ensuring interventions or treatments were provided according to the plan of care and the content of the note supports the needs (documentation, physical assessment, intervention). Beginning 3/20/23, ED or will complete 10 Plan of care reviews a week to ensure the plan of care is individualized and contains all the required components.	

	patient's diabetes and hypertensive chronic kidney disease (stage 3) symptoms were poorly controlled, and needed frequent adjustments in treatments and dose monitoring; the patient was short of breath with moderate exertion, and had urinary incontinence; hasn't had a HgbA1c (a blood test which estimates the average daily blood sugar levels over the past couple of months) test in the past 3 months, and contact physician to obtain an order; indicated patient checked blood sugars as ordered (no further information), results were within patient specific parameters (no further information), patient didn't perform foot exams, didn't have a podiatrist, needed help with dressing and grooming, and stated, "... Patient continues to require assistance with all transfers and bed mobility ... remains unsteady ambulating with walker ... remains a high fall risk ... shortness of breath with moderate exertion today ... pain levels are slowly improving following her fall a couple of weeks ago ... Patient reports ... she continues to require assistance with most daily		Any deviations to this process will be addressed with clinician remediation and disciplinary action as indicated. Monitoring will continue for and will continue until 100% compliance for 3 consecutive weeks. Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	

	activities due to generalized weakness ....” A document titled “Home Health Certification and Plan of Care” (for certification period 12/03/22 – 1/31/23), evidenced the patient lived alone, and failed to evidence it was individualized to include how the agency mitigated the patient’s poorly controlled diabetes and hypertensive chronic kidney disease symptoms, or the patient’s shortness of breath and urinary incontinence; failed to evidence a HgbA1c was ordered, how often the patient checked her blood sugars, order for a podiatrist evaluation, how the agency ensured the patient’s safety due to living alone, or received assistance with her daily activities and personal care. During an interview on 2/02/23 at 2:33 PM, the Administrator indicated the plan of care wasn’t individualized. * Clinical record review for patient #14 was completed on 2/02/23 (start of care date 10/27/22, certification period 10/27/22 – 12/25/22). A			

	document titled "Home Health Certification and Plan of Care" (for initial certification period 10/27/22 – 12/25/22), evidenced skilled nursing was ordered for 1 visit during the week of 10/30/22, PT was ordered once weekly for 7 weeks, then every other week for 2 weeks, and OT was ordered for 1 visit during the week of 11/06/22. The plan of care failed to evidence any skilled nursing or OT interventions or goals. During an interview on 2/02/23 at 3:01 PM, the Administrator indicated there were other orders in the medical record with nursing and OT interventions and goals, but did not indicate they were updates to the patient's plan of care. * Clinical record review for patient #15 was completed on 2/02/23. A document titled "Home Health Certification and Plan of Care" (for initial certification period 11/20/22 – 1/18/23), evidenced the patient's medications included levetiracetam (an anti-seizure medication); and stated, "... Patient ... medical history is			

	hypertension [high blood pressure] ... patient attributes frequent falls to syncopal [fainting] episodes ....” The plan of care failed to be individualized to include interventions or goals for syncope or seizures. A web base referenced on 2/01/23 from the National Library of Medicine (https://www.ncbi.nlm.nih.gov/books/NBK442006/), updated 6/21/22, titled “Syncope”, indicated seizures could mimic syncopal episodes. During an interview on 2/02/23 at 3:30 PM, the Administrator indicated there weren’t interventions or goals on the plan of care for syncope or seizures. * Clinical record review for Patient #16 was completed on 2/01/23 (start of care date 11/20/22). A document titled “Home Health Certification and Plan of Care” (for initial certification period 11/20/22 – 1/18/23), evidenced the patient’s primary diagnosis was Urinary Tract Infection (UTI); other diagnoses included			

	with the heart that can develop if you have high blood pressure but don't treat it for years) and chronic kidney disease (long-standing decline of kidney function) with heart failure (the heart's inability to pump blood and oxygen [O2] throughout the body) and stage 5 chronic kidney disease (end stage, requires dialysis to sustain life). The plan of care failed to be individualized to include interventions/goals for diagnoses of UTI, or hypertensive heart and chronic kidney disease with heart failure and stage 5 chronic kidney disease. During an interview on 2/01/23 at 2:15 PM, the Administrator indicated she didn't know why the patient's primary diagnosis was coded as UTI, and indicated there should be interventions and goals for pertinent diagnoses. * Clinical record review for Patient #17 was completed on 2/02/23 (start of care date 7/08/22). A document titled "Home Health Certification and Plan of Care" (for certification period 7/08/22 – 9/05/22),			

	ordered for one visit during the week of 7/17/22, and physical therapy (PT) was ordered weekly for 9 weeks. The document also evidenced the patient's primary diagnosis was (idiopathic) normal pressure hydrocephalus (a condition that happens when cerebrospinal fluid builds up inside your skull and presses on your brain, which causes gait issues, urinary incontinence, and cognitive difficulties), and other diagnoses included essential (primary) hypertension (high blood pressure). The plan of care failed to be individualized to include patient-specific interventions/goals for diagnoses of normal pressure hydrocephalus or hypertension; or any skilled nursing interventions/goals. During an interview on 2/02/23 at 3:45 PM, the Administrator indicated the nursing interventions/goals were on a subsequent order, but it was not titled as an updated plan of care, and the interventions/goals weren't specific to the patient's diagnoses.			

	17 IAC 17-13-1(a) *. Clinical record review for Patient #1 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 1/10/2023 – 3/10/2023, which stated, "… May use telehealth and telecommunications to provide services as necessary and appropriate according to the patient's condition and in accordance with the plan of care …." During an interview on 1/31/2023, at 9:56 AM, administrator/clinical manager #1 indicated the plan of care was individualized based on the patients' assessment. Administrator/clinical manager #1 indicated the plan of care should include individualized interventions and parameters based on the assessment of problems. Administrator/clinical manager #1 indicated the telephonic teaching visit shouldn't have been included in everyone's plans of care. *. Clinical record review for			

	Patient #2 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 11/30/2022 – 1/28/2023, which stated, "… May use telehealth and telecommunications to provide services as necessary and appropriate according to the patient's condition and in accordance with the plan of care …." *. Clinical record review for Patient #3 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 12/8/2022 – 2/5/2023, which stated, "… May use telehealth and telecommunications to provide services as necessary and appropriate according to the patient's condition and in accordance with the plan of care …." *. Clinical record review for Patient #4 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 12/8/2022 – 2/5/2023, which stated, "… May			

	telecommunications to provide services as necessary and appropriate according to the patient's condition and in accordance with the plan of care ...." *. Observation of a home visit for Patient #5 at 1/27/2023, at 8:30 AM, to observe a routine skilled nurse visit. During the visit, the patient was observed to have a colostomy (opening through the skin of the stomach, which connects to the large intestine, and allows stool to exit the body). Clinical record review for Patient #5 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 12/21/2022 – 2/18/2023, which failed to be individualized to include any treatment, orders, or diagnoses regarding patient's colostomy status. The plan of care stated, "... May use telehealth and telecommunications to provide services as necessary and appropriate according to the patient's condition and in			

	care ….” During an interview on 1/31/2023, at 12:32 PM, administrator/clinical manager #1 indicated the plan of care should have included information regarding the patient’s colostomy. *. Clinical record review for Patient #6 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 1/10/2023 – 3/10/2023, which stated, “… May use telehealth and telecommunications to provide services as necessary and appropriate according to the patient’s condition and in accordance with the plan of care ….” *. Clinical record review for Patient #7 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 12/2/2022 – 1/30/2023, which stated, “… May use telehealth and telecommunications to provide			

	services as necessary and appropriate according to the patient's condition and in accordance with the plan of care ...." *. Clinical record review for Patient #8 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 1/5/2023 – 3/5/2023, which stated, "... May use telehealth and telecommunications to provide services as necessary and appropriate according to the patient's condition and in accordance with the plan of care ...." The plan of care indicated the patient had a wound, and also included a goal of remaining free from skin breakdown. The goals on the plan of care failed to be individualized. During an interview on 1/30/2023, at 2:43 PM, administrator/clinical manager #1 indicated the goal of remaining free from skin breakdown was not individualized.			

*. Clinical record review for Patient #9 was completed on 2/2/2023, for certification period 7/24/2022 – 9/21/2022. Record review evidenced a recertification assessment dated 7/19/2022, which indicated the patient was at risk for falls.

Clinical record review evidenced a plan of care for certification period 7/24/2022 – 9/21/2022, which stated, "… May use telehealth and telecommunications to provide services as necessary and appropriate according to the patient's condition and in accordance with the plan of care …." The plan of care failed to be individualized to include any specific fall prevention techniques or measures to be taken to prevent falls.

During an interview on 2/1/2023, at 10:00 AM, administrator/clinical manager #1 indicated the plan of care should have had more specifics for fall prevention.

	410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician	G0574	The Patient Care Manager contacted Patient #1's physician on 2/24/23 regarding pertinent diagnosis and medications the patient is currently taking, and orders were received to update the plan of care. An on-line incident report has been completed. The Patient Care manager contacted Patient #2's physician on 2/24/23 regarding the diagnosis, interventions for foley catheter teaching, and updated medical equipment the patient is using in the home with orders received. An on-line incident report has been completed. The Patient Care Manager contacted Patient #3's physician on 2/24/23 regarding diagnosis not included in the patient's plan of care and orders were received to update the plan of care. An on-line incident report has been completed. Patient #4 has been discharged from service. An on-line incident report has been completed regarding diagnosis not included in the patient's plan of care with orders received to update the current plan of care. The Patient Care Manager contacted Patient #5's physician on 2/24/23 regarding diagnosis not included in the patient's plan of care with orders received to update the current plan of care. An on-line incident report was	2023-03-17

	or allowed practitioner may choose to include. Based on observation, record review, and interview, the home health agency failed to ensure the plan of care included: all pertinent diagnoses, the patients' mental/psychosocial, and cognitive status, the types of services, supplies and equipment required, the frequency and duration of visits to be made, nutritional requirements, all medications and treatments, safety measures, a description of the patient's risk for emergency department visits and hospital re-admission, and interventions to address the underlying risk factors, patient and caregiver education and training, patient-specific interventions and education, measurable outcomes and goals, information related to advanced directives, and/or any additional items in 14 of 17 clinical records reviewed. (#1, 2, 3, 4, 5, 7, 8, 9, 12, 13, 14, 15, 16, 17). The findings include: 10. A home visit was observed on 1/27/23 at 2:00 PM with Patient #12, PTA #2, and the		completed. The Patient Care Manager contacted Patient #7 physician on 2/24/23 regarding specific tube feeding instructions were not included in the plan of care with orders received to update the current plan of care. An on-line incident report was completed. The Patient Care Manager contacted Patient #8s physician on 2/24/23 regarding lack of diagnosis, specific tube feeding instructions, and wound care orders were incomplete with orders obtained. An on-line incident report was completed. 9, 13, 14, 16 and 17 have been discharged and an online occurrence has been completed for the failure of having a complete and updated plan of care. The Patient Care Manager for patient #12 contacted the physician on 2/24/23 regarding the plan of care failed to have all pertinent diagnosis, safety, allergies, diet, modalities for pain, psychosocial information, mitigations plan for hospital and emergency room visits, difficulty sleeping, and the need for handicap van for transportation and orders were obtained to update the plan of care as needed. An on-line occurrence has been completed. The Patient Care Manager for Patient #15 contacted the physician on 2/24/23 regarding the plan of care not including all the pertinent diagnosis, advance directives, nutritional requirements, treatment for wounds, safety requirements, and interventions and goals for diagnosis and to mitigate emergency room and hospitalization risk and pain, physician orders were received to update the plan. An on-line occurrence was completed. On 2/22/23 during a mandatory staff meeting,	

	Alternate Clinical Manager. The patient indicated her handicap accessible van broke down, so she was unable to get her medical appointment yesterday (1/26/23). PTA #2 instructed on the continued use of heat and ice for pain relief. Clinical record review for patient #12 was completed on 2/01/23 (start of care date 1/18/23, certification period 1/18/23 – 3/18/23). A document dated 1/18/23, titled "Visit Note Report" (PT start of care comprehensive assessment), evidenced the patient needed help with grooming and dressing, difficulty completing most daily activities, multiple emergency room visits over the past several months, significant difficulty with sleep, pain impacted mobility, and the patient preferred afternoon visits. A document dated and signed by Person #1 (the patient's certifying physician) on 1/13/23, evidenced the document was a physician's progress note, other physicians involved with the patient's care included Person #2 (Hematology/Oncology), Person #3 (Clinical Cardiac		all assessing clinicians on developing a patient specific plan of care. For any staff not present, the RVP or designee will provide instructions to the individual employees by 2/25/23. All Patient Care Reviewers will be by the Quality Coordinator or designee by 2/25/23 to ensure review of the patient individualized plan of care is complete and any recommendations or changes are addressed with the individual clinician and physician. All current patient records will be reviewed by the Executive Director, Patient Care Managers, or Performance Improvement coordinators by 3/4/23 to ensure 100% of plans of care included: all pertinent diagnosis, mental/psychosocial and cognitive status, the types of services, supplies and equipment required, frequency and duration of visits to be made, nutritional requirements, all medications and treatments, safety measures, description of measures to reduce hospital and emergency care, interventions to address underlying risk factors, patient and caregiver education and training, patient/specific interventions and education, measurable outcomes and goals, information related to advance directives, and dietary restrictions. All assessing clinicians will have a review with the Quality Coordinator or by 3/17/23 to ensure identification and individualized plan of care. Care Reviewers will have a review of their plan of care completed by the Director of Coding or designee to ensure identification and individualized plan of care has been developed. A plan of care review tool will be implemented with any PCM's who are reviewing plans of care ensure identification and completion of required elements to the plan of care.	

	Electrophysiologist), Person #4 (Cardiologist), Person #5 (patient's primary care nurse practitioner), and Person #6 (Gastroenterologist); thirty-two allergies included albuterol (an inhaled respiratory medication), Asmanex twisthaler (used to treat symptoms of asthma), aspartame (artificial sweetener), axid (an anti-acid), bentyl (used to treat spasms of the intestines), carafate (used to treat stomach ulcers and gastroesophageal reflux disease [acid reflux]), cleocin (an antibiotic), cloace (stool softener), demerol (a narcotic pain medication), Eliquis (a blood thinner), flagyl (an antibiotic), heparin (a blood thinner), iodinated contrast media (medication injected into a vein to enhance the ability to see blood vessels and organs on medical images), lidocaine (numbing agent), hydrocodone (a narcotic pain medication), minocin (an antibiotic), monosodium glutamate (MSG) (a flavor enhancer used in food recipes), morphine (a narcotic pain medicine), naproxen (nonsteroidal anti-inflammatory drug [NSAID] used to treat pain), neomycin (an antibiotic), nitrous oxide (a sedative agent,		Beginning 3/20/23, ED or will complete 10 Plan of care reviews a week to ensure the plan of care is individualized and contains all the required components. Any deviations to this process will be addressed with clinician remediation and disciplinary action as indicated. Monitoring will continue for and will continue until 100% compliance for 3 consecutive weeks. Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	

	"laughing gas"), oxycodone (a narcotic pain medication), Pradaxa (an anticoagulant used to treat and prevent blood clots and to prevent stroke in people with atrial fibrillation), prednisone (a steroid anti-inflammatory), propylene glycol (a laxative), protonix (used to decrease stomach acid production), statin drugs (used to lower cholesterol), sulfa drugs (sulfonamide antibiotics), ultram (a narcotic pain medication), valtrex (antiviral medication), vancomycin (an antibiotic), and Zithromax (an antibiotic); diagnoses included breast cancer, skin cancer, obesity, vitamin D deficiency (symptoms could include fatigue, back pain, hair loss, poor wound healing, and symptoms of depression), paroxysmal ventricular tachycardia (intermittent rapid heart beat which can cause dizziness, lightheadedness, and fainting), chronic orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying, causing lightheadedness, dizziness, or fainting), postural orthostatic tachycardia syndrome (POTS) (Symptoms related to the reduced blood			

	volume that occurs when a person stands up after lying down, and causes lightheadedness, fainting, and rapid heartbeat, which are relieved by lying down again), celiac disease (autoimmune disease where the ingestion of gluten leads to damage in the intestines), lumbosacral spondylosis without myelopathy (degeneration of the lower spine without damage to the spinal cord, and includes ongoing pain caused by compressed nerves), lumbosacral radiculitis (inflammation of a nerve root in the lower back, which causes symptoms of pain or irritation in the back and down the legs), and history of thromboembolism (blood clot); the patient had a left breast mastectomy on 3/30/15, and pacemaker placement occurred on 11/29/17; and ordered diet was gluten free, low sodium, and no MSG. A document titled "Home Health Certification and Plan of Care" (for certification period 1/18/23 – 3/23/23) evidenced the patient had a regular diet (no restrictions), and had no allergies. The plan of care failed			

	to include the significant diagnoses listed in the certifying physician's progress note which could affect he patient's safety, increased fall risk, and outcomes of treatment provided by the agency; failed to include the patient's 32 allergies, or ordered diet; modalities for pain relief included heat/ice (or indications/precautions for use); how the agency ensured daily activities were completed safely, how the agency mitigated multiple emergency room visits over the past several months, or significant difficulty with sleep; or psychosocial information included the patient preferred afternoon visits, and required a handicap accessible van for transportation. During an interview on 2/01/23 at 11:18 AM, the Administrator indicated heat/ice, compression stockings, and allergies should be on the plan of care; she wouldn't include the patient's (psychosocial needs) transportation needs and preference for afternoon visits on the plan of care; she didn't know what PT could do about the sleep disorder, and it was sort of not a PT task; the			

	patient only wanted certain services with certain people, that's all she'd allow, and didn't know if the clinical record included that information; they don't offer home health aide services, but did have OT for patients that have difficulty with personal care needs, sometimes patients accept the service, and sometimes they don't, but it should be documented. 11. Clinical record review for patient #13 was completed on 2/02/23 (start of care date 10/04/22, certification period 12/03/22 – 1/31/23). A document titled "Home Health Certification and Plan of Care" (for certification period 12/03/22 – 1/31/23), evidenced a medication order for daily application of antibiotic ointment to a heel wound. The plan of care failed to evidence a wound diagnosis, wound care orders (cleansing solution, cover dressing, who performed the care), or the location of the wound. A document dated 12/13/22, titled "Visit Note Report" (PT reassessment visit) evidenced the patient used heat and cold applications, and over the			

	counter medications for pain relief. The plan of care failed to evidence modalities of heat and cold application, or instructions/precautions for use; or any over the counter medications for pain relief. During an interview on 2/02/23 at 2:33 PM, the Administrator indicated the plan of care didn't include the heat or cold applications, or over the counter pain medications. 12. Clinical record review for patient #14 was completed on 2/02/23 (start of care date 10/27/22, certification period 10/27/22 – 12/25/22). A document dated 10/17/22, titled "... Order Category: Dietary, Pharmacy ... Active Orders As Of ... 10/17/22", evidenced the document originated from Entity #25 (a skilled nursing facility). The document listed the patient's current diagnoses, which included obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), UTI, dysphagia, oropharyngeal phase (difficulty initiating a swallow, and swallowing may be accompanied by regurgitation,			

	aspiration [the drawing in of a foreign substance into the lungs], and a sensation of residual food remaining in the throat), need for assistance with personal care, other symptoms and signs concerning food and fluid intake, and stage 2 pressure ulcer, other site (characterized by partial-thickness skin loss into but no deeper than the layers of the skin, which includes intact or ruptured blisters). A document dated 10/14/22, titled "[Entity #25] ... Progress Notes", evidenced the patient's family had an appointment with Entity #27 (an oxygen and medical equipment company) for training on BiPap (a device that helps with breathing, and forces intermittent air into the lungs), and the patient's advance directive was DNR (Do Not Resuscitate). A document titled "Home Health Certification and Plan of Care" (for initial certification period 10/27/22 – 12/25/22), evidenced the patient's primary diagnosis was acute (sudden) and chronic (long standing) respiratory failure with hypoxia (the respiratory system cannot adequately provide oxygen to			

	the body, resulting in an absence of enough oxygen in the tissues to sustain bodily functions), and additional diagnoses included pneumonitis due to inhalation of food and vomit (an infection of the lungs caused by inhaling saliva, food, liquid, vomit and even small foreign objects into the lungs), sepsis (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues), and type 2 diabetes (adult onset); had 10 hours paid caregiver support daily; the patient had no advance directives; and was on a regular diet (no dietary restrictions). The plan of care failed to include the patient's diagnoses of obstructive and reflux uropathy, UTI, need for assistance with personal care, other symptoms and signs concerning food and fluid intake, and stage 2 pressure ulcer, other site; equipment included a BiPap machine and associated mask, tubing, etc.; the patient's advance directive was DNR; safety measures included aspiration precautions and risk for skin breakdown; any dietary restrictions due to risk of aspiration; what services the			

paid caregivers provided; or patient-specific interventions and goals for the patient's diagnoses of pneumonitis due to inhalation of food and vomit, Sepsis, type 2 diabetes, obstructive and reflux uropathy, UTI, need for assistance with personal care, other symptoms and signs concerning food and fluid intake, and stage 2 pressure ulcer, other site; and failed to include the location or treatment of the pressure ulcer.

On 2/02/23 at 3:01 PM, during the clinical record review, the Administrator indicated the patient had multiple complex comorbidities that weren't addressed on the plan of care.

13. Clinical record review for patient #15 was completed on 2/02/23. A document dated 12/28/22, titled "History and Physical Reports" (Entity #15, a hospital), evidenced the patient was prescribed a heart healthy diet (low fat, cholesterol, and salt), and experienced recurrent syncope (fainting spells).

A document dated 1/09/23, titled "Outpatient Surgical Report/Discharge Summary",

	orthopedic surgeon) performed surgery on the patient to repair the right elbow on 1/09/23, and staples were used to close the skin. A document dated 11/13/22, titled "Visit Note Report" (PT start of care comprehensive assessment), evidenced the patient had a follow up appointment with Person #23 on 1/20/23, patient knowledge-based deficits included special diet/fluid restrictions, safety hazards included unsafe floor coverings, sanitation issues included cluttered/soiled living area, the patient had pain to the right elbow, and pain relief measures included immobility. A document titled "Home Health Certification and Plan of Care" (for initial certification period 11/20/22 – 1/18/23), evidenced PT was the only ordered service, the patient's certifying physician was person # 24, the patient's primary diagnosis was laceration without foreign body of other part of head, subsequent encounter (unspecified open wound of unspecified part of			

	included fracture of right elbow, generalized anxiety disorder, hypertension (high blood pressure), and UTI; medications included levetiracetam (an anti-seizure medication); risks for emergent care and hospitalization included multiple recent hospitalizations/emergency department visits in the past 6 months, decline in mental, emotional, or behavioral status in the past 3 months, currently taking 5 or more medications, and "other risks" (not further specified); safety measures included fall risk; nutritional requirements was regular (unrestricted diet); interventions included to change dressing as needed in order to maintain a clean dry dressing and cover with a nonadherent island dressing, and management of depression; goals included reduction in signs and symptoms of depression; and stated, "... Patient presents with a long arm splint [used to immobilize the elbow joint] ... Patient ... medical history is significant for frequent falls and hypertension [high blood pressure] ... patient attributes frequent falls to syncopal [fainting] episodes ...." The plan			

	of care failed to evidence a diagnosis of depression, the patient's nutritional requirement of a heart healthy diet, any treatment for the primary diagnosis of head laceration, or incision treatment included how the wound was cleansed; safety measures included seizure, skin, or syncope precautions; all interventions/goals to reduce hospitalizations/emergency department visits; pain relief modalities included use of and directions for the long arm splint; interventions/goals for hypertension, anxiety, UTI, or syncopal episodes; or Person #23 also provided care/treatment orders for the patient. 14. Clinical record review for Patient #16 was completed on 2/01/23 (start of care date 11/20/22). A document titled "Home Health Certification and Plan of Care" (for initial certification period 11/20/22 – 1/18/23), evidenced PT was ordered once weekly (no additional disciplines were ordered), the patient's primary diagnosis was urinary tract infection (UTI), other diagnoses			

	(problems with the heart that can develop if you have high blood pressure but don't treat it for years) and chronic kidney disease (long-standing decline of kidney function) with heart failure (the heart's inability to pump blood and oxygen [O2] throughout the body) and stage 5 chronic kidney disease (end stage, requires dialysis to sustain life), sick sinus syndrome (a type of heart rhythm disorder), acute (sudden) and chronic (long standing) respiratory failure with hypoxia (the respiratory system cannot adequately provide oxygen to the body, resulting in an absence of enough oxygen in the tissues to sustain bodily functions), and dependence on supplemental oxygen (O2) (2 liters per minute [LPM] continuous, via nasal cannula [small tubes inserted into the nostrils to administer oxygen]); provide instruction regarding non-pharmacological methods of pain relief (not further specified); nutritional requirements included a 32 ounce limit for fluid intake; risks for emergent care and hospitalization included multiple recent hospitalizations/emergency			

	department visits in the past 6 months, decline in mental, emotional, or behavioral status in the past 3 months, currently taking 5 or more medications, and "other risks" (not further specified); and stated, "... Patient was recently hospitalized for a UTI and PD [peritoneal dialysis] port infection ... also has the following co-morbidities that are new or have exacerbated within the last month ... HTN [hypertension (high blood pressure)] ... ESRD [end stage renal (kidney) disease] ... current procedures/treatment which cannot be performed by patient/caregiver due to documented lack of knowledge & or skill ... education on medication management ... Patient is further considered unstable as evidenced by ... increased low back pain ... poor balance ...." The patient's plan of care failed to evidence diagnoses included low back pain; was individualized to include any interventions or goals related to the patient's medical diagnoses of UTI, hypertensive heart and chronic kidney disease with heart failure and stage 5 chronic kidney disease, sick sinus syndrome, acute and chronic respiratory			

	failure with hypoxia; patient-specific non-pharmacological methods of pain relief used; nutritional requirements included what type of diet the patient was ordered; interventions/goals for identified risks of emergent care and hospitalization, or what patient-specific "other risks" were associated with potential for emergent care and hospitalization; interventions and goals for infection prevention and control related to UTI and recent PD port infection; or the specific procedures/treatment which couldn't be performed by patient/caregiver due to documented lack of knowledge, or associated interventions/goals. A document dated 11/20/22, titled "Visit Note Report" (PT start of care comprehensive assessment) evidenced the PT recommended palliative care (a specialized form of care that provides symptom relief, comfort and support to individuals living with serious illnesses, and also provides support to caregivers and those impacted by a loved one's condition). The plan of care			

	failed to evidence psychosocial needs included the recommendation for palliative care. During an interview on 1/27/23 at 10:00 AM, at Entity #16 (a dialysis facility), Person #17 (a registered nurse [RN]) indicated the patient transferred to Entity #16 from another dialysis facility in October 2022, subsequently trained at this facility on Mondays, Wednesdays, and Fridays for peritoneal dialysis, and did backup hemodialysis at Entity #18 (a dialysis facility) on Tuesdays, Thursdays, and Saturdays. A document received from Entity #16 on 1/27/23 at 10:22 AM, titled “Limited Encounter”, evidenced Person #19 managed the patient’s hemodialysis; diagnoses included myelofibrosis (a rare type of blood cancer in which bone marrow is replaced by fibrous scar tissue) and hypotension (low blood pressure). The plan of care failed to evidence diagnoses of myelofibrosis or hypotension; and failed to evidence any information			

needs, or Person #19 also provided care/treatment to the patient.

During an interview on 2/01/23 at 2:15 PM, the Administrator confirmed the patient's diagnoses required interventions, she wasn't sure why nursing services wasn't ordered, she didn't know why UTI was the primary diagnosis for a "therapy only" patient, there should be patient specific interventions and goals for the pertinent diagnoses, the plan of care did not include any, and there was no dialysis information on the plan of care.

During an interview on 2/02/23 at 1:55 PM, the Administrator indicated family was unrealistic with palliative care, repeatedly refused palliative care, family repeatedly did not want a nurse, family thought peritoneal dialysis was going to be the answer to make the patient well, agency staff felt the patient was experiencing end of life for some time now, the patient had frequent skin tears/issues due to immobility, remained in the same position too long, and her skin was very thin/fragile. The

patient/family psychosocial needs for coping with potential end of life situation, interventions/goals for skin issues, or interventions/goals to address the patient was left in the same position too long. The Administrator confirmed the plan of care or clinical record didn't include this information.

15. Clinical record review for Patient #17 was completed on 2/02/23 (start of care date 7/08/22). A document received from Entity #15 (a hospital) on 1/27/23 evidenced the patient's allergies included NSAIDs (non-steroidal anti-inflammatory drugs to reduce pain, decrease inflammation, decrease fever, and prevent blood clots), and if used, the patient's side effect(s) were severe, and included development of stomach ulcers.

A document titled "Home Health Certification and Plan of Care" (for certification period 7/08/22 – 9/05/22), evidenced skilled nursing was ordered for one visit during the week of 7/17/22, and physical therapy (PT) was ordered weekly for 9 weeks. The document also evidenced the patient's primary

	diagnosis was (idiopathic) normal pressure hydrocephalus (a condition that happens when cerebrospinal fluid builds up inside your skull and presses on your brain, which causes gait issues, urinary incontinence, and cognitive difficulties), and other diagnoses included essential (primary) hypertension (high blood pressure), and history of falling; advance directives included the patient had a durable power of attorney and a surrogate decision maker (a document that identifies an individual to make health care decisions on the patient's behalf when he or she is no longer be able to make such decisions); the patient had no known allergies, and safety measures included 24 hour supervision was required. The plan of care failed to include patient specific interventions/goals for the patient's diagnoses of (idiopathic) normal pressure hydrocephalus and hypertension, allergies included NSAIDs, or advance directives information included the name and/or contact information of the patient's durable power of attorney/surrogate decision maker.			

	A document dated 7/08/22, titled "Visit Note Report" (PT start of care comprehensive assessment) evidenced the patient's diagnoses also included cerebrovascular accident (CVA)(stroke)/transient ischemic attack (TIA)("mini-stroke"); non-pharmacological treatments for pain included use of cold application; the patient lived with a 24-hour caregiver; and the patient was fall risk, at risk for development of pressure injuries (wounds caused by unrelieved pressure or friction), and was dependent for personal care (tasks such as bathing, grooming, toileting). The plan of care failed to include diagnoses of CVA/TIA, therapeutic modalities for pain relief included cold application (and directions/precautions for use), safety measures included skin and fall precautions, or interventions/goals to meet the patient's personal care needs. An untitled document with order date 7/16/22 (a physician's order), evidenced the patient's additional/exacerbated diagnoses included Von Willebrand's Disease (a blood			

	disorder in which the blood does not clot properly, and symptoms may include recurrent and prolonged nosebleeds, bleeding from the gums, and excessive bleeding from a cut), and Acute Panmyelosis with Myelofibrosis (in remission) (a cancer of the blood and bone marrow, which can cause excessive bleeding). The plan of care failed to include the patient's diagnoses of Von Willebrand's Disease or Acute Panmyelosis with Myelofibrosis (in remission). A document dated 7/16/22, titled "Visit Note Report" (RN Add-On Evaluation), evidenced non-pharmacological treatments for pain included use of heat application, the patient had generalized (affecting many parts of the body) bruising, and required frequent laboratory blood testing to monitor the patient's blood coagulation and disease progression. The plan of care failed to include therapeutic modalities for pain relief included heat application (and directions/precautions for use), or safety measures associated with risk of excessive bleeding.			

	During an interview on 2/02/23 at 3:45 PM, the Administrator indicated the plan of care didn't include the name and/or contact information of the patient's durable power of attorney/surrogate decision maker, and confirmed the plan of care should include all diagnoses, heat/cold modalities, and safety measures/precautions. 1. Record review evidenced an agency policy revised 12/1/2021, titled "Plan of Care" which stated, "... The plan of care includes: ... Patient's mental psychosocial, and cognitive status ... Types, frequency, and duration of services required ... Prognosis ... Functional limitations and activities permitted ... Nutritional requirements ... Medications and treatments ... Safety measures to protect against injury ... Pertinent diagnoses ... Patient specific interventions and education; measurable outcomes and goals ... Required equipment and supplies ... Patient's risk for emergency department visits and re-hospitalization including			

	interventions that address underlying risk factors … Patient/caregiver education and training for timely discharge … Advance Directives … All patient care orders ….” 2. Clinical record review for Patient #1 was completed on 2/2/2023, for certification period 1/10/2023 – 3/10/2023. Record review evidence a referral order dated 7/8/2022, which included the following diagnoses which were not included in the plan of care: hypersomnia (excessive sleepiness), chronic constipation, recurrent urinary tract infections (bladder infections), and risk for imbalanced fluid volume. Clinical record review evidenced a plan of care for certification period 1/10/2023 – 3/10/2023, which indicated the patient was taking modafinil (medication to increase alertness), senna (stool softener), Dulcolax (for constipation), and cranberry tablets (to prevent urinary tract infections).			

During an interview on 1/31/2023, at 3:18 PM, administrator/clinical manager #1 indicated plans of care should have included all pertinent diagnoses from the referral documentation or history and physical.

3. Observation of a home visit for Patient #2 was conducted on 1/25/2023, at 10:00 AM, to observe a routine skilled nurse visit. During the visit, the following medical equipment was observed in use in the home, and not included on the plan of care: cane, rocksteady device, grabber, and shower chair.

Clinical record review for Patient #2 was completed on 2/2/2023, for certification period 11/30/2022 – 1/28/2023. Record review evidenced a referral order/history and physical dated 11/30/2022, which included the following diagnoses which were not included in the plan of care:

pressure), hyperlipidemia (high cholesterol), and cardiac arrythmia (irregular heart beat).

Clinical record review evidenced a plan of care for certification period 11/30/2022 – 1/28/2023, which indicated the skilled nurse was to instruct the patient on care of an indwelling catheter, including signs and symptoms of infection, and instruct the client on infection control measures. This document failed to include patient specific education regarding infection control, such as type of infection control measures, methods of infection control, or specific signs and symptoms the patient should look for. The plan of care failed to include patient specific instructions regarding indwelling catheter care.

During an interview on 1/31/2023, at 10:27 AM, administrator/clinical manager #1 indicated the plan of care should have been more detailed and include patient specific education on indwelling catheter care. At 10:29 AM,

	administrator/clinical manager #1 indicated all medical equipment the patient was using should have been included on the plan of care. 4. Clinical record review for Patient #3 was completed on 2/2/2023, for certification period 12/8/2022 – 2/5/2023. Record review evidenced a history and physical dated 12/17/2022, which included a diagnosis of vertigo (spinning sensation), which was not included on the plan of care. 5. Clinical record review for Patient #4 was completed on 2/2/2023, for certification period 1/20/2023 – 3/20/2023. Record review evidenced a start of care assessment dated 1/20/2023, which indicated the patient had a diagnosis of chronic obstructive pulmonary disease (disease which results in progressively worsening ability to breathe). Clinical record review evidenced			

	period 1/20/2023 – 3/20/2023, which failed to include a diagnosis of chronic obstructive pulmonary disease. During an interview on 1/31/2023, at 12:25 PM, administrator/clinical manager #1 indicated the plan of care should have included chronic pulmonary obstructive disease. 6. Clinical record review for Patient #5 was completed on 2/2/2023, for certification period 12/21/2022 – 2/18/2023. Record review evidenced a referral document dated 8/24/2022, which included a diagnosis of obstructive sleep apnea (low oxygen levels while sleeping), which was not included on the plan of care. 7. Clinical record review for Patient #7 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 12/2/2022 – 1/30/2023, which indicated the patient was receiving isosource			

	Jevity 1.5 tube feedings. During an interview on 1/30/2023, at 2:29 PM, administrator/clinical manager #1 indicated they did not know which tube feed the patient was receiving, but this information should have been included on the plan of care. 8. Clinical record review for Patient #8 was completed on 2/2/2023, for certification period 1/5/2023 – 3/5/2023. Record review evidenced a history and physical dated 1/10/2023, which included the following diagnoses which were not included in the plan of care: dysphagia (inability to swallow), and gastrostomy tube status (tube inserted through the skin of the abdomen into the stomach for nutrition and medications). Clinical record review evidenced a plan of care for certification period 1/5/2023 – 3/5/2023, which indicated the patient was			

	follows: Isosource 1.5, 6 – 8 bottles per day, at 750 milliliters per hour. The plan of care failed to include nutritional information such as total volume per day, if tube feed was bolus or continuous, free water flush information, or how many hours tube feeding would infuse. The plan of care indicated the physical therapist was to complete wound care but failed to include any wound care orders such as frequency of dressing changes, type of dressing, or any instructions for wound care. During an interview on 1/30/2023, at 2:40 PM, administrator/clinical manager #1 indicated all pertinent diagnoses should be included on the plan of care. Administrator/clinical manager #1 indicated the diagnoses are usually obtained from the history and physical or referral documentation. At 2:45 PM, administrator/clinical manager #1 indicated they were not sure if the tube feeds were continuous or bolus, and additional information should			

	of care. Administrator/clinical manager #1 indicated wound care orders should have been included on the plan of care. 9. Clinical record review for Patient #9 was completed on 2/2/2023, for certification period 7/24/2022 – 9/21/2022. Record review evidenced a physical therapy evaluation note dated 8/26/2022, which indicated the patient had been using a walker, which was not included in the plan of care. Clinical record review evidenced a history and physical dated 6/28/2022, which included the following diagnoses which were not included on the plan of care: lymphoid cancer (cancer of the lymphatic system), gilbert syndrome (a disorder in which the liver doesn't properly process bilirubin), atrial fibrillation (disease in which the heart beats irregularly), osteoporosis (weakening of the bones), heart failure, and hyperlipidemia (high cholesterol). This document also indicated the patient was taking			

	supplement), which was not included on the plan of care. Clinical record review evidenced a plan of care for certification period 7/24/2022 – 9/21/2022, which indicated physician #17 was the patient's physician. During an interview on 2/1/2023, at 10:13 AM, administrator/clinical manager #1 indicated physician #17 was retired, and the plan of care should have included physician #18. Administrator/clinical manager #1 indicated the diagnoses and nutritional supplements should have been included on the plan of care.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the home health agency failed to ensure	G0580	The Patient Care Manager contacted patient #3's physician on 2/24/23 regarding completing wound care without an order. An online occurrence report has been completed.	2023-03-17

	treatments were administered only as ordered by the physician in 1 of 7 home visits conducted. (#3) The findings include: Record review evidenced an agency policy revised 12/1/2022, titled "Physician Orders" which stated, "... No medications, treatments, diagnostic studies or therapeutics will be administered without the order of a qualified physician or authorized practitioner ...." Clinical record review for Patient #3 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 12/8/2022 – 2/5/2023, which did not include any wound care orders. Clinical record review evidenced a skilled nursing visit note dated 1/16/2023, which indicated the patient had a new wound to right great toe. This visit note indicated the nurse cleansed		On 2/1/23 the skilled nurse obtained wound care orders from the physician which is documented in the current plan of care. On 2/20/23 during a mandatory staff meeting, the ED, RVP, and Quality Coordinator reviewed home health policy "Physician Orders" with an emphasis on providing care only as ordered by the physician. For any staff not present, the RVP or designee will provide instructions to the individual employees by 2/25/23. All current patient records will be reviewed by the Executive Director, Patient Care Managers, or Performance Improvement coordinators by 3/4/23 to ensure 100% of all treatments were administered only as ordered by the physician. During morning team calls, the PCM will ensure any patients with reports of new wounds have current wound care ordered by the physician. If no orders PCM or Clinician will contact the physician for orders. Beginning 3/5/23 the Executive Director or designee will audit 4 visits notes per clinician per month. For clinicians scoring. All new clinicians will have 2 note audits per week 80% for 4 consecutive weeks then will go into the monthly rotation. The note audit will be a random pull of visits and will focus on	

	the toe and applied a dressing to the site. Record review failed to evidence any physician orders for wound treatment. During an interview on 1/31/2023, at 12:20 PM, administrator/clinical manager #1 indicated the nurse should have provided wound care only as ordered on the plan of care or called the physician to receive a wound care order. 410 IAC 17-13-1(a)		treatments were provided according to the plan of care Beginning 3/20/23, ED or will complete 10 record reviews per week to ensure care was provided per physician orders. Any deviations to this process will be addressed with clinician remediation and disciplinary action as indicated. Monitoring will continue for and will continue until 100% compliance achieved for 3 consecutive weeks. Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	
G0586	Review and revision of the plan of care 484.60(c) Standard: Review and revision of the plan of care. Based on record review and interview, the home health agency failed to review and revise the plan of care in 3 of 7 home visits conducted. (#1, 3, 5)	G0586	The Patient Care Manager contacted the physician for patient #1 on 1/7/23 and notified of the changes in wound appearance. Orders were received on 1/7/23 for wound care. An on-line occurrence report has been entered for the lack of notification. The Patient Care Manager completed an on-line occurrence report for #3 to reflect the lack of updating the diagnosis after a Resumption of Care. The patient was assessed	2023-03-17

	The findings include: 1. Record review evidenced an agency policy revised 12/1/2021, titled "Plan of Care" which stated, "... Physician/authorized practitioner's orders are obtained to updated the plan of care and may include problems and goals ... Alterations to the plan of care are made only with the physician/authorized practitioner's approval ... the patient is monitored for response to treatment and progress toward goals ... Case conference with staff involved in patient's care is held for each patient at least every 60 days: the plan of care is then reviewed, revised, and sent to the physician ...." 2. Clinical record review for Patient #1 was completed on 2/2/2023, for certification period 1/10/2023 – 3/10/2023. Record review evidenced a skilled nurse visit note dated 12/16/2022, which indicated all patient's wounds were healed, and the physician was made aware of healed wound status.		by a skilled nurse on 2/20/23 and assessment of the wound was completed. The physician was contacted on 2/24/23 for updated diagnosis and orders to the plan of care. The Patient Care Manager contacted the physician for patient #5 on 2/24/23 regarding the lack of notification of Heart rate greater than physician ordered parameters and received revised vital sign parameters. An on-line occurrence report has been completed for the lack of notification. On 2/20/23, ED, Quality Coordinator and RVP conducted a mandatory staff meeting. The staff were instructed on the requirement to provide care as ordered by the physician specifically to notify physician of new wounds and vital signs outside of the established parameters. The staff was also instructed the diagnosis list needed to include all the diagnosis affecting the patient's care. For any staff not present, the RVP or designee will provide instructions to the individual employees by 2/25/23. All current patient records will be reviewed by the Executive Director, Patient Care Managers, or Performance Improvement coordinators by 3/4/23 to ensure 100% of all current episodes of care have documentation of revisions to the plan of care if indicated. Daily beginning 2/24/23 the agency will implement a morning huddle phone call where clinicians will call in and report on any changes in the patient's condition that may need an updating to the patient's plan of care, with the expectation that the physician is notified of any changes immediately. Beginning 3/5/23 the Executive Director or designee will audit 4	

	Clinical record review evidenced a skilled nurse visit note dated 12/27/2022, which indicated the patient's coccyx (area at base of spine, above tailbone) wound had re-opened, and measured 1.5 cm (centimeters) x 1 cm x 0.1 cm. Record review failed to evidence the plan of care was reviewed or revised to address worsened wound status. During an interview on 1/31/2023, at 10:07 AM, administrator/clinical manager #1 indicated the plan of care should have been revised to address the enlarging wound. 3. Clinical record review for Patient #3 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 12/8/2022 – 2/5/2023, which indicated the patient's primary diagnosis was urinary tract infection. Clinical record review evidenced a coordination note dated		visits notes per clinician per month. For clinicians scoring. All new clinicians will have 2 note audits per week 80% for 4 consecutive weeks then will go into the monthly rotation. The note audit will be a random pull of visits and will focus on ensuring that interventions or treatments provided support the primary focus of care for the episode and other pertinent diagnosis or address critical/acute concerns noted/discovered at the time of the visit. Beginning 3/20/23, ED or will complete 10 record reviews per week to ensure revisions to the plan of care were revised to address change in wounds, diagnosis that affects the patient's care, and vital signs outside of parameters were addressed. Any deviations to this process will be addressed with clinician remediation and disciplinary action as indicated. Monitoring will continue for and will continue until 100% compliance for 3 consecutive weeks. Discussion of compliance will be discussed with the team during the quarterly Quality	

	1/4/2023, which indicated the patient was hospitalized on 12/18/2022, for cellulitis. Clinical record review evidenced a resumption of care assessment dated 1/10/2023, which indicated the patient had been hospitalized for cellulitis. Clinical record review evidenced a plan of care for certification period 12/8/2022 – 2/5/2023, which failed to have been revised to include the new diagnosis of cellulitis, or any additional revisions focused on cellulitis. During an interview on 1/31/2023, at 12:14 PM, administrator/clinical manager #1 indicated the clinician should have updated the plan of care at the time of the resumption of care. 4. Clinical record review for Patient #5 was completed on 2/2/2023. Record review		Assurance Performance Improvement team meetings until compliance is achieved.	

certification period 12/21/2022 – 2/18/2023, which indicated the patient's heart rate normal parameters were between 50 to 90 [normal heart rate is 60 - 100].

Clinical record review evidenced skilled nurse visit notes for the following dates, in which the patient's heart rate was outside of parameters: 12/16/2022, 12/24/2022, 12/30/2022, 1/7/2023, 1/13/2023, 1/20/2023, and 1/27/2023.

Clinical record review evidenced a skilled nurse visit note dated 12/24/2022, which indicated the patient's heart rate was 111, which was normal for the patient.

Clinical record review failed to evidence the plan of care was updated or revised to reflect accurate vital sign parameters.

During an interview on 1/31/2023, at 12:43 PM,

	#1 indicated the plan of care should have been revised to reflect current heart rate parameters for the patient.			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on observation, record review and interview, the home health agency failed to promptly alert the relevant physician to any changes in the patients' conditions or needs which suggested outcomes were not being achieved and/or the plan of care should have been altered in 10 of 17 clinical records reviewed. (#1, 2, 3, 5, 6, 9, 12, 13, 16, 17). The findings include: 8. A home visit was observed on	G0590	The Patient Care Manager contacted the physician for patient #1 on 2/24/23 and notified of the changes in wound appearance and receive updated orders. An occurrence report has been entered for the lack of notification. The Patient Care Manager contacted the primary physician for patient #2 on 1/25/23 and notified the physician that foley catheter changes had been ordered and the primary physician agreed to the change in the patient's plan of care. The Patient Care Manager contacted the primary physician for patient #3 on 2/24/23 and notified of the podiatrist was treating the patient's open toe wound. The wound was healed. An occurrence report has been completed for the lack of notification. The Patient Care Manager contacted the physician for patient #5 on 2/24/23 regarding the lack of notification of Heart rate greater than physician ordered parameters and to obtain orders to increase parameters. An occurrence has been completed for the lack of notification.	2023-03-17

	1/27/23 at 2:00 PM with Patient #12, PTA #2, and the Alternate Clinical Manager. The patient indicated she was unable to get her blood drawn yesterday (1/26/23) for her weekly PT/INR (to monitor therapeutic level of blood thinner medication), she went every Thursday for the blood draw, and she was very worried about it because her warfarin dose changed a lot. The patient also indicated she was dehydrated, her irritable bowel syndrome (IBS) (an intestinal disorder causing pain in the belly, gas, diarrhea, and constipation) was flaring up, and she had new onset significant pain. PTA #2 called the certifying physician and reported the patient's pain, but failed to report the patient missed her lab draw, she was dehydrated, or her IBS was flaring up. During an interview on 2/01/23 at 11:18 AM, the Administrator indicated all of the findings from the home visit should have been reported to the physician. 9. Clinical record review for Patient #16 was completed on 2/01/23 (start of care date 11/20/22). A document titled		Patient #6 has been discharged and an occurrence report has been filed on 2/24/23 for the lack of follow up with the swelling and new wound. Patient #9 has been discharged and an occurrence report has been filed on 2/24/23 for the lack of notification to the physician for medication compliance. Patient #12 had orders obtained for PT/INR on 1/30/23 with follow up and changes in medication and notified of pain on 1/27/23 with no new orders. An occurrence has been completed on 2/24/23. Patient #13 has been discharged and an occurrence file has been completed on 2/24/23 for the lack of following up with the physician when changes in condition occurred. Patient #16 has been discharged and an occurrence file has been completed on 2/24/23 for the lack of follow up with the physician when changes occurred. Patient #17 has been discharged and an occurrence file has been completed on 2/24/23 for the lack of follow up with the physician when changes occurred. A mandatory staff meeting was held on 2/20/23 to review policy titled "Coordination of care from admit through discharge" with the emphasis ensuring all changes in the patient's condition and any updates from the patient's supporting physicians was communicated to the primary home health physician. During this education, scenarios were provided to the clinicians with discussion of follow up and follow through opportunities identified. For any staff not present, the RVP or designee	

	"Home Health Certification and Plan of Care" (for initial certification period 11/20/22 – 1/18/23), evidenced the patient's primary diagnosis was urinary tract infection (UTI), other diagnoses included hypertensive heart (problems with the heart that can develop if you have high blood pressure but don't treat it for years) and chronic kidney disease (long-standing decline of kidney function) with heart failure (the heart's inability to pump blood and oxygen [O2] throughout the body) and stage 5 chronic kidney disease (end stage, requires dialysis to sustain life), sick sinus syndrome (a type of heart rhythm disorder), acute (sudden) and chronic (long standing) respiratory failure with hypoxia (the respiratory system cannot adequately provide oxygen to the body, resulting in an absence of enough oxygen in the tissues to sustain bodily functions), and dependence on supplemental oxygen (O2) (2 liters per minute [LPM] continuous, via nasal cannula [small tubes inserted into the nostrils to administer oxygen]). A document dated 11/20/22,		will provide instructions to the individual employees by 2/25/23. All current patient records will be reviewed by the Executive Director, Patient Care Managers, or Performance Improvement coordinators by 3/4/23 to ensure 100% of all current episodes of care have documentation that the home health physician was notified of any changes in the patient's changes made by supporting physicians.Daily beginning 2/24/23 the agency will implement a morning huddle phone call where clinicians will call in and report on any changes in the patient's condition and the follow up needed, with the expectation that the physician is notified of any changes immediately. The Patient Care Manager will ensure that any patients discussed has documentation to support the physician notification and follow up until resolved. Beginning 3/5/23 the Executive Director or designee will audit 4 visits notes per clinician per month. For clinicians scoring. All new clinicians will have 2 note audits per week audited until 80% for 4 consecutive weeks then will go into the monthly rotation. The note audit will be a random pull of visits and will focus on ensuring that evidence exists in documentation where clinician notified and appropriately coordinated care with appropriate team members (Primary Care/supervising RN, therapist, Physician, etc. of changes in the patient's condition and/or care needs)	

	titled "Visit Note Report" (PT start of care comprehensive assessment) evidenced no skin issues/problems were identified, and the patient had 2+ pitting edema (swelling that occurs when excess fluid builds up in the body due to heart, circulatory, and/or kidney problems, and when pressed by the tip of a finger, a "pit" remains; 1+ means the "pit" leaves an indentation of 0–2 millimeters [mm] that rebounds immediately; 2+ means the "pit" leaves an indentation of 3–4 mm that rebounds in fewer than 15 seconds; 3+ means the "pit" leaves an indentation of 5–6 mm that takes up to 30 seconds to rebound; and 4+ means the "pit" leaves an indentation of 8 mm or deeper that takes more than 20 seconds to rebound) to both lower extremities. A document dated 11/30/22, titled "Visit Note Report" (Physical Therapy Assistant [PTA] routine visit), indicated the patient sustained a skin tear on the right hip, it was covered with a bandage, and the patient had 3+ bilateral lower extremity edema (worse than previous visit). The document failed to evidence the physician was		Beginning 3/20/23, ED or will complete 10 record reviews per week to ensure the physician was notified of changes in the condition to ensure update to the plan of care. Any deviations to this process will be addressed with clinician remediation and disciplinary action as indicated. Monitoring will continue for and will continue until 100% compliance is achieved for 3 consecutive weeks. Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	

	notified. A document dated 12/07/22, titled "Visit Note Report" (PTA routine visit) evidenced the patient had 3-4+ pitting edema to both lower extremities (worse than last routine visit), and stated, "... [family] reports R [right] buttocks skin tear covered with bandage, reports changed bandage no bleeding noted, patient has bruising at face, UES [upper extremities] that have been long standing ...." The document failed to evidence the physician was notified. A document dated 12/15/22, titled "Visit Note Report" (PT reassessment) evidenced an assessment section, which indicated cardiovascular assessment was "NA" (not applicable), post intervention of pain was "NA", and the patient did not have a diagnosis or symptoms indicative of respiratory impairment. The document failed to evidence the physician was notified. A document dated 12/21/22, titled "Visit Note Report" (PTA routine visit), evidenced new			

	forearm and right middle finger, the right hip/buttock wound was healing, family addressed the wounds, the patient had 3+ edema to both feet, and used O2 at 2 LPM. The document failed to evidence the physician was notified. A document dated 12/28/22, titled "Visit Note Report" (PTA routine visit), stated, "... [patient/family] mention having a lot [more] fluid due to having to change dialysis routine and patient is a little boated feeling today. Mentions usually [only] wears supplement oxygen at night but has it on today due to mild shortness of breath without supplemental oxygen ... edema in BLE [bilateral lower extremities] being controlled per [family] ...." The clinical record failed to evidence a comprehensive reassessment was completed for the patient's significant decline in health status. The document failed to evidence the physician was notified. A document dated 1/05/23, titled "Visit Note Report" (transfer data collected, no visit made) evidenced the patient utilized the emergency			

department and was admitted to the hospital.

A document received from Entity #15 (a hospital) on 1/27/23, titled "Emergency Documentation" evidenced the patient was seen at Entity #15's emergency department, was diagnosed with a UTI, and was admitted for treatment on 12/30/22.

During an interview on 2/01/23 at 2:15 PM, the Administrator indicated the patient was declining and the physician should have been notified.

10. Clinical record review for Patient #17 was completed on 2/02/23 (start of care date 7/08/22). A document dated 7/08/22, titled "Visit Note Report" (PT start of care comprehensive assessment) evidenced no abnormal gastrointestinal (stomach/intestinal), integumentary (skin), cardiovascular (heart, blood vessels), or neurological (brain, spinal cord, and nerves) findings were identified.

A document dated 7/16/22, titled "Visit Note Report" (RN Add-On Evaluation), evidenced

	gastrointestinal assessment findings included abdominal pain in all four quadrants (all areas of the abdomen), and nausea/vomiting; integumentary findings included generalized (affecting many parts of the body) bruising; neurological assessment findings included dizziness, vertigo (a sensation of whirling and loss of balance), headache, and numbness of both upper extremities; cardiovascular assessment findings the patient's legs were pale, cool to touch with ruddy (reddish in color)/cyanotic (blue/purple skin color due to lack of oxygen) color to tips, with weak pulses bilaterally (both lower legs), and slightly edematous (swelling due to excess fluid buildup) without pitting (when pressure is applied to the swollen area, a "pit", or indentation, will remain); and stated "... care coordination ... indicate if you communicated with ... individuals involved with this case ... no ...." The document failed to evidence the physician was notified for the worsening edema. A document dated 7/22/22,			

	titled "Visit Note Report" (PT routine visit) evidenced family requested a Speech Language Pathology (SLP) evaluation due to the patient's cognitive changes (ability to comprehend, remember, and reason). The document failed to evidence the cognitive changes, or the physician was notified. A document titled "Home Health Certification and Plan of Care" (for certification period 7/08/22 – 9/05/22), evidenced Person #7 was the patient's certifying physician. A document dated 8/18/22, titled "Visit Note Report" (PT routine visit), evidenced the patient had an appointment with Person #10 (a neurosurgeon), and the patient was going to have a drain placed to decrease fluid on the brain. The document failed to evidence Person #7 was notified. During an interview on 2/02/23 at 3:45 PM, the Administrator indicated the plan of care didn't include the name and/or contact information for Person #10, or evidence Person #7 was			

	treatment orders for Patient #17. 1. Record review evidenced an agency policy revised 8/1/2019, titled "Coordination of Care, From Admit through Discharge" which stated, "... Coordination of care with physician: ... throughout care ... coordination of services is promoted through routine communication with the patient's physician: ... When changes occur l the patient's condition or response to treatment ... When changes occur in caregiver support or the environment that affect patient treatment ... When there is a need to change the patient's plan of care ...." 2. Clinical record review for Patient #1 was completed on 2/2/2023, for certification period 1/10/2023 – 3/10/2023. Record review evidenced a skilled nurse visit note dated 12/16/2022, which indicated all patient's wounds were healed, and the physician was made aware of healed wound status. Clinical record review evidenced			

	a skilled nurse visit note dated 12/27/2023, which indicated the patient's coccyx (area at base of spine, above tailbone) wound had re-opened, and measured 1.5 cm (centimeters) x 1 cm x 0.1 cm. Record review failed to evidence the physician was notified of the patient's change in condition. Clinical record review evidenced a recertification assessment dated 1/7/2023, which indicated the patient's coccyx wound now measured 2 cm x 2 cm x 0.1 cm. The assessment indicated the wound appeared to be deteriorated from the last skilled nurse assessment. Record review failed to evidence the physician was notified of the deterioration of the patient's wound. Clinical record review evidenced a skilled nurse visit note dated 1/11/2023, which indicated the patient's coccyx wound now measured 2.2 cm x 2 cm 2 x 0.1 cm. Record review failed to evidence the physician was notified of the enlarging wound.			

Clinical record review evidenced a skilled nurse visit note dated 1/19/2023, which indicated the patient's coccyx wound now measured 5 cm x 1 cm x 0.1 cm. Record review failed to evidence the physician was notified of the enlarging wound.

During an interview on 1/31/2023, at 10:05 AM, administrator/clinical manager #1 indicated the physician should have been contacted regarding the patient's wound opening up, deteriorating, and enlarging, so they could add wound care orders to the plan of care.

3. Clinical record review for Patient #2 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 11/30/2022 – 1/28/2023, which indicated physician #11 was the physician overseeing the plan of care.

Clinical record review evidenced

a skilled nurse visit note dated 12/30/2022, which indicated the patient's urologist was physician #12.

Clinical record review evidenced a physician order dated 1/3/2023, and signed by physician assistant #13, which included an order for the home health agency to change the patient's catheter.

Clinical record review failed to evidence physician #11 was notified of the need to change the plan of care.

During an interview on 1/31/2023, at 10:19 AM, administrator/clinical manager #1 indicated the physician listed on the plan of care should have been notified of any changes in orders on the plan of care from other physicians.

4. Clinical record review for Patient #3 was completed on 2/2/2023, for certification

	Record review evidenced a skilled nurse visit note dated 1/16/2023, which indicated the patient had a new wound to the right great toe but failed to evidence the physician was notified of the change in patient status. During an interview on 1/31/2023, at 12:21 PM, administrator/clinical manager #1 indicated the physician should have been notified of the new wound and need to update the plan of care. 5. Clinical record review for Patient #5 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 12/21/2022 – 2/18/2023, which indicated the clinician was to notify the physician for heart rate greater than 90. Clinical record review evidenced skilled nurse visit notes for the following dates, during which the patient's heart rate was			

	physician was not notified: 12/16/2022, 12/24/2022, 12/30/2022, 1/7/2023, and 1/13/2023. During an interview on 1/31/2023, at 12:43 PM, administrator/clinical manager #1 indicated the physician should have been notified every visit the heart rate was outside of parameters. 6. Observation of a home visit for Patient #6 was conducted on 1/31/2023, at 4:00 PM, to observe a routine physical therapy visit. During the visit, the patient was observed to have moderate swelling to lower extremities.			

	Clinical record review for Patient #6 was completed on 2/2/2023, for certification period 1/10/2023 – 3/10/2023. Record review evidenced a start of care assessment dated 1/10/2023, which did not indicate the patient had any swelling to lower extremities, and indicated the patient had no wounds. Clinical record review evidenced an occupational therapy visit note dated 1/13/2023, which indicated the patient had new bilateral lower extremity swelling but failed to indicate the physician was notified of the change in patient status. Clinical record review evidenced a physical therapy visit note dated 1/24/2023, which indicated the patient now had 1 + swelling to lower extremities (2 millimeters of indentation on skin when pressed, which rebounds immediately), but failed to evidence the physician was notified of new swelling. Clinical record review evidenced			

	an occupational therapy visit note dated 1/25/2023, which indicated the patient now had redness to his buttocks along the tailbone. Record review failed to evidence the physician was notified of new wound/area of redness. During an interview on 1/31/2023, at 1:12 PM, administrator/clinical manager #1 indicated the physician should have been notified of the swelling and new area of redness. 7. Clinical record review for Patient #9 was completed on 2/2/2023, for certification period 7/24/2022 – 9/21/2022. Record review evidenced a skilled nurse visit note dated 7/28/2022, which indicated the patient was non-compliant with taking metoprolol (medication to lower heart rate and blood pressure). Record review failed to evidence the physician was notified of the change in medication compliance.			

	During an interview on 2/1/2023, at 10:17 AM, administrator/clinical manager #1 indicated the physician should have been notified of medication non-compliance.			
G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on observation, record review, and interview, the home health agency failed to coordinate care delivery to meet the patient's needs in 5 of 17 clinical records reviewed. (#1, 2, 12, 13, 16). The findings include: 4. A home visit was observed on 1/27/23 at 2:00 PM with Patient #12, PTA #2, and the Alternate Clinical Manager. The patient indicated she was unable to get	G0608	The Executive Director contacted the provider who is providing home health aide services for #1 on 2/24/23 to coordinate care specifically the patient's plan of care regarding wound care. The wound care has been correctly communicated to the home health aide provider who will discontinue their wound care orders. Wound care is being provided by the husband every other day and skilled nurse of the home health provider weekly. Documentation of the care coordination has been included in the clinical record. The Executive Director contacted the provider who is providing home health aide services for #2 was contacted on 2/24/23 to coordinate care services between the Health provider and Aide service provider. Documentation of the care coordination has been included in the clinical record.	2023-03-17

	(1/26/23) for her weekly PT/INR (to monitor therapeutic level of blood thinner medication), she went every Thursday for the blood draw, she was very worried about it because her warfarin dose changed a lot, the patient indicated she informed the wound clinic that home care was coming today, and the wound clinic was waiting for a call back. PTA #2 failed to contact the patient's wound clinic during the visit. During an interview on 2/01/23 at 11:18 AM, the Administrator indicated she didn't know which coumadin clinic the patient went to, or who the physician was. 5. Clinical record review for patient #13 was completed on 2/02/23 (start of care date 10/04/22, certification period 12/03/22 – 1/31/23). A document dated 1/02/23, titled "Visit Note Report" (PTA routine visit) stated, "... Patient ... mentions ... having an aide come today to help with shower and cleaning of home ...." During an interview on 2/02/23 at 2:33 PM, the Administrator		The Executive Director contacted the provider who is providing Coumadin oversight for #12 on 2/24/23 to coordinate care services between the Health provider and Clinic. The clinical record has been updated to include the physician at the Coumadin clinic under the physician tab of the Electronic Medical Record. Patient #13 has been discharged. An on-line incident report was completed on 2/24/23 to document lack of collaboration of care. Patient #16 has been discharged. An on-line incident report was completed on 2/24/23 to document lack of collaboration of care. A mandatory staff meeting was held on 2/20/23 to review policy titled "Coordination of care from admit through discharge" with the emphasis on coordinating care with patient's care team such as dialysis, aide services, and Coumadin clinic. The staff was instructed to document the care coordination including the name of the entity with each Comprehensive assessment and as patient needs change. For any staff not present, the RVP or designee will provide instructions to the individual employees by 2/25/23.	

	their agency, and she didn't know who it was. 6. Clinical record review for Patient #16 was completed on 2/01/23 (start of care date 11/20/22). A document titled "Home Health Certification and Plan of Care" (for initial certification period 11/20/22 – 1/18/23), evidenced other diagnoses included hypertensive heart (problems with the heart that can develop if you have high blood pressure but don't treat it for years) and chronic kidney disease (long-standing decline of kidney function) with heart failure (the heart's inability to pump blood and oxygen [O2] throughout the body) and stage 5 chronic kidney disease (end stage, requires dialysis to sustain life). A document received from Entity #16 (a dialysis facility) on 1/27/23 at 10:22 AM, titled "Limited Encounter", evidenced Person #19 managed the patient's hemodialysis. During an interview on 1/27/23 at 10:00 AM at Entity #16 (a dialysis facility), Person #17 (a registered nurse [RN]) indicated		All patients will be assessed by the assessing clinicians for outside services not limited to aide services, Coumadin clinic and dialysis by 3/4/23 with documentation of care coordination with the entity documented in the Clinical record.Beginning 2/20/23 all patients who are identified as receiving dialysis will have a care type added that indicates the patient's dialysis schedule. Each assessing clinician can assess the care type in the Electronic Medical Record during their visit if care coordination is required. Beginning 2/20/23 all patients who are identified as receiving dialysis or who is under the Coumadin clinic physician for Coumadin monitoring will have the facility added in the patient information section of the Electronic Medical Record for all staff to access during care coordination. Beginning 2/20/23 all patients who are identified as receiving aide services through another entity will have a point of care alert entered into the Electronic Medical Record indicating the entity, hours, and what the agency is providing. With each comprehensive assessment and as needed, the assessing clinician will with the patients care team and document that conversation. The Patient Care Manager during weekly case conference will ensure any patients up for recert has been communicated with the Aide service, Dialysis Center, and Coumadin clinic of the continued need for Health services.	

	he started seeing the patient in October (2022), the patient trained at this facility on Mondays, Wednesdays, and Fridays for peritoneal dialysis, did backup hemodialysis at Entity #18 (a dialysis facility) on Tuesdays, Thursdays, and Saturdays, didn't know the patient had home health services, and didn't receive any communication from the agency. During an interview on 1/27/23 at 10:00 AM at Entity #16, Person #20 (a RN, who trained patients for home peritoneal dialysis) indicated she was unaware the patient had home health services. During an interview on 2/01/23 at 2:15 PM, when queried how the agency coordinated care with Entity #16, the Administrator indicated they ask the patients what days they go to dialysis. 1. Record review evidenced an agency policy revised 8/1/2019, titled "Coordination of Care, From Admit through Discharge" which stated, "... The agency provides care and services within an integrated continuum		The Executive Director is ultimately responsible for implementing the plan of care. Beginning 3/20/23, ED or will SOC reviews per week to ensure if patient has other services, that care coordination has occurred. Any deviations to this process will be addressed with clinician remediation and disciplinary action as indicated. Monitoring will continue for and will continue until 100% compliance for 3 consecutive weeks. Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	

	of care system … This is accomplished by: … Coordinating patient are among various disciplines to ensure that services are continuous and coordinated from admission through discharge ….” 2. Observation of a home visit for Patient #1 was conducted on 1/25/2023, at 8:30 AM, to observe a routine skilled nurse visit. The patient was observed to be bedbound, alert and oriented, but totally dependent. During the visit, a caregiver from home health agency #8 was present. Person #9 (caregiver from home health agency #8) indicated they were in the patient’s home 7 days per week, 4 hours in the morning, and 2 hours in the evenings. Person #9 indicated they provided the patient with bathing, transfers, activities of daily living, and wound care if needed. Clinical record review for Patient #1 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 1/10/2023 – 3/10/2023, which			

	failed to include any information on home health agency #8, or services provided to the patient by the other home health agency. The plan of care included the following wound care for a wound to the coccyx (area at the base of the spine): cleanse with normal saline, pat dry with gauze, apply calcium alginate with silver to wound bed, cover with foam dressing. Review failed to evidence any care coordination notes or documentation about home health agency #8.			

	Clinical record review evidenced a faxed plan of care from home health agency #8, which was obtained on 1/25/2023. This document indicated the home health agency was providing home health aide care 7 days per week for activities of daily living. This document indicated the home health aide was to apply Desitin (skin protective cream), and Neosporin (antibiotic ointment) to the sacral (area right above the tailbone) area 3 times daily to heal the skin, which were not included on the agency's plan of care. During an interview on 1/31/2023, at 10:03 AM, administrator/clinical manager #1 indicated if the patient was receiving care from another home health agency, it should have been noted in the medical record or plan of care, that the patient was receiving care from another agency. Administrator/clinical manager #1 indicated the medical record should have included information on how many hours the other agency was providing			

	information for follow-up communication between the agencies. Administrator/clinical manager #1 indicated the staff should have been coordinating care with other home health agencies providing care. At 10:11 AM, administrator/clinical manager #1 indicated they should have coordinated care with the other home health agency to find out what services they were providing in the home and to compare orders. 3. Observation of a home visit for Patient #2 was conducted on 10/25/2023, at 9:45 AM, to observe a routine skilled nurse visit. During the visit, the patient was observed to be alert and oriented, and wheelchair bound. There was a caregiver from home health agency #14 present at the time of the visit. The patient indicated the home health aide assisted with bathing, transfers, and activities of daily living. Clinical record review evidenced a plan of care from home health agency #14, dated 1/25/2023,			

	to receive 36 hours of home health aide services per week. Clinical record review failed to evidence there was any care coordination with the other home health agency.			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review, and interview, the home health agency failed to provide patients with written schedules in 3 of 7 home visits conducted. (#1, 4, 12). The findings include: 4. A home visit was observed on 1/27/23 at 2:00 PM with Patient #12, PTA #2, and the Alternate Clinical Manager. The home folder failed to evidence a visit schedule. The patient asked PTA #2 when the next visit was, and	G0614	Patient #1's patient instructions report which includes the frequency of visits to be provided by agency personnel was provided to the patient on 2/24/23 and placed in the home folder. Patient #4's patient instructions report which includes the frequency of visits to be provided by agency personnel was provided to the patient on 2/22/23 and placed in the home folder Patient #12's patient instructions report which includes the frequency of visits to be provided by agency personnel. Patient declined home visit on 2/24/23. Agency will attempt visit again week of 2/27/23 to provide document to the patient and place in the home folder A mandatory staff meeting was held on 2/20/23 to review policy titled "Coordination of care from admit through discharge" with the emphasis on providing the patient a visit schedule. The visit frequency will be included in all patient instruction reports sent to the patient's home and any changes	2023-03-17

	PTA #2 responded to the patient that it would be next week, and no further information was provided to the patient. 1. Record review evidenced an agency policy revised 8/1/2019, titled "Coordination of care, From admit through discharge" which stated, "... Written information obtained from the plan of care will be provided to the patient and caregiver outlining: ... Visit schedule including frequency of visits by agency staff and contract workers ...." 2. Observation of a home visit for Patient #1 was conducted on 1/25/2023, at 8:30 AM, to observe a routine skilled nurse visit. During the visit, the patient's home binder was reviewed, which failed to include a visit schedule. During an interview on 1/31/2023, at 9:50 AM, administrator/clinical manager #1 indicated the patients should have received a calendar in the		communicated to the patient and/or updated on the patient instruction form. For any staff not present, the RVP or designee will provide instructions to the individual employees by 2/25/23. A patient instruction report that indicates the patient's visit frequency will be hand delivered to 100% of all active patients /4/23. Staff will update the patient instructions report with any changes in visit patterns. Weekly beginning 3/5/23 the Business Manager or Designee will print out the Patient Instructions report for all patients who had an OASIS assessment that week and will mail to the patients home with an instruction sheet that requests the patient to place the form in the patient folder for staff use. With each visit, the clinician will review the patient instruction report with the patient and will update the patient instruction report with any visit frequency schedule changes per physician orders. If no patient instruction form is at the patient's home folder, the clinician will notify the Patient Care Manager to ensure the next clinician making the next scheduled visit hand delivers the patient instruction form to	

	should have filled that out. 3. Observation of a home visit for Patient #4 was conducted on 1/27/2023, at 10:15 AM, to observe a routine skilled nurse visit. During the visit, the patient's home binder was reviewed, which failed to include a visit schedule.		the home and placed in the home folder. Beginning the week of 3/20/23, the Executive Director or designee with complete 7 home visits weekly to ensure patient instructions sheets are in the patient's folder and includes frequency of visits. Monitoring will continue weekly for and will continue until 95% compliance is achieved for 3 consecutive weeks. Deficient findings will be addressed immediately, and clinician remediation and disciplinary action will occur as indicated Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review, and interview, the home health agency failed to ensure patients received written medication instructions which	G0616	A home visit was made to #1 on 2/24/23. A medication reconciliation was and the physician was notified of the changes in the patient's medication regimen. Physician orders were obtained on 2/24/23 and the patient instruction report was updated with the changes in the patient's medication regimen. A home visit was made to #2 on 2/23/23. A	2023-03-17

	included the medication name, dosage, and frequency of medications in 6 of 7 home visits conducted. (#1, 2, 3, 4, 5, 6) The findings include: 1. Record review evidenced an agency policy revised 8/1/2019, titled "Coordination of care, From admit through discharge" which stated, "... Written information obtained from the plan of care will be provided to the patient and caregiver outlining: ... Medication schedule/instructions including: medication name, dosage, and frequency, and which medications will be administered by agency staff and/or contract workers ...." 2. Observation of a home visit for Patient #1 was conducted on 1/25/2023, at 8:30 AM, to observe a routine skilled nurse visit. During the visit, the patient's medication bottles and home binder were reviewed, which contained a list of home medications. The list of medications failed to include		medication reconciliation was and the physician was notified of the changes in the patient's medication regimen. Physician orders were obtained on 2/23/23 and the patient instructions report was updated with the changes in the patient's medication regimen. A home visit was made to #3 on 2/20/23. A medication reconciliation was and the physician was notified of the changes in the patient's medication regimen. Physician orders were obtained on 2/20/23 and the patient instruction report was updated with the changes in the patient's medication regimen. A home visit was made to #4 on 2/20/23. A medication reconciliation was and the physician was notified of the changes in the patient's medication regimen. Physician orders were obtained on 2/20/23 and the patient instruction report was updated with the changes in the patient's medication regimen. A home visit was made to #5 on 2/24/23. A medication reconciliation was and the physician was notified of the changes in the patient's medication regimen. Physician orders were and the patient instruction report was updated with the changes in the patient's medication regimen. Patient #6 has been discharged from services. An on-line occurrence report was completed on 2/24/23 for failure to provide patient with updated medication report. A mandatory staff meeting was held on 2/20/23 to review policy titled "Monitoring Medications" with the emphasis on comparing all medications including OTC (over the counter) medication the patient is taking to physician orders and patient instruction report. Any discrepancies the clinician will notify the	

	the following medications the patient was taking: ibuprofen (for pain/fever) and topiramate (to prevent seizures) 100 milligrams twice daily. The medication list included sertraline (antidepressant) 100 milligrams once daily, and modafinil (medication to increase alertness), which the patient was not taking. During an interview on 1/31/2023, at 9:38 AM, administrator/clinical manager #1 indicated the patients should have had an accurate medication list in their homes, which included all medications they were taking including the correct dosage and frequency. 3. Observation of a home visit for Patient #2 was conducted on 1/25/2023, at 10:00 AM, to observe a routine skilled nurse visit. During the visit, the patient's medication bottles and home binder were reviewed. The home binder contained a list of home medications. The list of medications failed to include the following medications the patient was		physician of the changes and when orders are obtained will update the patient instruction report. For any staff not present, the RVP or designee will provide instructions to the individual employees by 2/25/23. Medication reconciliation to compare the medications the patient is taking to the patient instruction report and physician orders will occur to 100% of all active patients by 3/4/23 Staff will update the patient instructions report with any updated medication orders.Weekly beginning 3/5/23 the Business Manager or Designee will print out the Patient Instructions Report for all patients who had an OASIS assessment that week and will mail to the patients home with an instruction sheet that requests the patient to place the form in the patient folder for staff use. With each visit, the clinician will review the patient instruction report with the patient when any changes in medication and will update the patient instruction report with any medication changes per physician orders. If no patient instruction form is at the patient's home folder, the clinician will notify the Patient Care Manager to ensure the next clinician making the next scheduled visit hand delivers the patient instruction form to the home and placed in the home folder. Beginning the week of 3/20/23, the Executive Director or 7	

	taking: iron, vitamin B12, and folic acid. 4. Observation of a home visit for Patient #3 was conducted on 1/26/2023, at 10:00 AM, to observe a routine occupational therapy visit. During the visit, the patient's medication bottles and home binder were reviewed, which contained a list of home medications. The list of medications included the following medications the patient was not taking: aspirin, benzonatate, tizanidine, and tramadol 50 milligrams every 4 hours as needed for pain. The medication list failed to include ciprofloxacin, which the patient was taking. 5. Observation of a home visit for Patient #4 was conducted on 1/27/2023, at 10:15 AM, to observe a routine skilled nurse visit. During the visit, the patient's medication bottles and written home medication list were reviewed. Review evidenced the following medication bottles which were not included on the written medication list: ipratropium		patient instructions sheets are in the patient's folder and includes a medication list. Monitoring will continue weekly for and will continue until 95% compliance is achieved for 3 consecutive weeks. Deficient findings will be addressed immediately, and clinician remediation and disciplinary action will occur as indicated Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	

bromide nasal spray and ibuprofen.

6. Observation of a home visit for Patient #5 was conducted on 1/27/2023, at 8:30 AM, to observe a routine skilled nurse visit. During the visit, the patient's medication bottles and a written medication list were reviewed. Review evidenced the following medication bottles which were not included on the patient's written medication list: oxycodone-acetaminophen 10-325 milligrams every 6 hours as needed for pain, pepcid, baclofen 10 milligrams twice daily, and probiotic.

6. Observation of a home visit for Patient #6 was completed on 1/30/2023, at 4:00 PM, to observe a routine physical therapy visit. During the visit, the patient's medication bottles and a written medication list were reviewed. Review of the bottles evidenced the patient was taking flomax 0.4 milligrams twice daily and atorvastatin 10 milligrams twice daily. Review of the medication list indicated the patient was

	taking flomax 0.4 milligrams once daily, and atorvastatin 10 milligrams once daily. During the visit, the patient indicated they were using a barrier cream, for an open area to their buttock. This barrier cream failed to be included on the written medication list.			
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation, record review, and interview, the home health agency failed to ensure patients received in writing any treatments to be administered by home health agency personnel or personnel acting on behalf of the home health agency in 2 of 7 home visits observed (#4, 12). The findings include: A home visit was observed on 1/27/23 at 2:00 PM with Patient #12, PTA #2, and the Alternate Clinical Manager. The home	G0618	Patient #12's patient instructions report which includes the frequency of visits to be provided by agency personnel. Patient declined home visit on 2/24/23. Agency will attempt visit again week of 2/27/23 to provide document to the patient and place in the home folder Patient #4's patient instruction report which includes treatments to be administered by agency personnel was provided to the patient on 2/20/23 and placed in the home folder. A mandatory was held by the Quality Coordinator and the Vice President of Operations 2/20/23 with all visiting staff to review the expectation of ensuring every patient has a patient instruction report that outlines their care and treatment in the home. For any staff not present, the RVP or designee will provide instructions to the individual employees by 2/25/23.	2023-03-17

	folder failed to evidence a plan of care. Record review evidenced an agency policy revised 8/1/2019, titled "Coordination of Care, From Admit Through Discharge" which stated, "... Written information obtained from the plan of care will be provided to the patient and caregiver outlining: ... Treatments to be administered by staff or contract workers, including therapy services ...." Observation of a home visit for Patient #4 was conducted on 1/27/2023, at 10:15 AM, to observe a routine skilled nurse visit. During the visit, a home health binder was reviewed, which failed to include a plan of care or written treatment instructions. During an interview on 1/31/2023, at 12:30 PM, adminsitrator/clinical manager #1 indicated the patient should have received a written plan of care summary.		Patient instructions report which outlines the treatments provided by the agency staff will be hand delivered to 100% of all active patients by 3/4/23. Staff will update the patient instructions report with any updated orders. Weekly beginning 3/5/23 the Business Manager or Designee will print out the Patient Instructions Report for all patients who had an OASIS assessment that week and will mail to the patients home with an instruction sheet that requests the patient to place the patient instruction report in the patient folder for staff use. With each visit, the clinician will review the patient instruction report with the patient when any changes in treatment plan have been identified. If no patient instruction report is in the patient's home folder, the clinician will notify the Patient Care Manager to ensure the next clinician making a visit hand delivers the patient instruction form to the home and placed in the home folder. Beginning the week of 3/20/23, the Executive Director or 7 home visits weekly to ensure patient instructions sheets are in the patient's folder and includes treatments the patient is receiving from agency staff.	

			Monitoring will continue weekly for and will continue until 95% compliance is achieved for 3 consecutive weeks. Deficient findings will be addressed immediately, and clinician remediation and disciplinary action will occur as indicated Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	
G0652	Activities lead to an immediate correction 484.65(c)(1)(iii) (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Based on record review and interview, the home health agency failed to ensure the performance improvement activities led to an immediate correction of any identified problems which directly or potentially threatened the health and safety of patients. The findings include: Record review on 1/27/2023, evidenced an agency document dated 11/3/2022, titled "Quality assessment and Performance Improvement Team Meeting	G0652	During a mandatory meeting held on 2/24/23, the Regional Vice-President instructed the Executive Director using Policy # 4.001 Quality Assessment and Performance Improvement (QAPI) Plan and 4.002 - Quality Assessment & Performance Improvement (QAPI) Team with emphasis on ensuring the performance improvement activities are documented, implemented, monitored for effectiveness, and revised as indicated. Q4 22 Executive Summary report amended 2/24/23 by Executive Director to include root cause of falls taken to improve fall rate. The 1 executive summary will include a root cause of ensure discussion of the fall education activities by the team were implemented to include patient/caregiver education and identification to reduce falls. The home health agency collects data that is used to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement. Improvement strategies are implemented and monitored for effectiveness for any identified problems.	2023-03-17

	Purpose: The QAPI [quality assurance performance improvement] meeting is conducted quarterly and will ensure measurable improvement in indicators for which there is evidence that the improvement led to improved health outcomes, safety and quality of care for patients ….” Review of the agency’s QAPI program on 1/27/2023, evidenced a QAPI executive summary for the 3rd quarter of 2022, which indicated the agency had 48 falls per 412 patients, or a 12% fall rate for the 3rd quarter. This document indicated 1 patient fell 6 times, 1 patient fell 4 times, and 3 patients fell 3 times in the third quarter. This document indicated the agency was implementing fall recovery education and documentation of root cause of falls to address the falls. Review of the agency’s QAPI program on 1/27/2023, evidenced a QAPI executive summary for the 4th quarter of 2022, which indicated the		The agency Executive Director assumes responsibility for the overall implementation of the program. The home health agency summarizes quality assessment and performance improvement activities on a quarterly basis using the Quality and Performance Improvement Executive Summary. The report will summarize the data, improvement initiatives, trends, actions taken to improve, and analysis of intervention effectiveness for each quality component. The ED regularly reports activities and findings to the QAPI team. The QAPI Team is led by the ED and meets at least quarterly to define, implement, and maintain an ongoing program for quality improvement and patient safety. The team will also ensure that the performance improvement efforts are prioritized and evaluated for effectiveness. The QAPI Team ensures the following: an on-going program for quality improvement and patient safety is defined, implemented, and maintained; the provider-wide quality assessment and performance improvement plan will improve health outcomes, patient safety, and quality of care; and measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess	

	agency had 57 falls per 453 patients, and a 13% rate of falls. This document indicated there were 4 patients with multiple falls, and the agency was implementing fall recovery education and documentation of root cause of falls. Record review failed to evidence documentation of the root cause of falls, as indicated in the QAPI program. Record review failed to evidence the fall recovery education and root cause analysis of falls led to an immediate correction of the fall rate, or patients falling multiple times. During an interview on 1/27/2023, at 2:49 PM, administrator/clinical manager #1 indicated the agency discussed every morning on a phone huddle the root cause of any falls but indicated the root cause analysis discussion was not documented. 410 IAC 17-12-2(a)		processes of care, services, and operations. Beginning Q1 2023, the Regional Vice President will review the Quality Assessment and Performance Improvement Executive Summary quarterly for 3 quarters to ensure the improvement activities are led to improvement in any identified problems.	

G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review, and interview, the home health agency failed to ensure skilled professionals accurately prepared clinical notes and assessments in 11 of 17 clinical records reviewed (#1, 2, 3, 5, 7, 8, 9, 13, 14, 15, 16). The findings include: 6. Clinical record review for patient #13 was completed on 2/02/23 (start of care date 10/04/22, certification period 12/03/22 – 1/31/23). A document dated 12/13/22, titled "Visit Note Report" (PT Reassessment without OASIS data set), evidenced the patient reported pain as "5" (on a scale of 0-10, with 0=no pain and 10= worst pain possible), and stated, "... Patient reports she twisted her right knee while getting in and out of a vehicle on Saturday [12/10/22] ... has been experiencing significant	G0716	During a mandatory staff meeting held on 2/23/23, the Regional Vice-President instructed all clinical staff on accurate and complete documentation using the Clinical Note Review Tip Sheet, Integumentary Command Center – Overview Comprehensive Assessment job aid, and Policy # 2.2.001 - Wound Assessment, Documentation, And Photography, with emphasis on documentation of relevant assessment findings; interventions or treatments provide support for the primary focus of care for the episode and other pertinent diagnosis, as well as address critical/acute concerns noted/discovered at the time of the visit; lack of contradictory documentation; wound assessments completed at proper interval per policy; and proper use of the Integumentary Command Center (ICC) within HCHB to document wounds, wound assessment, and wound care provided. For any staff not present, the RVP or designee will provide instructions to the individual	2023-03-17

	pain with the right knee area ever since ... does not want to go to the emergency room ... she is now using the wheelchair for most mobility ... unable to safely use walker ....” The document failed to evidence assessment of the knee occurred. A document dated 12/19/22, titled “Visit Note Report” (PTA routine visit) indicated the patient’s right knee remained painful at a “6”, and she was going Wednesday (12/21/22) to have it checked out (no further information). The document failed to evidence assessment of the knee occurred. A document dated 12/27/22, titled “Visit Note Report” (PT reassessment without OASIS data) indicated the patient used over the counter and prescription medications for pain relief, the patient’s fear of falling was a high concern, and stated, “... Patient reports she did have a consult ortho [orthopedic] due to right knee pain ... ortho suspects a fracture ... continued pain ... difficult time getting around ... occasional assistance ....” The document failed to evidence		employees by 2/25/23.Clinical Notes will be prepared accurately, painting a picture of the visit to include relevant findings, what was done, patient’s response to teaching/training provided; reflecting interventions or treatments to support the primary focus of care for the episode and other pertinent diagnosis and address critical/acute concerns noted/discovered at the time of the visit; and there is no contradictory documentation within the visit note. Wound assessment findings will be documented within the ICC by utilizing the Wound Assessment Tool within HCHB. During routine visits, will be documented in the Wound Assessment Tool. Wound assessments will be performed by Registered Nurse, Physical Therapist, or qualified Occupational Therapist: 1) At least weekly for receiving negative pressure wound therapy, receiving daily wound care performed by the agency, an infected wound, or stage IV pressure injury with evidence of infection or exposed bone, tendon, or muscle tissue. 2) Every other week for patients receiving wound care by the agency at a frequency less than daily. Surgical incisions requiring wound care will be assessed by the supervising clinician (Registered Nurse, Physical Therapist, or qualified Occupational Therapist) every 2 weeks at a minimum unless the incision is exhibiting signs of infection or dehiscence. In this case the supervising clinician will assess the incision weekly, at minimum. Clinical Note Reviews will be completed by the Executive Director (ED) or designee, to ensure clinicians have evidence of documentation proficiency. A minimum of four notes each month, per clinician, will be reviewed. Clinicians who score < 80% month will be assigned prescriptive learning and/or an individual development plan; and will be	

	assessment of the knee occurred. A document dated 1/02/23, titled "Visit Note Report" (PTA routine visit) stated, "... Patient ... has MRI tomorrow for [right] knee ... presents [with] right knee brace on ... was not on appropriately ...." The document failed to evidence assessment of the knee occurred. A document dated 1/12/23, titled "Visit Note Report" (PTA routine visit) stated, "... Patient had [physician] appointment Tuesday [1/10/23] with [Person #29, an orthopedic physician] ... [patient to] wear [right] knee brace for two weeks then begin [outpatient] therapy ... remain [non-weight bearing right lower leg] ... has a fracture ...." The document failed to evidence assessment of the knee occurred. During an interview on 2/02/23 at 2:33 PM, the Administrator indicated the patient should have been reassessed. 7. Clinical record review for patient #14 was completed on 2/02/23 (start of care date 10/27/22, certification period 10/27/22 – 12/25/22). A		audited at a higher quantity and frequency to be determined by the ED. For new employees, three visit notes a week will be audited until results are at least 80% for four consecutive weeks. Beginning the week of 3/20/23, the Executive Director or 7 home visits weekly to patient assessment matches the visit notes with no contradictory documentation noted. Monitoring will continue weekly for and will continue until 95% compliance is achieved for 3 consecutive weeks. Deficient findings will be addressed immediately, and clinician remediation and disciplinary action will occur as indicated Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	

	document dated 10/17/22, titled "... Order Category: Dietary, Pharmacy ... Active Orders As Of ... 10/17/22", evidenced the document originated from Entity #25 (a skilled nursing facility). The document listed the patient's current diagnoses, which included obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), UTI, dysphagia, oropharyngeal phase (difficulty initiating a swallow, and swallowing may be accompanied by regurgitation, aspiration [the drawing in of a foreign substance into the lungs], and a sensation of residual food remaining in the throat), need for assistance with personal care, other symptoms and signs concerning food and fluid intake, and stage 2 pressure ulcer, other site (characterized by partial-thickness skin loss into but no deeper than the layers of the skin, which includes intact or ruptured blisters). A document dated 10/14/22, titled "[Entity #25] ... Progress Notes", evidenced the patient's lung sounds improved with crackles (sounds heard when			

	the small air sacs in the lungs fill with fluid and there's air movement in the sacs during breathing) since she was started on Lasix (a diuretic), and family had an appointment with Entity #27 (an oxygen and medical equipment company) for training on BiPap (a device that helps with breathing, and forces intermittent air into the lungs), and colace (stool softener) was added twice daily for constipation. A document titled "Home Health Certification and Plan of Care" (for initial certification period 10/27/22 – 12/25/22), evidenced the patient's primary diagnosis was acute (sudden) and chronic (long standing) respiratory failure with hypoxia (the respiratory system cannot adequately provide oxygen to the body, resulting in an absence of enough oxygen in the tissues to sustain bodily functions), and additional diagnoses included pneumonitis due to inhalation of food and vomit (an infection of the lungs caused by inhaling saliva, food, liquid, vomit and even small foreign objects into the lungs), sepsis (a potentially life-threatening condition that			

	occurs when the body's response to an infection damages its own tissues), type 2 diabetes (adult onset), dementia, and dependence on supplemental oxygen; and medications included oxygen at 4 LPM via nasal cannula (tubes inserted into the nose), and colace twice daily. A document dated 10/27/22, titled "Visit Note Report" (PT start of care comprehensive assessment), evidenced assessment findings, which indicated the patient had no skin problems, no cardiovascular problems, the only respiratory issue was the use of O2 at 2 LPM via nasal cannula, no urinary problems, no gastrointestinal problems, the patient didn't have diabetes, and there were no nutritional risks. The document failed to evidence the PT assessed the patient's heart, lung or bowel sounds, pedal (feet) pulses, performed a diabetic foot exam, assessed how often the patient checked her blood sugar level, identified the location or assessed the stage 2 pressure ulcer, assessed weight, correct O2 dose was 4 LPM, assessed ability to safely swallow, ability			

	to urinate, signs or symptoms of UTI, or signs/symptoms of aspiration. A document dated 11/03/22, titled "Visit Note Report" (PTA routine visit), failed to evidence the location of the stage 2 pressure ulcer.			

	An additional document dated 11/03/22, titled "Visit Note Report" (RN add-on evaluation), evidenced the patient had wound(s), but no further assessment was documented; the patient had a CPap (a device that helps with breathing, and forces continuous air into the lungs); the patient used O2 at 3 LPM; and the patient didn't have diabetes. The document failed to evidence the RN assessed the patient's heart, lung or bowel sounds, pedal (feet) pulses, performed a diabetic foot exam, assessed how often the patient checked her blood sugar level, identified the location or assessment of the stage 2 pressure ulcer, assessed weight, correct O2 dose was 4 LPM, assessed ability to safely swallow, ability to urinate, signs or symptoms of UTI, or signs/symptoms of aspiration. A document dated 11/08/22, titled "Visit Note Report" (PTA routine visit), failed to evidence the the location of the stage 2 pressure ulcer. An additional document dated 11/08/22, titled "Visit Note Report" (LPN routine visit) failed			

	to evidence the the location of the stage 2 pressure ulcer. On 2/02/23 at 3:01 PM, during the clinical record review, the Administrator confirmed adequate assessments weren't performed based on the patient's diagnoses. 8. Clinical record review for patient #15 was completed on 2/02/23. A document titled "Home Health Certification and Plan of Care" (for initial certification period 11/20/22 – 1/18/23), evidenced the patient's primary diagnosis was laceration without foreign body of other part of head, subsequent encounter (unspecified open wound of unspecified part of head), and other diagnoses included fracture of right elbow, and UTI; medications included levetiracetam (an anti-seizure medication); and stated, "... Patient ... medical history is significant for frequent falls [and hypertension [high blood pressure] ... patient attributes frequent falls to syncopal [fainting] episodes ...." A document dated 12/28/22,			

	Reports" (Entity #15, a hospital), evidenced the patient had a witnessed syncopal (fainting) episode and sustained a laceration (cut) to the back of her head; urinalysis (laboratory test of urine) was positive for UTI, the patient was started on antibiotics, and urine cultures were pending (to pinpoint the best antibiotic treatment based on the pathogen identified in the urine). A document dated 1/09/23, titled "Outpatient Surgical Report/Discharge Summary", evidenced the patient had surgery to repair the right elbow on 1/09/23, and staples were used to close the skin. A document dated 11/13/22, titled "Visit Note Report" (PT start of care comprehensive assessment), failed to evidence the patient's head was assessed, was assessed for any seizure or syncopal activity, or signs/symptoms of UTI. A document dated 1/16/23, titled "Visit Note Report" (PT routine visit), failed to evidence the patient's head was assessed, was assessed for any seizure or syncopal activity, or			

signs/symptoms of UTI.

A document dated 1/18/23, titled "Visit Note Report" (PT reassessment visit), failed to evidence the patient's head was assessed, was assessed for any seizure or syncopal activity, or signs/symptoms of UTI.

A document dated 1/23/23, titled "Visit Note Report" (PTA routine visit), evidenced the patient's staples were removed from the right elbow on 1/20/23, and the incision was covered with a dressing (type not specified). The document failed to evidence the patient's right elbow or head was assessed, assessed for any seizures or syncopal activity, or signs/symptoms of UTI.

During an interview on 2/02/23 at 3:30 PM, the Administrator indicated the patient's head wasn't assessed, wasn't assessed for any seizure or syncopal activity, signs/symptoms of UTI, and stated, "... I see this is a problem ...."

9. Clinical record review for Patient #16 was completed on 2/01/23 (start of care date

	printed date 11/14/22, titled "History and Physical Report", indicated the patient had permacath (a long, flexible tube [catheter] that is inserted into a vein most commonly into a large vein in the neck, and less commonly into a large vein in the groin, for dialysis) placement on 3/11/22, and peritoneal catheter (a tube that is inserted into the lining of the abdomen to filter blood within the body during dialysis) placement on 10/18/22. A document titled "Home Health Certification and Plan of Care" (for initial certification period 11/20/22 – 1/18/23), evidenced the patient's primary diagnosis was urinary tract infection (UTI), other diagnoses included hypertensive heart (problems with the heart that can develop if you have high blood pressure but don't treat it for years) and chronic kidney disease (long-standing decline of kidney function) with heart failure (the heart's inability to pump blood and oxygen [O2] throughout the body) and stage 5 chronic kidney disease (end stage, requires dialysis to sustain life), sick sinus syndrome (a type of heart rhythm			

	disorder), acute (sudden) and chronic (long standing) respiratory failure with hypoxia (the respiratory system cannot adequately provide oxygen to the body, resulting in an absence of enough oxygen in the tissues to sustain bodily functions), and dependence on supplemental oxygen (O2) (2 liters per minute [LPM] continuous, via nasal cannula [small tubes inserted into the nostrils to administer oxygen]). A document dated 11/20/22, titled "Visit Note Report" (PT start of care comprehensive assessment) evidenced no skin issues/problems were identified, and the patient had 2+ pitting edema (swelling that occurs when excess fluid builds up in the body due to heart, circulatory, and/or kidney problems, and when pressed by the tip of a finger, a "pit" remains; 1+ means the "pit" leaves an indentation of 0–2 millimeters [mm] that rebounds immediately; 2+ means the "pit" leaves an indentation of 3–4 mm that rebounds in fewer than 15 seconds; 3+ means the "pit" leaves an indentation of 5–6 mm that takes up to 30 seconds to rebound; and 4+ means the			

	"pit" leaves an indentation of 8 mm or deeper that takes more than 20 seconds to rebound) to both lower extremities. A document dated 11/30/22, titled "Visit Note Report" (Physical Therapy Assistant [PTA] routine visit), indicated the patient sustained a skin tear on the right hip, it was covered with a bandage, and the patient had 3+ bilateral lower extremity edema (worse than previous visit). The document failed to evidence the patient's O2 saturation (an assessment device that measures how much O2 is in your blood) level, weight, lung sounds, pedal (pulses on the top of the feet) pulses, signs/symptoms of UTI, the skin tear on the right hip, or integrity of the permacath and peritoneal catheters were assessed. A document dated 12/07/22, titled "Visit Note Report" (PTA routine visit) evidenced the patient had 3-4+ pitting edema to both lower extremities (worse than last routine visit), and stated, "... [family] reports R [right] buttocks skin tear covered with bandage, reports			

	noted, patient has bruising at face, UES [upper extremities] that have been long standing ....” The document failed to evidence the patient’s weight, lung sounds, pedal pulses, signs/symptoms of UTI, the skin tear on the right hip, or integrity of the permacath and peritoneal catheters were assessed/measured as indicated. A document dated 12/15/22, titled “Visit Note Report” (PT reassessment) evidenced an assessment section, which indicated cardiovascular assessment was “NA” (not applicable), post intervention of pain was “NA”, and the patient did not have a diagnosis or symptoms indicative of respiratory impairment. The document failed to evidence the patient’s O2 saturation, assessment for edema, pedal pulses, weight, lung sounds, right buttocks skin tear, facial and upper extremities bruising, signs/symptoms of UTI or integrity of the permacath and peritoneal catheters were assessed/measured as indicated. A document dated 12/21/22,			

	titled "Visit Note Report" (PTA routine visit), evidenced new skin tears to the patient's left forearm and right middle finger, the right hip/buttock wound was healing, family addressed the wounds, the patient had 3+ edema to both feet, and used O2 at 2 LPM. The document failed to evidence the patient's O2 saturation, pedal pulses, weight, lung sounds, right buttocks skin tear, skin tears to the patient's left forearm and right middle finger, facial and upper extremities bruising, signs/symptoms of UTI or integrity of the permacath and peritoneal catheters were assessed/measured as indicated. A document dated 12/28/22, titled "Visit Note Report" (PTA routine visit), stated, "... [patient/family] mention having a lot [more] fluid due to having to change dialysis routine and patient is a little boated feeling today. Mentions usually [only] wears supplement oxygen at night but has it on today due to mild shortness of breath without supplemental oxygen ... edema in BLE [bilateral lower extremities] being controlled per [family] ...." The document			

	failed to evidence the patient's pedal pulses, weight, lung sounds, right buttocks skin tear, skin tears to the patient's left forearm and right middle finger, facial and upper extremities bruising, signs/symptoms of UTI or integrity of the permacath and peritoneal catheters were assessed/measured as indicated. A document dated 1/05/23, titled "Visit Note Report" (transfer data collected, no visit made) evidenced the patient utilized the emergency department and was admitted to the hospital, but failed to evidence why the patient was hospitalized. A document received from Entity #15 (a hospital) on 1/27/23, titled "Emergency Documentation" evidenced the patient was seen at Entity #15's emergency department, was diagnosed with a UTI, and was admitted for treatment on 12/30/22. A document received from Entity #15 on 1/27/23, titled "History and Physical Reports", evidenced the patient was			

	1/02/23. A document received from Entity #15 on 1/27/23, titled "Discharge Summary", evidenced admit/discharge diagnoses included UTI and weakness. During an interview on 2/01/23 at 2:15 PM, the Administrator indicated she expected the patient to be assessed every visit based on the diagnoses. 1. Record review evidenced an agency policy revised 8/1/2022, titled "Wound Assessment, Documentation, and Photography" which stated, "... Wound location and description documentation is completed on all patients with wounds at the time of admit or upon development of a wound ... Wound assessment findings will be documented within the Integumentary Command Center by utilizing the Wound Assessment Tool ... During routine visits, wound will be documented in the Wound Assessment Tool ...." 2. Record review evidenced a			

obtained 2/1/2023, which stated, "... Accurately and thoroughly documents patient visits per policy ...."

3. Clinical record review for Patient #1 was completed on 2/2/2023, for certification period 1/10/2023 – 3/10/2023. Record review evidenced a skilled nurse visit note dated 1/11/2023, which inicated the patient had a wound which measured 2.2cm (centimeters) x 2cm x 0.1cm.

Clinical record review evidenced a skilled nurse visit note dated 1/19/2023, which indicated the wound now measured 5cm x 1cm x 0.1cm. This visit note indicated the wound was getting smaller.

During an interview on 1/31/2023, at 10:09 AM, administrator/clinical manager #1 indicated the documetnation was inaccurate regarding the wound getting smaller.

	4. Observation of a home visit for Patient #2 was conducted on 1/25/2023, at 10:00 AM, to observe a routine skilled nurse visit. During the visit, the nurse failed to assess the patient's blood glucose level. Clinical record review for Patient #2 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 11/30/2022 – 1/28/2023, which indicated the patient had a primary diagnosis of diabetes (problem regulating blood sugar levels). Clinical record review evidenced skilled nurse visit notes for the following dates, which failed to include an assessment of blood glucose levels: 11/30/2022, 1/6/2023, 1/13/2023, and 1/25/2023. Record review evidenced a start of care assessment dated 11/30/2022, which indicated the patient had wounds, and also indicated the patient had no wounds. This document			

	indicated the patient had an indwelling catheter which was changed on 11/25/2022. Clinical record review evidenced a skilled nurse visit note dated 12/30/2022, which indicated the indwelling catheter was changed on 11/23/2022. During an interview on 1/31/2023, at 10:29 AM, administrator/clinical manager #1 indicated the nurses should have checked/assessed the patient's blood glucose level every visit. At 10:39 AM, administrator/clinical manager #1 indicated the documentation of wounds was contradictory. At 10:41 AM, administrator/clinical manager #1 indicated the 12/30/2022, skilled nurse visit note documented the catheter change date in error. 5. Clinical record review for Patient #3 was completed on 2/2/2023, for certification period 12/8/2022 – 2/5/2023. Record review evidenced a skilled nurse visit note dated			

	1/16/2023, which indicated the patient had a new wound to the right great toe, but failed to include measurements, or documentation in the wound assessment tool as per policy. The visit note failed to document what type of dressing was applied, or with what the wound was cleansed. Clinical record review evidenced a skilled nurse visit note dated 1/23/2023, which indicated the patient had a new wound to the left buttock but failed to include a wound assessment including site appearance, measurements, drainage, or type of wound. During an interview on 1/31/2023, at 12:23 PM, administrator/clinical manager #1 indicated the nurse should have documented what dressing was applied and with what the wound was cleansed with. Administrator/clinical manager #1 did not know what wound care was provided. Administrator/clinical manager #1 indicated wounds should have been measured and			

documented in the wound tool.

6. Clinical record review for Patient #5 was completed on 2/2/2023. Record review evidenced a plan of care which indicated the nurse was to complete wound care weekly and assess wound site for complications or progress.

Clinical record review evidenced a skilled nurse visit note dated 1/7/2023, which failed to include wound measurements.

During an interview on 1/31/2023, at 12:46 PM, administrator/clinical manager #1 indicated the wound should have been measured every visit.

7. Clinical record review for Patient #7 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 12/2/2022 – 1/30/2023, which indicated the patient was to receive skilled nursing for assessment and

	catheter care, and assessment and instruction of gastrostomy tube (tube inserted into stomach to deliver feedings). Clinical record review evidenced skilled nurse visit notes for dates 12/16/2022, and 12/21/2022, which failed to include an assessment of patient's gastrostomy tube status. During an interview on 1/30/2023, at 2:21 PM, administrator/clinical manager #1 indicated the clinicians should have completed a head-to-toe assessment every visit, and assessed the gastrostomy tube site. 8. Clinical record review for Patient #8 was completed on 2/2/2023. Record review evidenced a plan of care for certification period 1/5/2023 – 3/5/2023, which indicated the physical therapist was to provide wound care, instruct the patient on wound care, and			

	to patient. The plan of care indicated the patient had a pressure ulcer on the coccyx (tailbone). Clinical record review evidenced physical therapy visit notes dated 1/11/2023, 1/25/2023, and 1/27/2023, which all failed to include assessment of wound such as wound measurements, dressing applied, frequency of dressing changes. The visit note dated 1/27/2023, failed to include any wound assessment. During an interview on 1/30/2023, at 2:48 PM, administrator/clinical manager #1 indicated any wounds should have been assessed and measured weekly. 9. Clinical record review for Patient #9 was completed on 2/2/2023, for certification period 7/24/2022 – 9/21/2022. Record review evidenced a skilled nurse visit note dated 8/16/2022, which indicated the patient had no falls since the last visit, and also indicated the			

	patient had fallen on 8/14/2022. Clinical record review evidenced a skilled nurse visit note dated 8/12/2022, which indicated the patient had no integumentary issues, and in another section indicated the patient had bruising from eyebrows down to the collar bone. During an interview on 2/1/2023, at 10:05 AM, administrator/clinical manager #1 indicated it was contradictory documentation, and probably not accurate. At 10:15 AM, administrator/clinical manager #1 indicated the 8/12/2022, skilled nurse visit note was not accurate.			
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and interview, the home health	G0718	Patient # 9 is discharged from home health services and an on-line incident report has been completed on 2/24/23.	2023-03-17

	professionals communicated with all physicians involved in the plan of care in 1 of 5 discharged clinical records reviewed. (#9) The findings include: Record review evidenced an agency policy revised 8/1/2019, titled "Coordination of Care, From Admit Through Discharge" which stated, "… Coordination of care with physician: … At admission, throughout care, and at discharge, coordination of services is promoted through routine communication with the patient's physician …." Clinical record review for Patient #9 was completed on 2/2/2023. Clinical record review evidenced a plan of care for certification period 7/24/2022 – 9/21/2022, which indicated the patient's physician was physician #17. Clinical record review evidenced a communication note dated 8/9/2022, which indicated the patient fell 3 times, and		During a mandatory staff meeting held on 2/22/23, the Regional Vice-President instructed all clinical staff on coordination of care using Policy # 2.1.017 Coordination of Care, From Admit Through Discharge, with emphasis on notifying the responsible physician of any orders from other physicians. During a mandatory staff meeting held on 2/22/23, the Regional Vice-President instructed the Business Manager (BM), clinical staff, and PCMs on ensuring the proper physician is selected on physician orders and coordination notes. For any staff not present, the RVP or designee will provide instructions to the individual employees by 2/25/23. Coordination of care will occur with physician from admission, throughout care, and at discharge, through routine communication when changes occur in the patient's condition or response to treatment; when a missed visit occurs altering the Plan of Care; when results of laboratory and other tests become available; and when there is a need to change the patient's plan of care. Revisions to the plan of care due to a change in patient's condition will be communicated to all physicians issuing orders, as applicable. The will be notified of any orders from other physicians. When entering orders and coordination notes, the clinician will ensure the proper physician is selected. When reviewing orders and coordination notes, the PCM will verify that the correct physician is selected on the document. Prior to sending correspondence to the physician, the BM will verify the accuracy of the intended	

	physician #18 was notified. Clinical record review evidenced a physician order dated 8/12/2022, to delay a physical therapy visit per spouse's request, which was sent to physician #18. Clinical record review evidenced a communication note dated 8/16/2022, which indicated the patient fell, and physician #18 was notified. Clinical record review evidenced a missed visit note dated 8/19/2022, which was sent to physician #18. Clinical record review evidenced a communication note dated 8/19/2022, with abnormal urinalysis results, which were sent to physician #18. During an interview on 2/1/2023, at 10:13 AM, administrator/clinical manager		recipient. Beginning 3/20/23, ED or will complete 10 record reviews a week to ensure the physician responsible for home care has been communicated changes as needed. Any deviations to this process will be addressed with clinician remediation and disciplinary action as indicated. Monitoring will continue for and will continue until 100% compliance for 3 consecutive weeks. Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.	

	#1 indicated they did not know why the clinicians were not communicating with the physician listed on the plan of care. 410 IAC 17-14-1(a)(1)(G)			

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
Lori Lenz	Administrator	2/25/2023 2:30:50 PM