HOME AND COMMUNITY BASED CARE NEWSLETTER

HCBC Newsletter 2023-03
December 13, 2023

HCBC Update:

- **Deficiency Plans of Corrections**
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Deficiency Plans of Correction

The Indiana Department of Health (IDOH) continues to receive correction plans that do not address the questions asked in the initial non-compliance notification letters. Providers are required to indicate how each deficiency was corrected (for both the specific patient listed in the citation and all patients who could be affected by the deficiency), the measures that were put in place to ensure the deficient practice does not recur, how continued compliance will be monitored (at a 100% threshold), and the person responsible for monitoring compliance. Please do not repeat the regulation in the plan of correction, and do not copy and paste from one citation to another. Each plan of correction needs to be specific to the findings cited.

When reviewing the responsible person to ensure continued compliance listed on a plan of correction, we have previously accepted a "designee" listed as a responsible party, i.e., "Administrator and/or designee." Per CMS, the plan of correction must specify the actual person

responsible for ensuring compliance and cannot refer to a "designee." Please ensure that all plans of correction specify who is responsible for compliance.

If you are having problems with the Gateway, such as not being able to see all tags to input the plans of correction or not being able to see the letter, please contact Rob Jones at the help desk ASAP (srshelpdesk@health.IN.gov or 317/233-7784) to prevent any delay of submission or approvals. Rob is the only person who can fix Gateway issues.

Physician Coordination of Patient Plans of Care

Under 42 CFR § 484.60(a)(1):
"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."

The interpretive guidelines state: "The patient's physician orders for treatments and services are the foundation of the plan of care. . . . In instances where the HHA receives a general referral from a physician who requests HHA services but does not provide the actual plan of care components (i.e. treatments and observations) for the patient, the HHA will not be able to create a comprehensive plan of care to include goals and services until a home visit is done and sufficient information is obtained to communicate with and receive approval from the physician." State Operations Manual, Appendix B, p. 31.

During surveys IDOH continues to see:

- "Eval and treat" orders. Per CMS, "eval and treat" orders are not acceptable and must be specific to the patient as to why home care is being referred.

- Clinicians are not contacting the physician and are failing to obtain verbal orders. Clinicians must review the plan of care with the physician responsible for the plan of care.

- Services cannot be provided without receiving a verbal or written order from a physician that contains the components of care. A provider may not fax a proposed physician's order to a physician's office and begin providing care until the physician's order is communicated to the provider verbally or in writing. Verbal physician's orders must be reduced to writing and sent to the physician for signature when admitting or recertifying a patient. If an agency has a policy that the plan of care will be a physician's verbal order, this must be documented in the comprehensive assessment or a coordination note indicating who was contacted, when they were contacted, and what was discussed.

There can only be one working plan of care. Therapy cannot have a separate plan of care; addendums or interim order added to the working plan of care are permissible.

Home Health and Hospice Responsibilities of Patients Residing in Assisted Living Facilities

Under 42 CFR § 484.60:
"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."

Under 42 CFR § 418.56(a)(1):
"Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services."

IDOH has found that some providers are relying on assisted living facilities to provide the majority of services, rather than assuming responsibility for all aspects of a patient's care when the patient resides in an assisted living facility. Here are a couple of scenarios that would not be compliant with the federal regulations:

- A physician orders wound care three times a week. The provider visits one day a week and relies on the assisted living facility to complete the wound care on the other two days.

- Providers do not conduct complete assessments and leave the responsibility of the assessment to the assisted living facility.

Scenarios such as these have resulted in citations at the immediate jeopardy level.

It is the HHA and hospice providers' responsibility to manage all aspects of patient care when their patients reside in an assisted living facility. Patients should not have to pay additional fees or be charged for a higher level of care by the assisted living facility (i.e., wound care) that the HHA or hospice is ordered to do, especially considering Medicare and Medicaid pays 100% of this service to the HHA and hospice provider.

Clinical Documentation

Under 42 CFR § 484.110(b):
"All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier of a primary author who has reviewed and approved the entry."

Clinician documentation cannot be changed or amended by agency leadership without discussing the change with the clinician and coming to an agreement. Providers should have a policy and procedure for documentation changes to clinical documentation.

Communicating with HCBC

When calling or emailing the Indiana Department of Health HCBC staff with a question about your agency or facility, please provide the doing-business-as (d/b/a) name, license and provider number. This will help us efficiently respond to your questions.

Nurse Aide Registry

Information about the registry for certified nurse aides, qualified medication aides, and home health aides can be found here. The registry is available online at https://mylicense.in.gov/EVerification/. If you have questions about the registry, you can contact the Aides Registry Program at aides@health.in.gov or 317-233-7442 (Option 1).