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	04/11/2023

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 Re-Survey was conducted by the Indiana Department of Health in accordance with 42 CFR §484.102. Survey Dates: 4/05/2023, 4/06/2023, 4/10/2023, and 4/11/2023. Census: 96 At this Emergency Preparedness survey, Indiana Homecare Northwest, was found to be compliant with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, including staffing and the implementation of staffing during a pandemic at 42 CFR §484.102.	E0000	*3rd POC accepted on 7-6-2023* *Deborah Franco, RN*	
E0017	HHA Comprehensive Assessment in Disaster	E0017	This tag is corrected.	2023-04-11

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 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.

* Clinical record review for Patient #3 was completed on 4/11/2023. Record review evidenced an initial comprehensive assessment, dated 3/18/2023. The document evidenced the patient's emergency evacuation location was a family member's residence, but failed to evidence the address of the family member.

During an interview on 4/11/2023 at 2:36 PM, the Administrator indicated the family member's address should

	evacuation location. 1. 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 ...." 2. Clinical record review for Patient #6 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 3/20/2023 - 5/18/2023, which indicated the patient used 2 liters of oxygen continuously. Record review evidenced an individual emergency preparedness plan which indicated the patient used oxygen, but failed to include a plan for oxygen use in the case of a power outage. During an interview on 4/6/2023, at 1:54 PM, Patient #6 indicated there was a storm which caused a power outage on 4/5/2023. The patient indicated they were supposed			

	continuously, but during the storm, they went without oxygen. Patient #6 indicated they did not have the strength in their hands to turn on the portable oxygen tank, so they weren't getting any oxygen during the power outage. During an interview on 4/10/2023, at 3:15 PM, the Administrator indicated the patient's oxygen use should have been addressed in the individual emergency preparedness plan. The Administrator indicated it was hard to keep track of patients' oxygen use.			
G0000	INITIAL COMMENTS This visit was for a Post-Condition Revisit for a Federal Recertification and State Re-licensure survey, originally conducted on 2/02/2023. Facility ID: IN005259 Survey Dates: 4/05/2023, 4/06/2023, 4/10/2023, and 4/11/2023. Census: 96 During this survey, 1 Condition	G0000		

	of Participation: 42 CFR 484.55 Comprehensive assessment of patients was corrected, 1 Condition of Participation: 42 CFR 484.60 Care Planning, Coordination of Care and Quality of Care was re-cited, 5 standard level deficiencies were corrected, and 14 standard level deficiencies were re-cited. Indiana Homecare Northwest, was precluded from providing its own home health aide training and competency evaluation for a period of two years from 2/2/2023 - 2/1/2025, 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.			
G0374	Accuracy of encoded OASIS data 484.45(b)	G0374	An occurrence report was entered for patients 3, 4,and 6. During a mandatory staff meeting held on 5/3/23, the PerformanceImprovement (PI) Team instructed all clinical staff	2023-05-11

	Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on record review and interview, the home health agency failed to ensure Outcome and Assessment Information Set (OASIS) data was accurate for 3 of 3 clinical records reviewed for the patient's initial certification period (Patient #3, 4, 6). The findings include: * Clinical record review for Patient #3 was completed on 4/11/2023. Record review evidenced an initial comprehensive assessment (with OASIS data), dated 3/18/2023. The OASIS data for medications evidenced no potential clinically significant medication issues were found during the drug regimen review. Record review of the patient's plan of care evidenced the patient's current medications included bupropion (a smoking deterrent), buspirone (for anxiety), ondansetron (for nausea), and sertraline (for depression/anxiety). On 4/11/2023 at 10:06 AM, drugs.com (a web base		and Patient Care Manager(PCM) on OASIS accuracy, using the Clinical Comment Intake Coordination NoteTip Sheet and M2001 Drug Regimen Review Tip Sheet, with emphasis on propercompletion of M1005 and M2001 OASIS items. For any staff not present, PI Team or designee willprovide instructions to the individual employees by 5/11/23. The assessing clinician accurately completes thecomprehensive assessment / OASIS. The assessing clinician will interview thepatient /caregiver and reference the Clinical Comment Intake Note and referraldocuments to aid in accurately answering M1005. The assessing clinician will complete a drug regimenreview as part of the comprehensive assessment. If any issues, including, butnot limited to drug interactions are identified, M2001 would be scored “1-yes.” Beginning 5/1/24, to enhance and validate the accuracyof OASIS, with each SOC and ROC, the Patient Care Manager (PCM)	

	reference drug interaction checker) (https://www.drugs.com/interactions) was reviewed, which evidenced 5 potentially major drug interactions existed between ondansetron and sertraline, bupropion and ondansetron, buspirone and ondansetron, buspirone and sertraline, and bupropion and sertraline; and potential major drug interactions were highly clinically significant, should be avoided, and the risk of the interaction outweighed the benefit(s). On 4/11/2023 at 2:36 PM, the Administrator confirmed 5 potentially major drug interactions existed, and they would be reported to the physician. * Clinical record review for Patient #4 was completed on 4/11/2023. Record review evidenced an initial comprehensive assessment dated 3/28/2023. The OASIS data for medications evidenced no potential clinically significant medication issues were found during the drug regimen review. Record review of the patient's		or designeewill review the Clinical Comment Intake Note and supporting documentation tovalidate the accuracy of M1005. The PCM will review M2001 to ensure this item isscored accurately and consistent with the results of the drug regimen reviewdocumented within the medical record. The Executive Director is ultimately responsible for the implementation of this plan of correction. Date of Completion - 5/11/2023 Once SOC visits resume, the ED or designee will review100% of Clinical Comment Intake Notes and M1005 in the comprehensive assessment/ OASIS for 3 weeks, and then 50% for 8 weeks to ensure M1005 accuracy. Monitoring will continue until 100% compliance isachieved for 3 consecutive weeks. For any deficient findings, the	

	plan of care evidenced the patient's current medications included aspirin and Eliquis (apixaban) (blood thinner). On 4/11/2023 at 11:34 AM, drugs.com was reviewed, which evidenced 1 potentially major drug interaction existed between aspirin and Eliquis; and potential major drug interaction(s) were highly clinically significant, should be avoided, and the risk of the interaction outweighed the benefit(s). On 4/11/2023 at 3:15 PM, the Administrator confirmed a potentially major drug interaction existed, based on the drugs the patient currently used. 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 #6 was completed on 4/11/2023, for certification period 3/20/2023 - 5/18/2023. Record review evidenced a referral document, which indicated the patient was		ED/designee willprovide clinician remediation/counseling to ensure future compliance. Once SOC visits resume, the ED or designee will review100% the drug regimen review and M2001 in the comprehensive assessment / OASIS for3 weeks, and then 50% for 8 weeks to ensure proper completion of M2001. Monitoring will continue until 100% compliance isachieved for 3 consecutive weeks. Any deviation will be addressed up to staffdisciplinary action. Discussion ofcompliance will be discussed with the team during the quarterly QualityAssurance Performance Improvement team meetings until compliance isachieved.	

	health care. Record review evidenced a start of care comprehensive assessment dated 3/20/2023, which included a section titled "M0104 Date of Referral" which indicated the date of referral was 3/18/2023. This document included a section titled "M1005: Inpatient discharge date" which indicated the patient was discharged on 3/17/2023. Record review evidenced a clinical intake form which indicated the patient was discharged from the hospital on 3/18/2023. During an interview on 4/10/2023, at 3:04 PM, the Administrator indicated the OASIS sections were inaccurate, and it was a known problem with the clinicians.			
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	G0536	An occurrence report was entered for patients 1, 2, 3,4, 5, and 6. Patient 1 is currently hospitalized. Physician was notified of lack of complete andaccurate	2023-05-11

	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 used; and/or failed to ensure the drug regimen review was conducted by a registered nurse in 6 of 7 active clinical records reviewed (Patient #1, 2, 3, 4, 5, 6). The findings include: 4. Clinical record review for Patient #1 was completed on 4/11/2023. Record review evidenced a comprehensive assessment for recertification of services, dated 3/23/2023. The document evidenced the nurse reviewed the patient's current medications. Record review evidenced a plan of care for certification period 3/27/2023 – 5/25/2023. The document evidenced current medications used by the patient included: codeine/guaifenesin liquid (prescription cough syrup), which was prescribed on 2/22/2023, could be used for up to 10 days (no later than 3/04/2023), and was not a currently prescribed medication;		medication list, and updated medication orders obtained for patient 2on 4/6/23. Medication review wascompleted by RN on patient 3 on 3/21/23. Clarified medication discrepancies (PetroleumJelly, Acetaminophen, Miralax, Refresh Tears, Melatonin, Ondansetron, and ProAir)with physician and updated orders received on 5/5/23. Patient 4 is currently hospitalized. For patient 5, physician notified of lack of completeand accurate medication list and medication interaction between hydrocodone /acetaminophen and hydromorphone on and updated medication orders obtained on 5/5/23. Patient was educated on the interactionbetween hydrocodone / acetaminophen and hydromorphone on 5/5/23. RN completed a medication review for patient 6 on 3/21/23. During a mandatory staff meeting held on 5/3/23, the PITeam instructed all clinical	

	ondansetron (for nausea), was prescribed on 2/28/2023, could be used for up to 7 days (no later than 3/07/2023), and was not a currently prescribed medication; sliding scale (dose based on blood sugar level) insulin (to treat diabetes) evidenced it was a high risk medication, but failed to evidence abnormal parameters to notify the physician; and application of two (2) lidocaine patches (topical pain relief) daily as needed, but failed to include directions to remove the patches after 12 hours and prior to application of new patches, to prevent duplicate drug therapy. On 4/11/2023 at 1:15 PM, the Administrator confirmed there were no parameters to call the physician for the sliding scale insulin. 5. Clinical record review for patient #2 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 3/23/2023 – 5/21/2023). The document evidenced medications included triple antibiotic ointment was ordered 11/22/2022, to be applied to wound bed three		health policiesMedication Monitoring; Patient Assessment, Initial and Reassessment; PhysicianOrders; and Plan of Care with an emphasison the requirement to complete a current and accurate medication reconciliationto identify all medications, including Over the Counter (OTC) medications, thepatient is taking; reconciling discrepancies with the physician; discontinuingmedications the patient is no longer taking; complete medication orders(including appropriate removal and anatomical location); identification of medicationinteractions; instructing patients on medication interactions, and parameters. For any staff not present, the PI Team or designeewill provide instructions to the individual employees by 5/11/23. Home Care Home Base(HCHB) is not currently identifying all medication interactions identified byDrugs.com. Issue has been previously submitted to HCHB for expediated reviewand correction. In the interim, medications will be	

	times weekly, but failed to identify the location of the wound; and medihoney (medical grade honey) was ordered 3/23/2023, to be applied to the left heel wound bed every other day. On 4/11/2023, the Administrator confirmed the triple antibiotic order was old, and wound treatment orders should include the anatomical location a medicine was applied. 6. Clinical record review for Patient #3 was completed on 4/11/2023. Record review evidenced an initial comprehensive assessment, dated 3/18/2023, was completed by Physical Therapist (PT) #1. The document stated, "... Medications awaiting MD [physician] approval ... petroleum jelly barrier cream. Apply daily to sacrum [lower back] ... Acetaminophen dosage change 325 mg [milligrams] to 500 mg ... miralax [laxative] ... daily as needed ... refresh eye drops 1 drop daily bilateral eyes ... discontinue melatonin [sleep aid] ... discontinue ondansetron [for nausea] ... discontinue ProAir HFA [inhaled drug to		manually entered intoDrugs.com for additional review to identify all potential interactions. A drug regimen review will be performed on allpatients in conjunction with all comprehensive assessments and as needed when new medications are prescribed to identify all medications the patient iscurrently taking and to identify issues such as potential adverse effects anddrug reactions; ineffective drug therapy; significant side effects; drugallergies; contraindicated medications; significant drug interactions; duplicatedrug therapy; noncompliance with drug therapy; dosage errors; and drugomissions. Additionally, all clinicians will participate inmedication review and reconciliation throughout the episode. For patients receiving skilled nursing and therapyservices, the skilled nurse is responsible for medication review andreconciliation throughout the episode. The therapist will participate bymonitoring and	

	open airway] ....” Review of the clinical record failed to evidence a Registered Nurse (RN) reviewed the patient’s medications. During an interview on 4/11/2023 at 2:36 PM, the Administrator indicated she didn’t see that the record evidenced the physician addressed the medications, and confirmed a RN didn’t reconcile the medications. 7. Clinical record review for Patient #4 was completed on 4/11/2023. Record review evidenced an initial comprehensive assessment, dated 3/28/2023, was completed by PT #1. The document evidenced the patient used over-the-counter medication(s) for pain relief, but failed to specify what medication(s) the patient used. Record review evidenced a Physical Therapy Assistant (PTA) visit note dated 4/03/2023. The document evidenced the patient used ibuprofen for pain relief. Record review evidenced a PTA visit note dated 4/10/2023. The document evidenced the		reporting any identified medication issues or non-compliance tothe PCM. For patients receiving only therapy services, thetherapist is responsible to facilitate drug regimen review and medicationreconciliation throughout the episode. The therapist will collaborate with thePCM to complete the process. For therapy only patients, the PCM will review thecomprehensive medication list formulated by the therapist and complete the drugregimen review which is documented in the medical record. The physician is contacted immediately if anydiscrepancies between agency information and patient medications are found. HCHB completes amedication review to identify medication interactions. This review has notyielded the same results as those obtained by Drugs.com. HCHB has completed anupgrade to their medication review process to enhance the identification ofdrug interactions. This “fix” will	

	patient used biofreeze (topical cream) for pain relief. Record review of the patient's plan of care failed to evidence the patient's current medications included use of ibuprofen or biofreeze. On 4/11/2023 at 3:15 PM, the Administrator indicated all medications should be included on the plan of care. 1. Record review evidenced an agency policy revised 5/1/2019, titled "Monitoring Medication" which stated, "... The discipline responsible for the drug regimen review will: ... Review all medications including over the counter medications, vitamins, herbs and herbal products, creams and topical ointments, and medical marijuana, to identify issues such as: ... Potential adverse effects and drug reactions ... Significant drug interactions ... Severity level 2 [severe interaction] The clinician will contact the patient's physician and await further orders ... Duplicate drug therapy ... Noncompliance with drug therapy ...." 2.Observation of a home visit		bereleased and ready for use on 5/10/23. Until such issue is resolved, clinicians will continue to manually entermedications into Drugs.com to identify any additional medication interactions until the HCHB “fix” is proven accurate. PCMs will ensure that medication interactions arereported to physicians and orders obtained to address the interactions asindicated for all major reactions. PCMs will verify that instructions are provided topatients regarding drug interactions as discussed in Monitoring Medicationspolicy per the identified severity level. Each patient has an individualized Plan of Care (POC)developed in consultation with the patient, physician or authorizedpractitioner, and staff that integrates comprehensive assessment findings toaddress patient problems, needs, and goals, as well as to address specificservices being provided. Patient specific parameters as ordered by physicianare incorporated into the POC as an appropriate guide forreference	

	on 4/10/2023, at 11:00 AM, to observe a routine skilled nurse visit. During the visit, the patient's medication bottles were observed and reviewed. The medication list indicated the patient was taking Norco (pain medication) 6 times daily as needed for pain, acetaminophen 1 time daily, potassium chloride (electrolyte) 20 milligrams twice daily, and failed to include docusate sodium (stool softener). Clinical record review for Patient #5 was completed on 4/11/2023, for certification period 3/29/2023 - 5/27/2023. Record review evidenced a medication list which contained orders for the following: Norco every 6 hours as needed for pain, acetaminophen every 6 hours as needed for pain, and docusate sodium daily. The medication list included duplicate orders for potassium chloride 20 milligrams twice daily. The medication list indicated it was reviewed by the registered nurse on 3/24/2023, for drug interactions. Record review evidenced a recertification assessment dated 3/24/2023, which indicated no		ranges as indicated. PCMs will utilize the PCM POC Review Tool whenreviewing the POC to ensure medication orders are complete, interactions are addressed,discrepancies are resolved, and parameters are present on the POC. Beginning 5/8/23 the Executive Director or designeewill audit 4 visit notes per clinician per month. Clinicians scoring less than 100% will be assigned prescriptive learning. All new clinicians will have 2 notes audited per week until 100% for 4 consecutive weeks then will go into the monthly rotation. The notes audited will be a random pull of visits and will focus on medication referenced in the clinical documentation are added to the medication profile. The Executive Director is ultimately responsible for the implementation of this plan of correction. Completion Date: 5/11/23	

	major drug interactions were identified during the medication review. Review of a web based source on 4/11/2023, at https://www.drugs.com/interactions-check.php , evidenced the following major drug interaction between hydromorphone (pain medication) and Norco: can cause respiratory depression, coma, and death. Record review failed to evidence any coordination notes which identified the interaction between Norco and hydromorphone. During an interview on 4/5/2023, at 11:48 AM, the Administrator indicated the nurses completed medication reviews during the recertification assessments, and any identified interactions would have been documented in coordination notes. During an interview on 4/11/2023, at 10:26 AM, the Administrator indicated the nurses should have ensured every visit that the medications were the same as what the patients' were taking.		Beginning the week of 5/14/23, the ED or designee withcomplete 9 home visits weekly and will review the medical records of thesepatients to verify accuracy of the medication lists and to ensure druginteractions were reported and addressed, patients received education on druginteractions. Beginning week of 5/14/23, the ED or designee willreview the POC to ensure the POC is individualized and contains parameters asindicated. Once SOC visits resume, the ED or designee will review100% of the POC for 3 weeks, and then 50% for 8 weeks to ensure the POC containsparameters, as indicated. Beginning 5/11/23, ED or designee will complete 10record reviews per week to ensure medication profile is accurate, includinglocation for topical medications. Monitoring will continue until 100% compliance isachieved for 3 consecutive weeks.	

	3. Clinical record review for Patient #6 was completed on 4/11/2023, for certification period 3/20/2023 - 5/18/2023. Record review evidenced a start of care comprehensive assessment dated 3/20/2023, which was completed by the physical therapist. This assessment indicated the physical therapist completed a drug regimen review, and did not identify any significant medication issues. During an interview on 4/10/2023, at 3:12 PM, the Administrator indicated physical therapy did complete drug regimen reviews instead of the nurses.		Deficient findings will be addressed immediately, andclinician remediation and disciplinary action will occur as indicated. Discussion of compliance will be discussed with theteam during the quarterly Quality Assurance Performance Improvement teammeetings until compliance is achieved.	
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. 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 a	G0544	Anoccurrence report was entered for patients 1 and 3. Patient1 is currently hospitalized. Patientreceived additional skilled nursing visits 4/13, 4/15, and 4/18. SkilledNursing services were initiated for patient 3 on 4/3/23. POC initiated thataddresses co-morbidities. Duringa mandatory staff	2023-05-11

	comprehensive assessment (including the administration of the OASIS [outcome and assessment information set]) was completed in 2 of 2 active clinical records reviewed where a decline in the patient's health status occurred (Patient #1, 3). The findings include: * Clinical record review for Patient #1 was completed on 4/11/2023. Record review evidenced a comprehensive assessment for recertification of services, dated 3/23/2023. The document evidenced the patient weighed 130 pounds, had properly fitting, partial, removable, upper and lower dentures, and failed to evidence any chewing/swallowing concerns were identified; and the patient was at a high/major nutritional risk. Record review evidenced a plan of care for certification period 3/27/2023 – 5/25/2023, which evidenced the patient's diagnoses included heart failure, kidney disease with dependence on dialysis, diabetes, and dementia. Record review evidenced a		Team reviewed home health policies SignificantChange in Condition and Patient Fall Reduction Program with emphasis on thecompletion of a comprehensive assessment when the agency is made aware of asignificant change in the patient's condition that was not envisioned in theoriginal plan of care during a 60-day episode and when the patient's conditionhas either severely deteriorated or greatly improved; appropriate follow upassessment and interventions are completed when significant findings areidentified in prior visits or after hours calls; and follow up assessments followingidentification of a patient fall. For any staff not present, the PI Team or designeewill provide instructions to the individual employees by 5/11/23. Clinicians will be required to complete daily reportto PCMs on each patient to report any changes in patient condition. Acoordination note will be completed to ensure any concerns are included in	

	dated 3/30/2023, which evidenced the patient weighed 124 pounds (6 pound weight loss in one week), the patient indicated he wasn't eating well due to issues with his teeth, and the RN encouraged the patient to eat soft foods in order to ensure caloric intake. Record review evidenced a RN visit note dated 4/04/2023, which evidenced the patient weighed 129 pounds (5 pound weight gain in one week), random blood sugar level was 354 (normal range 70-110), had pitting edema (indicates fluid retention) to both feet, the patient reported a chronic cough at night, and had difficulty breathing while walking and with activity, his appetite was poor, was non-compliant with taking insulin as ordered by the physician, and hasn't check his blood sugar levels since the last nursing visit (3/30/2023). Record review failed to evidence any nursing visits were made after 4/04/2023 (as of 4/11/2023). On 4/11/2023 at 1:15 PM, the Clinical Manager indicated the		themedical record. PCMs will ensure physician orders are obtained andschedule an RN evaluation / visit within 24 hours of the identified patientcare change in condition, and to complete a Significant Change in Condition assessmentas indicated. Clinicians will review visit and coordination notes priorto completing scheduled visits to identify significant findings requiring additionalassessment and intervention. For un-witnessed, staff witnessed, or non-staff witnessedfalls, the PCM will be contacted regarding the need for a Registered Nurse(RN), Physical Therapist (PT), or Occupational Therapist (OT) toperform an on-site assessment. Upon being made aware of a patient fall, the PCMwill coordinate the appropriate assessment, care, and/or modifications to theplan of care, as indicated. Beginning 5/8/23 the Executive Director or designeewill audit 4 visits notes per clinician per month. Clinicians scoring less	

	patient was not reassessed. * Clinical record review for Patient #3 was completed on 4/11/2023. Record review evidenced an initial comprehensive assessment, dated 3/18/2023. The document evidenced the patient's diagnoses included heart failure, which was poorly controlled, and required frequent adjustments in treatment and dose monitoring; the patient's weight was 125 pounds, had no swelling of the lower legs or feet, and no current heart issues were identified. Record review evidenced a plan of care for certification period 3/18/2023 – 5/16/2023, evidenced the patient's primary focus of home care was Physical Therapy (PT) and Occupational Therapy (OT). Record review evidenced an Occupational Therapy (OT) evaluation visit note dated 3/20/2023. The document evidenced the patient's weight was 125.4 pounds (0.4 pound weight increase), pitting edema was assessed, the patient got short of breath easily, had		prescriptive learning. All new clinicians will have 2 notes audited per week until 100% for 4 consecutive weeks then will go into the monthly rotation. The notes audited will be a random pull of visits and will focus on ensuring significant changes in condition were reported to the PCM, significant findings were reassessed and proper follow up was completed on subsequent visits; and proper notification and follow up assessments were completed following identification of a patient fall. The Executive Director is ultimately responsible for the implementation of this plan of correction. Completion date: 5/11/23 Beginning 5/14/23, ED or designee will complete 10medical record reviews per week to ensure: any significant changes in patient conditionwere reported to the PCM and an RN visit to evaluate	

	difficulty breathing with minimal exertion, and had a cough. Record review evidenced a Medical Social Worker (MSW) visit note dated 3/21/2023. The document evidenced the patient had moderate to severe anxiety/fear/excessive worries, and depression; and the patient indicated an anxiety pill may be missing from her pill box, which might be contributing to increased anxiety. Record review evidenced a Physical Therapy Assistant (PTA) visit note dated 3/23/2023. The document failed to evidence if the patient's weight or anxiety level was assessed, or if the anxiety medication was in the patient's pill box. Record review evidenced an OT visit note dated 3/27/23. The document evidenced the physician was notified of the patient's weight of 128.8 pounds (3.4 pound weight gain in 6 days), and fluctuating heart rate from 50-135 beats per minute (normal range 60-110). Record review evidenced a PTA visit note dated 3/30/2023. The document evidenced the		Significant Change in Condition assessment visit, if indicated, wascompleted within 24 hours of the change in condition; significant findings werereassessed and proper follow up was completed on subsequent visits; and propernotification and follow up assessments were completed following identificationof a patient fall. Any deviations to this process will be addressed withclinician remediation and disciplinary action as indicated. Monitoring will continue for 12 weeks and willcontinue until 100% compliance achieved for 3 consecutive weeks. Discussion of compliance will be discussed with theteam during the quarterly Quality Assurance Performance Improvement teammeetings until compliance is achieved.	

	physician was notified the patient felt "wiped out", reported some chest pain while coughing, the front of her chest ached, resting heart rate was 102-117 beats per minute, and had pitting edema to the right foot/ankle. Record review evidenced a clinical coordination note dated 3/31/2023. This document evidenced the MSW provided a telephonic MSW visit, and family reported the patient sustained a fall (no date identified). Record review evidenced a RN evaluation visit note dated 4/03/2023. The document evidenced the patient's weight was 129.4 pounds (0.6 pound weight gain in 4 days); was short of breath with exertion, and had expiratory wheezing (compromised airflow); and failed to evidence any follow up for reported fall. The document also failed to evidence administration of OASIS data. During an interview on 4/11/2023 at 2:36 PM, the Administrator confirmed the comprehensive assessment			

	patient's change in condition, the Clinical Manager did call to check on the patients, and the agency had limited nursing staff. 1. Record review evidenced an agency policy revised 3/1/2022, titled "Patient Assessment, Initial and Reassessment" which stated, "... A qualified clinician performs a comprehensive assessment or reassessment visit in the following situations: ... When the instability or acuity of the patient's medical condition warrants assessment [significant improvement or major decline] ...."			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of	G0570	See individual tags: G572, G574, G586, G608, G614,G616, and G618. Referrals placed on hold effective 4/26/23. An occurrence report was entered for patients 1, 3, 4,and 6. Patient 1 is currently hospitalized. Skilled Nursing services were initiated for patient 3on 4/3/23. Patient was reassessed for care	2023-05-05

	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 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); review and revise the plan of care (see tag G586); coordinate care delivery (see tag G0608);		needs on 5/3/23 by the RN. Noadditional care needs were identified. Patient 4 is currently hospitalized. Patient 6 was reassessed for care needs by RN on 5/4/23.No additional care needs identified. 100% of the current patients were assessed via homevisits completed by 5/5/23 to ensure their current needs were being met and theagency has the ability and resources to meet those patient's needs. An RN collaboratedwith the clinicians' providing services to each patient on service to ensurethe patient's needs were being met with services currently provided. If the need for additional disciplines andservices was identified, the physician was contacted to request the additionalservices and the POC was updated with the additional disciplines orderedby the physician. For those patients whose needs could not be met, the providercoordinated transfer to another provider in conjunction with the patient andphysician's orders and agreement.	

	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). This practice had the potential to affect all patients serviced by the agency. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care for the Condition of Participation 42 CFR §484.60: Care Planning, Coordination of Services, and Quality of Care. A standard level deficiency was also cited at this level as follows: Based on record review and interview, the home health agency failed to ensure it only accepted patients for services if the needs of the patient could		Provider is actively recruiting for a Home HealthAide. A staffing agreement will be obtained for Personal Care Services. Allpatients were evaluated for personal care needs by 5/5/23. In the interim, Nursingand Occupational Therapy staff utilized to perform Home Health Aide servicesfor 1 patients identified as having personal care needs. Provider is actively recruiting for RN and LPN staff. 1LHC travel RN and PCM began working in the agency. 1 Patient Care Manager hasbeen hired and is in orientation. 1 FT and 1 PT RN and 2 FT LPNs have beenhired and are working in the agency. Another FT RN has been hired and scheduledto start 5/22/23. 100% of all current medical records were reviewed toensure all services included in the POC were provided as ordered, the POCincluded all interventions necessary to address underlying risk factors,including risk for emergent care and hospitalization, and all safety risksincluding all education/training and patient specific education andinterventions to achieve	

	be met for 4 of 7 active records reviewed. (Patient #1, 3, 4, 6). The findings include: 3. Clinical record review for Patient #1 was completed on 4/11/2023. Record review evidenced a comprehensive assessment for recertification of services, dated 3/23/2023. The document evidenced the patient was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life), lived alone, needed help with personal care needs, a pressure wound on the lower back re-opened, was a high nutritional risk, weighed 130 pounds, and had slight swelling to both lower extremities; and evidenced wound care wasn't performed due to waiting for the physician's orders. No further nursing visits occurred until 3/30/2023. Record review failed to evidence the home health agency provided home health aide services to assist with personal care needs. Record review evidenced a skilled nursing visit note dated		outcomes and goals. Physician orders were obtained toupdate the POC accordingly. Patient Written Instructions Reports were distributedto all patients which included current visiting schedules, instructions ontreatments administered by the agency personnel and a written medication listincluding name, dose, and frequency of all medications currently taken. During a mandatory staff meeting held on 5/3/23, the PITeam instructed clinical staff on home health policy Patient Assessment,Initial and Reassessment with emphasis on assessing thetype of care and services to be provided and whether the patient needs can bemet safely in the home setting. For any staff not present, the PI Team or designeewill provide instructions to the individual employees by 5/11/23. Upon receiving a referral, the ED or PCM will reviewthe services required and will provide approval feedback to the referral sourceif the services	

	3/30/2023. Record review evidenced the patient weighed 124 pounds (6 pound weight loss in 1 week), the patient reported a poor appetite due to teeth issues, and the patient was supposed to self-check blood sugar level every morning, then self-administer a specific dose of insulin based on the results of the blood sugar level. The patient indicated he didn't check his blood sugar that morning due to malfunctioning device (freestyle libre). Record review evidenced a skilled nursing visit note dated 4/04/2023. Record review evidenced the patient didn't check his blood sugar level since last nursing visit (3/30/2023), the nurse performed a random test (not fasting), and the patient's blood sugar level was 354 (70-110 is normal range); the patient was unable to demonstrate competency with use of a glucometer (a machine used to check blood sugar levels); the patient was non-compliant with self-administering the correct dose of insulin based on his blood sugar level; swelling to		can be provided. Allcommunication will be documented within the medical record. If services are not able to be provided, the ED/PCMwill notify the referral source for alternative entity admission. The patient will have a comprehensive assessmentcompleted within 48 hours of referral or on a physicians ordered SOC date. The assessing clinician will assess thepatient for care needs. If the patient requiresSkilled Nursing, PT, OT, MSW, and/or Activities of Daily Living (ADL) care, thenappropriate clinicians will be requested and provide those services as orderedby the physician. If these services identified in the comprehensive assessment arenot able to be provided, the provider will coordinate transfer to anotherprovider in conjunction with the patient and physician. Clinicians will provide daily report to the ED/PCM andwill review patient care needs to include appropriate disciplines, frequencies,treatments,	

	than previously documented on 3/23/2023; the patient complained of a chronic cough, and requested a refill on his narcotic cough syrup; and the nurse offered Medical Social Worker (MSW) services to assist with medication management to include prefilled packaging from pharmacy, which the patient agreed to. Record review evidenced a coordination note dated 4/05/2023. The document evidenced the Clinical Manager called the patient for follow up on findings from nursing visit on 4/04/2023, but no actual nursing visit was made; the patient indicated he recently got home from dialysis, he didn't check his blood sugar this morning, or self-administer daily insulin; and failed to evidence if the patient received a prescription for the requested narcotic cough syrup. The document also evidenced the Clinical Manager called Person #5 (family, and the patient's primary caregiver), to inform the patient wasn't checking his blood sugars as ordered or taking his daily insulin; Person #5 indicated the patient was more interested in smoking and		interventions, and education are provided to ensure patient careneeds are adequately addressed. Physician orders will be obtained to revise the POC accordingly. Ifservices cannot be provided by the provider immediately to ensure safe andeffective care, then the patient will be transferred to an alternate providerto ensure these needs can be met. The Executive Director is ultimately responsible for the implementation of this plan of correction. Completion Date: 5/5/2023 Beginning 5/7/23, ED or designee will review 100% of SOC/ROC/Recert'sa week to ensure patient needs could be met. ED or designee will participate in daily clinicianreport and will verify that every identified patient concern has been addressedthrough services provided on the POC or that the physician was contacted,	

	watching television. As of 4/11/2023, no further nursing visits were made. Record review evidenced a coordination note dated 4/06/2023. The document evidenced MSW #1 called the patient on 4/06/2023, but no home visit occurred. Record review evidenced a coordination note dated 4/08/2023. The document evidenced the Clinical Manager called the patient on 4/08/2023, but no home visit occurred; and the patient remained non-compliant with checking blood sugar levels and self-administering insulin; a private duty caregiver was present, and the patient wanted to add more hours to the private duty caregiver to help with medication management and insulin. Record review evidenced a coordination note dated 4/11/2023. The document evidenced MSW #1 called the patient on 4/11/2023, but no home visit occurred; MSW #1 spoke to the patient about transferring to a different home health company.		andorders were obtained to add additional treatment and services to the POC asindicated. Any deviations to this process will be addressed withclinician remediation and disciplinary action as indicated. Monitoring will continue for 12 weeks and willcontinue until 100% compliance achieved for 3 consecutive weeks. Discussion ofcompliance will be discussed with the team during the quarterly QualityAssurance Performance Improvement team meetings until compliance isachieved.	

	On 4/11/2023 at 1:15 PM, the Administrator indicated no skilled nursing visits were made after 4/04/2023, confirmed no MSW home visits were completed, and indicated there were phone calls made. The Clinical Manager indicated phone calls shouldn't take the place of necessary home visits to meet the patient's needs. The Administrator indicated visits weren't provided due to lack of adequate staffing (nurses), and that's why MSW #1 called the patient to discuss transferring to another home health agency. The Administrator indicated the agency didn't currently employ any home health aides, the agency wasn't advertising for home health aide job opportunities, and the agency didn't have enough nursing staff to supervise home health aides if they did hire any. 4. Clinical record review for Patient #3 was completed on 4/11/2023. Record review evidenced home health referral documents from Entity #10 (a skilled nursing rehabilitation facility), dated 3/13/2023. The documents evidenced the patient required Skilled Nursing			

	Physical Therapy (PT), and Occupational Therapy (OT) services for gait training and transitioning into the home, upon discharge from the facility. Record review evidenced a plan of care for certification period 3/18/2023 – 5/16/2023, evidenced the patient's primary focus of home care was Physical Therapy (PT) and Occupational Therapy (OT), and Skilled Nursing wasn't ordered. Record review evidenced an initial comprehensive assessment, dated 3/18/2023, which was completed by PT #1. The document evidenced the patient's diagnoses included heart failure, which was poorly controlled, and required frequent adjustments in treatment and dose monitoring; and the patient's baseline weight was 125 pounds. Record review failed to evidence a request for Skilled Nursing to evaluate for poorly controlled heart failure. Record review evidenced an OT evaluation visit note dated 3/20/2023. The document evidenced the patient's weight was 125.4 pounds (0.4 pound			

	weight increase), pitting edema was assessed, the patient got short of breath easily, had difficulty breathing with minimal exertion, and had a cough. Record review failed to evidence a request for Skilled Nursing to evaluate for difficulty breathing and presence of cough. Record review evidenced a Medical Social Worker (MSW) visit note dated 3/21/2023. The document evidenced the patient had moderate to severe anxiety/fear/excessive worries, and depression; and the patient indicated an anxiety pill may be missing from her pill box, which might be contributing to increased anxiety. Record review failed to evidence a request for Skilled Nursing to evaluate for anxiety and medication management. Record review evidenced an OT visit note dated 3/27/23. The document evidenced the physician was notified of the patient's weight of 128.8 pounds (3.4 pound weight gain in 6 days), and fluctuating heart rate from 50-135 beats per minute (normal range 60-110). Record review failed to			

	evidence a request for Skilled Nursing to evaluate for evaluation of cardiac status. Record review evidenced a PTA visit note dated 3/30/2023. The document evidenced the physician was notified the patient felt "wiped out", reported some chest pain while coughing, the front of her chest ached, resting heart rate was 102-117 beats per minute, and had pitting edema to the right foot/ankle. Record review failed to evidence a request for Skilled Nursing to evaluate for evaluation of cardiac status. Record review evidenced a clinical coordination note dated 3/31/2023. This document evidenced the MSW provided a telephonic MSW visit, and family reported the patient sustained a fall (no date identified), and family was planning on hiring a caregiver. Record review failed to evidence a request for Skilled Nursing to evaluate for fall follow up, or home health aide to assist with personal care. Record review evidenced a RN evaluation visit note dated 4/03/2023 (16 days after start of			

	care). The document evidenced the patient was short of breath with exertion, and had expiratory wheezing (compromised airflow); and failed to evidence any follow up for the reported fall. During an interview on 4/11/2023 at 2:36 PM, the Clinical Manager indicated the agency had limited nursing staff. 5. Clinical record review for Patient #4 was completed on 4/11/2023. Record review evidenced an initial comprehensive assessment, dated 3/28/2023, was completed by PT #1. The document evidenced the patient and caregiver knowledge based deficits included pathophysiology (physical/mental changes caused by disease or injury) of disease process, signs and symptoms to report, special diet, and medications; the patient lived alone and had only short term occasional/short-term assistance; had pain affecting ability to perform personal care above shoulder level, and required human assistance with			

	personal care; and the patient was at risk for falls and further decline in mobility, had poor respiratory status, and pain impacting mobility. Record review evidenced an initial plan of care for certification period 3/28/2023 - 5/26/2023. The document evidenced the patient's primary diagnosis was chronic obstructive lung disease (COPD), the patient was recently hospitalized from 3/20/2023 - 3/24/2023 for exacerbation of COPD, and other new or exacerbated comorbidities (within the last month) included hypertension and atrial fibrillation; and the patient's ordered pain medication was tylenol every 8 hours for mild pain. The plan of care failed to evidence skilled nursing was ordered to ensure the patient's medical needs were met, home health aide was ordered to assist with personal care needs, or pain medication was ordered for moderate to severe pain. Record review evidenced an OT evaluation visit note dated 3/29/2023. The document evidenced the patient's reported pain level at "7"			

(moderate to severe), lived alone, difficulty breathing with minimum exertion, and assistance was needed with bathing and homemaking tasks.

Record review evidenced a coordination note dated 3/29/2023. The document evidenced the Clinical Manager called the patient to review the patient's medications, instruct on medication changes received from the certifying physician, but no skilled nursing visit was made.

Record review evidenced an OT coordination note dated 3/30/2023. The document evidenced the patient had a new diagnosis of congestive heart failure (CHF).

On 4/11/2023 at 3:15 PM, the Administrator indicated the primary diagnosis of COPD wasn't usually a therapy diagnosis, and the knowledge based deficits should be addressed by nursing.

6. During an interview on 4/05/2023 at 11:20 AM, the Administrator indicated the agency was very low on nursing staff.

	7. During an interview on 4/11/2023 at 3:30 PM, the Administrator indicated since the last survey (2/02/2023) the census was 184, and now it's 96, due to the survey findings, the agency currently only had three part time registered nurses (RNs), one was ending her employment with the agency on Friday (4/14/2023); and the remaining two RNs were currently working, one was a 0.1 FTE (full time equivalent) (4 hours per week), and the other was a 0.2 FTE (8 hours per week). 1. Record review evidenced an agency policy revised 4/1/2023, titled "Coordination of Care, from Admit through Discharge" which stated, "... The agency provides care and services within an integrated continuum of care system. This is accomplished by: ... Admitting only those patients whose health care needs can be met by the agency and making appropriate referrals to other organizations capable of			

	the agency is unable to do so ...." 2. Clinical record review for Patient #6 was completed on 4/11/2023, for certification period 3/20/2023 - 5/18/2023. Record review evidenced a start of care comprehensive assessment dated 3/20/2023, which indicated the patient was dependent for the following: dressing upper and lower body, grooming, oral hygiene, bathing, and transferring to and from the bathroom. The start of care assessment indicated the patient lived alone. This assessment indicated the patient was unable to take medications without assistance from another person.			

	Record review evidenced a plan of care for certification period 3/20/2023 - 5/18/2023, which indicated the patient was only receiving physical therapy and occupational therapy services for mobility training, transfer training, ambulation, and balance training. Record review failed to evidence the patient was offered home health aide services for assistance with activities of daily living or grooming/bathing assistance. During an interview on 4/10/2023, at 3:11 PM, the Administrator indicated the agency did not offer home health aide services, and did not know why the assessment indicated the patient was dependent or who was assisting the patient with those tasks. The Administrator did not know who was assisting the patient with medication administration. The Administrator indicated if the patient needed nursing services, the therapist should have let them know.			
G0572	Plan of care 484.60(a)(1)	G0572	Occurrence reports entered for patients 1, 2, 3, 4, 5,and 6. Patient 1 is currently	2023-05-11

	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 record review and interview, the home health agency failed to ensure plans of care were individualized and/or the patient received the services written in the plan of care in 5 of 7 active clinical records reviewed. (Patient #1, 2, 3, 4, 5, 6) The findings include: 3. Clinical record review for Patient #1 was completed on 4/11/2023. Record review evidenced a comprehensive assessment for recertification of services, dated 3/23/2023. The document evidenced the patient's baseline weight of 130 pounds, and random blood sugar level obtained was 242 (normal range 70-110). Record review evidenced a plan		hospitalized. Patient 2 reassessed by RN on 5/3/23 and POC revisedto reflect current needs with updated orders received on 5/5/23. Skilled Nursingservices were initiated for patient 3 on 4/3/23. POC initiated that addressesco-morbidities. Patient wasreassessed for care needs on 5/3/23 by the RN. No additional care needsidentified. Patient 4 is currently hospitalized. Patient 5 physician was notified wound care notperformed at ordered frequency. Updated orders were received on 4/7/23 forcaregiver to perform wound care on days skilled nurse not present. Caregivereducated and completed return demonstration 4/10/23. Patient 6 reassessed. POC and Emergency Preparednessplan revised to address oxygen use in case of an emergency on 5/4/23. 100% of the current patient’s medical records were reviewedby 5/5/23 to ensure	

	3/27/2023 – 5/25/2023. The document evidenced the patient's diagnoses included heart failure and diabetes, and evidenced the patient used sliding scale (dose based on blood sugar level) insulin (for diabetes). The plan of care failed to evidence individualized parameters for weight to report to the physician (plan of care parameters were less than 135 pounds or greater than 150 pounds), or individualized nonpharmacological methods to mitigate pain (plan of care methods were "such as rest and relaxation"). On 4/11/2023 at 1:15 PM, the Administrator indicated many of the elements in the electronic medical records were not able to be individualized. 4. Clinical record review for patient #2 was completed on 4/11/2023. Record review evidenced a comprehensive reassessment dated 3/22/2023. The document evidenced the patient's home was safe and sanitary, the patient had no pain, and no pain medications were ordered. Record review evidenced a plan		their current POC is individualized and addresses theircurrent needs and that the patient is receiving services written in the POC.The physician was notified of any services not being completed as ordered.Physician was contacted for any required revisions to the POC. A home visit will be completed on 100% of oxygenpatients by 5/5/23 to ensure the emergency preparedness plan addresses back-upoxygen needs. A copy of the revised Patient Disaster ID Form will be sent tothe office to be maintained in the Emergency Preparedness Binder. Duringa mandatory staff meeting held on 5/3/23, the PI Team provided an in-service toall assessing clinicians and PCM on home health policy Plan of Care withemphasis on: developing an individualized plan of care with containing interventionsspecific to patient needs, editing problem statements, addressingco-morbidities; ensuring care is provided per the POC and supplemental orders;and the Emergency	

	of care for certification period 3/23/2023 – 5/21/2023). The plan of care evidenced an intervention to instruct pharmacological and nonpharmacological methods to mitigate pain, but the patient had no pain; and an intervention to instruct on measures to improve home safety, but the patient's home was safe. On 4/11/2023, the Administrator indicated plans of care should be individualized. 5. Clinical record review for Patient #3 was completed on 4/11/2023. Record review evidenced home health referral documents from Entity #10 (a skilled nursing rehabilitation facility), dated 3/13/2023. The documents evidenced the patient required Skilled Nursing for medication management, Physical Therapy (PT), and Occupational Therapy (OT) services for gait training and transitioning into the home, upon discharge from the facility. Record review evidenced a plan of care for certification period 3/18/2023 – 5/16/2023, evidenced the patient's primary		Preparedness Plan addresses back-up oxygen. For any staff not present, the PI Team or designeewill provide instructions to the individual employees by 5/11/23. All Patient Care Reviewers will be in-serviced by the PITeam on 5/3/23 to ensure review of the patient individualized plan of care iscomplete and any recommendations or changes are addressed with the individualclinician and physician. All patients admitted to the agency will receive aninitial assessment. All patients receive ongoing and periodic reassessments. Theinitial assessment determines whether patient needs can be met safely in thehome setting and the type of care and services to be provided. Each patient has an individualized POCdeveloped in consultation with the patient, physician or authorizedpractitioner, and staff that integrates comprehensive assessment findings toaddress patient problems, needs, and goals, as well as to address	

	focus of home care was Physical Therapy (PT) and Occupational Therapy (OT); and new or exacerbated (within the last month) co-morbidities included chronic obstructive lung disease (COPD), Atrial Fibrillation, Hypertension, and Depression. The plan of care failed to be individualized to include how the agency would mitigate the new or exacerbated co-morbidities, specific to the patient. Record review evidenced an initial comprehensive assessment, dated 3/18/2023, which was completed by PT #1. The document evidenced the patient's diagnoses included heart failure, which was poorly controlled, and required frequent adjustments in treatment and dose monitoring. The plan of care failed to be individualized to include what individualized treatment and dose adjustment/monitoring was required for the patient. During an interview on 4/11/2023 at 2:36 PM, the Clinical Manager indicated the agency had limited nursing staff, and the Administrator indicated the plan of care was		specificservices being provided. The qualified clinician revises the POC under thedirection of the physician or authorized practitioner as indicated. Each clinician will provide a start of care reportafter each Start of Care or Resumption of Care assessment to communicatepatient care needs to the PCM including safety needs, comorbidities, personalcare needs, wound care treatment plans, need for additional disciplines,medication management, and pain management needs. The PCMs will utilize the PCM POC Review Tool toassist in developing an individualized POC. The POC tool will be used to ensurepatient care needs are identified from the medical record and align with needscommunicated through verbal SOC/ROC report. Beginning 5/8/23 the Executive Director or designeewill audit 4 visits notes per clinician per month. Clinicians scoring less than 100% will be assigned prescriptive learning. All new clinicians will have 2 notes	

	geared to therapy services. 6. Clinical record review for Patient #4 was completed on 4/11/2023. Record review evidenced an initial comprehensive assessment, dated 3/28/2023, was completed by PT #1. The document evidenced environmental/safety hazards included pets and unsafe floor coverings, narrow or obstructed doorways, and cluttered/soiled living area. Record review evidenced an initial plan of care for certification period 3/28/2023 - 5/26/2023. The document evidenced PT was to instruct on "any safety issues identified". The plan of care failed to be individualized to include the patient's specific safety issues. During an interview on 4/11/2023 at 3:15 PM, the Administrator indicated the EMR didn't let the clinicians fill in specific issues. 1. Record review evidenced an agency policy revised 12/1/2021, titled "Plan of Care" which stated, "... Each patient has an individualized Plan of Care developed in consultation		audited per week until 100% for 4 consecutive weeks then will go into the monthly rotation. The notes audited will be a random pull of visits and will focus on ensuring interventions or treatments were provided according to the plan of care. The patients will have an individualized emergency preparedness plan thatis documented and maintained on the Patient Disaster ID Form in the PatientOrientation Booklet. For oxygen patients, this will address back-up oxygenneeds. The Executive Director is ultimately responsible for the implementation of this plan of correction. Completion Date: 5/11/23 Beginning 5/14/23, ED or designee will complete 10Plan of Care reviews a week to ensure the plan of care is individualized and containsall the required components. Beginning 5/14/23, ED or	

	with the patient, physician or authorized practitioner, and staff ... Medications, treatments, and interventions are provided by qualified agency staff as ordered by the physician or authorized practitioner ...." 2. Clinical record review for Patient #5 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 3/29/2023 - 5/27/2023, which indicated the skilled nurse was to change a dressing to a malignant back lesion twice weekly, and Entity #2 (mobile wound clinic) was to change the dressing 1 time weekly. During an interview on 4/11/2023, at 2:00 PM, Person #3 (employee of Entity #2) indicated Patient #5 was discharged on 3/22/2023, because a coccyx (area at base of spine) wound healed. Record review evidenced the patient only received 2 skilled nurse visits the week of 3/26/2023, and 1 skilled nurse visit the week of 4/2/2023. Record review failed to evidence the malignant back		designee will complete 10 medicalrecord reviews a week to ensure the patient received the services written inthe POC. Beginning the week of 5/14/23, the ED or designee willcomplete 9 home visits weekly, to include a sample of oxygen patients, toverify the Patient Disaster ID Form addresses back-up oxygen needs. Any deviations to this process will be addressed withclinician remediation and disciplinary action as indicated. Monitoring will continue for 12 weeks and willcontinue 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.	

	times weekly as ordered on the plan of care. During an interview on 4/11/2023, at 10:39 AM, the Administrator indicated the patient should have received dressing care as was ordered on the plan of care.			
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;	G0574	Occurrence reports were entered for patients 1, 2, 3,4, 5, 6, and 7. Patient 1 is currently hospitalized. Patient 2 reassessed 5/3/23 to determine type ofspecial transportation required and how personal care needs are met. POC wasupdated on 5/5/23 to address co-morbidities, and risks associated withpotential life-threatening complications due to diagnosis of paraplegia andconcurrent indwelling urinary catheter, chair bound status, and atrialfibrillation. Skilled Nursing services were initiated for patient 3on 4/3/23. POC initiated that addresses	2023-05-11

	(xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the home health agency failed to ensure the plan of care included all required elements in 7 of 7 active clinical records reviewed. (Patient #1, 2, 3, 4, 5, 6, 7) The findings include: 5. Clinical record review for Patient #1 was completed on 4/11/2023. Record review evidenced a skilled nursing evaluation was completed on 1/30/2023. The document evidenced the patient had minimal assist from family, had a caregiver from Entity #6 (a private duty agency) 4 hours per day, 7 days per week, and the remainder of the time, the patient was alone; the patient was unable to care for himself, he received meals on wheels, but he was still hungry and		medicationmanagement. Patient was reassessed for care needs on 5/3/23 by the RN. Noadditional care needs were identified. Patient 4 is currently hospitalized. Patient 5 POC was updated 5/3/23 and 5/5/23 to reflectpatients' nutritional requirements and address hospitalization risk factors. Patient 6 POC was updated 5/4/23 to include CHFinterventions and address hospitalization risk factors. Patient 7 POC to be updated following patientrequested RN visit on 5/6/23 to include daily weights, proper safety measures,and address hospitalization risk factors. During a mandatory staff meeting held on 5/3/23, the PITeam provided an in-service to all assessing clinicians and PCM on home healthpolicy Plan of Care with emphasis on developing a patient specific plan of care,and the required components of a POC. For any staff not present, the PI	

	unable to shop and cook for himself most times, and he weighed 142 pounds; the patient went to Entity #7 (a dialysis center) on Mondays, Wednesdays, and Fridays, and had 2 intravenous (IV) access sites for administration of dialysis. Record review evidenced a comprehensive assessment for recertification of services, dated 3/23/2023. The document evidenced the patient weighed 130 pounds, was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life), lived alone, needed help with personal care needs, Person #5 (family) was the patient's power of attorney, and the patient checked his blood sugar levels per physician orders (not further specified). Record review evidenced a skilled nursing visit note dated 3/30/2023. Record review evidenced the patient had "paid help" (not further specified). Record review evidenced a plan of care for certification period 3/27/2023 - 5/25/2023. The		Team or designeewill provide instructions to the individual employees by 5/11/23. All Patient Care Reviewers received an in-service bythe PI Team on 5/3/23 to ensure review of the patient individualized plan ofcare is complete and any recommendations or changes are addressed with theindividual clinician and physician. 100% of the current patient's medical records were reviewedby 5/5/23 to ensure their current POC is individualized and complete, includingthe following components: patients mental, psychosocial, and cognitive status;nutritional requirements; safety measures; interventions to address risk foremergent care and rehospitalization; Advanced Directives; patient specific interventionsand education; goals; parameters. Physician was contacted for any requiredrevisions to the POC. A POC is developed for all patients and updated noless	

	plan of care evidenced the patient's primary diagnosis was hypertensive heart and chronic kidney disease with heart failure and end stage chronic kidney disease which required dialysis, but failed to evidence patient-specific interventions or goals related to the primary diagnosis; failed to evidence the patient's advance directives included the patient had a power of attorney, or name/contact information for the power of attorney; psychosocial status included the patient had minimal assist from family, had a caregiver from Entity #6- 4 hours per day, 7 days per week, and the remainder of the time, the patient was alone, the patient was unable to care for himself, he received meals on wheels, but he was still hungry and unable to shop and cook for himself most times, the patient received dialysis at Entity #7 on Mondays, Wednesdays, and Fridays, or how the patient was transported to dialysis; failed to evidence interventions/goals related to the patient's 12 pound weight loss (in 50 days), ongoing hunger, who ensured the patient's nutrition needs were met, interventions/goals		includes: a. Patient’s mental, psychosocial, and cognitivestatus b. Types, frequency, and duration of services required c. Prognosis and rehabilitation potential d. Functional limitations and activities permitted e. Nutritional requirements f. Medications and treatments g. Safety measures to protect against injury h. Pertinent diagnosis(es) i. Patient specific interventions and education;measurable outcomes and goals identified by the agency and patient j. Required equipment and supplies k. Patient’s risk for emergency department visits andre-hospitalization including	

	for how the patient's personal care needs were met, the patient had 2 intravenous (IV) access sites for administration of dialysis, location(s) and precautions for the IV access sites, or how often the patient was supposed to check his blood sugar. During an interview on 4/11/2023 at 1:15 PM, the Administrator indicated there weren't any interventions or goals for the patient's primary diagnosis listed on the plan of care, and the primary diagnosis should be the focus of home care. The Administrator indicated the plan of care didn't evidence the patient had meals on wheels or how often it was provided, how the patient's nutritional needs were met for meals other than those provided by meals on wheels, or interventions to address the patient's nutritional risk/weight loss. The Administrator indicated the plan of care didn't include who the patient's primary caregiver was, availability, or what assistance the primary caregiver provided. 6. Clinical record review for		interventions that address underlying risk factors l. Patient/caregiver education and training for timelydischarge m. Advance Directives n. All patient care orders Each clinician will be required to provide a start ofcare report after each Start of Care or Resumption of Care assessment tocommunicate patient care needs to the PCM including emergency department andhospitalization risk and interventions to reduce this risk, comorbidities,personal care needs, medication management, psychosocial and nutritional needs. The PCM POC Review Tool will be utilized by any PCM’swho are reviewing plans of care in order to ensure identification andcompletion of required elements to the POC and this aligns with medical recordand verbal report received from the clinicians. The Executive Director is ultimately responsible for the	

	4/11/2023. Record review evidenced a comprehensive assessment for recertification of services, dated 3/22/2023. The document evidenced the patient was paraplegic (paralyzed from the waist down), was chair bound, and required special transportation. Record review evidenced a plan of care for certification period 3/23/2023 – 5/21/2023, which evidenced diagnoses included presence of a urinary catheter, paraplegia, and atrial fibrillation. The document failed to evidence psychosocial status included what type/availability of special transportation the patient required, or how the patient's personal care needs were met; patient-specific interventions/measurable goals for risks associated with potential life-threatening complications (autonomic dysreflexia, sudden and severe rise in blood pressure due to painful sensory input) due to diagnosis of paraplegia and concurrent indwelling urinary catheter and chair bound status, or atrial fibrillation. Record review evidenced a		implementation of the plan of correction. Completion Date: 5/11/23 Beginning 5/14/23, ED or designee will review 100% of SOCs,ROCs, and Recertifications each week to ensure the POC is individualized andcontains all the required components. Any deviations to this process will be addressed withclinician remediation and disciplinary action as indicated. Monitoring will continue for 12 weeks and will continueuntil 100% compliance achieved for 3 consecutive weeks. Discussion ofcompliance will be discussed with the team during the quarterly QualityAssurance Performance Improvement team meetings until compliance is achieved.	

	The document evidenced the patient's diagnoses included neurogenic bladder (lack of bladder control) (which required chronic urinary catheterization), systemic lupus erythematosus (an autoimmune disease in which the immune system attacks its own tissues, causing widespread inflammation and tissue damage in the affected organs), and peripheral neuropathy (nerve damage). The plan of care failed to include these diagnoses, or associated interventions/measurable goals On 4/11/2023 at 2:18 PM, the Administrator confirmed there were no parameters to call the physician for the sliding scale insulin, and many of the elements in the electronic medical records were not able to be individualized. 7. Clinical record review for Patient #3 was completed on 4/11/2023. Record review evidenced home health referral documents from Entity #10 (a skilled nursing rehabilitation facility), dated 3/13/2023. The documents evidenced the patient required Skilled Nursing			

	Physical Therapy (PT), and Occupational Therapy (OT) services for gait training and transitioning into the home, upon discharge from the facility. Record review evidenced a plan of care for certification period 3/18/2023 – 5/16/2023. The plan of care failed to include Skilled Nursing services was required for medication management. During an interview on 4/11/2023 at 2:36 PM, the Clinical Manager indicated the agency had limited nursing staff, and the Administrator indicated it was common for referring facilities to generically order nursing, PT, and OT, and they were working with them to only order what was really needed. 8. Clinical record review for Patient #4 was completed on 4/11/2023. Record review evidenced an initial comprehensive assessment, dated 3/28/2023, was completed by PT #1. The document evidenced environmental/safety hazards included pets and unsafe floor coverings, narrow or obstructed			

	doorways, and cluttered/soiled living area; the patient lived alone with occasional/short-term assistance, and needed human assistance for personal care needs. Record review evidenced an initial plan of care for certification period 3/28/2023 - 5/26/2023. The plan of care failed to evidence the patient's psychosocial status included the patient lived alone with occasional/short-term assistance, and needed human assistance for personal care needs, or how the patient's needs were met when no agency staff was present; environmental/safety hazards included pets and unsafe floor coverings, narrow or obstructed doorways, and cluttered/soiled living area; or patient-specific interventions/goals to address psychosocial and safety needs. 1. Record review evidenced an agency policy revised 12/1/2021, titled "Plan of Care" which stated, "... The POC [plan of care] includes: ... Nutritional requirements ... Medications and treatments ... Safety			

	injury ... Pertinent diagnoses ... Patient specific interventions and education; measurable outcomes and goals identified by the agency and the patient ... Required equipment and supplies ... Patient's risk for emergency department visits and re-hospitalization including interventions that address underlying risk factors ... Advance Directives ... All patient care orders ...." 2. Observation of a home visit for Patient #5 was conducted on 4/10/2023, at 11:00 AM, to observe a routine skilled nurse visit. During the visit, the nurse assessed the patient's nutritional requirements, and the patient indicated they had been taking Ensure Clear (nutritional supplement). Clinical record review for Patient #5 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 3/29/2023 - 5/27/2023, which included the following risks for hospitalization: taking 5 or more medications and multiple emergency room visits. The plan of care failed to include			

	underlying risk factors. The plan of care failed to include the Ensure Clear nutritional supplement. During an interview on 4/11/2023, at 10:26 AM, the Administrator indicated the plan of care should have included interventions to address the risks for hospitalization identified such as patient education for each item. At 10:48 AM, the Administrator indicated the Ensure Clear should have been included in the plan of care. 3. Clinical record review for Patient #6 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 3/20/2023 - 5/18/2023, which included the following goal: Patient will verbalize understanding of CHF (congestive heart failure/disease in which the heart cannot pump blood efficiently) disease processes. The plan of care failed to include any patient-specific interventions related to the diagnosis of CHF. The plan of care identified the following risks for hospitalization: history of falls, multiple hospitalizations,			

	multiple emergency department visits, decline in mental, emotional, or behavioral status, history of difficulty complying with medical instructions, currently taking 5 or more medications, currently reports exhaustion, and other risks not listed. The plan of care failed to include interventions to address these risks for hospitalization. During an interview on 4/10/2023, at 3:00 PM, the Administrator indicated the plan of care should have included an intervention related to CHF. The Administrator indicated the plan of care should have included interventions such as education to address the risks for hospitalization identified. 4. Clinical record review for Patient #7 was completed on 4/11/2023. Record review evidenced a recertification comprehensive assessment dated 2/14/2023, which indicated the patient required daily weights. Record review evidenced a plan of care for certification period 2/19/2023 - 4/19/2023, which included the following risks for hospitalization: currently taking			

	5 or more medications, and currently reports exhaustion. The plan of care failed to include interventions to address the identified risks. The plan of care indicated the patient was taking Eliquis (blood thinner), but failed to include bleeding precautions under safety measures. The plan of care failed to include daily weights. During an interview on 4/10/2023, at 3:21 PM, the Administrator indicated they should have included the interventions to address the hospitalization risks. The Administrator indicated bleeding precautions should have been included under safety measures on the plan of care. The administrator indicated the plan of care should have included daily weights as identified in the comprehensive assessment.			
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.	G0580	Deficiency was corrected on 4/11/23	2023-04-11

	Corrected 4/11/2023. Corrected 4/11/2023			
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 ensure the plans of care were updated and revised in 3 of 7 active clinical records reviewed. (Patient #1, 3, 7) The findings include: 3. Clinical record review for Patient #1 was completed on 4/11/2023. Record review evidenced a skilled nursing evaluation was completed on 1/30/2023. The document evidenced the patient was unable to care for himself, he received meals on wheels, but he was still hungry and unable to shop and cook for himself most times, and he weighed 142 pounds. Record review evidenced a comprehensive assessment for	G0586	An occurrencereport was entered for patients 1, 3, and 7. Patient 1 is currently hospitalized. Skilled Nursing services were initiated for patient 3on 4/3/23. POC initiated that addresses co-morbidities. Patient was reassessedfor care needs on 5/3/23 by the RN. No additional care needs identified. Patient 7 POC revised 5/4/23 to include an accurategoal During a mandatory staff meeting held on 5/3/23, the PITeam instructed all clinical staff and PCMs on home health policy Plan of Care withemphasis on updating the POC with changes in patient condition. For any staff not present, the PI Team or designeewill provide instructions to the individual employees by 5/11/23. 100% of the current patient's medical records werereviewed	2023-05-11

	recertification of services, dated 3/23/2023. The document evidenced the patient weighed 130 pounds, had properly fitting, partial, removable, upper and lower dentures, and failed to evidence any chewing/swallowing concerns were identified; and the patient was at a high/major nutritional risk. Record review evidenced a Registered Nurse (RN) visit note dated 3/30/2023, which evidenced the patient weighed 124 pounds (6 pound weight loss in one week), the patient indicated he wasn't eating well due to issues with his teeth, and the RN encouraged the patient to eat soft foods in order to ensure caloric intake. Record review failed to evidence a revised plan of care which addressed the patient's weight loss, concerns with nutritional intake, or recommended diet change to soft foods. During an interview on 4/11/2023 at 1:15 PM, the Administrator indicated the plan of care was not revised. 4. Clinical record review for		by 5/5/23 to ensure all episodes of care have documentation ofrevisions to the POC if indicated. Clinicians will be required to complete daily reportto PCMs on each patient to report any changes in patient condition. Acoordination note will be completed to ensure any concerns are included in themedical record. Physicians' orders will be obtained to update the POC asindicated. Case conference with staff involved in patient's careis held for each patient at least every 60 days to review progress towardsgoals and ongoing needs. The case conference is documented in the Team CaseConference Note. The POC reflecting updated interventions treatments, and goalsis reviewed, revised, and sent to the physician or authorized practitioner forreview and approval/signature. Beginning 5/8/23 the Executive Director or designeewill audit 4 visits notes per clinician per month. Clinicians scoring less than 100% will be assigned	

	Patient #3 was completed on 4/11/2023. Record review evidenced an initial comprehensive assessment, dated 3/18/2023. The document evidenced the patient's diagnoses included heart failure, which was poorly controlled, and required frequent adjustments in treatment and dose monitoring; the patient's weight was 125 pounds, had no swelling of the lower legs or feet, and no current heart issues were identified. Record review evidenced an Occupational Therapy (OT) evaluation visit note dated 3/20/2023. The document evidenced the patient's weight was 125.4 pounds (0.4 pound weight increase), pitting edema was assessed, the patient got short of breath easily, had difficulty breathing with minimal exertion, and had a cough. Record review evidenced a Medical Social Worker (MSW) visit note dated 3/21/2023. The document evidenced the patient had moderate to severe anxiety/fear/excessive worries, and depression; and the patient		prescriptive learning. All new clinicians will have 2 notes audited per week until 100% for 4 consecutive weeks then will go into the monthly rotation. The notes audited will be a random pull of visits and will focus on ensuring that the PCM and physician were notified of changes in condition and the POC is revised as indicated. The Executive Director is ultimately responsible for the implementation of this plan of correction. Completion Date: 5/11/23 Beginning 5/11/23, ED or designee will complete 10record reviews per week to ensure revisions to the plan of care were revised toaddress changes in condition. Any deviations to this process will be addressed withclinician remediation and disciplinary action as indicated. Monitoring will continue for 12	

	indicated an anxiety pill may be missing from her pill box, which might be contributing to increased anxiety. Record review evidenced an OT visit note dated 3/27/23. The document evidenced the physician was notified of the patient's weight of 128.8 pounds (3.4 pound weight gain in 6 days), and fluctuating heart rate from 50-135 beats per minute (normal range 60-110). Record review evidenced a PTA visit note dated 3/30/2023. The document evidenced the physician was notified the patient felt "wiped out", reported some chest pain while coughing, the front of her chest ached, resting heart rate was 102-117 beats per minute, and had pitting edema to the right foot/ankle. Record review evidenced a clinical coordination note dated 3/31/2023. This document evidenced the MSW provided a telephonic MSW visit, and family reported the patient sustained a fall (no date identified). Record review evidenced a RN evaluation visit note dated		100% compliance achieved for 3 consecutive weeks. Discussion ofcompliance will be discussed with the team during the quarterly QualityAssurance Performance Improvement team meetings until compliance isachieved.	

	4/03/2023. The document evidenced the patient's weight was 129.4 pounds (0.6 pound weight gain in 4 days); was short of breath with exertion, and had expiratory wheezing (compromised airflow). Record review evidenced a plan of care for certification period 3/18/2023 – 5/16/2023, evidenced the patient's primary focus of home care was Physical Therapy (PT) and Occupational Therapy (OT). Record review failed to evidence the plan of care was revised on 3/20/2023, 3/21/2023, 3/27/2023, 3/30/2023, 3/31/2023, or 4/03/2023, due to the changes in the patient's condition or addition of nursing services. During an interview on 4/11/2023 at 2:36 PM, the Administrator confirmed the plan of care wasn't revised. 1. Record review evidenced an agency policy revised 12/1/2021, titled “Plan of Care” which stated, “… Physician/authorized			

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 #7 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 2/19/2023 - 4/19/2023, which indicated the patient's goal was to get stronger and walk.

Record review evidenced a recertification comprehensive assessment dated 2/14/2023, which indicated the patient was able to ambulate with the use of a walker.

Record review failed to evidence the plan of care was revised to reflect an accurate goal.

During an interview on

	4/10/2023, at 3:21 PM, the Administrator indicated the clinician did not update the plan of care with the correct patient goal, but should have.			
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 record review and interview, the home health agency failed to ensure the clinician notified the physician in 2 of 2 active clinical records reviewed where a decline in the patient's health status occurred (Patient #1, 3). The findings include: 1. Record review evidenced an agency policy revised 4/1/2023, titled "Coordination of Care, from Admit through Discharge" which stated, "... When the patient receives services from other organizations and/or individual's care is coordinated to ensure that patient's needs are met efficiently, without	G0590	An occurrence report was entered for patients 1 and 3. Patient 1 is currently hospitalized. For patient 3, physician was notified of all clinicalfindings identified by the OT, PT, and MSW on 5/2/23. Skilled Nursing serviceswere initiated on 4/3/23. POC initiated that addresses co-morbidities. Patientwas reassessed for care needs on 5/3/23 by the RN. No additional care needswere identified. During a mandatory staff meeting held on 5/3/23, the PITeam instructed all clinical staff and PCMs on home health policies Coordinationof Care from Admit Through Discharge and Patient Fall Reduction Program withemphasis ensuring all changes in the patient's condition, including falls, arereported to the physician. For any staff not present, the PI	2023-05-11

	duplication of services, including: ... Communication with other health care providers when there are significant changes in patient care and/or condition ...." 2. Clinical record review for Patient #1 was completed on 4/11/2023. Record review evidenced a comprehensive assessment for recertification of services, dated 3/23/2023. The document evidenced the patient was a high nutritional risk, weighed 130 pounds, and had slight swelling to both lower extremities. Record review evidenced a skilled nursing visit note dated 3/30/2023. Record review evidenced the patient weighed 124 pounds (6 pound weight loss in 1 week), the patient reported a poor appetite due to teeth issues, and the patient was supposed to self-check blood sugar level every morning, then self-administer a specific dose of insulin based on the results of the blood sugar level; the patient indicated he didn't check his blood sugar that morning due to a malfunctioning device (freestyle libre); and the		instructions to the individual employees by 5/11/23. 100% of current patient medical records were reviewedby 5/5/23 to ensure 100% of all current episodes of care have documentationthat the home health physician was notified of any changes in the patient'scondition or falls. Any changes incondition or falls without evidence of being reported were reported to thephysician. Clinicians will be required to complete daily reportto PCMs on each patient to report any changes in patient condition. Acoordination note will be completed to ensure any concerns are included in themedical record. PCM's will ensure that any patients discussed havedocumentation to support physician notification. Beginning 5/8/23 theED or designee will audit 4 visits notes per clinician per month. Clinicians scoring less than 100% will be assigned prescriptive learning. All new	

	document failed to evidence the physician was notified of weight loss, poor appetite, teeth issues, or the patient didn't check his blood sugar. Record review evidenced a skilled nursing visit note dated 4/04/2023. Record review evidenced the patient didn't check his blood sugar level since last nursing visit (3/30/2023), the nurse performed a random test (not fasting), and the patient's blood sugar level was 354 (70-110 is normal range); the patient was unable to demonstrate competency with use of a glucometer (a machine used to check blood sugar levels); swelling to lower extremities was worse than previously documented on 3/23/2023; and the nurse offered Medical Social Worker (MSW) services to assist with medication management to include prefilled packaging from pharmacy, which the patient agreed to; and the document failed to evidence the physician was notified of blood sugar level of 354, the patient didn't check his blood sugar levels for 1 week, was not competent to use a glucometer, and MSW services was		audited per week until 100% for 4 consecutive weeks then will go into the monthly rotation. The notes audited will be a random pull of visits and will focus on ensuring that evidence exists in documentation where clinicians notified the physician of changes in the patient's condition, falls, and/or care needs. The Executive Director is ultimately responsible for the implementation of this plan of correction. Completion Date: 5/11/2023 Beginning 5/14/23, ED or designee will complete 10record reviews per week to ensure the physician was notified of changes in the patient'scondition, including falls, to ensure update to the plan of care. Any deviations to this process will be addressed withclinician remediation and disciplinary action as indicated.	

	recommended. Record review evidenced a coordination note dated 4/11/2023. The document evidenced MSW #1 called the patient on 4/11/2023, but no home visit occurred; MSW #1 spoke to the patient about transferring to a different home health company, but failed to evidence the physician was notified. On 4/11/2023 at 1:15 PM, the Administrator indicated there were no parameters to notify the physician for blood sugar levels on the plan of care, and the physician should be notified for changes in the patient's condition. The Clinical Manager indicated they do call the certifying physician, but calls are often not returned. 3. Clinical record review for Patient #3 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 3/18/2023 – 5/16/2023, evidenced the patient's primary focus of home care was Physical Therapy (PT) and Occupational Therapy (OT), diagnoses included heart failure, and the PT clinical		Monitoring will continue for 12 weeks and willcontinue until 100% compliance is achieved for 3 consecutive weeks. Discussion of compliance will be discussed with theteam during the quarterly Quality Assurance Performance Improvement teammeetings until compliance is achieved.	

	summary indicated the patient's current co-morbidities included new or exacerbated (within the last month) chronic obstructive pulmonary disease (COPD). Record review evidenced an initial comprehensive assessment, dated 3/18/2023, which was completed by PT #1. The document evidenced the patient's diagnoses included heart failure, which was poorly controlled, and required frequent adjustments in treatment and dose monitoring; the patient's baseline weight was 125 pounds, and had no current heart or lung concerns. Record review evidenced an OT evaluation visit note dated 3/20/2023. The document evidenced the patient's weight was 125.4 pounds (0.4 pound weight increase), pitting edema was assessed, the patient got short of breath easily, had difficulty breathing with minimal exertion, and had a cough. The document failed to evidence the physician was notified of the clinical findings. Record review evidenced a Medical Social Worker (MSW) visit note dated 3/21/2023. The			

	document evidenced the patient had moderate to severe anxiety/fear/excessive worries, and depression; and the patient indicated an anxiety pill may be missing from her pill box, which might be contributing to increased anxiety. The document failed to evidence the physician was notified of the clinical findings. Record review evidenced a clinical coordination note dated 3/31/2023. This document evidenced the MSW provided a telephonic MSW visit, and family reported the patient sustained a fall (no date identified), and family was planning on hiring a caregiver. The document failed to evidence the physician was notified. During an interview on 4/11/2023 at 2:36 PM, the Administrator indicated the physician should have been notified. 410 IAC 17-13-1(a)(2)			
G0608	Coordinate care delivery 484.60(d)(4)	G0608	An occurrence report was entered for patients 1, 3,and 5. Patient 1 is currently	2023-05-11

	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 record review and interview, the home health agency failed to ensure care was coordinated in 3 of 7 active clinical records reviewed. (Patient #1, 3, 5) The findings include: 3. Clinical record review for Patient #1 was completed on 4/11/2023. Record review evidenced a skilled nursing evaluation was completed on 1/30/2023. The document evidenced the patient had a caregiver from Entity #6 (a private duty agency), and went to Entity #7 (a dialysis center) on Mondays, Wednesdays, and Fridays. Record review evidenced a comprehensive assessment for recertification of services, dated 3/23/2023. The document evidenced the patient's diabetes was managed by Person #8 (a physician), the patient had a HgbA1c (a blood test to determine average daily blood sugars over the past 2-3 months) test done within the		hospitalized. For patient 3, a fall report was completed, and allclinical findings were reported to the physician on 5/2/23. Nursing serviceswere initiated for patient 3 on 4/3/23. POC initiated that addressesco-morbidities. Patient was reassessed for care needs on 5/3/23 by the RN. Noadditional care needs were identified. Patient 5 physician was notified wound care notperformed at ordered frequency. Updated orders received on 4/7/23 for caregiverto perform wound care on days skilled nurse not present. Caregiver educated andcompleted return demonstration 4/10/23. During a mandatory staff meeting held on 5/3/23, the PITeam instructed all clinical staff and PCMs on home health policy Coordinationof Care from Admit Through Discharge with emphasis on interdisciplinary carecoordination and coordinating care with patient’s care team including outside services,including, but not limited to wound clinics.	

	past 3 months, and indicated the nurse was to request a copy of the results from Person #8; and Person #9 (a physician) was the patient's podiatrist. Record review failed to evidence coordination occurred with Person #8 or #9, and failed to evidence the agency obtained the patient's HgbA1c results. Record review evidenced a skilled nursing visit note dated 3/30/2023. Record review evidenced the patient had "paid help" (not further specified). Record review failed to evidence coordination occurred with the "paid help". During an interview on 4/11/2023 at 1:15 PM, the Administrator indicated the clinical record didn't include the patient's HgbA1c results, or evidence coordination with Person #8 or Person #9. The Clinical Manager indicated she left a message with Entity #6 on 4/05/2023. 4. Clinical record review for Patient #3 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 3/18/2023 – 5/16/2023, evidenced the		For any staff not present, the PI Team or designeewill provide instructions to the individual employees by 5/11/23. 100% of current patient medical records were reviewedby 5/5/23 to ensure 100% of all current episodes of care have documentationshowing evidence of care coordination with outside services including, but notlimited to wound clinics. All patients who are identified as receiving servicesthrough another entity will have a Point Care Visit Alert entered into HCHB indicatingthe entity and what the agency is providing. With each comprehensive assessment and as needed forchanges in condition, the assessing clinician will coordinate care with other disciplineson the patient’s care team, including outside services, and document thatconversation. Clinicians willprovide daily report to the PCM and will review significant patientfindings. PCM will	

	patient's primary focus of home care was Physical Therapy (PT) and Occupational Therapy (OT), diagnoses included heart failure, and the PT clinical summary indicated the patient's current co-morbidities included new or exacerbated (within the last month) chronic obstructive pulmonary disease (COPD). Record review evidenced an initial comprehensive assessment, dated 3/18/2023, which was completed by PT #1. The document evidenced the patient's diagnoses included heart failure, which was poorly controlled, and required frequent adjustments in treatment and dose monitoring; the patient's baseline weight was 125 pounds, and had no current heart or lung concerns. Record review evidenced an OT evaluation visit note dated 3/20/2023. The document evidenced the patient's weight was 125.4 pounds (0.4 pound weight increase), pitting edema was assessed, the patient got short of breath easily, had difficulty breathing with minimal exertion, and had a cough. The document failed to		the patient's POC are notified of the findingsincluding the physician. Additional team care coordination will occur in weeklycase conference. Documentation of all team communication will be included inthe medical record. Beginning 5/8/23 the ED or designee will audit 4 visits notes perclinician per month. Cliniciansscoring less than 100% will be assigned prescriptive learning. All new clinicians will have 2 notes audited per week until 100% for 4 consecutive weeks then will go into the monthly rotation. The notes audited will be a random pull of visits and will focus on ensuring that evidence exists in documentation where clinician coordinated care with other disciplines and outside services as indicated. The Executive Director is ultimately responsible for the implementation of this plan of correction. Completion date: 5/11/2023	

	clinical findings with the Clinical Manager. Record review evidenced a Medical Social Worker (MSW) visit note dated 3/21/2023. The document evidenced the patient had moderate to severe anxiety/fear/excessive worries, and depression; and the patient indicated an anxiety pill may be missing from her pill box, which might be contributing to increased anxiety. The document failed to evidence the MSW coordinated clinical findings with the Clinical Manager. Record review evidenced a clinical coordination note dated 3/31/2023. This document evidenced the MSW provided a telephonic MSW visit, and family reported the patient sustained a fall (no date identified), and family was planning on hiring a caregiver. The document failed to evidence the MSW coordinated clinical findings of a fall with the Clinical Manager. During an interview on 4/11/2023 at 3:42 PM, the Administrator indicated she was		Beginning 5/14/23, ED or designee will 100% of SOCs per week to ensure if patient has otherservices, that care coordination has occurred. Beginning 5/14/23, ED or designee will complete 10record reviews per week to ensure the care team, including outside entities, werenotified of changes in the patient's condition. Any deviations to this process will be addressed withclinician remediation and disciplinary action as indicated. Monitoring will continue for 12 weeks and willcontinue until 100% compliance achieved for 3 consecutive weeks. Discussion of compliance will be discussed with theteam during the quarterly Quality Assurance Performance Improvement teammeetings until compliance is achieved.	

there was no fall report made.

1. Record review evidenced an agency policy revised 4/1/2023, titled "Coordination of Care, from Admit through Discharge" which stated, "... When the patient receives services from other organizations and/or individual's care is coordinated to ensure that patient's needs are met efficiently, without duplication of services, including: ... Communication with other health care providers when there are significant changes in patient care and/or condition ...."

2. Clinical record review for Patient #5 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 3/29/2023 - 5/27/2023, which indicated the patient was to receive dressing changes to a malignant back lesion 3 times weekly: 2 times weekly from the skilled nurses, and 1 time weekly from Entity #2 (mobile wound clinic).

During an interview on 4/11/2023, at 2:00 PM, Person #3 (employee of Entity #2)

	discharged from services on 3/22/2023, due to coccyx (area at base of spine) wound being healed. Record review failed to evidence the patient received dressing changes to the malignant back lesion 3 times weekly as ordered on the plan of care for the weeks of 3/26/2023, and 4/2/2023. Record review failed to evidence any care coordination with Entity #2 (mobile wound clinic). During an interview on 4/11/2023, at 10:39 AM, the Administrator indicated the agency should have coordinated care with Entity #2 by calling them, and having them send over orders. The Administrator indicated they did not have any documentation of when the patient was discharged from Entity #2. The Administrator indicated the patient should have received dressing changes 3 times weekly even after Entity #2 discharged the patient.			
G0614	Visit schedule	G0614	Patient 5 was provided with a copy of the Patient	2023-05-11

	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 the patients with written visit schedules in 1 of 1 home visit conducted. (Patient #5) The findings include: Record review evidenced an agency policy revised 4/1/2023, 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 ...." Observation of a home visit for Patient #5 was conducted on 4/10/2023, at 11:00 AM, to observe a routine skilled nurse visit. During the visit, a home health binder was reviewed, which contained a visit schedule dated 2/20/2023, and 4/10/2023. Clinical record review for Patient		InstructionsReport in the home which contains the visit schedule on 5/3/23. During a mandatory staff meeting held on 5/3/23, thePI Team instructed all clinical staff and PCMs on home health policy Coordinationof Care from Admit Through Discharge with the emphasis on providing the patienta visit schedule. The visit frequencywill be included in all Patient Instruction Reports sent to the patient's homeand any changes communicated to the patient and/or updated on the patientinstruction form. For any staff not present, the PI Team or designeewill provide instructions to the individual employees by 5/11/23. Home visits were completed on 100% of current patientsby 5/5/23 to ensure 100% of all current episodes of care have a Patient InstructionReport that indicated the patient's visit frequency. Staff updated the Patient Instructions Reportwith any changes in visit patterns. The Business Manager or designee will print out	

	#5 was completed on 4/11/2023, for certification period 3/29/2023 - 5/27/2023. Record review evidenced a recertification assessment was completed on 3/24/2023. During an interview on 4/11/2023, at 3:43 PM, the Administrator indicated the visit schedule should have been provided to the patient during the recertification assessment.		thePatient Instructions Report weekly for all patients who had an OASIS assessmentthat week and will mail to the patient's home with an instruction sheet thatrequests the patient to place the form in the patient folder for staff use. With each visit, the clinician will review the PatientInstruction Report with the patient and will update the Patient Instruction Reportwith any visit frequency schedule changes per physician orders. If no Patient Instruction Report is in the patient's home folder, the clinician will notify the PCM to ensure the next clinician making the next scheduled home visit hand delivers the Patient Instruction Report to the home and places it in the home folder. The Executive Director is ultimately responsible for the implementation of this plan of correction. Completion Date: 5/11/2023	

			Beginning the week of 5/14/23, the Executive Directoror designee with complete 9 home visits weekly to ensure Patient Instructions Reportsare in the patient's folder and includes frequency of visits. Monitoring will continue weekly for 12 weeks and willcontinue until 95% compliance is achieved for 3 consecutive weeks. Deficient findings will be addressedimmediately, and clinician remediation and disciplinary action will occur asindicated. 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	G0616	Patient 5 was copy of Patient Instructions Report inthe home which contains the medication schedule on 5/3/23 During a mandatory staff meeting held on 5/3/23, thePI Team instructed all clinical staff and PCMs on home health policy ManagingMedications	2023-05-11

	health agency failed to ensure they provided patients with a written medication schedule in 1 of 1 home visits conducted. (Patient #5) The findings include: Record review evidenced an agency policy revised 4/1/2023, 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 ...." Observation of a home visit for Patient #5 was conducted on 4/10/2023, at 11:00 AM, to observe a routine skilled nurse visit. During the visit, a home health binder was reviewed which contained medication schedules dated 2/20/2023, and 4/10/2023. Clinical record review for Patient #5 was completed on 4/11/2023, for certification period 3/29/2023 - 5/27/2023. Record review evidenced a recertification assessment dated 3/24/2023. During an interview on		the patient a medication list. The medication list will be included in allPatient Instruction Reports sent to the patient's home and any changescommunicated to the patient and/or updated on the Patient Instruction Report. For any staff not present, the PI Team or designeewill provide instructions to the individual employees by 5/11/23. Home visits were completed on 100% of current patientsby 5/5/23 to ensure 100% of all current episodes of care had a PatientInstruction Report that included the current updated medication list. Staff updated the Patient Instructions Reportwith any changes in medications. The admitting / assessing clinician will ensure a currentpatient friendly medication list is in the home folder until the PatientInstructions Report is received. The Business Manager or designee will print out	

	4/11/2023, at 3:43 PM, the Administrator indicated the written medication schedule should have been provided to the patient during the recertification assessment visit.		weekly for all patients who had an OASIS assessmentthat week and will mail to the patient's home with an instruction sheet thatrequests the patient to place the form in the patient folder for staffuse. With each visit, the clinician will review the PatientInstruction Report with the patient when any changes in medication and willupdate the Patient Instruction Report with any medication changes per physicianorders. If no Patient Instruction Report is in the patient's home folder, the clinician will notify the PCM to ensure the next clinician making the next scheduled home visit hand delivers the Patient Instruction Report to the home and places it in the home folder. The Executive Director is ultimately responsible for the implementation of this plan of correction. Completion Date: 5/11/2023	

			Beginning the week of 5/14/23, the ED or designee withcomplete 9 home visits weekly to ensure Patient Instructions Reports are in thepatient's folder and includes a current updated medication list. Monitoring will continue weekly for 12 weeks and willcontinue until 95% compliance is achieved for 3 consecutive weeks. Deficient findings will be addressedimmediately, 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. Discussion ofcompliance will be discussed with the team during the quarterly QualityAssurance Performance Improvement team meetings until compliance is achieved.	
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	G0618	Patient 5 was provided a copy of Patient InstructionsReport in the home which contains treatment instructions on 5/3/23 During a mandatory staff meeting held on 5/3/23, thePI Team instructed all clinical staff	2023-05-11

	review, and interview, the home health agency failed to provide patients with written plans of care in 1 of 1 home visits conducted. (Patient #5) The findings include: Record review evidenced an agency policy revised 4/1/2023, 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 ...." Observation of a home visit for Patient #5 was conducted on 4/10/2023, at 11:00 AM, to observe a routine skilled nurse visit. During the visit, a home health binder was reviewed which contained written treatment instructions/plans of care dated 2/20/2023, and 4/10/2023.		and PCMs on home health policy Coordinationof Care from Admit Through Discharge with the emphasis on providing the patientwith treatment instructions. The treatmentinstructions will be included in all Patient Instruction Reports sent to thepatient's home and any changes will be communicated to the patient and/orupdated on the Patient Instruction Report. For any staff not present, the PI Team or designeewill provide instructions to the individual employees by 5/11/23. Home visits were completed on 100% of current patientsby 5/5/23 to ensure 100% of all current episodes of care have a Patient InstructionReport that included the treatment instructions. Staff updated the PatientInstructions Report with any changes in treatments. The Business Manager or designee will print out thePatient Instructions Report weekly for all patients who had an OASIS assessmentthat week	

	Clinical record review for Patient #5 was completed on 4/11/2023, for certification period 3/29/2023 - 5/27/2023. Record review evidenced a recertification assessment dated 3/24/2023. During an interview on 4/11/2023, at 3:43 PM, the Administrator indicated the written treatment instructions/plans of care should have been provided to the patient during the recertification assessment visit.		home with an instruction sheet thatrequests the patient to place the form in the patient folder for staffuse. With each visit, the clinician will review the PatientInstruction Report with the patient when any changes in treatments and willupdate the Patient Instruction Report with any treatment changes per physicianorders. If no Patient Instruction Report is at the patient'shome folder, the clinician will notify the PCM to ensure the next clinicianmaking the next scheduled visit hand delivers the Patient Instruction Report tothe home and placed in the home folder. The Executive Director is ultimately responsible for the implementation of the plan of correction. Completion Date: 5/11/2023 Beginning the week of 5/14/23,	

			withcomplete 9 home visits weekly to ensure Patient Instruction Reports are in thepatient's folder and includes treatments the patient is receiving from agencystaff. Monitoring will continue weekly for 12 weeks and willcontinue until 95% compliance is achieved for 3 consecutive weeks. Deficient findings will be addressedimmediately, and clinician remediation and disciplinary action will occur asindicated. Discussion of compliance will be discussed with theteam during the quarterly Quality Assurance Performance Improvement teammeetings until compliance is achieved.	
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 4 of 7 active	G0716	During a mandatory staff meeting held on 5/3/23, the PITeam instructed all clinical staff and PCMs on accurate and completedocumentation using home health policies Patient Assessment, Initial and Reassessment,Plan of Care, and Wound Assessment,Documentation, and Photography and the Clinical Note Review Tip Sheet	2023-05-11

	clinical records reviewed. (Patient #2, 5, 6, 7) The findings include: 5. Clinical record review for patient #2 was completed on 4/11/2023. Record review evidenced a comprehensive reassessment dated 3/22/2023. The document evidenced the patient had a wound on the left heel; the patient was paraplegic (paralyzed with absence of sensation from the waist down, and inability to control bowel or bladder), but then indicated the patient had no sensory deficit which would limit ability to feel or voice pain, and skin was rarely exposed to moisture; gastrointestinal assessment findings included only bowel sounds, but failed to indicate if the patient used an effective bowel program or was incontinent; the patient had a suprapubic urinary catheter (a tube inserted from a surgical opening in the lower abdomen into the bladder); and the nurse removed the old urinary catheter, cleansed the perineal area (skin between genitals and anus), and inserted a new		withemphasis on: completion of complete assessments including but not limited to Respiratory, Cardiovascular, Genitourinary, and Endocrine systems;monitoring and documentation of blood glucose levels; documentation of locationas indicated; lack of contradictory documentation; wound care documentation; andcompleting assessments as indicated on the POC. For any staff not present, the PI Team or designeewill provide instructions to the individual employees by 5/11/23. Clinical Notes will be prepared accurately, per interventionsoutlined in the POC, paintinga picture of the visit to include relevant findings, what was done, and thereis no contradictory documentation within the visit note. Clinicians will provide daily report to PCMs. Notes will be completed and synched into themedical record within 24/hours of the visit. ED / PCMs / designee will reviewclinical notes to ensure documentation	

	urinary catheter. Record review evidenced a coordination note dated 3/7/2023, which indicated the patient had a foley catheter (inserted into the urethra), not a suprapubic catheter. Record review evidenced a wound record report, which evidence the patient's right heel wound was resolved on 10/20/2022, and evidenced presence of a current wound to the left heel (onset date 9/26/2022). Record review evidenced a team case conference/coordination note dated 3/08/2023, which evidenced skilled nursing to continue management of wound care to right heel, and right heel was making good progress. Record review evidenced a team case conference/coordination note dated 3/15/2023, which evidenced care to be continued for care of nephrostomy tubes (thin plastic tube inserted in the back of the body, through the skin, and then into the kidney).		provided andwill begin monitoring compliance week of 5/8/23. Any noncompliance will beaddressed 1:1 with clinician and will include disciplinary action as indicated. Beginning 5/8/23 the ED or designee will audit 4visits notes per clinician per month. Clinicians scoring less than 80% will be assigned prescriptive learning. All new clinicians will have 2 notes audited per week until 80% for 4 consecutive weeks then will go into the monthly rotation. The notes audited will be a random pull of visits and will focus on ensuring that documentation in the clinical notes is completed and accurate, consistent with the POC, and lacking contradictory content. The Executive Director is ultimately responsible for the implementation of the plan of correction. Completion Date: 5/11/2023 Beginning the week of 5/14/23,	

	On 4/11/2023 at 2:18 PM, when informed of the documented discrepancies in the clinical record, the Administrator closed her eyes, shook her head left to right, and then indicated she couldn't believe it, and confirmed the patient's perineal area wouldn't be cleansed to insert a suprapubic catheter. 1. Record review evidenced a registered nurse job description obtained 4/11/2023, which stated, "... Essential Functions ... Documents patient visits thoroughly and completely per policy and payer requirements ...." 2. Record review evidenced an agency policy revised 3/1/2022, titled "Patient Assessment, Initial and Reassessment" which stated, "... Upon admission and reassessment, the qualified clinician performs the following assessment activities and collects the following data: ... Integumentary status ... Respiratory status ... Elimination status ...." 3. Clinical record review for Patient #5 was completed on 4/11/2023, for certification		the ED or designee willreview 10 medical records weekly to ensure patient assessments are complete andno contradictory documentation noted. Monitoring will continue weekly for 12 weeks and willcontinue until 100% compliance is achieved for 3 consecutive weeks. Deficient findings will be addressedimmediately, and clinician remediation and disciplinary action will occur asindicated. Discussion of compliance will be discussed with theteam during the quarterly Quality Assurance Performance Improvement teammeetings until compliance is achieved.	

	Record review evidenced a recertification comprehensive assessment dated 3/24/2023, which stated, "... No lesions 2+3d3ma ...." The comprehensive assessment failed to include a lung sound assessment. The comprehensive assessment indicated the patient had a urostomy (tube inserted into the bladder to drain urine), and failed to include an assessment of the urostomy site, or urine. The comprehensive assessment indicated the patient was diabetic (problem regulating blood sugars), but failed to include the patient's blood glucose measurement. Record review evidenced a plan of care for certification period 3/29/2023 - 5/27/2023, which indicated the patient had a nephrostomy (tube inserted into kidney to drain urine). The plan of care indicated the patient was to receive daily blood glucose checks, and assessments of nephrostomy tube sites every visit. Record review evidenced a skilled nurse visit note dated 3/31/2023, which failed to			

	measurement. This visit note also failed to include a nephrostomy tube assessment. This visit note indicated the patient had trace edema (swelling), but failed to identify the location of the swelling. This visit note also indicated the patient did not have diabetes. Record review evidenced a skilled nurse visit dated 4/7/2023, which indicated the patient had developed a new wound under the nephrostomy tube site, but failed to include an assessment of the wound, or measurements. During an interview on 4/11/2023, at 10:26 AM, the Administrator indicated the recertification assessment was documented in error. The Administrator indicated the comprehensive assessment should have included an assessment of lung sounds. The Administrator indicated the nurse should have documented nephrostomy tube on the comprehensive assessment and included an assessment of the site and urine. The Administrator indicated any patient with diabetes should			

	measurements included on all visit notes. At 10:34 AM, the Administrator indicated the nurse should have included an assessment on the 3/31/2023, visit note of the nephrostomy tubes. At 10:34 AM, the Administrator indicated the 3/31/2023, visit note should have indicated the location of edema, and that the patient did have diabetes. The Administrator indicated any new wound should have included a documented assessment and wound measurements. 4. Clinical record review for Patient #6 was completed on 4/11/2023, for certification period 3/20/2023 - 5/18/2023. Record review evidenced a start of care comprehensive assessment dated 3/20/2023, which indicated the patient wore oxygen, but failed to include lung sounds in the respiratory assessment, or heart sounds in the cardiac assessment. During an interview on 4/10/2023, at 3:07 PM, the Administrator indicated the comprehensive assessment should have included lung and			

	heart sounds. 5. Clinical record review for Patient #7 was completed on 4/11/2023, for certification period 2/19/2023 - 4/19/2023. Record review evidenced a skilled nurse visit note dated 3/20/2023, which indicated wound care was provided, but also indicated the patient had no wounds because they were healed. During an interview on 4/10/2023, at 3:28 PM, the Administrator indicated the documentation was inaccurate and shouldn't have had wound care provided to a healed wound.			
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 agency failed to ensure skilled professionals communicated with physicians involved in the plan of care in 3 of 7 active	G0718	An occurrence report was entered for patients 1, 3,and 4 Patient 1 is currently hospitalized. For patient 3, a fall report was completed, and allclinical findings were reported to the physician on 5/2/23. Nursing serviceswere initiated for patient 3 on 4/3/23. POC initiated that addressesco-morbidities. Patient was reassessed for care	2023-05-11

	clinical records reviewed. (Patient #1, 3, 4) The findings include: 1. Record review evidenced an agency policy revised 4/1/2023, titled "Coordination of Care, from Admit through Discharge" which stated, "... When the patient receives services from other organizations and/or individual's care is coordinated to ensure that patient's needs are met efficiently, without duplication of services, including: ... Communication with other health care providers ...." 2. Clinical record review for Patient #1 was completed on 4/11/2023. Record review evidenced a skilled nursing evaluation was completed on 1/30/2023. The document evidenced the patient had a caregiver from Entity #6 (a private duty agency), and went to Entity #7 (a dialysis center) on Mondays, Wednesdays, and Fridays. Record review evidenced a comprehensive assessment for recertification of services, dated 3/23/2023. The document evidenced the patient's diabetes		needs on 5/3/23 by the RN. Noadditional care needs were identified. Patient 4 is currently hospitalized. During a mandatory staff meeting held on 5/3/23, thePI Team instructed all clinical staff and PCMs on home health policiesCoordination of Care from Admit Through Discharge and Patient Fall ReductionProgram with emphasis ensuring all changes in the patient’s condition,including values outside of parameters and falls, are reported to thephysician. For any staff not present, the PI Team or designeewill provide instructions to the individual employees by 5/11/23.	

	was managed by Person #8 (a physician), the patient had a HgbA1c (a blood test to determine average daily blood sugars over the past 2-3 months) test done within the past 3 months, and indicated the nurse was to request a copy of the results from Person #8; and Person #9 (a physician) was the patient's podiatrist. Record review failed to evidence coordination occurred with Person #8 or #9, and failed to evidence the agency obtained the patient's HgbA1c results. Record review evidenced a skilled nursing visit note dated 3/30/2023. Record review evidenced the patient weighed 124 pounds (6 pound weight loss in 1 week), the patient reported a poor appetite due to teeth issues, and the nurse advised the patient to eat soft foods. The document failed to evidence the certifying physician was notified of the 6 pound weight loss, poor appetite, or recommended diet change. Record review evidenced a skilled nursing visit note dated 4/04/2023. Record review evidenced the nurse offered		Coordination of care will occur with physician fromadmission, throughout care, and at discharge, through routine communicationwhen changes occur in the patient's condition or response to treatment, assessmentfindings are outside of established parameters, or when patient falls. Clinicians will provide daily report to the ED/PCM andwill review patient care needs to include any changes in patientcondition. PCM/ED will ensure physiciannotification of any reported changes in condition occurs. Physician orders willbe obtained to revise the POC accordingly. Beginning 5/8/23 the ED or designee will audit 4visits notes per clinician per month. Clinicians scoring less than 80% will be assigned prescriptive learning. All new clinicians will have 2 notes audited per week until 80% for 4 consecutive weeks then will go into the monthly rotation. The notes audited will be a random pull of visits and will focus on ensuring that the physician was notified of changes in condition, including values outside of	

	Medical Social Worker (MSW) services to assist with medication management to include prefilled packaging from pharmacy, which the patient agreed to. The document failed to evidence the certifying physician was notified to request the addition of MSW services. Record review evidenced a coordination note dated 4/11/2023. The document evidenced MSW #1 called the patient on 4/11/2023. MSW #1 spoke to the patient about transferring home health services to a different home health company, to which the patient agreed. The clinical record failed to evidence the certifying physician was notified of the intent to transfer the patient to another home health agency. During an interview on 4/11/2023 at 1:15 PM, the Administrator indicated the clinical record didn't include the patient's HgbA1c results, or evidence coordination with Person #8 or Person #9. 3. Clinical record review for Patient #3 was completed on		physician ordered parameters. The Executive Director is ultimately responsible for the implementation of this plan of correction. Correction Date: 5/11/2023 Beginning 5/14/23, ED or designee will complete 10record reviews a week to ensure the physician was notified of changes incondition. Any deviations to this process will be addressed withclinician remediation and disciplinary action as indicated. Monitoring will continue for 12 weeks and willcontinue until 100% compliance achieved for 3 consecutive weeks. Discussion ofcompliance will be discussed with the team during the quarterly QualityAssurance Performance Improvement team meetings until compliance is achieved.	

	4/11/2023. Record review evidenced a plan of care for certification period 3/18/2023 – 5/16/2023, evidenced the patient's primary focus of home care was Physical Therapy (PT) and Occupational Therapy (OT), diagnoses included heart failure, and the PT clinical summary indicated the patient's current co-morbidities included new or exacerbated (within the last month) chronic obstructive pulmonary disease (COPD). Record review evidenced an initial comprehensive assessment, dated 3/18/2023, which was completed by PT #1. The document evidenced the patient's diagnoses included heart failure, which was poorly controlled, and required frequent adjustments in treatment and dose monitoring; the patient's baseline weight was 125 pounds, and had no current heart or lung concerns. Record review evidenced an OT evaluation visit note dated 3/20/2023. The document evidenced the patient's weight was 125.4 pounds (0.4 pound weight increase), pitting edema was assessed, the patient got			

	difficulty breathing with minimal exertion, and had a cough. The document failed to evidence the OT coordinated clinical findings with the certifying physician. Record review evidenced a Medical Social Worker (MSW) visit note dated 3/21/2023. The document evidenced the patient had moderate to severe anxiety/fear/excessive worries, and depression; and the patient indicated an anxiety pill may be missing from her pill box, which might be contributing to increased anxiety. The document failed to evidence the MSW coordinated clinical findings with the certifying physician. Record review evidenced a clinical coordination note dated 3/31/2023. This document evidenced the MSW provided a telephonic MSW visit, and family reported the patient sustained a fall (no date identified), and family was planning on hiring a caregiver. The document failed to evidence the MSW coordinated clinical findings of a fall with the certifying physician.			

	During an interview on 4/11/2023 at 2:36 PM, the Administrator indicated the physician should have been notified for the changes in condition. 4. Clinical record review for Patient #4 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 3/28/2023 - 5/26/2023, which indicated the clinician should report pain level greater than 6 (0-10 scale, with 0 being no pain, and 10 being the worst pain ever). Record review evidenced an OT evaluation visit note dated 3/29/2023. The document evidenced the patient reported pain level at 7. The document failed to evidence the OT coordinated clinical findings to the certifying physician. During an interview on 4/11/2023 at 3:15 PM, the Administrator indicated the physician should be notified for clinical findings outside the parameters on the plans of care. 410 IAC 17-14-1(a)(1)(G)			

N0000	Initial Comments	N0000		

This visit was for a Revisit for a State re-licensure survey, originally conducted on 2/02/2023.

Facility ID: IN005259

Survey Dates: 4/05/2023, 4/06/2023, 4/10/2023, and 4/11/2023.

Census: 96

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
Carla Johnson	Executive Director	7/6/2023 12:42:14 PM