

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157034	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/11/2023	
NAME OF PROVIDER OR SUPPLIER INDIANA HOMECARE NORTHWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 502 MARQUETTE STREET, VALPARAISO, IN, 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	<p>INITIAL COMMENTS</p> <p>This visit was a complaint survey for a hospice agency conducted by the Indiana Department of Health.</p> <p>Complaint #96654-deficiencies cited</p> <p>Survey Dates: 4/5/2023, 4/6/2023, 4/10/2023, and 4/11/2023.</p> <p>Facility ID: 005259</p> <p>Active Patient Census: 96</p> <p>Total Unduplicated Census Last 12 months: 914</p> <p>Quality Reviewed 04/25/2023</p>	G0000		
G0544	Update of the comprehensive assessment	G0544	Anoccurrence report was entered for patients 1 and 3.	2023-05-11

<p>484.55(d)</p> <p>Standard: Update of the comprehensive assessment.</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than-</p> <p>Based on record review and interview, the home health agency failed to ensure a comprehensive assessment was completed in 2 of 2 active clinical records reviewed where a decline in the patient's health status occurred (Patient #1, 3).</p> <p>The findings include:</p> <p>1. Record review evidenced an agency policy revised 3/1/2022, titled "Patient Assessment, Initial and Reassessment" which stated, "... A qualified clinician performs a comprehensive assessment or reassessment visit in the following situations: ... When the instability or acuity of the patient's medical condition warrants assessment [significant improvement or major decline]"</p> <p>2. Clinical record review for Patient #1 was completed on 4/11/2023. Record review</p>			<p>Patient1 is currently hospitalized. Patientreceived additional skilled nursing visits 4/13, 4/15, and 4/18.</p> <p>SkilledNursing services were initiated for patient 3 on 4/3/23. POC initiated thataddresses co-morbidities.</p> <p>Duringa mandatory staff meeting held on 5/3/23, the PI Team reviewed home health policies SignificantChange in Condition and Patient Fall Reduction Program with emphasis on thecompletion of a comprehensive assessment when the agency is made aware of asignificant change in the patient's condition that was not envisioned in theoriginal plan of care during a 60-day episode and when the patient's conditionhas either severely deteriorated or greatly improved; appropriate follow upassessment and interventions are completed when significant findings areidentified in prior visits or after hours calls; and follow up assessments</p>	
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<p>assessment for recertification of services, dated 3/23/2023. The document evidenced the patient weighed 130 pounds, had properly fitting, partial, removable, upper and lower dentures, and failed to evidence any chewing/swallowing concerns were identified; and the patient was at a high/major nutritional risk.</p> <p>Record review evidenced a plan of care for certification period 3/27/2023 – 5/25/2023, which evidenced the patient's diagnoses included heart failure, kidney disease with dependence on dialysis, diabetes, and dementia.</p> <p>Record review evidenced a Registered Nurse (RN) visit note dated 3/30/2023, which evidenced the patient weighed 124 pounds (6 pound weight loss in one week), the patient indicated he wasn't eating well due to issues with his teeth, and the RN encouraged the patient to eat soft foods in order to ensure caloric intake.</p> <p>Record review evidenced a RN visit note dated 4/04/2023, which evidenced the patient weighed 129 pounds (5 pound</p>		<p>following identification of a patient fall.</p> <p>For any staff not present, the PI Team or designee will provide instructions to the individual employees by 5/11/23.</p> <p>Clinicians will be required to complete daily report to PCMs on each patient to report any changes in patient condition. A coordination note will be completed to ensure any concerns are included in the medical record.</p> <p>PCMs will ensure physician orders are obtained and schedule an RN evaluation / visit within 24 hours of the identified patient care change in condition, and to complete a Significant Change in Condition assessment as indicated.</p> <p>Clinicians will review visit and coordination notes prior to completing scheduled visits to identify significant findings</p>	
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<p>weight gain in one week), random blood sugar level was 354 (normal range 70-110), had pitting edema (indicates fluid retention) to both feet, the patient reported a chronic cough at night, and had difficulty breathing while walking and with activity, his appetite was poor, was non-compliant with taking insulin as ordered by the physician, and hasn't check his blood sugar levels since the last nursing visit (3/30/2023).</p> <p>Record review failed to evidence any nursing visits were made after 4/04/2023 (as of 4/11/2023).</p> <p>On 4/11/2023 at 1:15 PM, the Clinical Manager indicated the patient was not reassessed.</p> <p>3. Clinical record review for Patient #3 was completed on 4/11/2023. Record review evidenced an initial comprehensive assessment, dated 3/18/2023. The document evidenced the patient's diagnoses included heart failure, which was poorly controlled, and required frequent adjustments in treatment and dose monitoring;</p>		<p>and intervention.</p> <p>For un-witnessed, staff witnessed, or non-staffwitnessed falls, the identifying clinician will notify the PCM regarding the need for a Registered Nurse (RN), Physical Therapist (PT), or Occupational Therapist (OT) to perform an on-site assessment. Upon being made aware of a patient fall, the PCM will coordinate the appropriate assessment, care, and/or modifications to the plan of care, as indicated. The PCM will document post-fall interventions in the medical record.</p> <p>Beginning 5/8/23 the Executive Director or designee will audit 4 visits notes per clinician per month. For clinicians scoring</p> <p>The Executive Director is ultimately responsible for the implementation of the plan of correction.</p> <p>Beginning 5/14/23, ED or designee will complete 10 medical record reviews per</p>	
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<p>the patient's weight was 125 pounds, had no swelling of the lower legs or feet, and no current heart issues were identified.</p> <p>Record review evidenced a plan of care for certification period 3/18/2023 – 5/16/2023, evidenced the patient's primary focus of home care was Physical Therapy (PT) and Occupational Therapy (OT).</p> <p>Record review evidenced an Occupational Therapy (OT) evaluation visit note dated 3/20/2023. The document evidenced the patient's weight was 125.4 pounds (0.4 pound weight increase), pitting edema was assessed, the patient got short of breath easily, had difficulty breathing with minimal exertion, and had a cough.</p> <p>Record review evidenced a Medical Social Worker (MSW) visit note dated 3/21/2023. The document evidenced the patient had moderate to severe anxiety/fear/excessive worries, and depression; and the patient indicated an anxiety pill may be missing from her pill box, which might be contributing to</p>	<p>changes in patient condition were reported to the PCM and an RN visit to evaluate the patient and complete the Significant Change in Condition assessment visit, if indicated, was completed within 24 hours of the change in condition; significant findings were reassessed and proper follow up was completed on subsequent visits; and proper notification and follow up assessments were completed following identification of a patient fall.</p> <p>Any deviations to this process will be addressed with clinician remediation and disciplinary action as indicated.</p> <p>Monitoring will continue for 12 weeks and will continue until 100% compliance achieved for 3 consecutive weeks.</p> <p>Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance</p>	
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increased anxiety.

Record review evidenced a Physical Therapy Assistant (PTA) visit note dated 3/23/2023. The document failed to evidence if the patient's weight or anxiety level was assessed, or if the anxiety medication was in the patient's pill box.

Record review evidenced an OT visit note dated 3/27/23. The document evidenced the physician was notified of the patient's weight of 128.8 pounds (3.4 pound weight gain in 6 days), and fluctuating heart rate from 50-135 beats per minute (normal range 60-110).

Record review evidenced a PTA visit note dated 3/30/2023. The document evidenced the physician was notified the patient felt "wiped out", reported some chest pain while coughing, the front of her chest ached, resting heart rate was 102-117 beats per minute, and had pitting edema to the right foot/ankle.

Record review evidenced a clinical coordination note dated 3/31/2023. This document evidenced the MSW provided a

is achieved.

	<p>family reported the patient sustained a fall (no date identified).</p> <p>Record review evidenced a RN evaluation visit note dated 4/03/2023. The document evidenced the patient's weight was 129.4 pounds (0.6 pound weight gain in 4 days); was short of breath with exertion, and had expiratory wheezing (compromised airflow); and failed to evidence any follow up for reported fall. The document also failed to evidence administration of OASIS data.</p> <p>During an interview on 4/11/2023 at 2:36 PM, the Administrator confirmed the comprehensive assessment wasn't completed for the patient's change in condition, the Clinical Manager did call to check on the patients, and the agency had limited nursing staff.</p>			
<p>G0608</p>	<p>Coordinate care delivery</p> <p>484.60(d)(4)</p>	<p>G0608</p>	<p>An occurrence report was entered for patient 5.</p> <p>Patient 5 physician notified wound care not performed at ordered frequency. Orders</p>	<p>2023-05-11</p>

<p>Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.</p> <p>Based on record review and interview, the home health agency failed to ensure care was coordinated in 1 of 7 active clinical records reviewed. (Patient #5)</p> <p>The findings include:</p> <p>Record review evidenced an agency policy revised 4/1/2023, titled "Coordination of Care, from Admit through Discharge" which stated, "... When the patient receives services from other organizations and/or individual's care is coordinated to ensure that patient's needs are met efficiently, without duplication of services, including: ... Communication with other health care providers when there are significant changes in patient care and/or condition"</p> <p>Clinical record review for Patient #5 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 3/29/2023 - 5/27/2023, which indicated the patient was to receive dressing changes to a malignant back</p>		<p>received on 4/7/23 for caregiver to perform woundcare on days skilled nurse not present. Caregiver educated and completed returndemonstration 4/10/23.</p> <p>During a mandatory staff meeting held on 5/3/23, the PITeam instructed all clinical staff and PCMs on home health policy Coordinationof Care From Admit Through Discharge with emphasis on interdisciplinary carecoordination and coordinating care with patient's care team including outside services,including, but not limited to wound clinics.</p> <p>For any staff not present, the PI Team or designee will provide instructions to the individual employees by 5/11/23.</p> <p>100% of current patient medical records will bereviewed by 5/11/23 to ensure 100% of all current episodes of care havedocumentation showing</p>	
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<p>lesion 3 times weekly: 2 times weekly from the skilled nurses, and 1 time weekly from Entity #2 (mobile wound clinic).</p> <p>During an interview on 4/11/2023, at 2:00 PM, Person #3 (employee of Entity #2) indicated Patient #5 was discharged from services on 3/22/2023, due to coccyx (area at base of spine) wound being healed.</p> <p>Record review failed to evidence the patient received dressing changes to the malignant back lesion 3 times weekly as ordered on the plan of care for the weeks of 3/26/2023, and 4/2/2023. Record review failed to evidence any care coordination with Entity #2 (mobile wound clinic).</p> <p>During an interview on 4/11/2023, at 10:39 AM, the Administrator indicated the agency should have coordinated care with Entity #2 by calling them, and having them send over orders. The Administrator indicated they did not have any documentation of when the patient was discharged from Entity #2. The</p>		<p>with outside services including, but not limited to wound clinics.</p> <p>All patients who are identified as receiving services through another entity will have a Point Care Visit Alert entered into HCHB indicating the entity and what the agency is providing.</p> <p>With each comprehensive assessment and as needed for changes in condition, the assessing clinician will coordinate care with other disciplines on the patient's care team, including outside services, and document that conversation.</p> <p>Beginning 5/8/23 the ED or designee will audit 4 visits notes per clinician per month. For clinicians scoring</p> <p>The Executive Director is ultimately responsible for the implementation of the plan of correction.</p> <p>Beginning 5/14/23, ED or designee will 100% of SOCs per week to ensure if patient has other services, that care coordination has occurred.</p>	
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	<p>Administrator indicated the patient should have received dressing changes 3 times weekly even after Entity #2 discharged the patient.</p>		<p>Beginning 5/14/23, ED or designee will complete 10 record reviews per week to ensure the care team, including outside entities, were notified of changes in the patient's condition.</p> <p>Any deviations to this process will be addressed with clinician remediation and disciplinary action as indicated.</p> <p>Monitoring will continue for 12 weeks and will continue until 100% compliance achieved for 3 consecutive weeks.</p> <p>Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.</p>	
<p>G0710</p>	<p>Provide services in the plan of care</p> <p>484.75(b)(3)</p> <p>Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care;</p> <p>Based on record review and</p>	<p>G0710</p>	<p>An occurrence report was entered for patients 5, 8, and 9.</p> <p>Patients 8 and 9 are discharged from home health services.</p>	<p>2023-05-11</p>

	<p>interview, the home health agency failed to ensure skilled professionals provided services as ordered in the plan of care in 3 of 5 clinical records reviewed. (Patient #5, 8, 9)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Record review evidenced an agency policy revised 12/1/2021, titled "Plan of Care" which stated, "... Each patient has an individualized Plan of Care developed in consultation with the patient, physician or authorized practitioner, and staff ... Medications, treatments, and interventions are provided by qualified agency staff as ordered by the physician or authorized practitioner" 2. Clinical record review for Patient #5 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 3/29/2023 - 5/27/2023, which indicated the skilled nurse was to change a dressing to a malignant back lesion twice weekly, and Entity #2 (mobile wound clinic) was to change the dressing 1 time weekly. <p>During an interview on</p>		<p>Patient 5 physician notified wound care not performed at ordered frequency. Orders received on 4/7/23 for caregiver to perform woundcare on days skilled nurse not present. Caregiver educated and completed return demonstration 4/10/23.</p> <p>During a mandatory staff meeting held on 5/3/23, the PI Team instructed all clinical staff and PCMs on home health policies Plan of Care, Patient Education, and On-Call Process with emphasis on: providing treatments and interventions ordered in the Plan of Care (POC); providing instruction and observing return demonstration on procedures, including intravenous (IV) therapy, prior to the patient/caregiver performing independently; and assuring that appropriate follow-up- visits are completed after hours if needed.</p> <p>For any staff not present, the PI</p>	
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	<p>#3 (employee of Entity #2) indicated Patient #5 was discharged on 3/22/2023, because a coccyx (area at base of spine) wound healed.</p> <p>Record review evidenced the patient only received 2 skilled nurse visits the week of 3/26/2023, and 1 skilled nurse visit the week of 4/2/2023. Record review failed to evidence the malignant back wound dressing was changed 3 times weekly as ordered on the plan of care.</p> <p>During an interview on 4/11/2023, at 10:39 AM, the Administrator indicated the patient should have received dressing care as was ordered on the plan of care.</p> <p>3. Clinical record review for Patient #8 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 1/31/2023 – 3/31/2023, which indicated the skilled nurse was to visit 1 time weekly for assessment of a right arm PICC line (peripherally inserted central catheter/intravenous line used for antibiotics).</p> <p>Record review evidenced a</p>		<p>Team or designee will provide instructions to the individual employees by 5/11/23.</p> <p>Each patient has an individualized Plan of Care (POC) developed in consultation with the patient, physician or authorized practitioner, and staff that integrates comprehensive assessment findings to address patient problems, needs, and goals, as well as to address specific services being provided.</p> <p>Medications, treatments, and interventions are provided by qualified agency staff as ordered by the physician or authorized practitioner.</p> <p>Per assessed knowledge deficit, patients and caregivers receive oral and/or written information on medication education to include:</p> <p>Self-administration and monitoring techniques.</p> <p>Using the progress/visit note, the clinician documents the level of patient/caregiver</p>	
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<p>skilled nurse visit note dated 2/8/2023, which failed to include an assessment of the PICC line.</p> <p>During an interview on 4/10/2023, at 3:38 PM, the Administrator indicated the nurse should have completed a head-to-toe assessment, including an assessment of the PICC line site.</p> <p>4. Clinical record review for Patient #9 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 12/1/2022 – 1/29/2023, which indicated the patient was to receive skilled nurse visit 3 times weekly for 1 week, and 2 times weekly for 8 weeks, for instruction on TPN (total parenteral nutrition/nutrition through an IV) administration. The plan of care indicated the patient was to receive nightly TPN infusions through a PICC line (peripherally inserted central catheter/intravenous line for nutrition and antibiotics).</p> <p>Record review evidenced the patient discharged on 12/1/2022, from the hospital.</p> <p>Record review evidenced a</p>		<p>comprehension, patient/caregiver return demonstration of skill(s) taught, compliance, and any follow-up with team members. Concerns are reported to the patient's physician.</p> <p>The agency will provide each client, upon admission to services, a designated on-call telephone number and will instruct each client to call this number to access care from the agency after regular business hours.</p> <p>The total response time from patient/caregiver call to patient/caregiver contact by clinician will be no longer than 30 minutes.</p> <p>Clinician will assess the needs of the patient and take the appropriate action; including, but not limited to making a home visit.</p>	
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skilled nurse start of care assessment dated 12/1/2022, which indicated Registered Nurse #3 educated the patient on TPN administration verbally. The visit note indicated the nurse administered an antibiotic by gravity during the visit.

Record review evidenced a skilled nurse visit note dated 12/2/2022, which indicated the patient indicated they were unable to infuse the TPN on 12/1/2022, as ordered because the pump was malfunctioning. This visit note indicated that upon assessment, the bag was not spiked completely. The visit note indicated Registered Nurse #3 used handouts to educate the patient on TPN administration with the IV pump. The visit note failed to evidence the patient had return demonstrated TPN administration and setup of the infusion pump.

Record review evidenced an on-call note dated 12/2/2022, at 9:11 PM, which indicated the patient was calling because the infusion pump was not working, and patient was unable to infuse the TPN. The on-call note indicated the patient requested

Clinicians will document responses and outcomes of appropriate calls on the On-Call Event Coordination note.

On call logs will be reviewed by the PCM daily to ensure appropriate follow up to after-hours calls occurred.

Beginning 5/8/23 the ED or designee will audit 4 visits notes per clinician per month. For clinicians scoring All new clinicians will have 2 note audits per week audited until 80% for 4 consecutive weeks then will go into the monthly rotation. The note audit will be a random pull of visits and will focus on ensuring that interventions were provided as ordered in the POC, and evidence of patient education and return demonstration is documented prior to patient/caregiver performing procedures independently.

The Executive Director is

<p>a nurse come to their home to help them infuse the TPN, since they hadn't received the prior night's infusion either. The on-call visit note indicated the nurse told the patient the on call service was for triage only, and for over the phone troubleshooting. The on-call note indicated the nurse put in an as needed visit for the next day to assist the patient.</p> <p>Record review evidenced a skilled nurse visit note dated 12/3/2022, which indicated the Clinical Manager assisted the patient in setting up the IV pump, and the patient return demonstrated setup of the IV pump 2 times during the visit.</p> <p>During an interview on 4/10/2023, at 3:51 PM, the Administrator indicated the nurse should have coordinated a visit with the patient when it was time to set up the TPN for administration. The Administrator indicated the nurse should have had the patient return demonstrate the IV pump setup, and TPN administration. The Administrator indicated the nurse should have made a visit the night the patient called the</p>		<p>implementation of the plan of correction.</p> <p>Beginning 5/14/23, ED or designee will complete 10 medical record reviews per week to ensure interventions are completed as ordered on the plan of care and the documentation reflects evidence of patient/ caregiver education and return demonstration prior to performing any procedures independently.</p> <p>Any deviations to this process will be addressed with clinician remediation and disciplinary action as indicated.</p> <p>Monitoring will continue for 12 weeks and will continue until 100% compliance achieved for 3 consecutive weeks.</p> <p>Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved</p>	
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	<p>on-call service, to assist with TPN administration.</p>		<p>Beginning 5/14/23, the ED will review the on-call logs weekly to ensure after hours calls have been addressed.</p> <p>Monitoring will continue for 12 weeks and will continue until 100% compliance achieved for 3 consecutive weeks.</p> <p>Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved</p>	
<p>G0716</p>	<p>Preparing clinical notes</p> <p>484.75(b)(6)</p> <p>Preparing clinical notes;</p> <p>Based on record review, and interview, the home health agency failed to ensure skilled professionals accurately prepared clinical notes and assessments in 5 of 10 clinical</p>	<p>G0716</p>	<p>During a mandatory staff meeting held on 5/3/23, the PI Team instructed all clinical staff and PCMs on accurate and completed documentation using home health policies Patient Assessment, Initial and Reassessment, Plan of Care, and Wound Assessment, Documentation, and Photography and the Clinical Note Review Tip Sheet with</p>	<p>2023-05-11</p>

records reviewed (Patient #2, 5, 6, 7, 8).

The findings include:

1. Record review evidenced a registered nurse job description obtained 4/11/2023, which stated, "... Essential Functions ... Documents patient visits thoroughly and completely per policy and payer requirements"

2. Record review evidenced an agency policy revised 3/1/2022, titled "Patient Assessment, Initial and Reassessment" which stated, "... Upon admission and reassessment, the qualified clinician performs the following assessment activities and collects the following data: ... Integumentary status ... Respiratory status ... Elimination status"

3. Clinical record review for Patient #5 was completed on 4/11/2023, for certification period 3/29/2023 - 5/27/2023. Record review evidenced a recertification comprehensive assessment dated 3/24/2023, which stated, "... No lesions 2+3d3ma" The

emphasis on: completion of complete assessments including but not limited to Respiratory, Cardiovascular, Genitourinary, and Endocrine systems; monitoring and documentation of blood glucose levels; documentation of location as indicated; lack of contradictory documentation; wound care documentation; and completing assessments as indicated on the POC.

For any staff not present, the PI Team or designee will provide instructions to the individual employees by 5/11/23.

Clinical Notes will be prepared accurately, per interventions outlined in the POC, painting a picture of the visit to include relevant findings, what was done, and there is no contradictory documentation within the visit note.

Beginning 5/8/23 the ED or designee will audit 4 visits notes per clinician per month. For clinicians scoring

comprehensive assessment failed to include a lung sound assessment. The comprehensive assessment indicated the patient had a urostomy (tube inserted into the bladder to drain urine), and failed to include an assessment of the urostomy site, or urine. The comprehensive assessment indicated the patient was diabetic (problem regulating blood sugars), but failed to include the patient's blood glucose measurement.

Record review evidenced a plan of care for certification period 3/29/2023 - 5/27/2023, which indicated the patient had a nephrostomy (tube inserted into kidney to drain urine). The plan of care indicated the patient was to receive daily blood glucose checks, and assessments of nephrostomy tube sites every visit.

Record review evidenced a skilled nurse visit note dated 3/31/2023, which failed to include a blood glucose measurement. This visit note also failed to include a nephrostomy tube assessment. This visit note indicated the patient had trace edema

The Executive Director is ultimately responsible for the implementation of the plan of correction.

Beginning the week of 5/14/23, the ED or designee will review 10 medical records weekly to ensure patient assessments are complete and no contradictory documentation noted.

Monitoring will continue weekly for 12 weeks and will continue until 100% compliance is achieved for 3 consecutive weeks. Deficient findings will be addressed immediately, and clinician remediation and disciplinary action will occur as indicated

Discussion of compliance will be discussed with the team during the quarterly Quality Assurance Performance Improvement team meetings until compliance is achieved.

(swelling), but failed to identify the location of the swelling. This visit note also indicated the patient did not have diabetes.

Record review evidenced a skilled nurse visit dated 4/7/2023, which indicated the patient had developed a new wound under the nephrostomy tube site, but failed to include an assessment of the wound, or measurements.

During an interview on 4/11/2023, at 10:26 AM, the Administrator indicated the recertification assessment was documented in error. The Administrator indicated the comprehensive assessment should have included an assessment of lung sounds. The Administrator indicated the nurse should have documented nephrostomy tube on the comprehensive assessment and included an assessment of the site and urine. The Administrator indicated any patient with diabetes should have blood glucose measurements included on all visit notes. At 10:34 AM, the Administrator indicated the nurse should have included an assessment on the 3/31/2023,

visit note of the nephrostomy tubes. At 10:34 AM, the Administrator indicated the 3/31/2023, visit note should have indicated the location of edema, and that the patient did have diabetes. The Administrator indicated any new wound should have included a documented assessment and wound measurements.

4. Clinical record review for Patient #6 was completed on 4/11/2023, for certification period 3/20/2023 - 5/18/2023. Record review evidenced a start of care comprehensive assessment dated 3/20/2023, which indicated the patient wore oxygen, but failed to include lung sounds in the respiratory assessment, or heart sounds in the cardiac assessment.

During an interview on 4/10/2023, at 3:07 PM, the Administrator indicated the comprehensive assessment should have included lung and heart sounds.

5. Clinical record review for Patient #7 was completed on 4/11/2023, for certification

period 2/19/2023 - 4/19/2023.

Record review evidenced a skilled nurse visit note dated 3/20/2023, which indicated wound care was provided, but also indicated the patient had no wounds because they were healed.

During an interview on 4/10/2023, at 3:28 PM, the Administrator indicated the documentation was inaccurate and shouldn't have had wound care provided to a healed wound.

6. Clinical record review for Patient #8 was completed on 4/11/2023. Record review evidenced a plan of care for certification period 1/31/2023 – 3/31/2023, which indicated the skilled nurse was to visit 1 time weekly for assessment of a right arm PICC line (peripherally inserted central catheter/intravenous line used for antibiotics).

Record review evidenced a skilled nurse visit note dated 2/8/2023, which failed to include an assessment of the PICC line.

During an interview on

Administrator indicated the nurse should have completed a head-to-toe assessment, including an assessment of the PICC line site.

7. Clinical record review for patient #2 was completed on 4/11/2023. Record review evidenced a comprehensive reassessment dated 3/22/2023. The document evidenced the patient had a wound on the left heel; the patient was paraplegic (paralyzed with absence of sensation from the waist down, and inability to control bowel or bladder), but then indicated the patient had no sensory deficit which would limit ability to feel or voice pain, and skin was rarely exposed to moisture; gastrointestinal assessment findings included only bowel sounds, but failed to indicate if the patient used an effective bowel program or was incontinent; the patient had a suprapubic urinary catheter (a tube inserted from a surgical opening in the lower abdomen into the bladder); and the nurse removed the old urinary catheter, cleansed the perineal area (skin between genitals and

anus), and inserted a new urinary catheter.

Record review evidenced a coordination note dated 3/7/2023, which indicated the patient had a foley catheter (inserted into the urethra), not a suprapubic catheter.

Record review evidenced a wound record report, which evidence the patient's right heel wound was resolved on 10/20/2022, and evidenced presence of a current wound to the left heel (onset date 9/26/2022).

Record review evidenced a team case conference/coordination note dated 3/08/2023, which evidenced skilled nursing to continue management of wound care to right heel, and right heel was making good progress.

	<p>Record review evidenced a team case conference/coordination note dated 3/15/2023, which evidenced care to be continued for care of nephrostomy tubes (thin plastic tube inserted in the back of the body, through the skin, and then into the kidney).</p> <p>On 4/11/2023 at 2:18 PM, when informed of the documented discrepancies in the clinical record, the Administrator closed her eyes, shook her head left to right, and then indicated she couldn't believe it, and confirmed the patient's perineal area wouldn't be cleansed to insert a suprapubic catheter.</p>			
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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.

<p>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Carla Johnson</p>	<p>TITLE RN, Executive Director</p>	<p>(X6) DATE 5/5/2023 6:40:37 PM</p>
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