STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157081	A. BUILDING B. WING	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACME HEALTH SERVICE INC	6302 N RUCKER RD STE J, INDIANAPOLIS, IN, 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness follow-up survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102, for a Medicare and Medicaid participating non-deemed Home Health Agency. Dates of Survey: 03-25-2024 and 03-26-2024 Census: 60 Unduplicated Skilled Admissions: 2 Acme Health Services INC was found to be in compliance with the requirements of Emergency Preparedness for Medicare and Medicaid providers and suppliers at 42 CFR 484.102. QR completed by Area 3 on 4-05-2024.	E0000		

G0000	INITIAL COMMENTS This was a Post-Condition revisit for a home health agency recertification and re-licensure survey conducted on 02/12/2024. Survey Dates: 03/25/2024 and 03/26/2024 12 Month Unduplicated Skilled Admissions: 2 During the post condition revisit survey Acme Home Health Services remains out of compliance with one previously cited condition, one previously cited condition was re-cited, two standards level deficiencies were corrected, and 1 additional standard was cited. Acme Home Health Services was found to be in compliance with CoP 484. 65 Quality Assurance and Performance Improvement, CoP 484.102 Emergency Preparedness, and CoP 484.105 Organization and Administration of Services. The agency remained out of compliance with Cop 484.60 Care Planning, coordination of services, and quality of care Acme Home Health Services	G0000		

	continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning February 12th, 2024, and continuing through February 11th, 2026. QR completed by Area 3 on 4-05-2024.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview the agency failed to ensure all patients received an individualized plan of care	G0570	The agency has made significantimprovements toward compliance in this area and recognizes that additional improvementsare still needed. In February 2024, theagency launched an extensive six-week nurse training program in which nursesand leadership began meeting at least once per week so that nurses, includingClinical Manager and Alternate Clinical Manager, could be in-serviced andre-trained on the process of both comprehensive assessments and care planning. Nurses have received extensive training bothindividually and in group sessions, step-by-step through each section of thecomprehensive assessment process, as well as through the care planning,coordination of services and quality of care processes. This training has	2024-04-25

	the plan of care to meet all required elements (G574); failed to ensure the plan of care was reviewed and revised every 60 days (G588), failed to ensure the coordination of care delivery (G608) for 4 of 6 active clinical records reviewed. (Patients #1, 4, 5, and 6) The cumulative effect of this systemic problem resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for 42 CoP 484.60 Care Planning, Coordination of Services, and Quality of Care. Findings Include: *		included, but has not beenlimited to, meeting the needs of therapy patients and notifying relevantphysicians of such, ensuring patient-specific and measurable outcomes andgoals, ensuring appropriate DME and documentation of such, appropriatelydocumenting specific frequency and duration of visits and treatments, safetymeasures to protect against injury, patient specific interventions, reportingsignificant changes to relevant physicians and coordinating care among otheragencies to ensure patient needs are met. The initial six-week training program ended, and Administrator and ExecutiveDirector performed a thorough review of newly performed assessments, plans ofcare and nurse documentation, which illustrated improvements had been made inthese areas, but also indicated that deficiencies in this process still exist,as related to the comprehensive assessment, care planning coordination of careand quality of care processes. Inaddition to this training, nurses will also receive further training on	

			appropriatephysician communication as related to sixty-day revisions to the plan of care. Weekly training sessions have been extendedand will continue indefinitely until leadership is confident that nurses have retainedthe information and that it is being appropriately applied in the course oftheir daily work with patients and their associated assessments and plans ofcare. Nurses will be held accountable tothe standard that all sections of the comprehensive assessment, care planning,coordination of services and quality of care processes are followed, and theClinical Manager will be responsible for ensuring that the standards are beingmet and that agency remains in compliance. Any deficiencies found by clinical management will be addressed with theattending nurse who will be responsible for correcting said deficiencies within24 hours and to report those corrections to clinical management for furtherreview. Clinical management will reportdirectly to the Administrator and Executive Director on this plan ofcorrection. This deficient	

			practice hadthe potential to affect all patients, and therefore, all patient assessments andplans of care will be held to this standard and corrected during each patient'snext scheduled re-certification visit. The Clinical Manager has the ultimateresponsibility to ensure that this plan of correction is followed. To further ensure said correction, theExecutive Director is auditing the most recent comprehensive assessment andplan of care for each current patient, is documenting audit findings and isreviewing the Clinical Manager, Administrator and respective attending nurses. After this phase ofadministrative audits are completed, the Administrator and Executive will continueto perform additional quality assurance checks on comprehensive assessments andplans of care. They will audit at least 10%of assessments and plans of care on a monthly basis. This plan of correction will remain ongoingin nature and compliance threshold is 100%.	

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 record review and interview, the agency failed to ensure each patient received an individualized plan of care and identified patient-specific measurable outcomes and goals for 2 of 6 active records reviewed (Patient #1 and #4). Findings include: 1. An agency policy with a revision date of October 2016, titled "Care Planning Process" indicated but was not limited to, "Purpose: To provide clinical direction to the clinicians providing patient care ... A written plan of care will be initiated within five (5) days of start of care and updated at least every 60 days or as patient's condition warrants ...	G0572	As previously noted in priordeficiency response to G0570, the agency has made significant improvementstoward compliance in both all areas of the care planning process and recognizesthat additional improvements are still needed. As also noted in G0570, in February 2024, the agency launched anextensive six-week nurse training program in which nurses and leadership beganmeeting at least once per week so that nurses, including Clinical Manager andAlternate Clinical Manager, could be in-serviced and re-trained on the processof both comprehensive assessments and care planning. Nurses have received extensive training bothindividually and in group sessions, step-by-step through each section of thecomprehensive assessment process, as well as through the care planning,coordination of services and quality of care processes. Theinitial six-week training program ended, and Administrator and ExecutiveDirector performed a thorough review of newly performed assessments, plans ofcare and nurse documentation, which	2024-04-25

	will participate in decisions regarding the plan of care ... The care planning process will be documented on the plan of care, individualized discipline-specific care plans ... The plan of care includes: ... G. Goals/outcomes to be achieved ... " 2. A review of the clinical record for Patient #1 contained a recertification comprehensive assessment dated/timed 03-13-2024,1600-1700 [4:00 PM – 5:00 PM] and electronically signed by the Clinical Manager. The comprehensive reassessment contained patient-specific goals, addressed progress towards any goals, and discharge plans indicating "Client has ongoing care needs." A review of the plan of care for Patient #1 with the recertification period from 03/16/2024 to 05/14/2024 indicated but was not limited to diagnoses, Spastic quadriplegic cerebral palsy (a condition that affects the ability to control muscles and movement in all four limbs, the trunk, and face), Neuromuscular scoliosis (a sideways curvature of the		illustrated improvements had been made inthese areas, but also indicated that deficiencies in this process still exist,as related to the comprehensive assessment and the overall care planning process. Weekly training sessions have been extendedand will continue indefinitely until leadership is confident that nurses have retainedthe information and that it is being appropriately applied in the course oftheir daily work with patients and their associated assessments and plans ofcare. The extended training also placesan emphasis on person-centered processes and ensuring that each plan of carehas patient-specific and measurable goals, physical limitations, nutritional requirements,mental status, rehabilitation potential, and discharge plans. Regarding patients #1 and #4, their plans ofcare have been corrected and nurses have been trained on the deficientprocesses within each of these respective plans of care. Nurses will be held accountable to thestandard that all sections of the comprehensive assessment, care planning,coordination of services and quality of care	

	spine), Localization-related (focal) (partial) symptomatic epilepsy (a condition caused by certain brain activity causing seizure activity). The sections titled "Goals/Rehabilitation Potential/Discharge Plans, Nutritional Requirements, Mental Status, Prognosis, Rehabilitation Potential, and Discharge Plans" were left blank. The plan of care failed to be patient-specific, failed to provide clinical directions to clinicians providing care, and failed to list any goals. During an interview on 03-25-2024 at 12:44 PM with the Clinical Manager, they reported Patient 1's plan of care for the certification period beginning 03/16/2024 was not completed and was still in quality review and they had not received a verbal order or physician's signature for the plan of care for this certification period. 3. A review of Patient '4's document titled "Start of Care/Follow-up Paraprofessional Assessment" indicated but was not limited to supportive assistance, physical evaluation, and service planning		processes are followed, and theClinical Manager will be responsible for ensuring that the standards are beingmet and that agency remains in compliance. Any deficiencies found by clinical management will be addressed with theattending nurse who will be responsible for correcting said deficiencies within24 hours and to report those corrections to clinical management for furtherreview. Clinical management will reportdirectly to the Administrator and Executive Director on this plan ofcorrection. This deficient practice hadthe potential to affect all patients, and therefore, all patient assessments andplans of care will be held to this standard and corrected during each patient'snext scheduled re-certification visit. The Clinical Manager has the ultimateresponsibility to ensure that this plan of correction is followed. To further ensure said correction, theExecutive Director is auditing the most recent comprehensive assessment andplan of care for each current patient, is documenting audit findings and isreviewing the Clinical Manager, Administrator and	

	evidencing assistance needed with activities of daily living such as meal preparation, grooming, bathing, dressing, and mobility. A review of Patient #4's clinical record evidenced a plan of care with a start of care date of 02-18-2019 and a recertification date from 03-23-2024-05/21/2024 indicated a primary diagnosis of Multiple Sclerosis (a disease of the brain and spinal cord affecting speech and movement), Idiopathic peripheral autonomic neuropathy (a disease causing damage to the nervous system, causing pain and weakness in the body), Hypertensive heart disease (chronic high blood pressure causing changes in the heart), Chronic diastolic heart failure (the main pumping chamber in the heart becomes stiff and fails to fill with blood properly), Hyponatremia (low sodium), Hypokalemia (low potassium), and Hyperlipidemia (high lipid levels, such as cholesterol). The plan of care failed to evidence patient-specific and measurable goals, physical limitations, nutritional requirements, mental		respective attending nurses. After this phase of administrative audits arecompleted, the Administrator and Executive will continue to perform additionalquality assurance checks on comprehensive assessments and plans of care. They will audit at least 10% of assessments andplans of care on a monthly basis. Thisplan of correction will remain ongoing in nature and compliance threshold is100%.	

	status, rehabilitation potential, and discharge plans and failed to provide clinical direction to clinicians providing care. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;	G0574	As previously noted in priordeficiency response to G0570 and G0572, the agency has made significantimprovements toward compliance in all areas of the care planning process andrecognizes that additional improvements are still needed. As also noted in G0570 and G0572, in February2024, the agency launched an extensive six-week nurse training program in whichnurses and leadership began meeting at least once per week so that nurses,including Clinical Manager and Alternate Clinical Manager, could be in-servicedand re-trained on the process of both comprehensive assessments and careplanning. Nurses have received extensivetraining both individually and in group sessions, step-by-step through eachsection of the comprehensive assessment process, as well as through the careplanning, coordination of	2024-04-25

	(xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure the Plan of Care was individualized and included all the required elements for 3 of 6 active clinical records reviewed (Patients #1, 4, and 6). Findings Include: 4. A review of the plan of care for Patient #1 for the recertification period of 03/16/2024 to 05/14/2024, electronically signed by the Clinical Manager, indicated but was not limited to diagnoses, Spastic quadriplegic cerebral palsy (a condition that affects the ability to control muscles and movement in all four limbs, the trunk, and face), Neuromuscular scoliosis (a sideways curvature of the spine), Localization-related (focal) (partial) symptomatic epilepsy (a condition caused by certain brain activity causing seizure activity). The sections titled “DME [durable medical equipment] and Supplies, Safety Measures, Nutritional Requirements, Prognosis,		services and quality of care processes. Theinitial six-week training program ended, and Administrator and ExecutiveDirector performed a thorough review of newly performed assessments, plans ofcare and nurse documentation, which illustrated improvements had been made inthese areas, but also indicated that deficiencies in this process still exist,as related to the comprehensive assessment and the overall care planning process. Weekly training sessions have been extendedand will continue indefinitely until leadership is confident that nurses have retainedthe information and that it is being appropriately applied in the course oftheir daily work with patients and their associated assessments and plans ofcare. The extended training also placesan emphasis on all pertinent diagnosis; patient’s mental, psychosocial andcognitive status; types of services, supplies and equipment required; frequencyand duration of visits; prognosis; rehabilitation potential; functionallimitations; activities permitted; all medications and treatments;	

	Goals/Rehabilitation and Potential/Discharge Plans" were left blank. The plan of care failed to be complete, patient-specific, failed to provide clinical directions to clinicians providing care, and failed to list any goals for Patient #1. During an interview on 03-25-2024 at 12:44 PM with the Clinical Manager, they reported Patient 1's plan of care for the certification period beginning 03/16/2024 was not completed and was still in quality review and they had not received a verbal order or physician's signature for the certification period. 5. A review of Patient #4's clinical record evidenced a plan of care with a start of care date of 02-18-2019 and a recertification of 03/23/2024 to 05/23/2024 indicating a primary diagnosis of Multiple Sclerosis (a disease of the brain and spinal cord affecting speech and movement), and other diagnoses including Idiopathic peripheral autonomic neuropathy (a disease causing damage to the nervous system, causing pain and weakness in		safetymeasures to protect against injury; risk for emergency departments visits andhospital re-admissions; advanced directive information; patient and familyspecific education, and measurable outcomes. Regarding patients #1, #4 and #6, each of their respective plans of carehave been corrected and nurses have been trained on the deficient processeswithin each of these respective plans of care. Regarding the re-certifying plan of care that was still in review forpatient #1, this was due to a system "conflict error" which could not becorrected by the Clinical Manager and it was necessary to work with thesoftware company to resolve this conflict. It has since been corrected. Nurseswill be held accountable to the standard that all sections of the comprehensiveassessment, care planning, coordination of services and quality of careprocesses are followed, and the Clinical Manager will be responsible forensuring that the standards are being met and that agency remains incompliance. Any deficiencies found byclinical management will be addressed with the	

	the body), Hypertensive heart disease (chronic high blood pressure causing changes in the heart), Chronic diastolic heart failure (the main pumping chamber in the heart becomes stiff and fails to fill with blood properly), Hyponatremia (low sodium), Hypokalemia (low potassium), and Hyperlipidemia (high lipid levels, such as cholesterol). The plan of care failed to evidence DME, supplies, safety measures, nutritional requirements, functional limitations, mental status, prognosis, goals, and discharge plans.		attending nurse who will beresponsible for correcting said deficiencies within 24 hours and to reportthose corrections to clinical management for further review. Clinical management will report directly tothe Administrator and Executive Director on this plan of correction. This deficient practice had the potential toaffect all patients, and therefore, all patient assessments and plans of care willbe held to this standard and corrected during each patient's next scheduledre-certification visit. The Clinical Manager has the ultimateresponsibility to ensure that this plan of correction is followed. To further ensure said correction, theExecutive Director is auditing the most recent comprehensive assessment andplan of care for each current patient, is documenting audit findings and isreviewing the Clinical Manager, Administrator and respective attending nurses. After this phase of administrative audits arecompleted, the Administrator and Executive will continue to perform additionalquality assurance checks on comprehensive	

	During an interview on 03/26/2024 at 10:45 AM with the Clinical Manager and the Executive Director, the Clinical Manager indicated the incomplete plan of care for Patient #4 was due to it not being finalized through their quality assurance and it should have been completed during the last 5 days of the previous certification period. The Executive Director further explained if a comprehensive assessment does not go through their quality review the information does not carry over to the plan of care. 410 IAC 17-13-1(a)(1)(D)(i, ii, iii, iv, v, vi, vii, vii, ix, x, xi, xii, xiv) 1. An agency policy revised October 2016 and titled “Care Planning Process”, Policy No. 4-001.1, indicated but was not limited to, “ … Policy … the patient plan of care will be developed or revised within five (5) working days of initiation of each service or of the reassessment of the patient … 1. Plan of Care … includes … D. Pertinent primary and secondary diagnoses, E. Food or drug allergies, F. Homebound status, G. Goals/outcomes to be		assessments and plans of care. They will audit at least 10% of assessments andplans of care on a monthly basis. Thisplan of correction will remain ongoing in nature and compliance threshold is100%.	

	achieved, H. Patient's mental status, I. Functional limitations, J. Activities permitted, K. Safety measures, L. Nutritional requirements, M. Medications including dose/frequency/route, N. orders for specific home health services and disciplines, treatments and procedures, including amount/frequency/duration, O. Supplies and equipment required, P. Discharge or referral plans, Q. Discharge teaching, R. Frequency and duration of visits, S. Prognosis, T. Rehabilitation potential ..." 2. A review of Patient #6's clinical record evidenced a Plan of Care (POC) with a start of care date of 03-10-2024 and a recertification date from 03-10-2024 to 05-08-2024. It indicated a primary diagnosis of Chronic combined systolic and diastolic, congestive heart failure (a disease where the ventricles of the heart are unable to produce enough pressure to circulate the blood appropriately and cannot relax, expand, or fill enough blood), Hypertension (high blood pressure), Osteoarthritis (wear and tear on the joints), pain in			

	abnormalities of gait and mobility. The POC indicated in the goals for the patient was for the Skilled Nurse to identify and implement an appropriate activity level, home safety program, and measures to manage pain by the next certification period. The POC failed to indicate the patient's pain goal level and a home safety program. The POC failed to have patient-specific goals. The POC failed to indicate the patient's risk for rehospitalization and emergency room visits. The POC evidenced the Discharge plans were left blank. 3. During an interview with the Executive Director, Clinical Manager, and Registered Nurse 1 on 03-26-2024 at 4:45 PM, they confirmed discharge planning was to be included in the plan of care and the goals were to be patient-specific.			
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the	G0588	The agency has re-trained allnurses on the requirement to appropriately communicate the patient physician asfrequently as the patient's condition or needs require, but to do so no less frequentlythan once every	2024-04-25

	home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Based on record review and interview the agency failed to evidence a recertification plan of care had been reviewed by a physician every 60 days in 1 of 6 clinical records reviewed. (Patient #1) Findings include: 1. A policy titled "Verification of Physician Orders" Policy No. 3-003.1 received from the Executive Director on 03/26/2024 at 9:43 AM, indicated but was not limited to, "PURPOSE To ensure that accurate physician . . . orders are obtained in accordance with applicable law and regulation. Orders will be obtained from a licensed physician (or other authorized licensed independent practitioner) for care and services provided to home health patients". 2. A review of the plan of care for Patient #1 for the recertification period of 03/16/2024 to 05/14/2024, electronically signed by the Clinical Manager, indicated but was not limited to "Respite RN 60.00 Hour Monthly for 1		60 days. Nurses havefurther been re-trained to document the exact time that they have spoken withthe physician, or his/her authorized designee, rather than following the timestamp in the software system. The EHRsoftware automatically stamps a time, based upon when the RN is in the systemand entering all the necessary data. Often, the RN's will do the assessment visits and later documenteverything in the system, and sometimes, this may occur during the eveninghours, merely depending upon the RN's workload on any given day. In the particular example of Patient #1, the RNmade the visit to see the client during late afternoon hours and did the dataentry and charting from home that same night; hence, the time stamp of 10:04 pm. Nurses have been re-educated on the timestampsystem and that they must manually change the times to reflect actual time thatthey spoke with the physician representative. The Clinical Manager has also been trained in her responsibility toensure that she is checking date and time stamps when performing QA on nursevisits	

	Certification Period(s) starting 3/16/2024, RN HOURLY I 76.00 Hour Weekly for 1 Certification Period(s) . . . RN ReCert Oasis 1 Visit for Certification Period(s) starting 3/16/2024. The sections titled "Clinician/Therapist signature and date of Verbal SOC where applicable" indicated "Verbal order obtained and electronically signed by [name of Clinical Manager] RN, 03/14/2024 at 22:04 [10:04 PM]" The plan of care failed to evidence a review was completed by the physician with a verbal order within 60 days. During an interview on 03/25/2024 at 12:44 PM the Clinical Manager reported they did not call the physician and receive a verbal order for Patient #1's plan of care for the certification period beginning 03/16/2024 and indicated they only call if there is a change in the plan of care and provided no evidence the physician had been notified of the recertification for review of the plan of care. IAC 17-13-1(a)(2)		and the plans of care. Nurse trainingswill weekly and indefinitely until administration leadership is confident thatnurses have corrected all deficiencies and are incorporating the training intotheir daily routine as they visit patients and prepare their plans of care. The Clinical Manager will be responsible forensuring that the agency is in compliance with this regulation by communicatingwith the physician as frequently as needed, upon a significant change or atleast every 60 days upon re-certification. The Clinical Manager is responsible for ensuring that all nurses aredocumenting physician contact and communication. This deficient practice had the potential toaffect all patients and the Clinical Manager has the ultimate responsibility toensure that this plan of correction is followed. To further ensure said plan of correction,the Administrator and Executive will perform monthly quality assurance checkson no less than 10% of patient records. This plan of correction will remain ongoing in nature and compliancethreshold is 100%.	

G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the agency failed to coordinated care delivery with other providers for 2 of 6 active clinical records reviewed. (Patients #5 and 6) Findings Include: 1. An agency policy with a revision date of October 2016, titled "Coordination of Services with Other Providers" Policy No. 4-016.1, indicated but was not limited to, " ... The Case Manager will act as a liaison with other organizations or individuals also providing care to the patient to assure effective coordination of related services ..." 2. During the Entrance conference on 03-25-2024 at 9:45 AM, when queried on how care was coordinated with other agencies, the Executive Director, Admin 2, indicated they had called the other agencies and	G0608	As previously noted in priordeficiency response to G0570, G0572 and G0574, the agency has made significantimprovements toward compliance in all areas of comprehensive assessments and thecare planning process, as well as the coordination of care delivery; and agencyrecognizes that additional improvements are still needed. As also noted in G0570, G0572 and G0574, inFebruary 2024, the agency launched an extensive six-week nurse training programin which nurses and leadership began meeting at least once per week so thatnurses, including Clinical Manager and Alternate Clinical Manager, could bein-serviced and re-trained on the entire assessment, care planning andcoordination of care delivery processes. Nurses have received extensive training both individually and in groupsessions, step-by-step through each of these processes. The training process for integrating andcoordinating care delivery of all services includes, but is not limited to,conducting multi-disciplinary meetings to ensure that patients' overall healthand goals	2024-04-25

	providers and received updates. They indicated they contacted the other providers in the patients' homes upon the patients' recertification. They indicated the communication and updates were listed in the electronic medical record titled "Case Communication". They indicated the other providers were also listed in the plans of care (POC). 3. During a review of Patient #5's clinical record, it evidenced, in the POC, a start of care date of 11-13-2019 and a recertification date of 02-20-2024 to 04-19-2024. The POC evidenced the patient received assistance from Entity C, a personal service agency, Sunday through Saturday 4:00 PM to 9:00 PM. During an interview with Person D, the owner of Entity C, on 03-25-2024 at 3:40 PM, they indicated the agency had never reached out to them regarding Patient #5. They indicated the only individual they received information from was Person E, Patient #5's relative and caregiver. 4. During a review of Patient		are being met; ensuring that members of the multi-disciplinary team,whether agency employees or joint providers, are receiving frequentcommunication regarding patient's overall health status, any significantchanges, recent or upcoming physician visits, the need for and receipt of anynew durable medical equipment, changes in living arrangements, changes in careproviders and any other pertinent information related to the patient. Given that deficiencies still exist, aspreviously noted, weekly training sessions have been extended and will continueindefinitely until leadership is confident that nurses have retained theinformation and that it is being appropriately applied in the course of theirdaily work with patients and their coordination of care delivery. The extended training also places an emphasison the responsibility of all nurses to communicate with other providers and todocument such communication in the appropriate areas of the EHR. In February, the agency developed andimplemented a	

	#6's clinical record, it evidenced, in the POC, a start of care date of 07-14-2023 and a recertification date of 03-10-2024 to 05-08-2024. The POC evidenced the patient received Attendant care services from Entity F, a personal service agency. During an interview with Person G, the owner of Entity F, on 03-26-2024 at 2:37 PM, they indicated they had provided services to Patient #6 for more than a year and was not aware the patient received services from the agency. They indicated they were never contacted by the agency regarding Patient #6. 5. During an interview with the Executive Director, Clinical Manager, and Registered Nurse 1 on 03-26-2024 at 4:45 PM, they confirmed they were supposed to coordinate care with other providers in the patient's home. 410 IAC 17-14-1(a)(1)(F)		new form, "joint provider listing," and the Alternate ClinicalDirector and another RN are communicating with all patients and/or theirauthorized representatives to ensure that the agency has a current list of alljoint providers. For the purposes ofdefining "joint provider," this may include, but not be limited to, other homehealth agencies, personal service agencies, dialysis clinics, coumadin clinics,IV infusion services, adult day programs, assisted living facilities, adultfamily care homes, waiver case managers, relevant physicians, social workersand mental health counselors and practitioners, transportation providers,emergency response systems, home delivered meals, providers of durable medicalequipment, pharmacies, providers of diabetic supplies and providers ofincontinent supplies. Attending nurses arerequired to take said listing to each patient visit and to review the listingwith patient and/or authorized representative and to update any changes. The attending nurse will further be requiredto document any changes within the patient's plan of care during	

			there-certification process. The ClinicalManager will be responsible for ensuring that the agency is compliance with thecoordination of care delivery and that there is appropriate documentation ofsuch within each patient's electronic health record. This deficient practice had the potential toaffect all patients and the Clinical Manager has the ultimate responsibility toensure that this plan of correction is followed. To further ensure said plan of correction,the Administrator and Executive will perform monthly quality assurance checkson no less than 10% of patient records. This plan of correction will remain ongoing in nature and compliancethreshold is 100%.	
G0958	Clinical manager 484.105(c) Standard: Clinical manager. One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following-- Based on record review and interview, the Clinical Manager failed to ensure the	G0958	Effective April 7, 2024, a changewas made in the Clinical Manager role. The former Clinical Manager remains with the agency and another RN hasmoved into the role of Clinical Manager. The new Clinical Manager has been involved in all prior weekly nursetraining sessions that have been a part of the agency's ongoing plan ofcorrection. She	2024-04-25

	coordination of care with other providers in the patient's home, failed to ensure patients' needs were continuously assessed, and provided services for all active patients for 5 of 6 active clinical records reviewed. (Patients #1, 4, 5, 6, and 14) Findings Include: 1. The Clinical Manager's job description titled "Clinical Director" dated 03-21-2023 indicated but was not limited to, " ... 1. Coordinates and oversees all direct and indirect patient services provided by clinical organization personnel ... 4. Provides help in assessment, planning, implementation and evaluation of patient and family/caregiver care to all clinical personnel as indicated ..." 2. A review of 2 of 6 active clinical records (Patients #5 and 6) failed to evidence any coordination of care notes with other providers providing care for the patients. The agency failed to coordinate care with Patient #5's personal service agency, Entity C. The agency failed to coordinate		is also receivingadditional orientation and training that is specific to her new role as ClinicalManager. To ensure that the new ClinicalManager has an understanding of this plan of correction and the various tags anddeficiencies associated with it, the Executive Director has reviewed the 2567and the plan of correction, with her and has incorporated it into the trainingof her new role. The Clinical Manager isbeing trained on all areas of responsibility, and those have includeddeficiencies related to coordinating and overseeing all direct and indirectpatient services provided by clinical personnel; assisting with assessing,planning, implementing and evaluating of patients; monitoring clinical visitsand ensuring that appropriate charting and documentation to assessments andplans of care occur; communicating with MD's and other joint providers and documentingsuch communication; ensuring that plans of care are current and accurate toinclude all providers, DME, mental health status, psychosocial and cognitivestatus, frequency and	

	care with Patient #6's personal service agency, Entity F. 3. During the Entrance Conference with the Executive Director on 03-25-2024 at 9:45 AM, they indicated the coordination of care notes would be in the electronic medical record titled "Case Communication" or "Client Logging". The clinical records evidenced no communication to Entity C and Entity F.		duration of visits, prognosis, rehabilitation potential,functional limitations, activities permitted, nutritional requirements, allmedications and treatments, safety, hospitalization potential, patient andcaregiver education and training, interventions, advanced directives andpatient-specific goals. The deficient practices in thisarea noted had the potential to affect all patients, and therefore, the new ClinicalManager has received additional training on the overall care coordinationprocess, along with the discharge process, and will have the ultimateresponsibility to ensure that this entire plan of correction is followed. To further ensure said correction, theExecutive Director has tasked the new Clinical Manager with the responsibilityof personally contacting each client to discuss each of their respective plansof care and their overall care experience. This will allow the new Clinical Manager to become personally familiarwith those patients whom she has not previously met and will	

	4. During a review of 3 of 6 active clinical records (Patients #1, 4, and 6), the Clinical Manager failed to ensure plans of care were updated, complete, patient-specific, and contained all pertinent diagnoses, patient's mental, psychosocial, and cognitive status, types of services, durable medical equipment (DME), frequency and duration of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety, hospitalization potential, patient and caregiver education and training, interventions, advanced directive, and patient-specific goals. 5. During an interview with the Clinical Manager on 03-26-2024 at 4:45 PM, they indicated the plan of care needed to be patient-specific and individualized. 6. During a review of the document titled "Resident Census" on 03-25-2024, it evidenced Patient #14 was an active patient with a start of care date of 09-25-2023. A review of the document titled		allow her theopportunity to correct any further deficiencies as related to each of theirpersonalized plans of care. The ClinicalManager will be directly supervised by the Executive Director who will continueto assist in training of Clinical Manager and the monitoring of this plan ofcorrection. This plan of correction willremain ongoing in nature and compliance threshold is 100%.	

	"Discharge Details Reports" failed to evidence Patient #14 was discharged from the agency. During a review of the patient's clinical record, it failed to evidence a current plan of care, physician orders for services, comprehensive assessment, and Home Health Aide (HHA) visit notes. The clinical record evidenced a plan of care with a start of care date of 09-25-2024 and an initial certification date of 09-25-2024 to 11-23-2023. The plan of care was signed by the patient's primary care provider, Person H, on 11-20-2023. . The clinical record evidenced the patient's relative and primary caregiver signed consents for service documents. The clinical record evidenced Registered Nurse 1 performed a Start of care assessment on Patient #14 on 09-25-2023. The clinical record failed to evidence any further visits for the patient since 09-25-2023. Patient #14's clinical record evidenced documents titled "Client Logging Report". The report evidenced on 10-12-2023 at 5:43 PM, the			

	the note they had thought they had an aide for the patient, but the aide was not able to work the hours the patient needed. The note indicated Person I had said, "will take whatever (sic Patient #14) can get, as far as hours, at this point". A note dated 12-04-2023 by Admin 5, Intake and Clerical staff, indicated Person I informed the Scheduler, Admin 4, they had a relative who was willing to be certified to care for Patient #14. The clinical record evidenced no further notes or documentation. During an interview with Person I, Patient #14's relative and primary caregiver, on 03-26-2024 at 11:04 AM, they indicated the patient never received any services from the agency. Person I indicated a nurse had performed an assessment on the patient and they completed the initial admission paperwork during the visit. They indicated the agency informed them they were unable to staff the patient. They indicated the agency had not assisted them with finding another agency for the patient. During an interview with the Executive Director on			

	03-26-2024 at 10:30 AM, they indicated they were unsure who Patient #14 was because they had only spoken to Person I. They indicated they were unable to staff the patient because of the patient's location. They indicated they never discharged the patient. During an interview with Person I on 03-26-2024 at 12:15 PM, they indicated they had no one to care for the patient during the hours they were at work. They indicated Patient #14 was not a patient at another home health agency. They indicated they were under the impression the patient was never admitted because of staffing. During an interview with RN 1 on 03-26-2024 at 1:10 PM, they confirmed the document titled "Resident Census" was the active roster. They indicated they may have seen Patient #14 once or twice when the patient first started. They admitted the patient on the first initial assessment but were unable to find an aide for the patient to meet the patient's needs. They confirmed the patient was not discharged. They confirmed for active patients, they needed to			

	have a new plan of care every 60 days. They indicated if they were unable to staff the patient, they were to discharge the patient. They indicated they had not had to help Person I find another agency for the patient. They indicated active patients were to receive all services according to physician orders on the plan of care. They indicated the patient never received any services from the agency and the patient should have been discharged. During an interview with the Clinical Manager on 03-26-2024 at 1:52 PM, they indicated a patient was admitted to the agency when they received orders from the physician and the Admission paperwork was completed. They indicated they would discharge the patient if they were unable to provide staff and assist the patient in finding another agency. The Clinical Manager indicated they were not aware of who Patient #14 was and were unaware of the patient being an active patient. 410 IAC 17-12-1(d)			

N0000	Initial Comments	N0000		

This visit was a post condition revisit for a State Re-licensure survey of a Home Health Agency.

Survey Dates: 03-25-2024 and 03-26-2024.

QR completed by Area 3 on 4-05-2024.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kamala M. West	Executive Director	4/18/2024 7:54:05 PM