STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100263320A	A. BUILDING B. WING	12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOME CARE SERVICES INC	1909 SOUTH HEATON STREET, KNOX , IN, 46534

(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	This survey was a Post Condition Recertification Survey for a home health agency. Survey Dates: 12/2/2021, 12/3/2021, 12/6/2021, 12/7/2021, and 12/8/2021. Facility ID: 157078 This deficiency report reflects State Findings cited in accordance with 410 IAC 17.	G0000		2022-01-31
N0000	Initial Comments This survey was a State re-licensure survey for a home health agency. Survey Dates: 12/2/2021, 12/3/2021, 12/6/2021, 12/7/2021, 12/8/2021 Facility ID: 157078	N0000		2022-01-31
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Survey Dates: 12/2/2021, 12/3/2021, 12/6/2021, 12/7/2021, and 12/8/2021 Facility ID: 157078	E0000		2022-01-31

	At this Emergency Preparedness survey, Community Home Care Services, Inc. was found to not be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.			
E0030	Names and Contact Information 484.102(c)(1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under	E0030	In response to E0030, the agency's Emergency Preparedness contact list/call tree was updated during the survey to include the name and contact information for the Alternate Administrator. The Administrator made certain that each member of the agency team was provided with a copy of the updated EPP contact list. The Emergency Preparedness Plan is reviewed minimally every 2 years. The Administrator is responsible for assuring that all employees are always updated on the EPP list. On a monthly basis, the Administrator will review the EPP list to assure that all current employees are included on the list. The agency's Emergency Preparedness contact	2022-01-05

	arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following:		list/call tree was updatedduring the survey to include the name and contactinformation for the Alternate Administrator. The Administrator made certainthat each member 1/5/2022 Of the agency team wasprovided with a copy of The updated EPP contactlist. The Emergency Preparedness Plan is reviewedminimally every 2 years. The Administrator isresponsible for assuring that 1/5/2022 all employees are always updatedon the EPP list. On a monthly basis, theAdministrator will review 1/5/2022 the EPP list to assure that allcurrent employees are	

(2) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Volunteers.

(iv) Other OPOs.

(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).

Review of an agency policy, revised January 2020, and obtained 12/8/2021, titled Communication Plan and Policy for Emergency Operations Plan (EOP) stated, & The Agency has developed and maintains an emergency preparedness communication plan that complies with federal, state and local laws. The communication plan is reviewed and updated at least every two years & The communication plan includes the following: Names and contact information for the following: Staff &.

Review of the agency s emergency preparedness plan on 12/6/2021 evidenced a document the administrator indicated was the call tree as part of the communication plan. The document failed to evidence the name and contact information for the alternate administrator.

During an interview at the entrance conference on 12/2/2021 at 10:45 AM, the alternate clinical manager indicated employee D was the alternate administrator.

During an interview on 12/6/2021 at 9:42 AM, the administrator indicated the alternate administrator s name and contact information

included on the list.

	should be included on the call tree of the communication plan.			
G0374	Accuracy of encoded OASIS data 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Review of agency policy, revised March 2019 and obtained 12/8/2021, titled Reporting of OASIS (The Home Health Outcome and Assessment Information Set) Information stated, & Agency staff will ensure that the accuracy of OASIS data reflects the patient s status at time of assessment and data collection & The encoded OASIS data must accurately reflect the patient s status at the time of assessment " Clinical record review on 12/6/2021 for patient #5, start of care 11/1/2021, evidenced an agency document titled Home Health Certification and Plan of Care which indicated a principal diagnosis of displaced pilon fracture left tibia (a type of break that occurs at the bottom of the shinbone and involves the weight-bearing surface of the ankle joint). This document stated under summary of skilled nurse orders, patient to be non-weight bearing to LLE (left lower extremity), assess surgical wound site to LLE." Review of an agency document titled Start of Care (D1) , dated 11/1/2021 and electronically signed by RN [registered nurse] J, indicated patient had surgical diagnosis of multiple surgeries on left ankle fracture, displaced pilon fracture left tibia. This document indicated patient was to be non-weight bearing to left lower extremity and stated there was a surgical incision and boot to left lower extremity. Review of an agency document titled Discharge from Agency (D1) , dated 11/23/2021 and electronically signed by RN J, indicated that patient had surgical wound to right lower extremity and dressing to right lower extremity. This document stated, the wound to right lower extremity continued healing . This document indicated that patient remained non-weight bearing to right lower extremity. The document failed to evidence the OASIS was accurate to	G0374	The agency counseled RN J related to the need for accuracy of documentation in the client’s medical record to include the accurate location of the wound and weight bearing status of the left lower extremity vs. the right lower extremity. Clinicians will be educated regarding accuracy of documentation and review of clinical note prior to submission. The agency hasimplemented a quality review process to assure accuracy of clinicaldocumentation. If errors are identifiedin the clinician documentation, the clinician is notified to review and correctthe documentation. 100% of clinical notesare reviewed for accuracy prior to completion as part of the qualityprogram. This review will continue until100% accuracy of documentation validated. At that time, review will reduce to 50% per clinician to assure ongoingcompliant documentation. The Administrator isresponsible for assuring ongoing documentation	2022-01-24

	dressing. The document failed to evidence an accurate representation of the patient s current status in OASIS. During an interview on 12/7/2021 at 11:54 AM, the alternate clinical manager indicated the surgical wound location should have been documented as left lower extremity. Alternate clinical manager indicated that the OASIS document was not accurate, and weight bearing status should have been the left lower extremity.		clinical record review willtrack and trend clinician accuracy on quarterly basis.	
G0414	HHA administrator contact information 484.50(a)(1)(ii) (ii) Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints. Record review of an undated agency document titled "Admission Agreement" stated "Patient Rights ... You have the right to voice grievances about your treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone furnishing services on behalf of the agency without being subjected to discrimination or reprisal ...." During observation of a home visit for patient #1, on 12/3/2021, at 2:56 PM, with RN [registered nurse] E, a review of the patient s home folder evidenced clinical manager C s name as the administrator. The observation failed to evidence the current administrator's contact information, including but not limited to the administrator's name, was provided to the patient. During an interview on 12/8/2021, at 10:12 AM, alternate clinical manager B indicated clinicians should ensure information is correct in the patient s home folder.	G0414	The Agency hascorrected the contact information in the home folder for patient #1. This was corrected during the survey. All active patients on census were providedwith new/revised information identifying the name and contact information forthe Administrator. This information was mailed to all patients. A review of the admission handbooks in theoffice was conducted to assure all packets have the correct Administratorcontact information. The Administrator isresponsible for assuring that patients have accurate contact information in thehome. The Administrator will assure ongoing checks of handbooks for accuracy.	2022-01-24

			During visits topatient homes, RNs will be educated to review the admission handbooks to assureaccuracy of information related to Administrator contact information.	
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. Review evidenced an agency policy titled, Personnel Records revised October 2017, stated ... The personnel record or personal information for an employee will include, but not be limited to, the following: & Verification of education, certification and/or licensure &.	N0458	The Agency hasinstituted a process to conduct re-verification of all licenses of professionalstaff in January of each calendar year. If a license is expiring during that year, a spreadsheet will be used totrack expiring licenses, receipt of the renewed license and validation of thelicense. This PT license was verified asactive during the survey. The Administrator is responsible for assuring licenses are active and verifiedfor all staff.	2022-01-20

	Review evidenced an agency policy titled, License, Registration or Certification Requirements revised October 2017, stated & When current licensure, certification and/ or registration are required by law and/ or regulation to practice a profession, the Agency verifies such credentials with the primary source at time of hire and prior to or upon expiration of credentials. Primary source verification will occur through the applicable State Board of practice ...." Personnel record review on 12/3/2021 for physical therapist (PT) H, hire date 1/14/2020, and first patient contact date 1/14/2020, indicated the PT license for PT H expired 6/30/2020. Review failed to evidence the PT license was verified and active. During an interview on 12/3/2021 at 11:34 AM, the administrator indicated the license for PT H had not been verified since 2020.			
N0460	Home health agency administration/management 410 IAC 17-12-1(g) Rule 12 Sec. 1(g) As follows, personnel records 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.	N0460	The supervising nurseannual evaluation has been completed and placed in the personnel file. The Administrator is responsible for conducting a personnel file reviewannually to assure that all personnel files are complete with all requireddocuments for all staff.	2022-01-05

	Review evidenced an agency policy titled, Personnel Records revised October 2017, which stated & The personnel record or personnel information for an employee will include, but not be limited to, the following: & Performed appraisal/evaluation forms Review evidenced an agency policy titled, Performance Appraisals/ Evaluations revised October 2017, which stated & The evaluation must be signed by the employee and supervisor & Additional [accrediting body] Requirements & 1. Personnel evaluations are completed, shared, reviewed, and signed by the designated manager/ supervisor and personnel no less frequently than every twelve (12) months & 2. Qualified personnel observe and evaluate each direct care staff member performing their job duties at least annually as part of the performance evaluation &. Personnel record review for the alternate clinical manager on 12/3/2021, failed to evidence a performance evaluation since 7/19/2020. Review failed to evidence the supervising nurse failed to follow the agency s policy to have an evaluation no less than every 12 months. During an interview at the entrance conference on 12/2/2021 at 10:45 AM, the alternate clinical manager indicated the clinical manager, registered nurse C, was on medical leave and indicated as the alternate clinical manager, she was the supervising nurse. During an interview on 12/3/2021 at 11:58 AM, the administrator indicated she did not see a performance evaluation for the alternate clinical manager since 7/19/2020.			
N0460	Home health agency administration/management 410 IAC 17-12-1(g) Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall:	N0460	The supervising nurseannual evaluation has been completed and placed in the personnel file. The Administrator is responsible for conducting a personnel file reviewannually to assure that all	2022-01-05

	(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. the.		personnel files are complete with all requireddocuments for all staff.	
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Review of an agency policy, revised March 2018, titled Medication Reconciliation stated, Policy & The Agency will reconcile patient s medications at time of admission and on an ongoing basis in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with drug therapy ... Purpose & To define the medication reconciliation process & Procedure & 1. At the time of admission, the admitting RN, PT, or SLP will create and document a complete list of medications that the patient is taking at home, including dose, strength, route, and frequency ... Discrepancies include duplications, omissions, changes, contraindications and/ or unclear information ... The Agency Provides the patient and/ or caregiver with written patient medication schedule/ instructions including medication	G0536	The Agency is working with the organization’s EMR, Point Click Care to expedite a request for the EMR to flag any duplicative (generic/brand) drug therapy in the medication profile and/or Plan of Care. Until this enhancement is completed, the agency has implemented a clinical quality review of medication profiles and plans of care to assure there is no duplicative drug therapy documented by clinicians on the medication profile or plan of care. 100% of medication profiles will be reviewed to assure accuracy until EMR enhancement	2022-01-30

	name, dose, strength, route and frequency as well as which medications will be administered by Agency staff and staff acting on behalf of the Agency & 2. Medications ordered while the patient is receiving care will be compared to the medication list/ profile. The medication list/ profile will be updated with each new or changed medication. The patient's medication list in the home will also be updated &. Clinical record review on 12/8/2021, for patient #1, start of care 9/2/2021, diagnoses included but were not limited to stage 2 and 3 pressure ulcers, spina bifida, and type 2 diabetes with diabetic polyneuropathy, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/1/2021 12/30/2021. This document had an area subtitled "10. Medications: Dose/Frequency/Route" which stated "... Montelukast Sodium [anti-inflammatory medication used to treat asthma and allergies]10mg [milligram]/ one tablet/ Daily/ Oral/ Start Date: 09/01/2021 ... Singulair [brand name for Montelukast Sodium] 10 mg/ One tablet/ Daily/ Oral/ Start Date: 09/01/2021 ...." Review evidenced the same medication, mentioned twice on the ordered medications on the plan of care. Review failed to evidence the medications were reviewed for duplicate drug therapy. During an interview on 12/8/2021, at 10:21 AM, alternate clinical manager B indicated the medication reconciliation should recognize duplicate drug therapy. Alternate clinical manager B indicated they were unsure why the system would not catch montelukast and singulair as a duplicate drug therapy.		completed. The Administrator is responsible for assuring process is effective in assuring accuracy of medication profiles. Clinical record reviews will be conducted to assure medication profiles are accurate as a component of the QAPI program with results reported quarterly. Trending of accuracy will be reported to agency leadership.	
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;	G0574	The agency will conductretraining for clinicians regarding adding patient identified goals to the planof care and assure that goals related to the primary diagnosis are added to theplan of care. A quality reviewprocess has been implemented to assure	2022-01-24

	(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; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Clinical record review on 12/6/2021, for patient #3, start of care 4/14/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 10/11/2021 12/9/2021, which was signed by RN J on 11/4/2021. This document indicated the patient s primary diagnosis was diabetes (a chronic disease that affects how your body uses blood sugar.) The document indicated the patient lacked understanding of complications related to diabetes and failed to evidence specific skilled interventions and goals to address the patient s lack of understanding regarding diabetes. This document failed to evidence individualized blood sugar parameters. Review of an agency document titled Skilled Visit Note , signed by RN J and dated 11/22/2021,		plans of care are comprehensive aftercompletion by the clinician. If reviewof the admission documents reflects the need for additional goals, theclinician will review and approve all recommended additions by the quality teamto assure patient identified goals and goals specific to the primary diagnosis. The Administrator isresponsible for assuring complete and thorough plans of care inclusive ofpatient identified goals and goals specific to primary diagnosis. 100% of plans of carewill be reviewed prior to submission to physician to assure accuracy of goals. The agency will conductretraining for clinicians regarding adding blood sugar reporting parameters andnotifying physicians of blood sugars not within range. A quality reviewprocess has been implemented to assure plans of care include blood sugarparameters. Blood sugar parameterswill be	

	indicated the patient indicated the fasting blood sugar was 265. During an interview on 12/7/2021 at 11:20 AM, the alternate clinical manager indicated blood sugar parameters were individual for each patient and indicated the blood sugar parameters should be included on the plan of care.		added to each plan of care for patients with diabetes for whichclinicians should report blood sugar results outside of range. 100% of plans of carewill be reviewed prior to submission to physician to assure blood sugar parametersare included on plan of care. The Administrator isresponsible for assuring complete and thorough plans of care. The agency reviewed thesituation with patient #1 plan of care not including skilled nursingfrequencies. It was identified thatfrequencies were identified in the correct location in the OASIS document whichshould pull the frequencies to the plan of care. There was not an explanation provided as toreason for the computer glitch. The agency hasinstituted a review process for plans of care	

			prior to having them sent tophysician for signature. This reviewwill include assurance that frequencies for all disciplines are included on theplan of care. The agency created averbal order for skilled nursing frequencies and sent this to the physician forsignature for certification period 11/1/2021 – 12/30/2021. The Administrator isresponsible for assuring complete and thorough plans of care.	
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made;	G0574	The agency will conductretraining for clinicians regarding adding patient identified goals to the planof care and assure that goals related to the primary diagnosis are added to theplan of care. A quality reviewprocess has been implemented to assure	2022-01-24

	(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; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Review of agency policy, revised March 2019 and obtained 12/8/2021, titled Plan of Care CMS #485 and Physician Orders stated &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 Agency 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. & patient-specific measurable outcome is a change in health status, functional status, or knowledge, which occurs over time in response to a health care intervention that provides end-result functional and physical health improvement/stabilization. & Patient-specific goals must be individualized to the patient based on the patient s medical diagnosis, physician s orders, comprehensive assessment and patient input. Progress/non-progress toward achieving the goals is evaluated through measurable outcomes. The Agency includes goals for the patient, as well as patient preferences and service schedules, as a part of the plan of care. Clinical record review on 12/6/2021 for patient		plans of care are comprehensive aftercompletion by the clinician. If reviewof the admission documents reflects the need for additional goals, theclinician will review and approve all recommended additions by the quality teamto assure patient identified goals and goals specific to the primary diagnosis. The Administrator isresponsible for assuring complete and thorough plans of care inclusive ofpatient identified goals and goals specific to primary diagnosis. 100% of plans of carewill be reviewed prior to submission to physician to assure accuracy of goals. The agency will conductretraining for clinicians regarding adding blood sugar reporting parameters andnotifying physicians of blood sugars not within range. A quality reviewprocess has been implemented to assure plans of care include blood sugarparameters. Blood sugar parameterswill be	

	#6, start of care 8/30/2021, evidenced an agency document titled, Home Health Certification and Plan of Care for certification period 10/29/2021 12/27/2021, which was electronically signed by RN J on 12/3/2021. This document indicated the patient s principal diagnosis was chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). This document stated, Summary of SN [skilled nurse] Orders: & instruct on COPD (chronic obstructive pulmonary disease) disease process, prescribed treatments, s/s to report to SN/MD [skilled nurse/medical doctor]". Plan of care failed to evidence goals related to principal diagnosis. Plan of care failed to evidence measurable outcomes and goals related to patient education about COPD. Plan of care failed to comply with agency policy and procedures regarding patient-specific goals based on patient s medical diagnosis. In interview 12/7/2021 at 11:39 AM alternate clinical manager indicated the plan of care should include goals that relate to education provided, and primarily be focused on the principal diagnosis. Alternate clinical manager indicated that patient education would be marked complete when goal was met. The alternate clinical manager was in agreeance that there were not any patient-specific, measurable goals in the plan of care related to primary diagnosis of COPD and patient education.		added to each plan of care for patients with diabetes for whichclinicians should report blood sugar results outside of range. 100% of plans of carewill be reviewed prior to submission to physician to assure blood sugar parametersare included on plan of care. The Administrator isresponsible for assuring complete and thorough plans of care. The agency reviewed thesituation with patient #1 plan of care not including skilled nursingfrequencies. It was identified thatfrequencies were identified in the correct location in the OASIS document whichshould pull the frequencies to the plan of care. There was not an explanation provided as toreason for the computer glitch. The agency hasinstituted a review process for plans of care	

			prior to having them sent tophysician for signature. This reviewwill include assurance that frequencies for all disciplines are included on theplan of care. The agency created averbal order for skilled nursing frequencies and sent this to the physician forsignature for certification period 11/1/2021 – 12/30/2021. The Administrator isresponsible for assuring complete and thorough plans of care.	
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made;	G0574	The agency will conductretraining for clinicians regarding adding patient identified goals to the planof care and assure that goals related to the primary diagnosis are added to theplan of care. A quality reviewprocess has been implemented to assure	2022-01-24

	(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; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Clinical record review on 12/8/2021, for patient #1, start of care 9/2/2021, diagnoses included but were not limited to stage 2 and 3 pressure ulcers, spina bifida (spinal cord failed to fully develop), and type 2 diabetes with diabetic polyneuropathy (Malfunction of many peripheral nerves throughout the body), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/1/2021 - 12/30/2021. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" which described the physical therapist's frequencies and duration. This section also outlined orders for physical therapy and skilled nursing services. Review failed to evidence frequencies and duration for skilled nursing services. On 12/3/2021, at 2:00 PM, an observation of a home visit for patient #1, with skilled nurse, RN E was conducted. During the home visit, RN E was observed performing skilled nursing services including but not limited to wound care, assessment of the heart and lungs, and vital sign assessments. During an interview on 12/8/2021, at 10:17 AM,		plans of care are comprehensive aftercompletion by the clinician. If reviewof the admission documents reflects the need for additional goals, theclinician will review and approve all recommended additions by the quality teamto assure patient identified goals and goals specific to the primary diagnosis. The Administrator isresponsible for assuring complete and thorough plans of care inclusive ofpatient identified goals and goals specific to primary diagnosis. 100% of plans of carewill be reviewed prior to submission to physician to assure accuracy of goals. The agency will conductretraining for clinicians regarding adding blood sugar reporting parameters andnotifying physicians of blood sugars not within range. A quality reviewprocess has been implemented to assure plans of care include blood sugarparameters. Blood sugar parameterswill be	

	skilled nurse frequency and durations are correct in the electronic medical record (EMR) system, but did not transfer to the printed plan of care.		added to each plan of care for patients with diabetes for whichclinicians should report blood sugar results outside of range. 100% of plans of carewill be reviewed prior to submission to physician to assure blood sugar parametersare included on plan of care. The Administrator isresponsible for assuring complete and thorough plans of care. The agency reviewed thesituation with patient #1 plan of care not including skilled nursingfrequencies. It was identified thatfrequencies were identified in the correct location in the OASIS document whichshould pull the frequencies to the plan of care. There was not an explanation provided as toreason for the computer glitch. The agency hasinstituted a review process for plans of care	

			prior to having them sent tophysician for signature. This reviewwill include assurance that frequencies for all disciplines are included on theplan of care. The agency created averbal order for skilled nursing frequencies and sent this to the physician forsignature for certification period 11/1/2021 – 12/30/2021. The Administrator isresponsible for assuring complete and thorough plans of care.	
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Review of an agency policy, revised October 2017, titled Assessment and Reassessment Guidelines stated, Procedure & Assessment/Reassessment: & The type, extent, and content of assessments and reassessments performed by each discipline are defined by	G0606	The Agency has revisedthe process to assure that the Administrator documents case conferencediscussions held regarding patients during the time of the case conference. Regarding the patientreferenced, patient #1, the agency did not employ a Home Health Aide	2022-01-11

	and forms & Assessment data gathered by each discipline will be used to assess the patient s needs and problems initially and on an ongoing basis & 2. Parameters of Assessment for Each Category of Personnel: & Reassessments for nursing may be conducted by RNs [Registered Nurses] and LPNs [Licensed Practical Nurses] during nursing visits & 4. Pertinent assessment and reassessment data will be communicated to team members, patient and the patient s physician by case conference, telephone, in person or in writing &. Clinical record review on 12/8/2021, for patient #1, start of care 9/2/2021, diagnoses included but were not limited to stage 2 and 3 pressure ulcers [injuries to the skin and underlying tissue, caused by prolonged pressure to the area], spina bifida [incomplete development of the spinal cord], and type 2 diabetes with diabetic polyneuropathy [malfunction of peripheral nerves throughout the body], evidenced an agency document titled "Start of Care" from 9/2/2021, and signed by registered nurse [RN] J. This document had an area subtitled "Bathing" which indicated the patient required assistance and supervision for bathing. Record review evidenced an agency document titled "Resumption of Care" from 10/29/2021, and signed by RN E . This document indicated the patient required assistance and supervision for bathing and dressing. Record review evidenced an agency document titled "Physical Therapy Evaluation" on 11/4/2021, and signed by PT [physical therapist] H. This document had an area subtitled "ADL's [activities of daily living]" which indicated the patient either required assistance or was dependent with all ADL's, except feeding/eating. Record review evidenced an agency document titled Case Management Meeting which was dated 11/15/2021, and indicated PT H attended the meeting via telephone. This document indicated patient name under sections including but not limited to discharges, upcoming recertification, and case management review. Review failed to evidence the plan of care for patient #1 was discussed at the meeting. Record review evidenced an agency document titled Discharge/Transfer Summary dated		during thetime period in question, and the patient was informed of that. Attempts were made to locate another agency thatcould provide the personal care services for the patient without success. Documentation related to these discussionswas not noted in the chart. Cliniciansand leadership were re-educated related to need to document all patient relatedinterventions and discussions. Patient #1 remainsactive with the agency and the patient has been provided with the opportunityto transfer care to an agency who could provide personal care services. The patient has refused transfer stating “I love my nurse anddo not want to transfer”. The patient and agency are working togetherto obtain personal care services from a community agency. The patient will also be offered personalcare from the LPN and if accepted by the patient, the LPN will be scheduled toprovide personal care. In the future,should this discipline not be available, the agency will utilize LPN servicesto provide personal care.	

	11/23/2021, and signed by PT H on 11/25/2021. This document had an area subtitled Care Summary (care given, intervention, progress, regress including therapies) which stated Pt [patient] completes 15/16 scheduled PT visits after R [right] shoulder surgery and more recent hysterectomy. Pt focused on improved strength, endurance, balance and stability for safety with transfers, ADLs and function with less pain and assist & Goals not met & reasons (if applicable): most goals met, but pain, weakness and impaired balance continue, plateau in progress due to pain &. Review failed to evidence the patient maintained independence with ADL's since the start of care. Review failed to evidence the patient's needs were discussed during the case management meeting prior to the discharge from skilled PT services. Review failed to evidence the patient was offered any other home health or outside services) to help meet the patient's activities of daily living needs. During an interview on 12/3/2021, at 2:54 PM, patient #1 indicated they are anxious for the agency to get a bath aide because they have not been able to get a complete sponge both or get into the shower for almost a week. The patient indicated the agency was aware. The patient's caregiver added "I really need the help" and indicated would benefit from a bath aide and housekeeper. During an interview on 12/8/2021, at 10:07 AM, alternate clinical manager B was queried if the patient was offered a home health aide since the start of care. She indicated they would have to go back and look through the documentation to find out. No further documentation or comment was provided prior to exit date 12/8/2021.		The Administrator isresponsible for assuring that case conference documentation is recorded foreach patient discussed. TheAdministrator is also responsible for assuring that all patients receiveservices required such as personal care services, and that all discussions withpatient regarding care available is documented. The Administrator has additionally made provisions to utilize alternatecare providers such as LPN to provide services needed in absence of HHA. Education has beenprovided to leadership and clinicians regarding documentation requirementsrelated to care coordination. QAPI clinical recordreview will be completed to assure that patients receive all services requiredduring episode of care and trend results as well as tracking case conferencedocumentation. Results will be utilizedto determine need for additional interventions.	
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. 1. Review of an agency policy, revised March 2018, titled Medication Reconciliation stated,	G0616	The Agency hasinstituted a process to mail a medication profile to the patient followingStart of Care. Modification to theprocess includes adding a large print note with the documents mailed to thepatient home stating “Add this	2022-01-30

	Policy & The Agency will reconcile patient s medications at time of admission and on an ongoing basis in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with drug therapy ... Purpose & To define the medication reconciliation process & Procedure & 1. At the time of admission, the admitting RN, PT, or SLP will create and document a complete list of medications that the patient is taking at home, including dose, strength, route, and frequency ... Discrepancies include duplications, omissions, changes, contraindications and/ or unclear information ... The Agency Provides the patient and/ or caregiver with written patient medication schedule/ instructions including medication name, dose, strength, route and frequency as well as which medications will be administered by Agency staff and staff acting on behalf of the Agency & 2. Medications ordered while the patient is receiving care will be compared to the medication list/ profile. The medication list/ profile will be updated with each new or changed medication. The patient's medication list in the home will also be updated &. 2. During observation of a home visit for patient #1, on 12/3/2021, at 2:56 PM, with RN [registered nurse] E, a review of the patients home folder failed to evidence a current medication list. 3. During observation of a home visit for patient #2 on 12/6/2021, at 3:09 PM, with LPN [licensed practical nurse] F, review of the patient s home folder evidenced an agency document title Home Health Certification and Plan of Care which contained a list of prescribed medications for the previous certification period, that ended on 11/25/2021. Observation failed to evidence a current medication list in the patient s home folder. 4. During an interview on 12/8/2021, at 10:12 AM, alternate clinical manager B indicated current plans of care and medication lists are sent to each patient s home via mail, at the start of each new certification period. She indicated some patient s had chosen not to use the home folders, but clinicians should ensure information is correct in the folder.		form to the patienthome folder". A consistent location has been identified to assure the home folder canbe found in each patient home. Staff will be educatedto the process of assuring a medication profile is in the home, and the need toupdate the medication profile with new/changed/discontinued medicationorders. The Administrator isresponsible for assuring the patient has a medication profile in the home andwill conduct intermittent visits to 10%patient homes to assure all documents are in the patient folder. These visits will evaluate compliance withthis process. These visits will continueuntil 100% compliance is identified with medication profiles in the home.	

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; 1. Review of an agency policy, revised March 2019, titled Plan of Care CMS #485 and Physician Orders stated, Policy & Skilled nursing and other home health services will be in accordance with Plan of Care based on the patient s diagnosis and assessment of immediate and long range needs and resources & Procedure & 1. Patients are accepted for treatment on the reasonable expectation that Agency can meet the patient s medical, nursing, rehabilitative and social needs in his or her place of residence ... The individualized plan of care must specify the care and services necessary to meet this patient specific needs as identified in the comprehensive assessment, including identification of the responsible disciplines and the measurable outcomes that the agency anticipates will occur as a result of implementing and coordinating the plan of care ... Services must be furnished in accordance with accepted standards of practice &. 2. Review of an agency policy, revised March 2018, titled Nursing Services stated, Policy & Patients receiving nursing services will have appropriate assessments, reassessments, care planning and established outcomes performed ... Procedure & 1. Nursing care will be provided in accordance with patient s plan care, under supervision of a Registered Nurse & 3. The License Practical Nurse or Licensed Vocational Nurse will supplement the nursing care needs of the patient as provided by the Registered Nurse and include: & Assisting the Registered Nurse in carrying out the plan of care &. 3. Review of an agency policy, revised October 2017, titled Professional Standards of Practice stated, Agency and staff will comply with accepted standards of practice and plans of care & Procedure & 2. Agency staff will provide care, treatment and services to each patient according to the plan of care &. 4. Review of an agency policy, revised October 2017, titled Assessment and Reassessment Guidelines stated, Procedure & Assessment/Reassessment: & The type, extent, and content of assessments and reassessments	G0710	The Agency has revisedthe process to assure that the Administrator documents case conferencediscussions held regarding patients during the time of the caseconference. PT H has been counseledregarding the need to document pending discharge discussions with the patientwith adequate notification of the pending discharge timeline. 100% of dischargesconducted by PT H will be reviewed to assure adequate documentation until 100%compliance noted. Reviews will then bereduced to 50% for 3 months to assure ongoing compliance. The Administrator isresponsible for assuring that case conference documentation is recorded foreach patient discussed. Reviews will beconducted by the quality team during QAPI to assure case conference isconducted for each patient and documents pending discharge discussions appropriately. The Agency willreeducate LPN F regarding appropriate clinical observations to be	2022-01-28

	Agency discipline-specific documentation tools and forms & Assessment data gathered by each discipline will be used to assess the patient s needs and problems initially and on an ongoing basis & 2. Parameters of Assessment for Each Category of Personnel: & Reassessments for nursing may be conducted by RNs [Registered Nurses] and LPNs [Licensed Practical Nurses] during nursing visits & 4. Pertinent assessment and reassessment data will be communicated to team members, patient and the patient s physician by case conference, telephone, in person or in writing &. 5. Review of an undated agency policy titled Diabetic Foot Care stated, Diabetes can cause two problems that affect feet & Proper foot care can help prevent common foot problems and/or treat them before they cause serious complications & Diabetic Neuropathy: Uncontrolled diabetes can damage the nerves. If nerves in feet and legs are damaged, it affects the clients ability to feel heat, cold or pain & Peripheral Vascular Disease: Diabetes affects the flow of blood. Without good blood flow, it takes longer for wounds to heal & Purpose & To prevent common foot problems related to diabetes & Applies to & Licensed Practical/Vocational Nurses & Procedure & 5. Examine the foot & 7. Wash feet & 10. Apply lotion liberally to hands and feet & 14. When to contact a physician: a. Changes in skin color, temperature. b. Swelling in foot or ankles & d. Open sores on feet. e. Ingrown toenails or infected toenails. f. Corns or calluses. g. Dry, cracking skin &. 6. Clinical record review on 12/8/2021, for patient #1, start of care 9/2/2021, diagnoses included but were not limited to stage 2 and 3 pressure ulcers, spina bifida (spinal cord failed to fully develop), and type 2 diabetes with diabetic polyneuropathy (Malfunction of many peripheral nerves throughout the body) , evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/1/2021 12/30/2021. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated, Effective on 11/04/2021: PT [physical therapist]: 1W4 [once a week, for 4 weeks] & Summary of PT Orders: -balance training -Endurance training strength training Monitor and mitigate pain Home safety and interventions Transfer training &.		conductedduring a patient ordered to receive diabetic foot care, including but notlimited to need to remove client socks and shoes and observe the foot forlesions. 100% of clinical notesof LPN F will be reviewed to assure adequate documentation until 100%compliance noted. Reviews will then bereduced to 50% for 3 months to assure ongoing compliance. The Administrator isresponsible for assuring that patients receive ordered care. Clinical record reviews will be conducted bythe quality team as a component of the QAPI program to assure documentationreflects appropriate clinical care based on standards of practice for diabeticfoot care.	

	Record review evidenced an agency document titled Case Management Meeting which was dated 11/15/2021, and indicated PT H attended the meeting via telephone. This document indicated patient name under sections including but not limited to discharges, upcoming recertification, and case management review. Review failed to evidence the status of patient #1 was discussed at the meeting. Record review evidenced an agency document titled Therapy Visit Note dated 11/23/2021, and signed by PT H on 12/5/2021. This document had an area subtitled Behavior/Mental Status which stated Comments: & Discussed plans for D/C [discharge] due to plateau in progress, pt and [patient s caregiver] verbalize understanding and agree & Another area stated Discharge Planning: Discussed planned d/c with pt and [patient s caregiver], both agree with D/C this date. Pt D/C from skilled PT &. Review failed to evidence the patient was informed of the discontinued skilled PT services until 11/23/2021, which was the last date the patient received PT. Record review evidenced an agency document titled Discharge/Transfer Summary dated 11/23/2021, and signed by PT H on 11/25/2021. This document had an area subtitled Care Summary (care given, intervention, progress, regress including therapies) which stated Pt completes 15/16 scheduled PT visits after R shoulder surgery and more recent hysterectomy. Pt focused on improved strength, endurance, balance and stability for safety with transfers, ADLs and function with less pain and assist & Goals not met & reasons (if applicable): most goals met, but pain, weakness and impaired balance continue, plateau in progress due to pain &. Review failed to evidence the patient was informed of the discontinued skilled PT services until 11/23/2021, which was the last date the patient received PT.			

	During an interview on 12/8/2021, at 10:07 AM, when queried about the process to determine when a patient should be discharged from PT services, alternate clinical supervisor B indicated upcoming discharges or changes in patient condition is discussed at the interdisciplinary (IDT) meeting. Alternate clinical supervisor B indicated PT should finish out the frequencies, and because discharge discussions are started on admission, the patient would be aware prior to discharge. 7. Clinical record review on 12/8/2021, for patient #2, start of care 3/31/2021, diagnoses included but were not limited to malignant neoplasm of the prostate and bone, hypertension, and type 2 diabetes, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/26/2021 1/24/2022. This document had an area subtitled 21. Orders for Discipline and Treatment (Specify Amount/Frequency/Duration) which stated & Summary of SN [skilled nurse] Orders & Diabetic care to include diet, activity, stress, foot care, skin care. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care & Clinician to assess feet each visit for presence of skin lesions &. During an observation of a home visit on 12/6/2021, at 2:47 PM, for patient #2, licensed practical nurse [LPN] F was observed performing skilled care as ordered on the plan of care. The patient was observed sitting in a chair, wearing shoes and sock. LPN F queried patient when new diabetic shoes would arrive. At 3:04 PM, LPN F bent down to patient s feet and squeezed each ankle with her forefinger and thumb, which completed the bilateral foot assessment. Observation failed to evidence the LPN removed the patient s shoes or socks prior to foot assessment. Observation failed to evidence the LPN observed the patient s feet or lower extremities for lesions. Observation failed to evidence the LPN performed skilled services as ordered on the plan of care. During an interview on 12/8/2021, at 10:27 AM, alternate clinical manager B indicated a foot assessment would consist of the clinician removing the patient s sock to inspect the feet and in between the toes, and look for sores or areas of concern.			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii)	G0948	The agency hascounseled LPN F regarding appropriate dress code	2022-01-10

	(ii) Be responsible for all day-to-day operations of the HHA; Record review of an agency document titled Home Health Care Personnel Manual revised March 2016, had an area subtitled Section 30: Other Policies. This area stated & 30.3 Dress Code: & For visiting staff: Either scrubs or a lab coat over street clothes is required. Closed toe, hard soled shoes are required and may not be removed in the patient s home & Name tags are a required component of the dress code. Employees clothing must be tasteful and professional in style so as to neither offend nor endanger a client & For both office staff and visiting staff: jeans, jogging suits, T-shirts with writing on them, and athletic wear are not acceptable on-the-job. Examples of appropriate clothing will be given at orientation &. An observation of a home visit was conducted on 12/6/2021, at 2:45 PM, for patient #2, start of care 3/31/2021. Licensed practical nurse [LPN] F was met outside the patient's home where she indicated her ID [identification] badge would not hook on to her shirt, but evidenced it was in her coat pocket. Inside the patient's home at 2:52 PM, LPN F was observed wearing jeans, hot pink long sleeved t-shirt, and gray, knee-high boots. Observation failed to evidence LPN F had followed the agency's dress code policy. Review evidenced the administrator failed to ensure day-to-day operations and policies were followed. During an interview on 12/8/2021, at 10:29 AM, alternate clinical supervisor B indicated field staff clinicians are instructed to wear scrubs and tennis shoes during work hours.		and notified her of potentialimplications of not following dress code up to and including termination. Dress code will bereviewed with all staff during January staff meeting. The Administrator isresponsible for assuring correct dress code is in place and adhered to byclinicians.	
N9999	Final Observations Based on record review and interview, the home health agency failed to randomly test for controlled substances in at least 50% of the unlicensed employees with direct patient contact.	N9999	The agency hasimplemented a tracking process for drug testing 50% of the agency's non-licensed personnel annually and ifreasonable suspicion that an employee engaged in illegal use of a controlledsubstance. This employee will be drug tested in January, 2022.	2022-01-31

	The findings include: 410 IAC 16-27-2.5 & Section 2.(a) A home health agency must: (1) have a written drug testing policy that is distributed to all employees; and (2) require each employee to acknowledge receipt of the policy. (b) A home health agency shall randomly test: (1) at least fifty percent (50 %) of the home health agency's employees who: (A) have direct contact with patients; and (B) are not licensed by a board or commission under IC 25; at least annually; or (2) when the home health agency has reasonable suspicion that an employee is engaged in the illegal use of a controlled substance .... Reviewed an undated agency policy on 12/3/2021 titled Substance Abuse and Employee Testing Policy stated, & Employees will be required to take a substance abuse test in the following situations: (a) If state or federal law requires drug testing &. Personnel record review on 12/2/2021, of an agency document titled Employee Listing evidenced home health aide (HHA) N with a first patient contact date 3/31/2021. Review failed to evidence any drug screening since date of hire. Personnel record review on 12/8/2021, of an agency document titled Termed Employees evidenced HHA K, first patient contact date 2/24/2020, HHA L, first patient contact date 4/1/2021, and HHA M, first patient contact date 9/10/2020. Review failed to evidence any random or annual drug screening during active employment. During an interview on 12/3/2021at 12:09 PM, the administrator indicated the agency had never done random drug screens. During an interview on 12/6/2021 at 10:30 AM, the alternate clinical manager indicated there was no other agency policy regarding random employee drug screening and asked when the random drug screening rule went into effect.		The Administrator is responsible for assuring that this process isfollowed. The QAPI program will trackand trend this as a component of the QAPI trending	

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