

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157034	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  07/18/2023	
NAME OF PROVIDER OR SUPPLIER  INDIANA HOMECARE NORTHWEST		STREET ADDRESS, CITY, STATE, ZIP CODE  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	<p>Initial Comments</p> <p>An Emergency Preparedness Re-Survey was conducted by the Indiana Department of Health in accordance with 42 CFR §484.102.</p> <p>Survey Dates: 7/17/2023 -7/18/2023</p> <p>Census: 29</p> <p>At this Emergency Preparedness survey, Indiana Homecare Northwest, was found to be compliant with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, at 42 CFR §484.102.</p>	E0000	na	
G0000	INITIAL COMMENTS	G0000	na	

Survey Dates: 7/17/2023 – 7/18/2023.

Census: 29

During this survey, 1 Condition of Participation: 42 CFR 484.60 Care Planning, Coordination of Care and Quality of Care was corrected, 11 standard level deficiencies were corrected, and 5 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.

<p>G0374</p>	<p>Accuracy of encoded OASIS data</p> <p>484.45(b)</p> <p>Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment.</p> <p>Based on record review and interview, the home health agency failed to ensure Outcome and Assessment Information Set (OASIS) data was accurate for 2 of 3 clinical records reviewed for the patient's initial certification period (Patient #3, #6).</p> <p>The Findings include:</p> <ol style="list-style-type: none"> <li>1. An agency policy titled "OASIS Accuracy Review," revised 1/01/15, stated, " ... To enhance and validate accuracy of OASIS...."</li> <li>2. Clinical record review on 7/17/2023 for Patient #3 evidenced an Physical Therapy Oasis, dated 7/6/2023. The OASIS data for medications evidenced no potential clinically significant medication issues were found during the drug regimen review.</li> </ol> <p>Clinical record review of the Patient's plan of care evidenced</p>	<p>G0374</p>	<p>An occurrence report was entered for patients #3 and #6.</p> <p>Patient # 3 OASIS M2001 corrected.</p> <p>Patient #6 OASIS M2102 corrected.</p> <p>During a mandatory staff meeting to be held on 8/2/23,the Executive Director (ED) instructed all clinical staff and Patient CareManagers (PCM) on OASIS accuracy, with emphasis on utilizing Drugs.com toensure M2001 scored accurately, and M2102.</p> <p>As part of the Orientation process, the ED willinstruct all new hires, including contract and shared employees on use ofDrugs.com to accurately score M2001, and M2102.</p> <p>The assessing clinician accurately completes thecomprehensive assessment / OASIS.</p> <p>A drug regimen review is completed as part of thecomprehensive assessment utilizing Drugs.com and Home Care Home Base (HCHB). Ifany issues, including, but not limited</p>	<p>2023-08-02</p>
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<p>the patient's current medications included hydrocodone/acetaminophen (for pain) tramadol (for pain) gabapentin (for nerve pain) and dalfampridine (used to help improve motor function)</p> <p>Clinical record review evidenced on 7/6/2023, evidenced the agency used drugs.com (an internet drug interaction checker) to review potential adverse interactions of the patient's medications. This review identified 5 potentially major drug interactions existed between hydrocodone/acetaminophen and gabapentin, hydrocodone/acetaminophen and tramadol, gabapentin and tramadol, and tramadol and dalfampridine. The potential major drug interactions were highly clinically significant and should be avoided, and the risk of the interaction outweighed the benefit(s).</p> <p>During an interview on 7/18/2023 at 5:15 PM, the administrator indicated the OASIS information was documented incorrectly.</p> <p>3. Clinical record review on</p>		<p>to significant drug interactions are identified, M2001 would be scored "1- yes."</p> <p>Following completion of the comprehensive assessment, the clinician will initiate a Start of Care (SOC) Report with the PCM, with discussion to include the types and amount of assistance required.</p> <p>During the Plan of Care (POC) review, the PCM will review the SOC Report, referral documentation, and content of the comprehensive assessment to ensure M2102 is scored accurately.</p> <p>The PCM will review M2001 to ensure this item is scored accurately and consistent with the results of the drug regimen review documented within the medical record.</p> <p>The Executive Director is ultimately responsible for the implementation of this plan of correction.</p> <p>Completion date: 8/2/23</p>	
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<p>7/18/2023 for Patient #6, start of care 6/30/2023, evidenced a Registered Nurse (RN) OASIS Admission dated 6/30/2023. The assessment indicated Patient walks frequently and has no limitations for mobility. Patient #6 requires assistance with grooming, assistance with putting on socks and shoes, requires supervision for bathing, needs assistance with toiling hygiene, needed assistance transferring This document evidenced the patient receives occasional short-term assistance at his home. This document also indicated Patient #6 has two daughters assisting him with his daily needs. The OASIS Assessment failed to evidence accurate assessment information.</p> <p>Clinical record review evidenced a skilled nursing visit note dated 7/17/2023. This visit note indicated Patient #6 receives assistance from relatives, friends, or neighbors outside the home.</p> <p>Clinical record review evidenced a skilled nursing visit note dated 7/7/2023. This visit note indicated Patient #6 does not</p>		<p>Beginning 8/3/23, the ED or designee will review 100% ofSOC and ROC OASIS for 3 weeks, and then 50% for 3 weeks to ensure M2001 andM2102 are score accurately.</p> <p>Monitoring will continue until 100% compliance is achieved for 3 consecutive weeks.</p> <p>For any deficient findings, the ED/designee will provide clinician remediation/counseling to ensure future accuracy.</p> <p>Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.</p>	
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	<p>This document failed to evidence accurate information on who was assisting Patient #6 with his needs.</p> <p>During a phone interview on 7/18/2023 at 12:17 PM, Patient #6 indicated his daughters help him with his needs, but he does a lot himself. He indicated the agency offered to send someone to have Physical Therapy come out, but he doesn't need any other help at this time.</p> <p>During an interview on 7/18/2023 at 3:17 PM, the Administrator indicated the information was not accurate and should reflect an accurate assessment of the Patient. She indicated she assumed the documentation on the nursing note was an error because the patient receives help from his daughters.</p>			
<p>G0572</p>	<p>Plan of care</p> <p>484.60(a)(1)</p> <p>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</p>	<p>G0572</p>	<p>Occurrence reports entered for patients #1.</p> <p>Patient # 1 Plan of Care (POC) was updated to reflect the current parameters.</p> <p>During a mandatory staff meeting to be held on 8/2/23,</p>	<p>2023-08-02</p>

<p>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.</p> <p>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 1 of 6 active clinical records reviewed. (Patient #1)</p> <p>The findings include:</p> <p>Record review evidenced an agency policy titled "Plan of Care," revised 12/1/2021, which stated, "... Each patient has an individualized Plan of Care developed in consultation 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 ...."</p> <p>Clinical record review on 7/17/2023, for Patient #1 evidenced a Physician order dated 5/29/2023, for the caregiver to monitor blood pressure daily and report to the</p>		<p>the Executive Director (ED) instructed all assessing clinicians and Patient Care Managers (PCM) on policy 2.1.007 Plan of Care with emphasis on developing an individualized POC containing current physician ordered parameters.</p> <p>As part of the Orientation process, the ED will instruct all new hires, including contract and shared employees on individualized POC, including current physician ordered parameters.</p> <p>Each patient has an individualized POC developed in consultation with the patient, physician or authorized practitioner, and staff that integrates comprehensive assessment findings to address patient problems, needs, goals, address specific services being provided, and include any physician specific reporting parameters.</p> <p>The qualified clinician revises the POC under the direction of the physician or authorized practitioner as indicated.</p>	
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	<p>Physician if blood pressure is above 170/95 [normal blood pressure is 120/80].</p> <p>Clinical record review of the plan of care, for certification period 7/9/2023 – 9/6/2023, evidenced blood pressure parameters which indicated the following parameters should be reported to the Physician: systolic blood pressure less than 85 or greater than 180, diastolic blood pressure less than 49 and greater than 100. This plan of care failed to be individualized to include the Patient’s specific blood pressure parameters.</p> <p>During an interview on 7/18/2023 at 4:50 PM, the Administrator indicated the care plan should have included Patient #1’s individualized blood pressure parameters.</p> <p>410 IAC 17-13-1(a)</p>		<p>The PCMs will utilize the PCM POC Review Tool while reviewing the comprehensive assessment and POC to ensure the POC is individualized.</p> <p>The Executive Director is ultimately responsible for the implementation of this plan of correction.</p> <p>Completion date: 8/2/23</p> <p>Beginning 8/3/23, the ED or designee will review 100% of POCs per week for 3 weeks, then 50% for 3 weeks to ensure the POC is individualized and contains accurate reporting parameters. Monitoring will continue until 100% compliance achieved for 3 consecutive weeks.</p> <p>For any deficient findings, the ED/designee will provide clinician remediation/counseling to ensure future accuracy.</p> <p>Discussion of compliance will be discussed with the team during</p>	
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			<p>the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.</p>	
<p>G0574</p>	<p>Plan of care must include the following</p> <p>484.60(a)(2)(i-xvi)</p> <p>The individualized plan of care must include the following:</p> <ul style="list-style-type: none"> <li>(i) All pertinent diagnoses;</li> <li>(ii) The patient's mental, psychosocial, and cognitive status;</li> <li>(iii) The types of services, supplies, and equipment required;</li> <li>(iv) The frequency and duration of visits to be made;</li> <li>(v) Prognosis;</li> <li>(vi) Rehabilitation potential;</li> <li>(vii) Functional limitations;</li> <li>(viii) Activities permitted;</li> <li>(ix) Nutritional requirements;</li> <li>(x) All medications and treatments;</li> <li>(xi) Safety measures to protect against injury;</li> <li>(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.</li> <li>(xiii) Patient and caregiver education and training to facilitate timely discharge;</li> <li>(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;</li> </ul>	<p>G0574</p>	<p>Occurrence reports were entered for patients #1, 2, and 6.</p> <p>Patient # 1 Plan of care (POC) was updated to include goals and interventions to address Multiple Sclerosis, PVD, and hospitalization risk factors.</p> <p>Patient # 2 POC was previously updated to include Oxygen.</p> <p>Patient # 6 POC was previously updated to reflect accurate medications.</p> <p>During a mandatory staff meeting held on 8/2/23, the Executive Director (ED) instructed all clinicians and the Patient Care Manager (PCM) on policy 2.1.007 Plan of Care with emphasis on developing a patient specific plan of care, with emphasis on ensuring the POC addresses hospitalization risks, primary and secondary diagnosis, includes oxygen if applicable, and contains an accurate list of all the</p>	<p>2023-08-02</p>

(xv) Information related to any advanced directives; and

(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.

Based on record review and interview the home health agency failed to ensure the plan included all the required elements in 3 of 6 records reviewed. (Patient #1, #2, #6)

The findings include:

1. Record review evidenced an agency policy titled "Plan of Care," revised 12/1/2021, stated "... The POC [plan of care] includes: ... Medications and treatments ... Pertinent diagnoses ... Patient specific interventions and education; measurable outcomes and goals identified by the agency and the patient ... Patient's risk for emergency department visits and re-hospitalization including interventions that address underlying risk factors ... All patient care orders ...."
2. Clinical record review on 7/17/2023, for patient #1 evidenced a plan of care, for certification period 5/10/2023 -7/8/2023, which included the following diagnoses: Multiple Sclerosis (disease where the

medications the patient is currently taking.

As part of the Orientation process, the ED will instruct all new hires, including contract and shared employees on required components of the POC, including addressing hospitalization risks, primary and secondary diagnosis, includes oxygen if applicable, and contains an accurate list of all the medications the patient is currently taking.

A POC is developed for all patients and updated no less than every 60 days. The POC shall include:

- a. Patient's mental, psychosocial, and cognitive status
- 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,

<p>protective covering of the nerves), Peripheral Vascular Disease (circulatory condition in which blood vessels reduce blood flow in the limbs). The plan of care included the following risks for hospital readmission: difficulty in complying with medical instructions, currently taking 5 or more medications, and reports of exhaustion. The plan of care failed to include goals and interventions for Multiple Sclerosis and Peripheral Vascular Disease and failed to include interventions to address the hospital readmission risks.</p> <p>During an interview on 7/18/2023 at 4:46 PM, the Administrator indicated the plan of care should include the goals and interventions for Multiple Sclerosis and hospitalization risks.</p> <p>3. Clinical record review on 7/17/2023 for patient #2, start of care 6/21/2019, evidenced the medication report. This report evidenced Patient #2 had had an order for 2 liters of Oxygen as needed.</p> <p>Clinical record review for Patient #2 evidenced a Physician order</p>		<p>including oxygen</p> <p>g. Safety measures to protect against injury</p> <p>h. Pertinent diagnosis(es)</p> <p>i. Patient specific interventions and education;measurable outcomes and goals related to pertinent diagnosis</p> <p>identified by the agency and patient</p> <p>j. Required equipment and supplies</p> <p>k. Patient’s risk for emergency department visits andre-hospitalization including interventions that address underlying risk factors</p> <p>l. Patient/caregiver education and training for timelydischarge</p> <p>m. Advance Directives</p> <p>n. All patient care orders</p> <p>The PCM POC Review Tool will be utilized by PCM’s whoare reviewing the POC to ensure the required elements of the POC are present.</p> <p>Clinicians will complete a</p>	
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<p>dated 6/22/2023 for 2 Liters of oxygen as needed.</p> <p>Clinical record review of the plan of care, for certification period 5/31/2023-7/29/2023, failed to include Patient #2's oxygen order.</p> <p>During an interview on 7/18/2023 at 2:35 PM, the Administrator indicated when she was performing chart audits she noticed the oxygen and added the order to the medication list.</p> <p>4. Clinical record review on 7/18/2023 for Patient #6, start of care 6/30/2023, evidenced a medication report for admission date 6/30/2023. This report indicated Patient #6 was to take Glipizide Er (for blood sugar regulation), start date 7/5/2023, Klor Con (potassium supplement), start date 7/4/2023, and indicated Potassium Gluconate (supplement) was discontinued on 5/23/2023.</p> <p>Clinical record review for Patient #6, evidenced the plan of care, for certification period 6/30/2023 – 8/28/2023. This plan of care failed to evidence the discontinued Potassium</p>		<p>medicationreview and reconciliation at comprehensive assessments to ensure the medicationlist is accurate.</p> <p>The Executive Director is ultimately responsible for the implementation of this plan of correction.</p> <p>Completion date: 8/2/23</p> <p>Beginning 8/3/23, the ED or designee will review 100%of POCs per week for 3 weeks, then 50% for 3 weeks to ensure the POC is individualized and contains measures to address hospitalization risk factors,pertinent diagnosis, oxygen (if applicable), and complete list of medications.Monitoring will continue until 100% compliance achieved for 3 consecutiveweeks.</p> <p>Beginning 8/3/23, the ED or designee will complete 2home observation visits per week on the visit immediately following thecomprehensive assessment to review the medications to</p>	
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	<p>Gluconate and the addition of Glipizide ER and Klor Con.</p> <p>During an interview on 7/18/2023 at 3:19 PM, the Administrator indicated the Plan of care was the 485. She indicated the changes to the medications were made on the medication List and would be added to the Plan of care on the recertification.</p> <p>410 IAC 17-13-1(a)(1)(A)</p> <p>410 IAC 17-13-1(a)(1)(D)(ii, ix, and xiii)</p>		<p>ensure medications on the POC are accurate. Monitoring will continue for 6 weeks and until 100% compliance achieved for 3 consecutive weeks.</p> <p>For any deficient findings, the ED/designee will provide clinician remediation/counseling to ensure future accuracy.</p> <p>Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.</p>	
<p>G0586</p>	<p>Review and revision of the plan of care</p> <p>484.60(c)</p> <p>Standard: Review and revision of the plan of care.</p> <p>Based on record review and interview, the home health agency failed to ensure the plans of care were updated and revised in 3 of 6 active clinical records reviewed. (Patient #1, #2, #4)</p> <p>The findings include:</p>	<p>G0586</p>	<p>An occurrence report was entered for patients #1, 2, and 4.</p> <p>Patient # 1 Plan of Care (POC) was updated to reflect the current parameters.</p> <p>Patient #2 POC updated to reflect correct frequency of nursing visits.</p> <p>Patient # 4 POC was updated to remove the duplicate medication.</p> <p>During a mandatory staff meeting held on 8/2/23,</p>	<p>2023-08-02</p>

<p>1. Record review evidenced an agency policy titled "Plan of Care" revised 12/1/2021, which stated "... Physician/authorized practitioner's orders are obtained to updated the plan of care and may include problems and goals ... Alterations to the plan of care are made only with the physician/authorized practitioner's approval ... the patient is monitored for response to treatment and progress toward goals ... Case conference with staff involved in patient's care is held for each patient at least every 60 days: the plan of care is then reviewed, revised, and sent to the physician ...."</p> <p>2. Clinical record review on 7/17/2023, for Patient #1 evidenced a Physician order dated 5/29/2023, for the caregiver to monitor blood pressure daily and report to the Physician if blood pressure is above 170/95.</p> <p>Clinical record review of the plan of care, for certification period 7/9/2023-9/6/2023, failed to evidence the order to the caregiver to monitor the blood pressure daily and report to the Physician if it is above</p>		<p>theExecutive Director (ED) instructed all clinicians and the Patient Care Manager(PCM) on policy 2.1.007 Plan of Care with emphasis on ensuring the POC reflectscurrent parameters, visit frequency, and contains no duplicate medications;editing visit frequencies; and the POC is modified when changes in the POC arerequired.</p> <p>As part of the Orientation process, the ED willinstruct all new hires, including contract and shared employees completing andupdating the POC, with emphasis on accurate parameters, visit frequency, andmedication list is accurate and free of duplications.</p> <p>A POC is developed for all patients and updated noless than every 60 days. Physician/authorized practitioner's orders areobtained to update the POC as indicated.</p> <p>When developing the POC, clinicians will ensure reporting parameters reflect current physician ordered parameters, the visitfrequency is edited to</p>	
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	<p>170/95.</p> <p>During an interview on 7/18/2023 at 4:52 PM, the Administrator indicated the plan of care should have been updated to include the patient's blood pressure monitoring orders and parameters.</p> <p>3. Clinical record review on 7/17/2023, for Patient #2 evidenced a plan of care, for certification period 5/31/2023 – 7/22/2023. The plan of care evidenced Patient #2 was to receive skilled nursing once a week for one week and two visits every 5 weeks for 5 weeks.</p> <p>Clinical record review evidenced a clinical note dated 7/12/2023, which indicated Patient #2's daughter only wanted skilled nursing services once monthly for Foley catheter (for urine retention) changes. This note indicated the Nurse called the Physician and the Physician was aware the Nurse was only going to go monthly. Record review failed to evidence Patient #2's plan of care was revised to reflect the once a monthly only visit.</p> <p>During an interview on 7/18/2023 at 2:14 PM, the</p>		<p>scheduled visit frequency, and the medication list is accurate and free of duplicate entries.</p> <p>The PCM POC Review Tool will be utilized by PCM's who are reviewing the POC to ensure the parameters, if ordered, are correct, visit frequency is accurate, and medication list is free of duplicate medications.</p> <p>The Executive Director is ultimately responsible for the implementation of this plan of correction.</p> <p>Completion Date: 8/2/23</p> <p>Beginning 8/3/23, the ED or designee will review 100% of POCs per week for 3 weeks, then 50% for 3 weeks to ensure the POC contains correct physician ordered parameters, if indicated; proper visit frequency, and no duplicate medications. Monitoring will continue until 100% compliance achieved for 3 consecutive weeks.</p> <p>For any deficient findings, the</p>	
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<p>Administrator indicated the Physician was aware and had agreed for the agency to provide care once a month to change the Foley catheter.</p> <p>4. Clinical record review on 7/17/2023, for Patient #4, start of care 8/23/2023, evidenced a medication list Loratadine as needed for sinus drainage was discontinued and Loratadine as needed for allergy symptoms and sinus congestion was a current medication order.</p> <p>Clinical record review evidenced a plan of care for certification period 6/19/2023 – 8/17/2023. This plan of care evidenced an order for Loratadine as needed for sinus drainage, and Loratadine as needed for allergy symptoms and sinus congestion. The plan of care failed to be updated with the correct unduplicated Loratadine order.</p> <p>During an interview on 7/17/2023 at 4:42 PM, the Administrator indicated the duplicated order was discontinued in the medication list when the drug review was completed.</p>		<p>ED/designee will provide clinician remediation/counseling to ensure future accuracy.</p> <p>Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.</p>	
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<p>G0716</p>	<p>Preparing clinical notes</p> <p>484.75(b)(6)</p> <p>Preparing clinical notes;</p> <p>Based on record review and interview, the home health agency failed to ensure skilled professionals accurately prepared clinical notes and assessments in 2 of 6 active clinical records reviewed. (Patient #2, #4)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Record review evidenced a registered nurse job description received 7/17/2023, which stated "... Essential Functions ... Documents patient visits thoroughly and completely per policy and payer requirements ...."</li> <li>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: ... functional status ... pertinent</li> </ol>	<p>G0716</p>	<p>An occurrence report was entered for patients #2 and4.</p> <p>Patient # 2 Plan of Care (POC) was updated to includeDuoneb.</p> <p>Patient # 4 documentation was amended to correct incorrectassessment finding.</p> <p>During a mandatory staff meeting held on 8/2/23, theExecutive Director (ED) instructed all clinicians and the Patient Care Manager(PCM) on policy 2.1.007 Plan of Care and the Clinical Note Review Tip Sheetwith emphasis on ensuring the POC is updated when changes in the POC areidentified, and ensuring documentation is accurate and consistent, lackingcontradictory entries.</p> <p>As part of the Orientation process, the ED willinstruct all new hires, including contract and shared employees on updating thePOC as indicated, and ensuring documentation is accurate and not contradictoryin nature.</p> <p>Physician/authorized</p>	<p>2023-08-02</p>

	<p>physical findings....”</p> <p>3. Clinical record review on 7/17/2023, for Patient #2 evidenced a nurse visit note dated 6/22/2023. This visit note evidenced the Nurse completed a medication reconciliation during the visit and would add oxygen and DuoNebS to the Patient’s medication list. During the visit, the Registered Nurse educated the family on the use of DuoNebS (opens the airways to make breathing easier) and the signs and symptoms of adverse reactions.</p> <p>Clinical record review evidenced a Physician order dated 6/22/2023, for oxygen 2 liters as needed but failed to evidence an order from the Physician for DuoNebS.</p> <p>.During an interview on 7/18/2023 at 4:22 PM, the Administrator indicated it did not look like the Physician ordered the DuoNebS, but she would find out if there should be an order for the medication.</p> <p>4. Clinical record review on 7/19/2023, for Patient #4, evidenced a plan of care, for certification period 6/19/2023 –</p>		<p>practitioner’s orders areobtained to update the POC as indicated.</p> <p>Clinical Notes will be prepared accurately, per interventionsoutlined in the POC, andinclude nocontradictory documentation.</p> <p>The ED or designee will audit 4 visits notes per clinician per month. For clinicians scoring.</p> <p>The Executive Director is ultimately responsible for the implementation of this plan of correction.</p> <p>Completion date: 8/2/23</p> <p>Beginning 8/3/23, the ED or designee will review 4random medical records per week for 3 weeks, then 2 random medical records for3 weeks to ensure the POC is updated as indicated, and the documentation isaccurate and free of contradictory statements. Monitoring will continue until 100% complianceachieved for 3</p>	
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	<p>evidenced the Skilled Nurse was to instruct the patient on diabetic foot care and inspect the lower extremities for lesions every visit.</p> <p>Clinical record review evidenced a nursing visit note dated 6/27/2023, which indicated during the visit Patient #4 ambulated with a cane from the kitchen to the living room and the Patient was educated on wearing shoes and socks for foot care and safety, and the lower extremity assessment findings indicated the assessment was not applicable because the patient was an above the knee amputee.</p> <p>During an interview on 7/19/2023 at 3:05 PM, the Administrator indicated the patient was not an amputee, the nurse documented incorrect information on the skilled nursing visit.</p> <p>410 IAC 17-14-1(a)(1)(E)</p> <p>410 IAC 17-14-1(c)(5)</p>		<p>consecutive weeks.</p> <p>For any deficient findings, the ED/designee will provide clinician remediation/counseling to ensure future accuracy.</p> <p>Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.</p>	
N0000	Initial Comments	N0000	na	

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

Facility ID: IN005259

Survey Dates: 7/17/2023 – 7/18/2023

Census: 29

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  
Carla Johnson

TITLE  
Executive Director

(X6) DATE  
8/1/2023 4:11:58 PM