STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157116	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CLINICAL SERVICES INC	8102 GEORGIA STREET, MERRILLVILLE, IN, 46410

(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
G0000	INITIAL COMMENTS This survey was a complaint investigation survey for a home health agency. Survey dates: 2/23/2023 to 3/7/2023 Complaint #95666-substantiated. Federal deficiencies were cited. Facility ID: IN005307 Census: 115 Unduplicated census last 12 months: 486 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Quality Review completed 03/21/2023	G0000		

G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on observation, record review and interview, the agency failed to ensure the skilled professional informed patient and caregiver discharge education in 2 of 10 patient records reviewed (Patient #2, 9). The findings include: 1. Record review of an agency policy titled “Discharge Summary” revised March 2018,	G0434	ID Prefix: G0434: Participate in care-Failed to ensure theskilled professional informed the patient and caregiver discharge education. QAPI Project G0434 : To Ensure the skilled professional provides patient and caregiver discharge education either verbally or inwriting. Discharge education and documentation requirements will beprovided to all 100% Of Skilled Staff by Director of Clinical Services by3/28/23, to include: The patient is informed of discharge plan in a timelymanner and acknowledges understanding reason. The evaluation of a patient’sdischarge needs and discharge plan must be documented in a timely manner. Theevaluation must be included in the medical record and discussed with patient orpatient representative. All relevant information from the Agency will beincorporated into the discharge plan to avoid	2023-03-28

	Summary will be completed for all patients discharged from the agency .... " 2. An observation of a home visit was conducted on 2/24/2023, from 11:02 AM to 11:58 AM, for patient #2, start of care 12/14/2022, where the home admission booklet was reviewed for education provided to include medication instruction, schedule information, and information on the patient's plan of treatment. Record review failed to evidence educational information about the patient's care was provided by the skilled professionals. Clinical record review on 3/6/2023, for patient #2, start of care 12/14/2022, diagnoses included but not limited to high blood pressure and dementia, evidenced agency documents titled "SN [skilled nurse] Discharge Summary" electronically signed by Registered Nurse (RN) #2. This document had an area that stated "Discharge instructions given to ..." which remained blank, and another area stated "Discharge Instructions ...." which also remained blank.		delays. Physicianand other care providers will be informed and knowledgeable of discharge. Dischargeplanning begins at time of admission and will be reflected in thedocumentation. Staff willbe knowledgeable about discharge procedures including instructions and follow-upresponsibilities. Thepatient's continuing care needs, if any, are assessed at discharge. Patients willreceive verbal or written discharge instructions. A completelist of reconciled medications will be provided to each patient on discharge. The list will be explained to patient/familyand interaction documented. Patients and families will be reminded todiscard all old medication lists and to update health Recordswith physicians and retail pharmacies. Toprevent re-occurrence of above deficiency Director of clinical services willverify all	

	Record review failed to evidence the patient/caregiver received discharge instructions from the skilled nurse. During an interview on 03/07/2023 at 9:54 AM, Clinical Manager #2 stated “OK.” 3. Clinical record review on 3/7/2023, for patient #9, start of care 6/17/2022, primary diagnosis of wound care post surgical amputation, evidenced an agency document titled "Home Health Discharge Summary" electronically signed by Clinical Manager #2 on 2/13/2023. This document evidenced a section subtitled "Transfer Discharge Instructions" which remained incomplete. Record review failed to evidence the patient/caregiver received discharge instruction and education. During an interview on 3/7/2023, at 11:15 AM, Clinical Manager #2 indicated they did not see discharge instructions documented on the discharge summary. 4. During an interview on 3/2/2023, at 2:44 PM, when queried where discharge		discharges have provided discharge education either verbally or inwriting as evidenced by chart review	

	instructions provided to the patient were documented, Clinical Manager #2 indicated on the Discharge Summary.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review and interview, the agency failed to follow a plan of care established and reviewed by the physician in 6 of 10 patient records reviewed (Patient #1, 2, 4, 5, 7, 8). The findings include: 1. Review of an agency policy titled "Plan of Care - CMS #485 and Physician Orders", revised March 2019, indicated each patient must receive the home	G0572	ID Prefix G0572: Plan of care QAPI Index: G0572: Each patient will receive the home healthservices that are written in an individualized plan of care that identifiespatient -specific measurable outcomes and goals which are established upon admissionand reviewed periodically and signed by a physician. The Agency failed to follow plan of care, established andreviewed by the Physician. Plan of Correction:	2023-03-28

	in an individualized plan of care that has been established and periodically reviewed by the physician. The policy indicated each plan of care must be signed and dated by the physician. Review of an agency policy titled "Home Health Aide Supervision" revised March 2018, stated "Procedure ... 4. Home Health Aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: ... Following the patient's plan of care for completion of tasks assigned to a Home Health Aide by the registered nurse or other appropriate skilled professional ...." 2. Clinical record review for Patient #1, start of care 2/13/2023, certification period 2/13/2023 to 4/13/2023, failed to evidence a plan of care signed by the physician. During an interview on 3/6/2023 at 2:55 PM, the Clinical Manager indicated the plan of care was created based on the start of care assessment,		Skilled nursing and other home health services will be inaccordance with the Plan of Care based on the patient's diagnosis andassessment of immediate and long range needs and resources. Each Plan of Caremust be signed and dated by the physician. The agency will provide 100% of patient and caregiver with writteninstructions related to the Plan of care. 100% of patients will receive the home health services thatare written in an individualized plan of care that identifies patient -specificmeasurable outcomes and goals which are established upon admission and reviewedperiodically and signed by a physician. 100% of patient/caregivers will receive a individualizedplan of care by mail stating interventions and goals. Plan of care will sent topatient/caregiver after SOC, and after recertification thru the service period. Documentation will be entered in each patient's chart within3 days of admission and recertification.	

	then sent to the physician to be signed and returned. When queried, the Clinical Manager indicated the agency did not have a signed plan of care for Patient #1. 3. Clinical record review for Patient #4, start of care 1/30/2023, certification period 1/30/2023 to 3/30/2023, failed to evidence a plan of care signed by the physician. During an interview on 3/6/2023 at 3:40 PM, when queried, the Clinical Manager indicated the agency did not have a signed plan of care for Patient #4. 4. Clinical record review for Patient #5 evidenced a start of care assessment dated 1/28/2023. In a subsection titled, "Nutritional Approaches", this assessment indicated the patient was receiving IV feedings. Review of the plan of care for certification period 1/27/2023 to 3/27/2023 indicated the patient was on a low cholesterol, heart healthy, low fat, no added salt diet. Review of the plan of care failed to evidence IV feedings. Clinical record review for		100% of Staff will be inserviced by the Director of nursingby 03/28/2023. If deficiency occurs, it will be corrected with 24 hours ofnoted deficiency and documented. We will prevent this deficiency from reoccurring by theDirector of Nursing reviewing a report- checking all SOC and recertificationsmonthly for such documentation. Home HealthAide supervision must ensure that aides furnish care in a safe and effectivemanner, including, but not limited to, the following elements: · Following the patient's plan of carefor completion of tasks assigned to a Home Health Aide by the registered nurseor other appropriate skilled professional. · Maintaining an open communicationprocess with the patient, representative or (if any), caregiver and family. · Demonstrating competency withassigned tasks. · Complying with infection	

	certification period 1/28/2023 to 3/28/2023, failed to evidence a plan of care signed by the physician. During an interview on 3/6/2023 at 3:46 PM, the Clinical Manager indicated Patient #5 did not receive IV feedings, and the nurse documented the IV feedings in error. During an interview on 3/6/2023 at 3:57 PM, when queried, the Clinical Manager indicated the agency did not have a signed plan of care for Patient #5. 5. Clinical record review for Patient #7, start of care 5/31/2022, 1/26/2023 to 3/26/2023, failed to evidence a plan of care signed by the physician. On 3/7/2023 at 10:32 AM, when queried, the Clinical Manager indicated the agency did not have a signed plan of care for the certification period 1/26/2023 to 3/26/2023. 6. Clinical record review for Patient #8, start of care 8/25/2022, certification periods		preventionand control policies and procedures. · Reporting changes in the patient'scondition. · Honoringpatient rights. If adeficiency in aide services is verified by the registered nurse or otherappropriate skilled professional during an on-site visit, then the Agency (orqualified professional) will conduct retraining, and the Home Health Aide willcomplete a competency evaluation on the specific deficient skills. 100% ofstaff will be in serviced/ educated on HHA assignment sheet/ Care Plan by3/28/2023 *Missed Visits Procedure –effective 3/28/2023. To assurethat the physicians for Home Healthcare patients are informed of missed visitsand the need to change visit frequency when necessary. The work week startsSunday thru Saturday. If a missed visit is noted on Monday – Wednesday, theclinician has to the end of the week to reschedule that visit. If the missedvisit is unable to be	

	10/24/2022 to 12/22/2022, failed to evidence plans of care signed by the physician. On 3/7/2023 at 10:40 AM, when queried, the Clinical Manager indicated the agency did not have a signed plan of care for either certification period 8/25/2022 to 10/23/2022 or 10/24/2022 to 12/22/2022. 7 . An observation of a home visit was conducted on 2/24/2023, for patient #2, start of care 12/14/2022, from 11:02 AM to 11:58 AM, with home health aide (HHA) #1. At 11:25 AM, HHA #1 picked up a green and yellow aerosol can and stated, "It's sitting here so [patient #2] must need it." and sprayed the patient's feet. When queried what was sprayed on the patient's feet, HHA #1 stated "Foot spray." Throughout the visit, observation failed to evidence oral care was provided or offered. Clinical record review on 3/6/2023, for patient #2, evidenced an agency document titled "HHA [home health aide] Care Plan" for episode 2/12/2023 – 4/12/2023, electronically signed by Clinical		rescheduled or covered by an alternate staff member,contact the office. No patient's visit should extend 7 days in between eachvisit. Home health care staff will inform the physician in writingof missed visits that cannot be rescheduled to ensure the that the physician isaware of the missed visit and if there is a need for a frequency change. Education: All staff and contracted employees will beinserviced by The Director of Nursing on the proper procedure when addressing amissed visit and the proper documentation. Handout of procedure will be givento each clinician. We will prevent this deficiency from reoccurringby having staff notify the office when a scheduled visit is missed, running aMissed visits report weekly to ensure all documentation has been completed, andchecking the patient's charts with the missed visits for attached faxconfirmation. Missed visit form will be initiated, inserviced, and checkedweekly by the Director of Nursing for compliance.	

	Manager #2. This document listed tasks for the HHA to complete during every visit which included but was not limited to oral care. Review of the HHA care plan failed to evidence instruction for the HHA to apply foot spray. Record review evidenced an agency document titled "HHA Visit" electronically signed by HHA #1 on 2/24/2023, evidenced oral care was refused by the patient. Record review failed to evidence the application of foot spray was recorded. Observation and record review failed to evidence HHA #1 followed the written instructions on the HHA Care Plan. Clinical record review evidenced agency documents titled "Missed Visit" from 1/7/2023 and 1/14/2023, which were electronically signed by Clinical Manager #2. These documents stated, "Physician Office Notified: No ...." Record review failed to evidence the physician was notified of missed visits. During an interview on 3/2/2023, at 2:45 PM, when			

	communicated with the physician, Clinical Manager #2 indicated if multiple visits were missed, they would communicate with the physician and patient's family/caregiver. Clinical Manager #2 stated "If it's one visit, no. But more than one, then we would let the doctor know." 410 IAC 17-13-1(a)			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review and interview, the home health agency failed to ensure accepted standards of practice and standard precautions were implemented by all clinicians to prevent the possible spread of infectious diseases in 2 of 3 home visits conducted (Home health aide #1, RN #2) The findings include: 6. Observation of a skilled	G0682	ID Prefix:G0682 Infection Prevention/Standard Precautions QAPI Project G0682: Standard Precautions – Blood and bodyfluid precautions will be followed for all patients. To ensure that all Agency staff and patients are educated andunderstand specific procedures regarding infection control/prevention Staffwill be trained during orientation and annually as specific to their jobs. ***Staff*** 1. Allemployees who come into contact with blood, body	2023-03-28

	nurse visit for Patient #4 was conducted on 2/27/2023 at 2:00 PM. RN (registered nurse) #2 entered the patient's room, set up barriers on the couch, and put her bag and equipment on the barriers. A cat was visible walking around the room. While RN #2 was checking the patient's vital signs, the surveyor observed the cat walk across the nurse's clean barrier. After being informed of the cat by the surveyor, the nurse asked a family member to take the cat away, cleaned the area, and placed new barriers down. RN #2 then performed picc (peripherally inserted central catheter)(an extended use IV) line care. When cleaning the insertion site of the picc line, RN #2 swabbed in an up and down motion, then back and forth over the site. Observation of the skilled nurse visit in its entirety failed to evidence a head to toe assessment of the patient. RN #2 failed to assess the patient's post-surgical site (left hip) for infection. Clinical record review evidenced the patient had a diagnosis of Lymphoma (a cancer of the lymphatic system, which is part of the body's germ-fighting		body part or substance of any patient will use the following specificprocedures in compliance with Standard Precautions procedures: 2. Wear anapron or gown and protective eyewear if danger of body fluid splash is present. 3. Any piece ofdisposable equipment which has been in contact with blood/body fluids or moistbody substances must be disposed of in a plastic bag. 4. Handleall lab specimens, body secretions/tissue, lab tubes and syringes used inspecimen collection as if contaminated. 5. When a needle stick or body fluid splash/exposureoccurs, wash the area thoroughly and report the incident to the Director ofClinical Services. Complete a *Variance/IncidentReport: Patient or Employee*. *Patient Education* 1. Instructin all basic principles of Standard Precautions and any other procedures asapplicable to the	

network) and was at high risk for infection.

During an interview on 3/6/2023 at 3:19 PM, the Clinical Manager indicated the nurse should ask the patient or family to remove pets from the room where a picc line dressing is being performed and the nurse should cleanse the picc line site in a circular motion away from the point of insertion. The Clinical Manager indicated the nurse should have assessed the patient head-to-toe for any signs of infection.

1. Record review of an agency policy titled "Standard Precautions" revised March 2018, stated "Policy ... Blood and body fluid precautions will be followed for all patients ... Purpose ... To Prevent transmission of communicable diseases ... Procedure ... 1. The concept of body substance isolation encompasses all the principles of Standard Precautions/ blood and body fluid precaution, and extends to all moist body parts/tissues/surfaces, including fluids, solids, tissue and moist areas, e.g., mucous membranes

patient's care.

2. Instruct in modes of transmission ofall possible contaminants and specific organisms, if known.

3. Instruct regarding disposal of allinfectious wastes.

4. Instruct toreport any contaminated needle stick or exposure to a physician immediately.

5. Instruct tomake a 10% bleach solution for cleaning equipment and decontamination.

6. Instruct to run one (1) cup of bleachthrough the washing machine for laundering contaminated linens and clothing.

7. Patientswho have Hepatitis, Staph, TB, MRSA, VRE or enterobacterium should use separatedishes.

8. Foodleftovers from infectious patients should be bagged before discarding.

9. Bathroomsshould be cleaned with a 10% bleach solution.

	… 2. … All health care workers will routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any patient is anticipated ….” 2. Record review of an agency policy titled “Guidelines for COVID-19 Virus” dated July 2020, stated “Policy The Agency will implement current CDC [Center for Disease Prevention and Control] guidelines for patients and staff who are diagnosed or suspected of having the COVID-19 virus … Procedure … Home Visits … 4. Staff must utilize appropriate PPE per current CDC guidelines ….” 3. Review of the Center for Disease Prevention and Control website evidenced an article titled “Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic” updated September 27, 2022, stated “…1. Recommended routine infection		10. Instructpatient/caregivers to cover the nose and mouth when coughing or sneezing. 11. Contact infection control specialists ata local hospital or the local health department for procedures regardingspecific organisms, when known. 12. Thepatient/caregiver should demonstrate understanding following teaching. Evaluateand record patient/caregiver compliance in the nurses’ notes periodically. The policywill be in serviced to SN staff and therapists by 03/28/2023 by Director ofNursing. Home health aide will be in serviced by a licensed nurse from anoutside agency. The Directorof Nursing will provide in-service staff (SN and Therapist) with writtenmaterial, tests, and demonstration for skilled competencies as per Standard ofPrecautions. Nursing, Therapy, and HomeHealth aide in-services will be scheduled separately. Inservicewill include (clinician	

	prevention and control (IPC) practices during the COVID-19 pandemic ... Implement Source Control Measures ... Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing ... People, particularly those at high risk for severe illness, should wear the most protective form of source control they can that fits well and that they will wear consistently ... HCP [healthcare providers] and healthcare facilities might also consider using or recommending source control when caring for patients who are moderately to severely immunocompromised ...." 4. Review of an agency policy titled, "PERIPHERALLY INSERTED CENTRAL CATHETER (PICC) MAINTENANCY AND MANAGEMENT OF POTENTIAL COMPLICATIONS" dated March 2005 indicated the site should be cleaned in a circular fashion moving from the exit site of the		specific): 1. Handwashing 2. IV/PICC/ PACline dressing maintenance and change 3. Covid 19 CDCguidelines/ PPE equipment training 4. InfectionControl Guideline Standards 5. Bag Technique 6. Demonstration ofBed bath (simulated) according to Standards of Practice 7. Wound care andproper disposal of soiled contaminated supplies/ equipment Home healthaide will be in serviced by licensed nursing staff from an outside agency. In service forthe Home health aide will be thru lecture, written material, demonstration ofskills, and tests. Home health will be in serviced annually and monthly perguidelines. *Homehealth aides will receive at least (12) CE hours from January 1st through December 31st with a*	

	catheter out at least 3-4 inches in diameter, then allowed to air dry. 5. An observation of a home visit was conducted on 2/24/2023, for patient #2, start of care 12/14/2022, from 11:02 AM to 11:58 AM, with home health aide (HHA) #1. During the observation at 11:04 AM, HHA #1 pulled down their mask and indicated the patient understood better with it that way. HHA #1 assisted the patient to undress and onto the shower chair. At 11:09 AM, HHA #1 wet a clean washcloth with warm water and handed to the patient to wash their face, ears and neck. HHA #1 rinsed and applied soap to the same washcloth and washed patient #2's upper back, shoulders and under arms. At 11:11 AM, patient #2 requested to wash their face again and was allowed to use the washcloth that had been used on soiled body parts. Observation evidenced HHA #1 failed to follow current CDC recommendations per agency policy to wear a mask for source		*minimum of (8) hours in the followingsubject areas. All staff, nurses, home health aides, and therapists Must doHIPPA,FALLS, ABUSE/Neglect annually and All new hires.* We willprevent the deficiency from recurring by conducting immediate competencies toall clinicians by 03/28/2023 and annually. The Director of Nursing will make on-sitejoint visits with skilled staff annually. Home healthaide competencies will be completed immediately and quarterly by onsite visitsand simulated demonstrations evaluated by RN. Agency will perform targeted infection control surveillanceas follows: Patient infections to be reported at time of admission: · Patient infections to be reported whilepatient is on service: *wound infections*that develop **30** days or greaterafter admission which require an antibiotic or identified by lab test or MDthat may or may not	

	control to prevent the spread of the Covid-19 virus. Observation evidenced patient #1 washed their face with a clean washcloth, then used a soiled washcloth on their face. Observation failed to evidence standard precautions were implemented to prevent the spread contaminated materials to mucous membranes, such as the eyes, nose and mouth. Observation failed to evidence Standard Precaution and Covid-19 policy and procedures were followed to prevent the transmission of communicable disease and infection. During an interview on 3/6/2023, at 9:58 AM, clinical manager #2 indicated clinicians should wear a mask in patient homes. During an interview on 3/6/2023, at 9:59 AM, clinical manager #2 indicated HHA #1 should have gotten a clean washcloth to use on the patient's face.		require an antibiotic; central-line associated bloodstreaminfections, all infections associated with tubes and lines, and all infectionsthat are identified as infections to be reported at admission. · Employee infections to be reported: if anemployee develops or has a known exposure to: *conjunctivitis, MRSA, VRE*, and any reportable communicable diseaseas defined by the local health department. · Written reporting ofinfections will occur through documentation on the applicable log (patient oremployee). · At least quarterly, theDirector of Clinical Services and infection control and QAPI Committees willreview and assess the infection control logs. Data will be aggregated andanalyzed on the *Infection ControlQuarterly Data Aggregation and Analysis: Patients and Employees* form. Problemsand/or undesirable trends in infections will be identified, including	

			acquired and/or community acquired infections. If suchproblems or undesirable trends are identified, the infection control and QAPICommittees will identify any common factors that could have led to thetransmission of the infection(s). The committees will make recommendationsfor and implement improvement activities.	
G0684	Infection control 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention.	G0684	ID Prefix: G0684: Infection Control G0684: HHA must maintain a coordinated agency-wide programfor the surveillance, identification, prevention, control, and investigation ofinfection and communicable diseases that is an integral part of the HHA's QAPI program Identifying infectious andcommunicable disease. Agency will performtargeted infection control surveillance as follows: · Patient infections to be	2023-03-28

	Based on observation, record review and interview, the agency failed to maintain a program for the surveillance, identification, prevention, control and investigation of infectious and communicable diseases in 4 of 4 records reviewed with known or obtained infection (Patient #4, 5, 6, 7). The findings include: 1. Review of an agency policy titled "Infection Control Surveillance System: Prioritized Risks Defined", revised March 2018, indicated the agency will perform infection control surveillance for patient infections reported at time of admission, patient infections reported while on service, and employee communicable infections. 2. Clinical record review evidenced Patient #4 was admitted to home health on 1/30/2023 for IV antibiotic therapy due to Bacteremia (infection in the blood). Review of the agency's infection log on 2/23/2023 from 11/29/2022 to present failed to		reported at time ofadmission: *chicken pox, German measles,hepatitis B, small pox, TB*, or any reportable communicable disease (asdefined by local health department). · Patient infections to be reported whilepatient is on service: *wound infections*that develop **30** days or greaterafter admission which require an antibiotic or identified by lab test or MD thatmay or may not require an antibiotic; central-line associated bloodstreaminfections, all infections associated with tubes and lines, and all infectionsthat are identified as infections to be reported at admission. · Employee infections to be reported: if anemployee develops or has a known exposure to: *conjunctivitis, MRSA, VRE*, and any reportable communicable diseaseas defined by the local health department. · Written reporting ofinfections will occur through documentation on the applicable log (patient oremployee).	

#4.

3. Clinical record review evidenced Patient #5 was admitted to home health on 1/28/2023 for IV antibiotic therapy due to an infected abscess of the back.

Review of the agency's infection log on 2/23/2023 from 11/29/2022 to present failed to evidence any entries for Patient #5.

4. Observation of a home visit for Patient #7 on 2/28/2023 at 11:36 AM evidenced a conversation between the patient and LPN (licensed practical nurse) #1. The patient indicated they had a urinalysis at their doctor's office about 3 weeks ago, and were started on an antibiotic, which they took for 8 days. LPN #1 indicated she was aware and that she would have to re-check the patient's urine in one month.

Review of the agency's infection log on 2/23/2023 from 11/29/2022 to present failed to evidence any entries for Patient #7.

5. During an interview on 3/6/2023 at 2:50 PM, the

A plan for the appropriate actionsthat are expected to result in improvement and disease prevention

Per our Infection Control Policy we will perform infection control surveillance forpatient infections reported at time of admission, patient infections reportedwhile on service, and employee communicable infections.

At time of initial referral, information will be reviewedfor evidence of reportable infection, communicable disease and reported toDirector of Clinical service and all staff to provide care for patient byinitial communication for admission, it will be logged to infection control logby Director of Clinical services.

Intake staff will be trained by in service/education by3/28/2023 to recognize and document infections and communicable diseases asreported by referral source for 100% of admissions, readmissions andresumptions of care.

Admission, readmission,

	Clinical Manager indicated if a patient is diagnosed with an infection or is being treated with antibiotics, they should be entered in the Infection Control Log. 6. Clinical record review on 3/6/2023, for patient #6, start of care 2/1/2023, evidenced a faxed document from entity #1, titled "Physician Orders Details" signed by the wound care physician on 2/13/2023. This document had an area subtitled "Wound Orders" which stated "… Keflex [antibiotic medication used to treat a wide variety of bacterial infections] to be taken as ordered until GONE …." Record review failed to evidence the agency staff reported/documented the patient was prescribed an antibiotic or had an infection. Record review failed to evidence patient #6 listed on the agency's infection log. During an interview on 3/6/2023, at 10:57 AM, clinical manager #2 indicated they did not know why the patient was taking the antibiotic medication, Keflex.		resumption of care report will beprovided and documented by Clinical Manager on 100% of all patients to includeany and all infections and communicable diseases. Director of clinical services will notify all staff involvedin patient care as well as precautions and isolation procedures that will be inplace. 100% of all staff will be in-serviced educated by 3/28/2023 onreporting verbally or in writing order, of all infections, communicable diseasedirectly to Director of Clinical services, who will then addinfection/communicable disease to Infection control log and direct care relatedto infection precautions and isolation needs. 100% of staff will be in-serviced/education provided by3/28/2023 on notifying Director of Clinical service of any staff personalinfection/communicabl e disease. Director of clinical services will direct staffto ability to see patients and precautions to be taken. At least quarterly, the Director	

			of Clinical Services andinfection control and QAPI Committees will review and assess the infectioncontrol logs. Data will be aggregated and analyzed on the *Infection Control Quarterly Data Aggregation and Analysis: Patients andEmployees* form. To prevent deficiency from recurring infectioncontrol log will be monitored by chart review of 100% of patient records byDirector of Clinical services, Oasis reviewer and reviewed quarterly by QAPIand reported to Governing Board. [D1]E+	
G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on record review and interview, the agency failed to ensure the involvement of all skilled professional staff in the patient's plan of care in 1 of 2 active patient records receiving IV [intravenous] antibiotics (Patient #5). The findings include: Review of an agency policy titled "Care Planning Process" dated March 2018 indicated the	G0706	ID Prefix: G0706 – Interdisciplinary assessment of thepatient QAPI Project G0706 Care Planning Process - In order to assure that care provided is appropriately planned to meeteach patient's specific needs and problems, the Agency will utilize data/informationgathered during patient assessments in the care planning process. The agency failed to ensure the involvement of all skilledprofessional staff in the patient's Plan of Care.	2023-03-28

	agency will utilize information gathered during patient assessments to create the patient's care plan. Review of the plan of care for 1/27/2023 to 3/27/2023 for Patient #5 indicated nurse shall assess the patient's need for therapy services. Review of the start of care assessment dated 1/28/2023, signed by RN (registered nurse) #1 indicated the patient required maximum assistance to safely leave the home, had poor balance, unsteady gait, activity intolerance, and muscle weakness. The assessment indicated the patient was previously independent with activities of daily living without any assistance, but now requires human assistance and a cane. Clinical record review failed to evidence the nurse requested a physical therapy evaluation.		Plan of Correction The patient's plan of care for **Therapy services**(PT,OT,ST) will be: The plan of care CMS#485 (certification/recertificationorders) developed and implemented with physician. Demonstrates problems andinterventions through physician orders and long term goals. **InitialAssessment** – description of problems and changes. Demonstrates identifiedproblems, interventions, and goals at time of admission. **Visit notes** –documentation modifications to care/service, current problems, interventionsand short term goals, individualized, will be revised as problems identified.Review and revisions will be ongoing with each home visit, and will based onthe patient's health status, environment and relevant baseline data fromassessment, and **100% of** initial and ongoing assessments will utilize relevantbaseline data to determine patient's problems, needs, interventions and goals. The patient plan of care for	

	During an interview on 3/6/2023 at 3:45 PM, when informed of the findings, the Clinical Manager indicated based on the admission assessment, the nurse should have entered a physical therapy evaluation. 410 IAC 17-12-2(g)		**Skilled Nursing** will be:Initial plan of care will be CMS#485 Plan of care, which is developed andimplemented with the physician. **Demonstrates** problems (Diagnoses), **Interventions**(Physician Orders) and long-term goals. The **Nursing care plan** will be utilized to update the careplan between certifications and re-certifications to document modifications.Will reflect new problems, interventions, goals, and goal evaluation/goalresolution. Physician orders may also be used to update the care plan. 100% ofinitial and ongoing assessments will utilize relevant baseline data todetermine patient's problems, needs, interventions and goals. **Education – 100% of Staff will be inserviced on Oasis SOCcriteria (Initial Assessment**), **Care planning**, **Revising/Modifying**care plans and goals, **Visit Notes**, and criteria for **Initial** and **Ongong** assessments by the Director of Nursing by 03/28/2023. We will prevent this deficiency	

			100% during the **QA process** - **Reviewing Oasis SOC**,**Recertifications**, and **Visits notes** prior to **Approval**. The **Directorof Nursing** will monitor the **SN Visits Notes**, **QA Reviewer** willmonitor **SN Oasis** and **SN Recertifications** and the **Administrator**will monitor **Therapy oasis** and **Recertifications** and **Therapyvisits**. **All** Skilled staff will be notified immediately of anydeficiencies and corrections will be made **within 24 hours of notification.**	
G0710	Provide services in the plan of care 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; Based on observation, record review and interview, the agency failed to provide services as ordered in the plan of care in 3 of 7 active patient records reviewed (Patient #4, 5, 7). The findings include: 1. Review of an agency policy	G0710	ID Prefix: G0710: Provide services in the Plan of care QAPI Project G0710 Plan of care – CMS #485 and Physician Orders Skilled nursing and other home health services will be inaccordance with the Plan of Care based on the patient's diagnosis andassessment of immediate and long range needs and resources. Each Plan of Caremust be signed and dated by the physician. The agency will provide the patient and caregiver with	2023-03-28

	and Physician Orders", revised March 2019, indicated each patient must receive the home health services that are written in an individualized plan of care that has been established and periodically reviewed by the physician. 2. Review of the plan of care for Patient #4, certification period 1/30/2023 to 3/30/2023, evidenced the following skilled nursing orders: perform complete physical assessment with each visit with emphasis on lymphoma (cancer of the lymphatic system, which is part of the body's germ-fighting network) with recent bacteremia (an infection in the blood) and left hip replacement; assess integumentary (skin) status, identify any signs and symptoms of impaired skin integrity. During a home visit on 2/27/2023 at 2:00 PM, RN (registered nurse) #2 was observed checking Patient #4's vital signs, drawing blood from the picc (peripherally inserted central catheter)(an extended use IV) line, and changing the dressing on the picc line. The		writteninstructions related to the Plan of care. comprehensiveprocess that reviews the health of all major body systems (from"head-to-toe," hence the name). head-to-toe assessments are usually performedby nurses as part of a physical exam, although physician assistants, EMTs, anddoctors also sometimes perform head-to-toe assessments. Head to Assessments - How toproperly assess a patient using the 4 basic techniques (Inspection, Palpation,Auscultation, and Percussion). Each body system Neurological, Cardiovascular,Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary,and Psychosocial. Vital signs, Pain assessment, Weight (CHF) and Glucose onetouch (Diabetes). If not able to assess due to medical reasons or patient'srefusal – it must be documented in the patient's chart and/or order. Skilled staff	

	arms) remained covered with a blanket throughout the visit. RN #2 failed to use a stethoscope and to visualize the patient's skin at any time during the visit. Observation of the visit, viewed in its entirety, failed to evidence a complete physical assessment. During an interview on 3/6/2023 at 3:13 PM, the Clinical Manager indicated the nurse should perform a head-to-toe assessment at each visit including listening to the patient's chest, back and abdomen with a stethoscope. The Clinical Manager indicated the patient's skin should be assessed by visualizing the skin, especially the heels, elbows, hips and sacral area. When informed of the findings, the Clinical Manager shook their head and was silent.		will inserviced on abnormalfindings in each body system. Education will be completed by 03/28/2023. 1. Order received from orderingPhysician/Pharmacist 2. SN communicates to the office by text patient'sname and where – (what hospital) the specimen was dropped off for processing. 3. Labs are Retrieved the same day if labs aredropped off before Noon and retrieved the next day if dropped off after Noon. 4. When labs are retrieved, they are Scanned inunder the Documents section in the patient's chart 5. Faxed to the ordering physician and if theordering physician is not the primary doctor- Labs are faxed to the primaryphysician also. 6. Faxed confirmation sheet/sheets are attachedunder documents section from each physician receiving the lab results 7. Labs are sent to the SN for	

	3. Review of the plan of care for Patient #5, certification period 1/27/2022 to 3/27/2023, indicated the nurse was to draw labs weekly and send the results to Physician #4. Clinical record review failed to evidence lab results drawn on 2/2/2023, 2/9/2023, and 2/20/2023 were sent to Physician #4 During an interview on 3/6/2023 at 3:49 PM, the Clinical Manager indicated the lab results should be sent to the physician, and this should be documented in the patient's electronic medical record (Axxess). When informed of the findings, the Clinical Manager reviewed the patient's record and indicated it failed to evidence lab results were sent to Physician #4.		review thru ourconfidential web site. 8. Staff member documents in a communication note inthe patient's chart– Ordered labs retrieved, faxed to ordering physicians andscanned in patient's chart. Education:Non – nursing staff will be inserviced on the Lab Procedure policy by03/28/2023 by The Director of Nursing. Procedurewill be discussed and demonstrated to all. Lab procedure policy will be givento staff. Wewill prevent this deficiency from reoccurring by monitoring 100% of weekly labsfor compliance by using a check off sheet for patient's rec3eiving lab work.	

4. Review of the plan of care for Patient #7, certification period 1/26/2023 to 3/26/2023, evidenced the following skilled nursing orders: perform complete physical assessment with each visit with emphasis on wound care; assess integumentary (skin) status, identify any signs and symptoms of impaired skin integrity.

During observation of a home visit on 2/28/2023 at 11:00 AM, LPN (licensed practical nurse) #1 performed wound care for Patient #7 (a wheelchair bound paraplegic). The patient was observed to be wearing a long sleeved sweater and socks. Observation of the visit failed to evidence LPN visualizing the patients elbows and heels.

During an interview on 3/6/2023 at 3:13 PM, the Clinical Manager indicated the nurse should perform a head-to-toe assessment at each visit. The Clinical Manager indicated the patient's skin should be assessed by visualizing the skin, especially the heels, elbows, hips and sacral area.

	When informed of the findings on 3/7/2023 at 10:13 AM, the Clinical Manager indicated LPN #1 should have moved or removed the patient's clothing in order to perform a skin assessment. *. Clinical record review on 3/6/2023, for patient #2, start of care 12/14/2022, diagnoses included but not limited to high blood pressure, diabetes, and dementia, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 12/14/2022 – 2/11/2023. This document had an area subtitled “Orders for Discipline and Treatment” which stated “Nursing … SN [skilled nurse] to provide skilled assessment, teaching/training and reinforcement of teaching, to properly assess, manage and mitigate pain … SN to assess cardiovascular status, identify any signs and symptoms of impaired cardiovascular function … SN to assess patient with Senile dementia disease, identify any signs and symptoms requiring intervention … SN to assess and instruct patient/caregiver on the importance of proper diabetic			

	foot care and precautions ....” Record review evidenced an agency document titled “Missed Visit” signed by Clinical Manager #2 on 1/14/2023, which stated “Family – Caregiver able to assist Patient” as the reason for the missed visit. Record review failed to evidence patient #2’s caregiver could provide skilled assessments for pain, impaired cardiovascular function, dementia, or diabetic foot care. Record review failed to evidence the skilled professionals followed the Plan of Care. During an interview on 3/6/2023, Clinical Manager #2 indicated the caregiver would monitor the patients vitals and medication but could not provide skilled assessments. Clinical Manager #2 indicated the visit should have been made up.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes;	G0716	QAPI Project G0716: Skilled Professional Services - Patients receiving skilledprofessional services will receive appropriate	2023-03-28

	Based on observation, record review and interview, the nurse failed to prepare current, complete, and accurate clinical notes in 7 of 10 patient records reviewed (Patient #2, #4, #5, #6, #7, #8, #10). The findings include: 1. Review of an agency policy titled "Skilled Professional Services", revised March 2018, indicated skilled professionals will provide appropriate assessments, reassessments, care planning, and provide care per physician orders. The policy indicated skilled professionals must assume responsibility for preparing clinical note Review of an agency policy titled "Medical Record Entries and Authentication, revised March 2018, indicated all entries in patient records will be legible, clear, complete, appropriately authenticated, dated and timed. Review of an agency policy titled "Timely Submission of Patient Documentation", revised October 2017, indicated the agency will ensure the timely and proper submission of patient documentation. The		assessments, reassessments, careplanning, established out comes and care per physician orders. Medical Records Content – The Agency will provide anaccurate and current medical record for every patient seen by the Agency. Coordination of Patient Care - Agency staff membersregularly communicate to ensure that their efforts are coordinated effectivelyand ultimately support the objectives in the plan of care. Timely Submission of Patient Documentation – The Agency willensure the timely and proper submission of patient documentation. All skilled professional services (SN,PT,OT,ST, Physician,MSW) will directly or under contract must participate in the Coordination ofcare. Skilled professionals must assume responsibilities for, but not berestricted to : ongoing interdisciplinary assessment of the patient, developplan of care with patient, representative or caregiver, provides servicesordered by the	

	policy indicated physicians' orders must be submitted to the agency within 3 days of receipt, all visit notes must be submitted within 3 days from the date of visit, and the patient discharge summary must be submitted within 5 business days. 2. Review of the electronic medical record (Axxess) for patient #1 evidenced a start of care visit was completed on 2/13/2023 and regular skilled nurse visits on 2/14/2023, 2/17/2023, and 2/20/2023. Clinical record review on 2/27/2023 at 10:13 AM failed to evidence any completed visit notes for any regular skilled nurse visits. During an interview on 2/23/2023 at 9:41 AM, when queried what timeframe was allowed for clinicians to turn in documentation following a visit, the Clinical Manager stated "Five days. I'll have to check. I need to look that up." 3. Clinical record review for Patient #4, start of care 1/20/2023, evidenced skilled nursing visit notes dated 2/6/2023, 2/13/2023, and		physician as indicated in the Plan of Care, Patient/caregivereducation. Communication with all physicians (primary, specialist) woundclinics, dialysis centers and other agencies providing care to the patient. Education of 100% of staff by 3/28/2023 will be educated onparticipation of care, care planning, assessments, reassessments, and providingcare per physicians order. (New hireswill be inservices during orientation.) The policy will be inserviced by The Directorof Nursing to all professional staff thru written material, test and handouts. We will prevent this deficiency from recurring by theDirector of Nursing printing a weekly report of all visits notes to patent'svisit calendar to ensure documentation is present for each visit on thecalendar. If a note is not present the Director of Nursing will contact theclinician to submit documentation for that visit on the same day as contacted.Once 100% compliance is achieved, over 3 months, 25% of weekly visits noteswill be compared to	

	2/20/2023. Each of these notes had a section titled "Labs" which indicated the nurse drew blood from the patient's picc (peripherally inserted central catheter)(an extended-use IV access), and blood test was obtained via venipuncture (inserting a needle into a vein) using a 25 gauge needle. During an interview on 3/6/2023 at 3:02 PM, the Clinical Manager indicated a lab draw was either drawn via the picc line or venipuncture, but not both. The Clinical Manager indicated the labs should have been drawn via the picc line, but the nurse's documentation was not clear.		patient visits schedule to ensure compliance is maintained. Coordination of care will be initiated at the SOC andmonitored and reverified with each recertification and resumption thru out theepisode. COC with physician will be completed within every 30 days. COC/education will be completed with each schedule visit and the clinician willdocument on 100% of each note. During the intake process when verifyingdemographics with patient, inquires will be made if other services are beingprovided by other agencies and documented. Education of 100% of staff will be inserviced by theDirector of Nursing by 3/28/2023 on the time frames for submissions of patientdocumentation. (Policy/ handout provided) Physician orders must be submitted within 3 business daysafter receipt. Documentation must be completed for each visit within 3business days after the scheduled visit. Discharge summaries must be	

	4. Clinical record review for Patient #5 evidenced a start of care assessment dated 1/28/2023. In a subsection titled, "Nutritional Approaches", this assessment indicated the patient was receiving IV feedings. Review of the plan of care for certification period 1/27/2023 to 3/27/2023 indicated the patient was on a low cholesterol, heart healthy, low fat, no added salt diet. Review of the plan of care failed to evidence IV feedings. During an interview on 3/6/2023 at 3:46 PM, the Clinical Manager indicated Patient #5 did not receive IV feedings, and the nurse documented the IV feedings in error. 5. Observation of a home visit for Patient #7 was conducted on 2/28/2023 at 11:00 AM. When performing wound care to the patient's 3 wounds, LPN (licensed practical nurse) #1 indicated they normally use alginate (a specialized wound care product) in the wound, then cover it with gauze, but because the patient was going to be getting bathed later that day, she covered the wounds		submitted with 5 business daysafter the discharge. Discharge medical records are to be completed with 30 daysof the discharge. 100% staff will be inserviced on external agencies (homemedical equipment, wound clinics, dialysis centers, and other agenciesproviding care in the home. Infor will be entered on the patient’s profilesheet. (Policy/Handout will be provided). COC upon admission, recerts, resumptions COV education pt/cg each visit COC with physician with every change (decline, improvement,or no change in status.) All will be documented on scheduled visit note. External agency providers will be verified upon agencynotification and documented. Director of Nursing will communicate with staff and documentif there are any changes in the patient’s	

	with plain gauze in order to not waste the alginate. Observation of the home visit failed to evidence the nurse measuring the patient's wounds. Review of LPN #1's visit note for 2/28/2023 indicated they used alginate on 2 of the 3 wounds. Review of the visit note failed to evidence wound care observed at the home visit. Review of the visit note evidenced measurements for all 3 wounds. During an interview on 3/7/2023 at 10:10 AM, the Clinical Manager indicated the nurse should document the care as it was provided at the visit. 6. Clinical record review for Patient #8 evidenced a document identified by the Clinical Manager as the 60-day summary, dated 11/8/2022, signed by RN (registered nurse)#3 and a document identified by the Clinical Manager as the discharge summary, dated 1/11/2023, signed by the Clinical Manager. Both of these documents had a subsection titled, "Emergency Preparedness" which indicated the patient went to Entity #3 for		condition, changes in the Plan ofcare or new physician orders. Director of Nursing will communicate/case conference with clinicianson all new admissions and recertification's within 30 days of occurrence anddocumentation will be maintained in the patient's chart. We will prevent this deficiency from recurring during the QAprocess by QA checking 100% of all oasis, recert, and resumptions during the QAprocess of patient documentations. Each SOC, Recert and or Resumption will bedocumented if other agencies/services are or are not being provided at thattime. 100% of patient's receiving care from outsideagencies will be verified every episode. Discharge summaries reports will beprinted 2 x week to ensure that the summary is completed within 5 business dayswith the confirmation page being attached in the chart.	

	Wednesday, and Friday. Review of the patient's clinical record in Axxess failed to evidence the patient was on dialysis. During an interview on 3/7/2023 at 10:58 AM, the Clinical Manager indicated the patient had never been on dialysis while on their service. The Clinical Manager indicated she did not know why dialysis information was included on both documents.			

7. Clinical record review on 3/6/2023, for patient #2, start of care 12/14/2022, diagnoses included but not limited to diabetes and dementia, evidenced agency documents titled "SN [skilled nurse] Discharge Summary" electronically signed by Registered Nurse (RN) #2 on 2/3/2023. An area subtitled "Patient Condition and Outcomes" indicated the patient was stable but failed to indicate the status goals were met or not. An area subtitled "Service(s) Provided" indicated skilled nursing and physical therapy but failed to indicate home health aide services provided. Review of this document failed to evidence discharge instructions were given to the patient/caregiver. Record review failed to evidence the skilled nurse prepared complete and accurate documentation on the discharge summary.

	Record review of agency documents titled "SN Teaching/Training Visit" from 1/20/2023 and 1/27/2023, which were electronically signed by RN #2. These documents had an area subtitled "Neurological [pertaining to the brain, central nervous system, and peripheral nerves]" which indicated the patient was oriented to person, place, and was forgetful. Another area subtitled "Visit Narrative" which indicated the patient was alert and oriented to self only. An area subtitled "Endocrine [pertaining to hormones secreted in the blood]/Hematologic [pertaining to the blood]" indicated there were no problems identified during the assessment. Record review failed to evidence blood sugar information related to the patient's pertinent diagnosis of diabetes was accurately assessed and documented. Record review evidenced contradictory documentation of the patient neurological status. Record review failed to evidence complete documentation of the patient's endocrine assessment. Record review failed to evidence the skilled nurse prepared			

complete and accurate documentation on the skilled nurse visit notes.

During an interview on 3/6/2023, at 10:18 AM, Clinical Manager #2 indicated the patients diabetes was managed by diet and all blood sugar information should be documented under the Endocrine/Hematologic section.

8. Clinical record review on 3/1/2023, for patient #6, start of care 2/1/2023, primary diagnosis to Type 2 diabetes with foot ulcer, of the agency's Electronic Health Record (Axxess) evidenced Skilled Nurse (SN) visits were not started for 2/15/2023 (14 days late), and 2/17/2023 (12 days late).

On 3/1/2023, at 3:51 PM, agency documents were retrieved titled "SN Wound Care Visit" for 2/15/2023, and 2/17/2023, which were completed and signed by Licensed Practical Nurse (LPN) #1.

During an interview on 3/6/2023, at 10:47 AM, when

	queried why the visits were not completed when requested, but completed when received, Clinical Manager #2 indicated they sent a message on their communication application (WhatsApp) to all clinicians to complete outstanding documentation. Clinical Manager #2 indicated it took LPN #1 12 – 14 days to complete documentation for visits 2/15/2023, and 2/17/2023. 9. Clinical record review on 3/7/2023, for patient #10, start of care 11/15/2022, primary diagnosis of bladder cancer, evidenced an agency document titled “SN Teaching/Training Visit” electronically signed by RN #2, on 11/21/2022, had a section subtitled "Labs" which indicated a blood test was obtained venipuncture from the right upper arm PICC with a 24 gauge needle. Record review evidenced an agency document titled "OASIS-D1 Resumption of Care" electronically signed by RN #2 on 12/6/2023, which had an area subtitled "Labs and Infection Control" which			

	indicated a blood test was obtained venipuncture from the right upper arm PICC with a 25 gauge needle. During an interview on 3/7/2023, at 11:22 AM, Clinical Manager #2 indicated the agency nurse should not draw blood venipuncture from a PICC.			
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 observation, record review and interview, the skilled professionals failed to communicate pertinent information regarding the patient's plan of care to the physician for 3 of 7 active clinical records reviewed (Patient #2, #3, #6). The findings include: 4. Review of the plan of care for	G0718	ID Prefix: G0718 - Communicating with Physician QAPI project G0718 *Coordination of Patient Care - Agency staff membersregularly communicate to ensure that their efforts are coordinated effectivelyand ultimately support the objectives in the plan of care. All skilled professionalservices (SN,PT,OT,ST, Physician, MSW) will directly or under contract mustparticipate in the Coordination of care. Skilled professionals must	2023-03-28

	Patient #5, certification period 1/27/2023 to 3/27/2023, evidenced Physician #5 (primary care) and Physician #4 (infectious disease specialist) were both following the patient. The plan of care indicated the patient was receiving IV antibiotics for an abscess to their back. Clinical record review evidenced a Communication Note dated 2/17/2023, signed by RN (registered nurse) #2, which indicated the patient cancelled the skilled nurse visit because they had flu-like symptoms. Clinical record review failed to evidence Physician #4 was notified of the patient's flu-like symptoms. During an interview on 3/6/2023 at 3:54 PM, when informed of the findings, the Clinical Manager indicated the nurse should have notified both Physician #4 and Physician #5 of the patient's new symptoms. 1. Record review of an agency policy titled "Plan of Care – CMS #485 and Physician Orders" revised March 2019, stated "Procedure ... 4. ... Discharge planning begins early in the		assumeresponsibilities for, but not be restricted to : ongoing interdisciplinaryassessment of the patient, develop plan of care with patient, representative orcaregiver, provides services ordered by the physician as indicated in the Planof Care, Patient/caregiver education. Communication with all physicians(primary, specialist) wound clinics, dialysis centers and other agenciesproviding care to the patient. Coordination of care will be initiated at the SOC andmonitored and reverified with each recertification and resumption thru out theepisode. COC with physician will be completed within every 30 days. COC/education will be completed with each schedule visit and the clinician willdocument on each note. During the intake process when verifying demographicswith patient, inquires will be made if other services are being provided byother agencies and documented. Education 100% of staff will be in serviced by the Directorof Nursing on COC with physician	

	provision of care and must be revised as the patient's condition or life circumstances change. There must be evidence in the medical record that the Agency discussed any such changes with the patient, his or her representative (if any) and the responsible physician. Other physicians who contributed orders to the patient's plan of care must also be notified of changes to the patient's discharge plan ... The patient's physician orders for treatments and services are the foundation of the plan of care. If the Agency misses a visit or a treatment or services as required by the plan of care, which results in any potential for clinical impact upon the patient, then the Agency must notify the responsible physician of such missed treatment or service. The physician decides whether the treatment or service may be skipped or whether additional intervention is required by the Agency due to the clinical impact on the patient ....” 2. An observation of a home		improvement, or nochange in status.) Director of Nursing will communicate with staff and documentif there are any changes in the patient’s condition, changes in the Plan ofcare or new physician orders. COC with physician with every change (decline, improvement,or no change in status) and document in patient’s record. Director of Nursing will communicate with staff and documentif there are any changes in the patient’s condition, changes in the Plan ofcare or new physician orders. We will prevent this deficiency from recurring by Directorof Nursing will communicate/case conference with clinicians on 100% of new admissions, recertification’s, resumptionswithin 3 days of occurrence and documentation will be maintained in thepatient’s chart.	

	2/27/2023, from 12:35 PM to 1:30 PM, with patient #3 and Physical Therapist (PT) #2. At 12:50 PM, patient #3 stated, "I want to get back to work." At 12:59 PM, patient #3 stated, "I'm going back to work next week." PT #2 replied "One more visit. I'll make sure you're safe." Observation evidenced PT #2 and patient #3 discussed a plan for discharge after one more PT visit. Clinical record review on 3/6/2023, for patient #3, start of care 2/2/2023, failed to evidence a plan for discharge was communicated to the patient's physician. During an interview on 3/2/2023, at 2:43 PM, when queried how changes in the patient's services were communicated to the patient, Clinical Manager #2 indicated when patient goals are met, the clinician should notify the Clinical Manager, who would notify the physician to verify and create a physician order or communication note. During an interview on 3/6/2023, at 10:35 AM, Clinical Manager #2 indicated they were		*Missed Visits Procedure –effective 3/28/2023. To assurethat the physicians for Home Healthcare patients are informed of missed visitsand the need to change visit frequency when necessary. The work week startsSunday thru Saturday. If a missed visit is noted on Monday – Wednesday, theclinician has to the end of the week to reschedule that visit. If the missedvisit is unable to be rescheduled or covered by an alternate staff member,contact the office. No patient's visit should extend 7 days in between each visit. Home health care staff will inform the physician in writingof missed visits that cannot be rescheduled to ensure the that the physician isaware of the missed visit and if there is a need for a frequency change. Written in the chart should be a missed visit note whichwill consist of the date of the missed visit, the reason for the missed visitand a request for an order if necessary.	

	unaware of an upcoming PT discharge for patient #2. 3. Clinical record review on 3/6/2023, for patient #2, start of care 12/14/2022, diagnoses included but not limited to high blood pressure and dementia, evidenced agency documents titled "Missed Visit" from 1/7/2023 and 1/14/2023, which were electronically signed by Clinical Manager #2. These documents stated, "Physician Office Notified: No ...." Record review failed to evidence the physician was notified of missed visits. During an interview on 3/2/2023, at 2:45 PM, when queried how missed visits were communicated with the physician, Clinical Manager #2 indicated if multiple visits were missed, they would communicate with the physician and patient's family/caregiver. Clinical Manager #2 stated "If it's one visit, no. But more than one, then we would let the doctor know." 4. Clinical record review on		The missed visit note should be signed, dated, and faxed tothe physician. Faxed confirmation sheet will be attached to the missed visitnoted in the patient's chart to validate that the physician has been notified. Contracted employees will notify the agency of missed visitsas soon as the visit occurs if it cannot be rescheduled. The agency will faxmissed visit notes to the physician. At the end of each episode, each scheduled visit will have acompleted clinician note or a missed visit note. Education: 100% of staff and contracted employees will beinserviced by The Director of Nursing on the proper procedure when addressing amissed visit and the proper documentation. Handout of procedure will be givento each clinician by 3/28/2023 We will prevent this deficiency from recurringby having staff notify the office when a scheduled visit is missed, running aMissed visits report weekly to ensure all	

	3/6/2023, for patient #6, start of care 2/1/2023, primary diagnosis to Type 2 diabetes with foot ulcer, evidenced a document from Entity #1, titled "Visit Discharge Instructions Details" dated 1/23/2023 and signed by Person #6. This document described the orders for treatment to be provided by the home health agency was to apply silver alginate (for use in the treatment of high risk or infected chronic wounds) to the wound bed, cover with dry gauze, wrap with rolled gauze and secure with tape, 3 times per week. Record review of a document from Entity #1, titled "Physician Orders Details" electronically signed by Person #6 on 2/13/2023, which indicated the patient was prescribed an antibiotic. This document also indicated an updated wound care treatment to apply medical grade Honey (used to speed the healing of wounds through its anti-inflammatory effects) to the wound bed, cover with dry dressing, and change every other day. Review of this document evidenced a new medication and an updated		documentation has been completed, andchecking the patient's charts with the missed visits for attached faxconfirmation. Missed visit form will be initiated, inserviced, and checkedweekly by the Director of Nursing for compliance.	

ordered by Person #6.

Record review of a document from Entity #1, titled "Physician Orders Details" electronically signed by Person #6 on 2/27/2023, which indicated an updated wound care treatment to apply Iodosorb (topical medicated gel for wounds) to the wound bed, cover with dry dressing, and change every other day. Review of this document evidenced an updated wound care treatment was orderd by Person #6.

Record review failed to evidence the updated orders on 2/13/2023 and 2/27/2023, from Person #6 were communicated to the patient's primary physician listed on the plan of care.

During an interview on 3/6/2023, at 10:57 AM, Clinical Manager #2 indicated they were unsure why the patient was prescribed an antibiotic.

During an interview on 3/6/2023, at 11:00 AM, Clinical Manager #2 indicated when the agency received documents from Entity #1, they were printed and scanned into the

	(Axxess). Clinical Manager #2 indicated they should receive a copy of the orders to review and write new orders for the patient's primary physician as needed.			
G0818	HH aide supervision elements 484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. Based on record review and interview, the skilled professional failed to provide oversight to ensure all assistants followed written instructions for 1 of 1 HHA supervised by a Physical Therapist (PT #1).	G0818	G0818 ID Prefix G0818: HH aide supervision elements CFR(s)484.80(h)(4)(i-vi) Home HealthAide supervision must ensure that aides furnish care in a safe and effectivemanner, including, but not limited to, the following elements: · Following the patient's plan of carefor completion of tasks assigned to a Home Health Aide by the registered nurseor other appropriate skilled professional. · Maintaining an open communicationprocess with the patient, representative or (if any), caregiver and family. · Demonstrating competency withassigned tasks. · Complying with infection	2023-03-28

The findings include:

Record review of an agency policy titled “Home Health Aide Supervision” revised March 2018, stated “Procedure … 4. Home Health Aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: … Following the patient's plan of care for completion of tasks assigned to a Home Health Aide by the registered nurse or other appropriate skilled professional … Demonstrating competency with assigned tasks … Reporting changes in the patient's condition ….”

Clinical record review on 3/6/2023, for patient #2, start of care 12/14/2022, evidenced an agency document titled “HHAide [home health aide] Care Plan” for episode 12/14/2022 – 2/11/2023, electronically signed by Registered Nurse (RN) #1. This document listed tasks for the HHA to complete during every visit which included but were not limited to shampoo/comb

preventionand control policies and procedures.

· Reporting changes in the patient’scondition.

· Honoring patient rights.

The Agencyfailed to provide oversight to ensure all assistants followed writteninstructions.

Plan ofCorrection; If Home Health Aide services are provided to a patient who isreceiving skilled nursing, physical or occupational therapy or speech-languagepathology services, a registered nurse or other appropriate skilledprofessional who is familiar with the patient, the patient’s plan of care andthe written patient care instructions must make an onsite visit to thepatient’s home no less frequently than every 14 days. The Home Health Aide doesnot have to be present during the visit.

· If an area of concern in aideservices is noted by the supervising registered nurse or other appropriateskilled professional, then the supervising individual will make

	hair, and assistance with ambulation, elimination, and incontinent care. Record review evidenced agency documents titled "HHA Visit" electronically signed by HHA #1, failed to evidence the HHA Care Plan was implemented as instructed. Record review evidenced skin and pericare (cleaning of patients private parts including the genitals and buttocks) every HHA Visit but was not listed on the HHA Care Plan. Record review failed to evidence HHA #1 offered shampoo and combed the patient's hair on 12/20/2022, 1/11/2023, and 1/23/2023. Record review failed to evidence HHA #1 offered shampoo and incontinence care on 1/4/2023, and 1/6/2023. Record review failed to evidence HHA #1 offered shampoo/comb hair and assistance with elimination on 1/13/2023. Record review failed to evidence HHA #1 offered shampoo/comb hair, or assistance with elimination and ambulation on 1/19/2023. Record review evidenced an agency document titled "HHA Supervisory Visit" for patient #2		an on-sitevisit to the location where the patient is receiving care in order to observeand assess the aide while he or she is performing care. · A registered nurse or otherappropriate skilled professional will make an annual on-site visit to thelocation where a patient is receiving care in order to observe and assess eachaide while he or she is performing care. If adeficiency in aide services is verified by the registered nurse or otherappropriate skilled professional during an on-site visit, then the Agency (orqualified professional) will conduct retraining, and the Home Health Aide willcomplete a competency evaluation on the specific deficient skills. 100% ofstaff will be in serviced/ educated on HHA assignment sheet/ Care Plan by3/28/2023 The patient care plan for the Home Health Aide will be: · Home Health Aide assignmentsheet: developed by a Registered Nurse (Physical Therapist or Speech	

	and HHA #1, electronically signed by PT #1 on 1/23/2023, which indicated HHA #1 followed the plan of care as assigned. Record review failed to evidence the skilled professional supervised the assistant to include review of the HHA visit notes to ensure the written care plan was being followed as instructed. During an interview on 3/2/2023, at 2:35 PM, Clinical Manager #2 indicated the SN or PT would report to the HHA the patient's needs and a care plan would be created. Clinical Manager #2 indicated the HHA could not perform tasks that were not listed on the care plan because additional tasks added would need to be verified by the physician.		LanguagePathologist, if nursing not ordered) prior to Home Health Aide rendering care.Reviewed at least every 14 days during supervisory visit and based on patient'shealth status and environment. Revised in writing by RN, PT or SLP with changesin health status, environment and/or physician orders. Utilized to documentmodification to care/services. · The assignment sheet/plan ofcare will be communicated to the Home Health Aide by the appropriatediscipline. · The assignment sheet/plan ofcare will include: - Type service/procedure to be provided. - Frequency of visits. - Diagnosis/prognosis, if relevant to care. - Functional limitation. - Patient's mental status. - Activities permitted. - Nutritional requirements. - Specific procedure to be	

			performed including amount, frequency andduration. - Safety measures including use of specific equipment. - Instructions for completion of documentation. - Reporting changes in patient's condition and needs. - Allergies, as applicable. Toprevent from recurring Supervising Professional will make Joint visit with HHAwithin the first 14 days of care being provided by HHA to monitor for accuracyin following written plan of care provided for HHA for the next 3 patientsreceiving services of the HHA. Thereafter On-Site joint visits will occur 1x anepisode. For the next 3 months tracked and reported to QAPI committee.	
G0984	In accordance with current clinical practice 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Based on observation, record review and interview, the agency failed to ensure skilled professional services practiced according to the agency's policies and procedures in 5 of 5 active patient records with a wound or IV [intravenous]	G0984	ID prefix: G0984 – Professional Standards of Practice QAPI Project G0984 Agency and staff will comply with accepted standards ofpractice and plans of care. The agency and staff will comply with acceptedprofessional standards and principles that apply to the professionals who arefurnishing care. Patient care and services will be provided for each patientaccording to applicable	2023-03-28

	antibiotics (Patient #4, #5, #6, #7, #10). The findings include: 1. Review of an agency policy titled "Professional Standards of Practice", revised October 2017, indicated all agency and staff will comply with accepted standards of practice and plans of care. 2. Review of an agency policy titled, "PERIPHERALLY INSERTED CENTRAL CATHETER (PICC) MAINTENANCY AND MANAGEMENT OF POTENTIAL COMPLICATIONS" dated March 2005, indicated the site should be cleaned in a circular fashion moving from the exit site of the catheter out at least 3-4 inches in diameter, then allowed to air dry. The policy also indicated the external catheter length should be measured to verify it corresponds to initial placement measurement. 3. Observation of a skilled nurse visit for Patient #4 was conducted on 2/27/2023 at 2:00 PM. RN (registered nurse) #2 entered the patient's room, set up barriers on the couch, and put her bag and equipment on the barriers. At 2:05 PM, RN #2		law, regulation, and accepted standards of practice.Agency maintain copies of all applicable standards of practice from statelicensing authority. Staff must also comply with: Federal applicable regulations,Agency policies and procedures, and Accepted standards established by national organizations,board and council, the American Nurses' Association Standards. Agency and contractual staff will provide care, treatment,and services to each patient according to the plan of care. Education – Staff will be inserviced by the Director ofNursing on state and federal regulations and laws, including MedicareConditions of Participation (CoPs) and state licensure requirements by 03/28/3023. Staff will be inserviced by The Director of Nursing oncompleting a comprehensive head to toe assessment, wound care measurementsprocedure, and PICC line measurements procedure, cleansing site properly, andmanagement of potential complications, Bag technique procedure, and	

	took the patient's blood pressure on their right wrist. The patient was observed to have a picc (peripherally inserted central catheter) line in their right arm. When cleaning the insertion site of the picc line, RN #2 swabbed in an up and down motion, then back and forth over the site. Observation of the home visit failed to evidence the nurse measured the external catheter length. Clinical record review of all nurse's assessments for certification period 1/30/2023 to 3/30/2023, failed to evidence picc line measurements. Review of all nurse's assessments for certification period 1/30/2023 to 3/30/2023, indicated the nurse took the blood pressure on the same arm as the picc line (right side). During an interview on 3/6/2023 at 3:19 PM, the Clinical Manager indicated the nurse should measure the picc line as written in the agency policy. The Clinical Manager indicated if a patient has a picc line, the blood pressure should never be taken on the same arm, above or below the picc		proper andtimely completion of the Infection Log by 03/28/2023. We will prevent this deficiency from reoccurringby the Director of Nursing doing joint visits on site with the SN on patient'sscheduled visit every other month until 100% compliance is met.	

line.

4. Review of the plan of care for certification period 1/27/2023 to 3/27/2023, indicated Patient #5 had a right upper arm picc line. Review on 3/2/2023,of all nurse's assessments for certification period 1/27/2023 to 3/27/2023, failed to evidence picc line measurements.

During an interview on 3/6/2023 at 3:19 PM, the Clinical Manager indicated the nurse should measure the picc line as written in the agency policy.

5. Observation of a wound care home visit for Patient #7 was conducted on 2/28/2023 at 11:00 AM. Observation of the home visit failed to evidence LPN (licensed practical nurse) #1 measured the patient's wounds. Observation during the home visit at 11:36 AM, evidenced a conversation between the patient and LPN #1. The patient indicated they had a urinalysis at their doctor's office about 3 weeks ago, and were started on an antibiotic, which they took for 8 days. LPN #1 indicated she was aware and

the patient's urine in one month.

Clinical record review evidenced the patient received one skilled nurse visit per week.

During an interview on 2/28/2023 at 11:45 AM, LPN #1 indicated it was the agency's policy to measure patient wounds once per week.

During an interview on 3/7/2023 at 10:18 AM, the Clinical Manager indicated it was the agency's policy to measure patient wounds once per week, and LPN #1 should have measured the patient's wounds at the home visit, as it was the only nurse visit that week.

Clinical record review of all orders and current visit notes back to 12/31/2022, failed to evidence an antibiotic or urinalysis.

During an interview on 3/7/2023 at 10:14 AM, when informed of the findings, the Clinical Manager indicated the nurse should have written an order for the antibiotic and urinalysis after talking to the patient's physician. When

	queried, the Clinical Manager indicated the patient's clinical record failed to evidence communication with or orders from the physician for an antibiotic or urinalysis. Clinical record review on 3/2/2023, indicated the nurse was providing wound care for 3 different wounds: sacrum, right hip, and right buttocks. Clinical record review evidenced the current wound care was ordered on 9/23/2022. Review of the skilled nurse visit notes indicated no change in the sacral wound size from 9/28/2023 to 2/24/2023. Review of the skilled nurse visit notes indicated no change in the right hip wound from 9/28/2022 to 11/18/2022, then only .5cm change in size from 11/30/2022 to 2/24/2023. Review of the skilled nurse visit notes indicated no change in the right buttocks wound from 10/7/2022 to 2/24/2023. Clinical record review failed to evidence a change in wound care despite no improvement of the wounds. Clinical record review failed to evidence communication with the			

physician about the unchanged wound sizes and current treatment.

During an interview on 3/7/2023 at 10:20 AM, the Clinical Manager indicated if a wound was not improving within 2 weeks of starting treatment, it was the agency's policy that the nurse contact the physician to determine if a change in treatment was needed.

6. Clinical record review on 3/6/2023, for patient #6, start of care 2/1/2023, primary diagnosis of type 2 diabetes with foot ulcers, evidenced agency documents titled "LPN/LVN [licensed practical nurse/licensed vocational nurse] Visit" signed by LPN #1, which indicated the patient had 3 ulcers to the patient's left foot: Wound 1 located on the mid foot measured (length by width by depth in centimeters) 10 cm x 8 cm x 0.1 cm; Wound 2 located on the great toe measured 2 cm x 2 cm x 0.1 cm; Wound 3 located on the fifth toe measured 1 cm x 1 cm x 0.1 cm. These measurements were documented for the following LPN Visit dates: 2/3/2023,

	2/9/2023, 2/15/2023, 2/17/2023, 2/22/2023, and 2/24/2023. Review failed to evidence a change in the size in the patients wound. Record review evidenced documents titled "Physician Orders Details" electronically signed by Person #6 on 2/13/2023 and 2/27/2023, which indicated assessments provided by the nursing staff at Entity #1. Record review of these documents evidenced a decrease in size of the 3 diabetic ulcers on the patient's left foot. On 2/27/2023, wound 1 measured 3 cm x 4 cm x 0.1 cm, wound 2 measured 0.6 cm x 1 cm x 0.1 cm, wound 3 measured 0.7 cm x 1.1 cm x 0.1 cm. Record review failed to evidence the skilled nurse documented wound care according to agency policy and procedure, to include weekly measurements. During an interview on 3/1/2023, at 10:23 AM, Clinical Manager #2 indicated wounds should be measured by the skilled nurse weekly, using a paper ruler to measure the			

	length and width, and Q-tip to measure depth. 7. Clinical record review on 3/7/2023, for patient #10, start of care 11/15/2022, primary diagnosis of bladder cancer, all nurse's assessments for certification period 11/15/2022 to 12/6/2022, failed to evidence picc line measurements. Record review failed to evidence the skilled nurse performed picc line assessments per agency policy and procedure.			
N0000	Initial Comments This survey was a State re-licensure survey of a home health agency in conjunction with complaints. Survey dates: 2/23/2023 to 3/7/2023 Complaint #29725 - substantiated. State deficiencies were cited. Complaint #31901 - substantiated. State deficiencies were not cited.	N0000		

	Complaint #95666 - substantiated. Federal deficiencies were cited. Facility ID: IN005307 Census: 115 Unduplicated census last 12 months: 486			
N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the agency failed to ensure administrative control and lines of authority were clearly set forth in writing and readily identifiable. The findings include: Review of an agency policy titled "Leaders and Governing	N0440	N0440 ID Prefix N0440: Home Health agencyadministration/management CFR(s) 410 IAC 17-12-11(a) Rule 12 Sec. 1**(a)** Organization,services furnished, administrative control, and lines of authority for thedelegation of responsibility down to the patient care level shall be: **(1)** Clearly set forth in writing; and **(2)** Readily identifiable.	2023-03-10

	Body Orientation", revised March 2018, indicated the organizational chart shall demonstrate lines of authority of the agency. Review of the agency's organizational chart received 2/23/2023 at 11:08 AM from the Clinical Manager failed to evidence an Alternate Administrator. During an interview on 3/1/2023 at 9:55 AM, the Administrator indicated Administrative Staff #4 was the Alternate Administrator of the agency since December 2022.		Deficiency: Agency failed to ensure administrative controland lines of authority were clearly set forth in writing and readily identifiable. Correction Plan: As per Agency Policy Organization, services furnished, administrative control andthe lines of authority for the delegation of responsibility for patient careare clearly defined in writing and are readily identifiable. **LINES OF AUTHORITY** The ***GoverningBody*** assumes full legal authority and responsibility for all thoseemployed by the Agency, for operation of the Agency and for the safety andquality of care provided. The ***Administrator***is responsible to the members of the Governing Body.	

In theabsence of the Administrator, the ***Director of Clinical Services*** willassume his/her administrative duties.

The ***Directorof Clinical Services*** is responsible to the Administrator.

The ***QualityAssessment and Performance Improvement Coordinator*** is responsible tothe Director of Clinical Services/Clinical Manager.

The ***ClinicalManager*** is responsible to the Director of ClinicalServices/Administrator.

RegisteredNurses (RNs) are responsible to the Clinical Manager and the Directorof Clinical Services.

LicensedPractical Nurses (LPNs) are responsible to the RNs, Clinical Managerand the Director of Clinical Services.

HomeHealth Aides are responsible to the RN in charge of their patients andto the Clinical Manager. May be supervised by PT, OT and SLP.

Physical Therapists, OccupationalTherapists and Speech Language Pathologists are responsible to theClinical Manager and the Director of Clinical Services.

MedicalSocial Workers are responsible to the Clinical Manager and the Directorof Clinical Services. If Social Work Assistant: responsible to Medical SocialWorker.

PhysicalTherapy Assistants are responsible to the Physical Therapist, theClinical Manager and the Director of Clinical Services.

OccupationalTherapy Assistants are responsible to the Occupational Therapist,

			theClinical Manager and the Director of Clinical Services. The ***OfficeManager*** is responsible to the Administrator. The ***OfficeStaff*** are responsible to the Office Manager. Allstaff is responsible to the ***Patient***. 100% ofall staff will be educated/ in-serviced on the above policy administrativecontrol and the lines of Authority. By 3/28/2023. To include presentationCorrected of Organizational chart and lines of Authority.	

			Agencywill Post on Agency Entranceway Wall a copy of updated Organizational Chart andLines of Authority to be Visible to all entering Agency by 3/10/2023. ResidentialClinical Services, Inc OrganizationalChart Effective Feb 1 2023 Boardof Directors AdministratorDr Ahmed Mohamed Alternate Administrator Dr Sayed Yousef Directorof Clinical Services- Joi Watson RN BusinessManager Human Resource Clinical Manager KarenDavis Karen Davis Joi Watson Rehab Coordinator IntakeCoordinator	

			Karen Daniels NanetteP Payroll LuzPerez Therapy QA QA/.AideSupervisor Dr Ahmed Mohamed Joi Watson Biller PT's OT's ST's RN's,LPN's, HHA's, MSW's Edgar Tubaqlinal PurchasingSupplies Orders Manager OASIS QA/Coder KarenDaniels Eslam Elhakim MedicalRecord Keeper CandiLindstrom PATIENTS	
N0442	Home health agency administration/management 410 IAC 17-12-1(b)	N0442	N0442 ID Prefix n0442: Home Health agencyadministration/management	2023-03-28

	Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency. Based on record review and interview, the governing body failed to adopt and periodically review bylaws to maintain individualized information of the agency. The findings include: Record review of an agency policy titled “Governing Body” revised in March 2018, stated “Responsibilities … The Governing Body will have bylaws (or equivalent) which will be reviewed and revised annually and as needed. These bylaws will: …Be available to all members of the Governing Body. Clearly define the scopes of responsibility to the Agency and its legal accountability to its patients … Define term of office, frequency of meetings, attendance requirements, definition of a quorum, conflict of interest disclosure requirements and overall responsibilities ….” Record review of an agency		CFR(s): 410 IAC 17-12-1(b) Rule 12 Sec. 1 **b)** A governingbody, or designated person or persons so functioning, shall assume full legalauthority and responsibility for the operation of the home health agency. Thegoverning body shall do the following: **(1)** Appoint a qualified administrator. **(2)** Adopt and periodically review written bylawsor an acceptable equivalent. **(3)** Oversee the management and fiscal affairs ofthe home health agency. Deficiency: Based onRecord review and interview the Governing Body failed to adopt and periodicallyreview bylaws to maintain individual information of the agency. Plan of Correction: Board of Directors held an EmergencyMeeting on 3/7/2023 @ 7:00p.m. The reason to call the meeting was to inform the GoverningBoard of the conclusion of the state survey	

	3/2/2023, titled "By-Laws of Residential Clinical Services, Inc." stated "Article V Office ... Section 1. Principle Office: The principal office of the agency is in its State of Incorporation, (the "State"). The agency may have other offices, either within or without the State as the Board of Directors may determine or as the affairs of the Agency may require from time to time ...." This document failed to evidence the location of the agency, including the state in which the agency was incorporated. Record review failed to evidence the bylaws were periodically reviewed to include individual agency information. During an interview on 3/7/2023, at 1:42 PM, administrator #1 indicated he could not find an agency address or the name of the state where the agency was incorporated. When queried when the bylaws were last reviewed, administrator #1 indicated it was probably in 2018.		conducted by Indiana Department ofHealth with Survey Dates of 2/23/2023 to 3/7/2023. The result of the Exit of the surveyors cited RCS withMultiple deficiencies and substantiated the three complaints that led to thevisit and expanded Survey. A detailed report will be sent by the Department of Health thatcan be accessed on Survey Report System (SMS). Failure to respond may result inlegal actions against RCS. The Board then reviewed the Bylaws and updated asappropriate and filed the changes in the Governing Body book. The board agreed with the Plan presented by Dr Ahmed forAgency to establish a detailed plan of correction implementing QAPI. On 3/24/2023 The Governing Board again meet and reviewed andApproved By-laws. On 3/24/2023 the Governing Board approved the Agency	

			received as result of Survey Findings. Plan to include but not limited to : QAPI Project: N0472: Based on State Survey conducted2/23/2023 to 3/7/2023 and as required by QAPI Policy and Procedure and asdirected by our own Governing Board each Deficiency will become a PerformanceImprovement Project (PIP) with the result of actions taken will show measurablesuccessful results and tracked to ensure that improvements are sustained. (PIP) Process Improvement will cover QAPI Project: N0440,N0442, N0447, N0458, N0460, N0462, NO472, N0524, N0604, N0608, G0434, GO572,G0682, G0684, G0706, G0710, G0716, G0718, G0818, G0984 Process Improvement for Deficiencies and Plan of Correctionwill be addressed by 3/28/2023 with 100% completion of Initial training byDirector of Clinical Services of actions to improve system, improve staffknowledge, effect	

			staff behavior. All improvement processes will continue to be analyzed every30 days for 3 months then quarterly thereafter by Administrator, Director ofClinical Services, QAPI committee and overseen by Governing body. Thereafter the QAPI committee will meet quarterly and willcompile and analyze collected Data. Statistical techniques will be utilized, asappropriate, to compile and analyze data. Such assessment is initiated by:comparison internally (Chart /Record review, supervised visits, Educationalopportunities, use of Infection control monitoring, Interview) With others(references database) With standards, With practice guidelines, With bestpractice. To prevent recurring deficiency Governing Board will reviewand approve ByLaws annually and review QAPI findings with each meeting and makerecommendations to Administrator to be performed by Agency.	

N0447	Home health agency administration/management 410 IAC 17-12-1(c)(4) Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on record review and interview, the administrator failed to ensure the accuracy of all public information to include hours of availability and services provided by the agency. The findings include: On 3/2/2023 at 6:30 PM when calling the agency, there was no answer and a message was left on the voicemail requesting a return phone call. No return call was received. On 3/3/2023 at 9:40, when informed of the findings, the Clinical Manager indicated the agency has had a problem with the phones and will have to get	N0447	ID Prefix: N0447: Accuracy of Info/ On Call Phone QAPI project N0447: After Hours Accessibility policy will bein serviced to staff (Nursing and Non-nursing) by 03/10/2023 by Administrative Assistant. Agency office hours are 8am to 4:30pm Monday through Friday.A RN is available 24 hours per day, 7 days per week. Contact can be made by telephoneor pager through the on-call system. At time of admission patients will beinformed of the on-call system. The Director of Clinical services develops the on-call schedule.Monthly master calendar will be developed quarterly and prevented to QAPI. Non-Nursing on Callperson will contact Nurse assigned to that patient or Nurse on call assignedwhen non-nursing staff is on call. On call sheet to be completed daily by on call staffassigned.	2023-03-10

	it checked out. Record review of an document titled "Job Description Administrator" revised March 2018, stated "Responsibilities ... 3. Ensures the accuracy of public information materials and activities ...." Record review of the agency's home health admission booklet on 2/23/2023, evidenced the agency's office hours and after hours coverage on the inside of the front cover, which stated "Office Hours: Our office hours are 8:00 a.m. to 4:30 p.m., Monday through Friday, except holidays ... After Hours Coverage: We have a nurse on call 24 hours a day, seven days a week to ensure that you receive necessary home care services ... After office hours and on weekends, an answering service will reach the nurse and he/she will return you call, answer your questions and concerns or come see you, if necessary ..." On page 2 of the admission booklet evidenced the information of the services provided, which stated "Services ... Working with your physician, our qualified staff will plan coordinate and provide care or		Daily notation of calls /voice mails received of Who called,what was needed, and Action taken. We will prevent the deficiency from recurring by checking the calls/ voicemail daily, andrecording each call received daily after hours on an ON call Log, by Directorof Clinical services.	

	services in your home tailored to meet your needs. Our services may include … Medical Social Services are provided by a Medical Social Worker. Services may include short-term counseling services, referral to and coordination with community resources and assistance with living arrangements, finances and long-range planning ….”			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.	N0458	ID Prefix N0458: Home Health Agencyadministration/management Rule 12 sec. 1(F) Personnel practices for employees shall besupported by written policies. All employees caring for patients in Indiana shall besubjected to Indiana current licensure, certification and/or registration arerequired by law and/or regulation to practice a profession. Personnel records of employees who deliver home healthservices shall be kept current and include documentation of orientation to thejob, including the following:	2023-03-29

	Based on record review and interview, the agency failed to ensure all employee records included: orientation to the job, receipt of job description, criminal background check and annual performance evaluations in 5 of 6 non-administrative employee records reviewed (PTA #3, HHA #1, RN #1, PT #1, PT #4) The findings include: 1. Review of an agency policy titled "Personnel Records", revised March 2018, indicated the personnel record for an employee will include, but not be limited to: performance evaluations, criminal history check, signed job description, and agency employee orientation. 2. Personnel record review on 2/24/2023 for PTA (physical therapy assistant) #3, first patient contact date 5/7/2021, failed to evidence orientation to the job, receipt of job description, criminal background check, and annual performance evaluation.		Receipt of Job Description Qualifications A copy of limited criminal history pursuant to IC 16-27-2 A copy of current license, certification, or registration. Annual performance evaluations. QAPI Project N0458: Purpose: To provide a mechanism wherebythe Agency assures that all personnel license(s) or certification(s) are keptcurrent and are documented in Agency records. Personnel files will be established and maintained for allstaff. All information will be considered confidential and will be made availableto authorized management personnel only. Upon Hire Administrator or Office Manager will verify thecompleteness of Employee Personnel Record.	

	3. Personnel record review on 2/24/2023 for HHA (home health aide) #1, first patient contact date 11/14/2018, failed to evidence a completed annual evaluation since 11/13/2020. 4. Personnel record review on 2/24/2023 for RN (registered nurse) #1, first patient contact date 7/18/2018, failed to evidence any annual evaluation. 5. Personnel record review on 2/24/2023 for PT (physical therapist) #1, first patient contact date 3/1/2018, failed to evidence orientation to the job and any annual evaluation. 6. Personnel record review on 2/24/2023 for PT (physical therapist) #4, first patient contact date 3/1/2018, failed to evidence an annual evaluation. 7. During an interview on 2/24/2023 at 3:00 PM, the Clinical Manager indicated the personnel records should include orientation to the job, receipt of job description, criminal background check and annual performance evaluation.		As a result of recent State Survey the Governing Board hasordered a QAPI project to ensure accuracy of all employee records to begin witha Re-orientation for all staff. All staff will take part in the re-orientation process toestablish accuracy of 100% of employee files by 3/29/2023 to be provided byAdministrator, Director of Clinical Services and Office manager. Employee files will be verified against the new Check-offsheet to confirm presence of all required documentation including: (but limitedto) · Employment application/resume. · Observed competencies: initial duringorientation and ongoing (minimally every 3 years) for all patient care staff. · Home Health Aide competency evaluation:initially and annually. · References, if obtained, or work history. · I-9 form – separate folder.	

· Salary recaps.

· Change of status forms.

· CPR, if required.

· Performance appraisal/evaluation forms.

· Verification of education, certificationand/or licensure.

· Agency employee orientation.

· Inservice education record.

· Other data which is directly related to theemployment, promotion, additional compensation, disciplinary action or termination.

· Criminal history check, if required by law.

· Job description: reviewed and signed byemployee.

· Certification for specialty areas ofpractice, if applicable.

· Dated and signed withholding statements.

· National sex offender registry (ACHC).

· Agencies in receipt of

			funds from Medicare,Medicaid and all other federal plans and programs verify that individuals hiredare not on the Office of the Inspector General (OIG) List of ExcludedIndividuals and Entities (LEIE). · Each employee who will have direct patientcontact shall have a physical examination by a physician or nurse practitionernot more than one hundred eighty (180) days before the date that the employeehas direct patient contact. The physical examination shall be of sufficientscope to ensure that the employee will not spread infectious or communicablediseases to patients. To prevent this fromrecurring the Office Manager will review 100% of employee records quarterly andreport results to QAPI committee	
N0460	Home health agency administration/management 410 IAC 17-12-1(g) Rule 12 Sec. 1(g) As follows, personnel records	N0460	ID Prefix N0460: Home health agency administration/management Rule 12 Sec. 1(g) as follows, personnel records of the	2023-03-07

	of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment. Based on record review and interview, the agency failed to ensure the personnel record of the supervising nurse included orientation to the job (Clinical Manager). The findings include: Review of an agency policy titled "Personnel Records", revised March 2018, indicated the personnel record for an employee will include, but not be limited to: performance evaluations, criminal history check, signed job description,		supervisingnurse, appointed under subsection (d) of the rule, shall: Be Kept Current, Include a copy of Limited criminal history pursuantto IC 16-27-2, Nursing License, Annual performance evaluations, Documentationof Orientation to the job QAPI Project N)460: Administration/Management: AdministratorRole: Ensuresstaff development including orientation, inservice education and continuingeducation Clinical Manager w/ no evidence of Orientation to the job. Correctionplan: 1. Orientationfor all employees will be coordinated, performed and documented by supervisorystaff, peers and/or preceptors. 2. The *Orientation Checklist* will be used todocument orientation for all staff Orientation to current Clinical	

	orientation. Personnel record review on 2/24/2023 for the Clinical Manager failed to evidence orientation to the job. During an interview on 2/24/2023 at 3:00 PM, the Clinical Manager indicated all personnel records should include orientation to the job.		Manager has been provided byPrevious Clinical Manager and overseen by Administrator, Documentation ofOrientation has been reviewed and signed by Administrator and Present Clinical Manageron 3/7/2023. · Orientation included but not limited to: · Reviewof the individual's job description and duties performed and their role in theorganization. · Organization chart. · Mission statement. · Agency philosophy. · Record keeping and reporting. · Confidentiality and privacy of ProtectedHealth Information. · Patient's rights. · Advance Directives. · Conflict of interest. Written policies andprocedures. · Emergency Plan. · Training specific to job requirements.	

· Additional training for special populations,if applicable (e.g., pediatrics).

· Cultural diversity.

· Communication barriers.

· Ethical issues.

· Professional boundaries.

· Quality Assessment and PerformanceImprovement Plan.

· Corporate Compliance Program.

· Conveying of charges for care/services.

· OSHA requirements, safety, infection controland Right to Know law.

· Orientation to equipment, if applicable asoutlined in job description.

· Incident/variance reporting.

· Handling of patient complaints/grievances.

· OASIS and other required documentation.

To Prevent this deficiency from

			Office manager will review Employee records quarterly and presentfindings to QAPI committee.	
N0462	Home health agency administration/management 410 IAC 17-12-1(h) Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on record review and interview, the home health agency failed to ensure a physical examination was performed to establish the employee was free of communicable diseases prior to, but not more than 180 days before, the first date of patient contact in 3 of 8 personnel records reviewed (Administrator, HHA #1, PT #4). The findings include: 1. Review of an agency policy	N0462	ID Prefix: N0462 Home Health Agencyadministration/management CFR(s) 410 IAC 17-12-1(h) Rule Sec. 12.1 QAPI Project N0462: Agency Failed to ensure a physicalexamination was performed to establish the employee was free of communicablediseases prior to, but not more than 180 days before, the 1st dateof patient contact. Correction process: Agency has established with 100% of allemployees that will have direct patient contact a re-orientation process toupdate all legal requirements to provide care to Home Health Patients includinga Physical Examination by a Physician or Nurse Practitioner by 3/29/2023 andnot more than 180 days before 3/29/2023 that shall be of sufficient scope toensure that	2023-03-29

	titled "Employee Infectious Diseases", revised March 2018, indicated the agency will monitor employees for infectious disease in order to prevent the spread of infectious diseases to patients and other employees. Review of an agency policy titled "Personnel Records", revised March 2018, indicated all personnel records will contain employee health information required by the agency. 2. Personnel record review on 2/24/2023 for the Administrator failed to evidence a physical indicating they were free from communicable disease. 3. Personnel record review on 2/24/2023 for HHA (home health aide) #1, first patient contact date 11/14/2018, evidenced a physical dated 10/17/2019. Personnel record review failed to evidence a physical indicating they were free from communicable disease prior to first patient contact date. 4. Personnel record review on 2/24/2023 for PT (physical therapist) #4, first patient		infections or communicable diseases topatients. 100% of staff that has direct patient contact will haveprovided a copy of Physical exam to Agency from their own Physician or Providerarranged by Agency on or before 3/29/2023. All employee records of Employees with Direct patientcontact will be reviewed quarterly by Administrator/ office manager andreported to QAPI committee. All new hires willnot be allowed patient contact until a sufficient Physical provided byPhysician or Nurse Practitioner is provided to Agency.	

	contact date 11/5/2019, evidenced a physical dated 10/10/2013. Personnel record review failed to evidence a physical indicating they were free from communicable disease less than 180 days prior to first patient contact date. 5. During an interview on 2/24/2023 at 3:00 PM, the Clinical Manager indicated the Administrator would occasionally do start of care visits if needed, but she did not know and could not locate his first patient contact date. The Clinical Manager indicated not all of the personnel records were complete because they were someone else's job before she started in this position, and it was something they were working on fixing.			
N0472	Q A and performance improvement 410 IAC 17-12-2(a) Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or	N0472	ID Prefix: N0472: QA and Performance Improvement. QAPI Project: N0472: Based on State Survey conducted2/23/2023 to 3/7/2023 and as required by QAPI Policy and Procedure and asdirected by our own	2023-03-28

	under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview, the agency failed to develop, implement, maintain and evaluate a quality assessment and performance improvement program. The findings include: Review of an agency policy titled "Quality Assessment and Performance Improvement (QAPI) Plan and Program", revised March 2019, indicated the agency will establish an ongoing, agency - wide, data-driven program of quality assessment and performance improvement and maintain documentary evidence of its program. The policy indicated the agency must measure, analyze and track quality indicators to assess processes of care, services and operations. The policy indicated frequency and detail of the data collection must be approved by the Governing Body. Review of the agency's QAPI		Governing Board each Deficiency will become a PerformanceImprovement Project (PIP) with the result of actions taken will show measurablesuccessful results and tracked to ensure that improvements are sustained. (PIP) Process Improvement will cover QAPI Project: N0440,N0442, N0447, N0458, N0460, N0462, NO472, N0524, N0604, N0608, G0434, GO572,G0682, G0684, G0706, G0710, G0716, G0718, G0818, G0984 Process Improvement for Deficiencies and Plan of Correctionwill be addressed by 3/28/2023 with 100% completion of Initial training byDirector of Clinical Services of actions to improve system, improve staffknowledge, effect staff behavior. All improvement processes will continue to be analyzed every30 days for 3 months then quarterly thereafter by Administrator, Director ofClinical Services, QAPI committee and overseen by Governing body. Thereafter the QAPI committee	

	binder on 3/1/2023 failed to evidence any ongoing performance improvement projects or collecting of data. During an interview on 3/1/2023 at 3:25 PM, the Clinical Manager indicated the current QAPI focus was getting physician orders signed, but she had no documentation of the current performance improvement program. When queried if the current improvement project was approved by the governing body, the Clinical Manager stated, "No".		will meet quarterly and willcompile and analyze collected Data. Statistical techniques will be utilized, asappropriate, to compile and analyze data. Such assessment is initiated by:comparison internally (Chart /Record review, supervised visits, Educationalopportunities, use of Infection control monitoring, Interview) With others(references database) With standards, With practice guidelines, With bestpractice.	
N0524	Patient Care 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits.	N0524	ID Prefix:N0524: Patient Care failure to ensure the patients plan of care included allthe required components. Failed to evidence the indications for use of the as-neededvisit and medication. QAPIproject; N0524: 100% of staff will beeducated on the use of PRN or As Needed visits and meds. By 3/28/2023 byDirector of Clinical Services INSERVICE/ EDUCATION ON USE OF PRN	2023-03-28

(iv) Prognosis.

(v) Rehabilitation potential.

(vi) Functional limitations.

(vii) Activities permitted.

(viii) Nutritional requirements.

(ix) Medications and treatments.

(x) Any safety measures to protect against injury.

(xi) Instructions for timely discharge or referral.

(xii) Therapy modalities specifying length of treatment.

(xiii) Any other appropriate items.

Based on observation, record review and interview, the agency failed to ensure the patient's plan of care included all required components in 7 of 10 patient records reviewed (Patient #1, 2, 3, 4, 5, 7, 8).

The findings include:

1. Review of an agency policy titled "Plan of Care - CMS #485 and Physician Orders", revised March 2019, indicated the individualized plan of care must specify the care and services necessary to meet the patient - specific needs as identified in the comprehensive assessment. The policy indicated the plan of

Orders for services to be furnished "as needed" or"PRN" must be accompanied by a description of the patient's medicalsigns and symptoms that would occasion a visit and a specific limit on thenumber of those visits to be made under the order before an additionalphysician or allowed practitioner order would have to be obtained.

FOR PRN SKILLED VISITS:

Example 2: “Skilled nurse 1-2x/week for 2 weeks PRN for pain rated greater than 8 on the 0to 10 pain scale.”

This order is for as neededvisits 1 to 2 times per week for 2 weeks for a specific symptom with a specificperiod of time. If the signs and symptoms indicate a need for morevisits, a new physician order would need to be obtained.

Example 3: So in the case of our wound care patient, if the doctorgave you an order for prn visits, write: “Skilled Nurse to perform 2 prn visits for wound care fordressing dis-lodgment or soiling. (and if the doctor gaveyou the order you could continue) “Ifdressing becomes dislodged or soiled in skilled nurse absence patient/caregivermay apply normal saline moistened to wound, cover with gauze square, wrap withgauze and secure with tape.” Now you have covered allbases and you have a complete order.

FOR PRN MEDICATION:

	care must include all pertinent diagnoses, types of services, supplies and equipment required, frequency and duration of visits to be made, nutritional requirements, all medications and treatments, and safety measures to protect injury. 2. Review of the plan of care for Patient #1, certification period 2/13/2023 to 4/13/2023, evidenced the frequency of skilled nursing including one as-needed visit. The plan of care failed to evidence indications for use of the as-needed visit. The plan of care indicated the nurse was to perform wound care every 3 days and as needed. The plan of care failed to evidence indications for why additional wound care would be needed.		PRNMedication Orders are given on an "as needed" basis for specificsigns & symptoms. **Example:**	

Review of the plan of care indicated the patient was diabetic and on insulin. The plan of care indicated the skilled nurse was to assess the patient's diabetic status and monitor blood sugar levels. Review of the plan of care failed to evidence who was checking the patient's blood sugar and at what frequency.

Review of the nurse's start of care assessment dated 2/13/2023 indicated the patient was using oxygen and a Holter monitor (a portable heart rhythm recording device) and abdominal binder. Review of the medication list on the plan of care failed to evidence oxygen. Review of the plan of care failed to evidence the patient was using a Holter monitor and abdominal binder.

During an interview on 3/6/2023 at 2:39 PM, the Clinical Manager indicated the plan of care should include all medications, treatments, and equipment for the patient. The Clinical Manager indicated oxygen is a medication and should be included on the medication list in the plan of

indicated any as-needed order should include an indication for use.

3. Review of the plan of care for Patient #4, certification period 1/30/2023 to 3/30/2023, evidenced an order for Sennosides - Docusate to be taken daily as needed. Review of the plan of care failed to evidence an indication for usage of the medication.

Review of the plan of care evidenced an order for the nurse to perform wound care to the left hip after the wound vac (a wound care treatment using a suction pump, tubing, and a dressing to remove drainage and promote healing) treatment was complete. The order indicated the nurse shall cleanse the wound with saline, pat dry, and cover with Aquacel Ag (a specialized wound dressing that can be used for up to 14 days). Review of the plan of care failed to evidence when and by whom the wound vac was to be removed. Review of the plan of care failed to evidence how long the Aquacel Ag dressing was to stay in place and what wound care should be performed when it was

removed.

During an interview on 3/6/2023 at 3:30 PM, the Clinical Manager indicated the plan of care should give clear instruction for what was to be used on the wound, who was performing the wound care, and how frequently it should be done.

4. Review of the plan of care for Patient #5, certification period 1/27/2023 to 3/27/2023, evidenced a primary diagnosis of Cutaneous abscess of the back (a localized collection of pus in the skin). Review of all nurse's assessments failed to evidence a wound or assessment of the skin on the back.

During an interview on 3/3/2023 at 11:40 AM, Patient #5 indicated they had an abscess of a disk in the spine, not the skin of the back.

During an interview on 3/6/2023 at 3:56 PM, the Clinical Manager indicated the primary diagnosis on the plan of care should be changed because it did not accurately reflect the patient's status.

	5. Review of the plan of care for Patient #7, certification period 1/26/2023 to 3/26/2023, evidenced the following wound care frequencies: care for a sacral wound was to be performed daily and PRN (as needed), right hip wound--every 3 days and PRN, right buttocks wound--every 3 days and PRN. The plan of care failed to evidence indications for why additional wound care would be needed. During an interview on 3/6/2023 at 2:39 PM, the Clinical Manager indicated any as-needed order should include an indication for use. 6. Review of the plan of care for Patient #8, certification period 10/24/2022 to 12/22/2022, evidenced a primary diagnosis of Type 2 Diabetes Mellitus (a disease that affects how the body uses blood sugar). The plan of care indicated the skilled nurse was to assess the patient's diabetic status and monitor blood sugar levels. Review of the plan of care failed to evidence who was checking the patient's blood sugar and at what frequency.			

Review of the plan of care evidenced wound care for 4 different patient wounds. The plan of care indicated wound care was to be performed twice daily and PRN for all 4 wounds. The plan of care failed to evidence indications for why additional wound care would be needed.

During an interview on 3/6/2023 at 2:39 PM, the Clinical Manager indicated the plan of care should include all treatments for the patient and any as-needed order should include an indication for use. When queried, the Clinical Manager indicated the nurse may enter who is checking the blood sugar in the visit notes, but it is not routinely put in the plan of care.

7. An observation of a home visit was conducted on 2/24/2023, from 11:02 AM to 11:58 AM, for patient #2, start of care 12/14/2022, with Home Health Aide (HHA) #1. During the home visit, HHA #1 assisted the patient with a shower, where grab bars and a shower chair was observed. At 11:17 AM, a cane, wheelchair, and

	observed in the patient's bedroom. Clinical record review on 3/6/2023, for patient #2, start of care 12/14/2022, pertinent diagnoses include but were not limited to dementia and a history of falls, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 2/12/2023 – 4/12/2023. This document had an area subtitled "DME [Durable Medical Equipment] and Supplies" which listed a walker, exam gloves, alcohol wipes, under pads, personal protective equipment, and blood glucose monitor with test strips and lancets. This document failed to evidence all DME was listed observed in the home. During an interview on 3/6/2023, at 9:52 AM, Clinical Manager #2 indicated a cane, wheelchair, and rollator walker was not listed on the plan of care document. 8. An observation of a home visit was conducted on 2/27/2023, from 12:35 PM to 1:30 PM, with patient #3 and Physical Therapist (PT) #2.			

	Observation evidenced the patient had DME including but not limited to a walker, cane, bedside commode, gait belt, and grab bars throughout the patient's home. Clinical record review on 3/6/2023, for patient #3, start of care 2/2/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 2/2/2023 – 4/2/2023, which indicated the patient's DME included a walker, gloves, alcohol wipes, and a tub/shower bench. Record review failed to evidence a cane, gait belt, bedside commode, and grab bars listed on the plan of care. During an interview on 3/2/2023, at 2:41 PM, Clinical Manager #2 indicated the skilled professional who completed the Start of Care (SOC) assessment would perform a walkthrough to check for equipment in the patient's home. They indicated that information is documented in the SOC assessment note and pulled to the patient's Plan of Care document.			

N0604	Scope of Services 410 IAC 17-14-1(m) Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist. Based on observation, record review, and interview, the home health agency failed to ensure all home health aides (HHA) reported pertinent information to the supervising nurse for 1 of 1 clinical record reviewed where a home visit was conducted with an HHA (HHA #1). The findings include: An observation of a home visit was conducted on 2/24/2023, from 11:02 AM to 11:58 AM, for patient #2, start of care 12/14/2022, with Home Health Aide (HHA) #1. At 11:37 AM, the patient's caregiver, person # stated "the afternoon aide" was coming about noon and explained "The one to watch [patient #2]." When queried about Entity #2's role in the home, the caregiver indicated Entity #2 came to the home 3 times a week, for 4 hours to watch the patient, so the	N0604	N0604 Prefix ID N0604: Scope of Service CFR(s): 410 IAC 17-14-1(m) Rule 14 Sec. 1 (m) the home health aide must report anychanges observed in the patient's conditions and needs to the supervisory nurseor therapist. Deficiency: Agency failed to ensure all home health aides(HHA) reported pertinent information to the supervising nurse. Plan of Correction: The Agency will ensure accuratedocumentation of home health aide services. 100% of HHA will be educated / in serviced in Documenting andreporting on patient care by 3/28/2023 by Qualified RN. To provide documentation of the care performed by the HomeHealth Aide (HHA) on each visit. To provide documentation of the HHA'sobservations on each visit. To provided data from which the RN/Therapist canplan	2023-03-28

	caregiver could run errands and take care of personal needs. Clinical record review on 3/6/2023, for patient #2, evidenced an agency document titled "HHA Visit" signed by HHA #1 on 2/24/2023. This document had a section subtitled "Comments" which remained blank. Review of this document failed to evidence the HHA documented information of Entity #2's existence in the patient's home. Record review failed to evidence care coordination with Entity #2 since the start of care. During an interview on 3/2/2023, at 2:50 PM, Clinical Manager #2 indicated the HHA can add comments to the visit note to relay pertinent information. During an interview on 3/6/2023, at 10:03 AM, when queried who should be contacted if a clinician was aware of another agency providing care to a Residential Clinical Services (RCS) patient, Clinical Manager #2 indicated they should let the clinical manager know the name of the other agency so RCS can		the patient's future care. 1. The HHA will document services rendered to the patient on the appropriateHome Health Aide charting form as directed in the Aide care plan/assignmentsheet. 2. The HHA will beresponsible for reporting any changes in the patient's condition and/or otherpertinent observations to the supervising RN/Therapist. 3. The Clinical Manager or designated RN/Therapist is responsible forreviewing the HHA's charting. 4. The original documentation will be filed in the medical record withinseven (7) days of the visit. HHA was re-trained includingsimulated visit by an outside qualified RN under	

	coordinate what services are being provided.		andcorrect methods to use when documenting patient interactions, visits, andchange of condition and needs to the supervisory nurse or therapist on3/26/2023. To prevent recurringdeficiency Clinical Manager will talk to HHA each day she works to reviewpatients seen and discuss anything that needs to be included in thedocumentation reported to supervising Nurse or Therapist for 30 days. Ifafter 30 days QA'd notes demonstrate appropriate documentation of changes,needs, pertinent observations the Clinical manager will verbally communicatewith the HHA weekly for 3 months. After the completed 3 months the PIP will bereviewed and presented to the QAPI committee.	
N0608	Clinical Records 410 IAC 17-15-1(a)(1-6) Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity	N0608	ID Prefix: N0608: Clinical Records QAPI Project N0608: Discharge Summary Policy will be in-servicedto 100% of staff. By 3/28/2023 by Director of Clinical services. We will prevent the deficiency from re-occurring by: Director of Clinical services orAdministrative assistant if	2023-03-28

orders.

(4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.

(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.

(6) A discharge summary.

Based on record review and interview, the home health agency failed to ensure all clinicians prepared clinical records to include discharge summary for 1 of 1 closed clinical record reviewed due to death (patient #10).

The findings include:

Record review of an agency policy titled “Discharge Summary” revised March 2018, stated “Policy A Discharge Summary will be completed for all patients discharged from the agency ... Procedure ... 2. Discharge Summary will be sent within 5 business days of patient discharge to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient ....”

Clinical record review on

Director unavailable will pull a report ofDischarged patients 2x a week and confirm on each patient receipt of faxconfirmation and address any summaries not sent.

	of care 11/15/2022, primary diagnosis of bladder cancer, evidenced an agency document of a discharge assessment signed by Registered Nurse (RN) #4 on 12/12/2022. Review of this document evidenced the patient was discharged due to death. Record review failed to evidence a discharge summary was created for this patient. During an interview on 3/7/2023, at 11:17 AM, when queried on the discharge process for this patient, Clinical Manager #2 indicated the skilled nurse tried calling to schedule a visit and the patient's spouse informed them of the patient's passing. Clinical Manager #2 indicated they did not ask the spouse how the patient expired and the physician was unaware as well. Clinical Manager #2 indicated they were unsure what to do in that situation and a discharge summary was not created and sent to the physician.			

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES | FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES | OMB NO. 0938-0391

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ahmed Mohamed	Administrator	4/4/2023 2:36:09 PM