STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157067	A. BUILDING B. WING	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE	501 COMFORT PLACE, MISHAWAKA, IN, 46545

(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 was a partially extended State and Federal Home Health Agency (HHA) Re-Licensure Survey completed by the Indiana Department of Health (IDOH). Survey Dates: 10/20, 10/21, 10/22, 10/25, 10/26, 10/27/2021. Facility Number: IN005279 Provider Number: 157067 Current Census: 22 Based on the Condition-level deficiency during the October 27, 2021 survey, Center for Hospice and Palliative Care Inc., The, was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 7/27/21. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, Center for Hospice and Palliative Care Inc. is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for the two years beginning October 27, 2021 and	G0000		2022-01-31

	2023 for being found out of compliance with the Condition of Participation 42 CFR §484.58: Discharge planning. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.			
N0000	Initial Comments This was a State Home Health Agency (HHA) Re-Licensure Survey completed by the Indiana Department of Health (IDOH). Survey Dates: 10/20, 10/21, 10/22, 10/25, 10/26, 10/27/2021. Facility Number: IN005279 Provider Number: 157067 Current Census: 22	N0000		2022-01-31
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with Condition of Participation for Home Health Agencies (HHAs): 42 CFR §484.102.	E0000	TheDirector of Nursing, Director of Quality, and alternate Administrator updatedthe current Emergency Preparedness manual with input from Center for Hospice Care's (CHC) Safety committee onNovember 7,2021. All staff have access to the Emergency Preparedness Manual throughthe agencies Microsoft Teams drive along with printed copy in each CHC site. The Emergency Preparedness Manual will bereviewed at the	2022-01-31

	Survey Dates: 10/20, 10/21, 10/22, 10/25, 10/26, 10/27/2021. Facility Number: IN005279 Provider Number: 157067 Current Census: 22 At this Emergency Preparedness survey, Center for Hospice and Palliative Care Inc., The, was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR §484.102.		next all staff meeting in February to ensure compliance andunderstanding of all new updates. Completion Date 12/07/2021	
E0006	Plan Based on All Hazards Risk Assessment 494.62(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*	E0006	TheDirector of Nursing, Director of Quality, and alternate Administrator updatedthe current Emergency Preparedness manual to include the top four risk factors identified in the HVA andstrategies to address them including strategies to continue essential businesspractices. In addition to the current HVA for Mishawaka office, HVA wascompleted for Elkhart, LaPorte, and Plymouth.	2021-12-07

(2) Include strategies for addressing emergency events identified by the risk assessment.

* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.

(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.

(2) Include strategies for addressing emergency events identified by the risk assessment.

*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.

(2) Include strategies for addressing emergency events identified by the risk assessment.

A policy with reviewed date 5/20/2021, titled Maintain and Annual Emergency

	stated ... development of the Emergency Preparedness Plan ... Identification of all business functions essential to the agency s operations that should be continued during an emergency ... Identification of all risks ... Identification of all contingencies ... Consideration of the ... location ... Determination of what arrangements may be necessary ... will discuss emergency preparedness concerns with the landlord of its rented facilities ... will develop strategies for addressing emergency events .... During an interview on 10/27/2021 at 10:53 AM, the alternate administrator, clinical director, and director of quality assurance C indicated the policy failed to evidence the agency s business functions essential to the agency s operations that would be continued during an emergency, identified all risks, identified all contingencies, considered the location of all facilities, determined arrangements that would be necessary, emergency preparedness concerns with the landlord of its rented facilities, or strategies which addressed emergency events.			
E0007	EP Program Patient Population 494.62(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3),	E0007	TheDirector of Nursing, Director of Quality, and alternate Administrator updatedthe current Emergency Preparedness manual to address strategies to provide skilled nursing services and/or therapiesfrom either an alternative CHC office	2021-12-07

	§485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] A policy with review date 5/20/2021, titled Emergency Preparedness Program Patient Population (E-0007) stated ... will implement an emergency operation plan to continue essential patient care .... , but failed to evidence the types of patients the HHA provided services to, or essential services the HHA would provide during an emergency. During an interview on 10/20/2021 at 10:12 AM, the clinical director indicated the		or via telehealth.	

	(but not limited to) infusion therapy (medications administered via a catheter inserted into a vein), tracheostomy care (an opening in the windpipe made to relieve an obstruction to breathing), wound care, urinary catheter care (a tube inserted into the bladder to drain urine), enteral feeding (a tube inserted into the stomach for administration of nutrition, fluids, and/or medications), and patients who received dialysis at outpatient facilities. During an interview on 10/27/2021 at 10:53 AM, the alternate administrator, clinical director, and director of quality assurance C indicated the HHA s patient population was not addressed in the Emergency Preparedness Plan, or services the HHA would provide during an emergency.			
E0013	Development of EP Policies and Procedures 494.62(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The	E0013	The Director of Nursing,Director of Quality, and alternate Administrator updated the current EmergencyPreparedness manual to include the top four risk factors identified in the HVA forthe integrated emergency plan for each CHC site. This integrated policy includes strategies onmoving services to a non-affected CHC site. Emergency Preparedness manual wasupdated to include strategies to respond to	2021-12-07

	updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. A policy with review date 5/20/2021, titled Development of Emergency Preparedness		emergencies that could affect itsability to care for patients.	

	Procedures (E-0013) stated ... Emergency Preparedness policies and procedures will be based on the Emergency Preparedness Plan .... During an interview on 10/27/2021 at 10:53 AM, the alternate administrator, clinical director, and director of quality assurance C indicated the HHA was part of an integrated healthcare system, agreed the HHA s Emergency Preparedness Program policies and procedures was based largely on the corporation s hospice program, and several elements required in the policies and procedures for the HHA s compliance with the program were missing.			
E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. 1. A policy with review date	E0017	Education will be given to the nursing staff oncompletion of the electronic medical records module that assesses the patientneeds in the event of an emergency. Education will include printing of the emergency plan and completion ofa patient emergency plan to leave in each patient homes. Education wascompleted on 11/16/21 on completing the patient emergency plan form for everypatient. Education will be completed by12/22/21 on the electronic medical records emergency module that will becompleted on admission and updated as needed. Following education, staff will ensure the emergency plan is in the homeat the next patient visit. Each PatientCare Coordinators will visit two (2) patients in their place of residence perquarter for compliance with policy.	2021-12-22

	5/20/2021, titled Comprehensive Patient Assessment in Disaster (E-0017) stated ... will ensure all patients have an individualized plan of care in the event of an emergency ... included as a part of the patient s comprehensive assessment ... keep a copy of the individualized emergency plan in the patient s file, as well as provide a copy to the patient and/or caregiver. 2. A document with copyright date 2019 by 5 Star Consultants, LLC titled Patient Emergency Plan evidenced a section which stated ... [HHA] clinician reviewed this Emergency Plan with patient/caregiver and I [patient/caregiver] received a copy .... The document included a space for dates and signatures for the patient/representative and clinician. 3. A policy with revised date 10/2021 titled Initial Assessment of Patient, Family, Caregiver stated ... the nurse will gather the following baseline data at the time of admission .... The document failed to evidence completion of the patient s comprehensive assessment included the development of the patient s individualized emergency preparedness plan. 4. A home visit observation was conducted with patient #7 on 10/21/2021 at 9:00 AM. During			

	reviewed, which failed to evidence documentation of a patient specific emergency plan. 5. A home visit observation was conducted with patient #6 on 10/22/2021 at 10:30 AM. During this time, the home folder was reviewed, which failed to evidence documentation of a patient specific emergency plan. 6. A home visit observation was conducted with patient #5 on 10/22/2021 at 1:00 PM. During this time, the patient s caregiver indicated there were no HHA documents or folder present in the home. 7. During an interview on 10/26/2021 at 10:00 AM, the director of quality assurance indicated the policy titled Initial Assessment of Patient, Family, Caregiver also represented the policy for comprehensive assessment. 8. During an interview on 10/27/2021 at 10:53 AM, the alternate administrator, clinical director, and director of quality assurance C indicated they could not confirm if there were copies of patient individualized emergency plans in the patients homes, there were not copies in the HHA clinical records, and the patient handbooks contained general emergency instructions, not patient specific plans.			

E0021	HHA- Procedures for Follow up Staff/Pts. 484.102(b)(3) §484.102(b)(3) Condition of Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact. A policy with review date 5/20/2021, titled Procedure for Follow Up (E-0021) stated ... will follow-up with on duty staff and patients ... will address what actions would be required due to the inability to make contact with staff or patients .... The policy failed to evidence the specific procedure on how the agency would follow up, or specific actions required as a result of inability to contact staff or patients. During an interview on 10/27/2021 at 10:53 AM, the alternate administrator, clinical director, and director of quality assurance C indicated the emergency preparedness plan should have indicated specific procedures and actions required,	E0021	TheDirector of Nursing, Director of Quality, and alternate Administrator updatedthe current Emergency Preparedness manualto include procedures on contacting of staff and patients in the event of anemergency. CHC obtained a writtenagreement with a home health agency for assistance in the event CHC staff isunable to provide care.	2021-11-18

	not simply broad statements such as will develop ... will follow-up ... will determine			
E0024	Policies/Procedures-Volunteers and Staffing 494.62(b)(5) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. A policy with review date 5/20/2021, titled Policies and	E0024	The Director of Nursing,Director of Quality, and alternate Administrator updated the current EmergencyPreparedness folder to include Health Departments Contacts for the State andNational Medical Reserve Corp.	2021-12-07

	(E-0024) stated ... will determine the use of ... volunteers in an emergency or other staffing strategies, including the process and role for integration of State and Federally designated health care professionals .... The policy failed to evidence the specific procedure on how and/or when the use of volunteers was determined, or the process for integration of State and Federally designated health care professionals. During an interview on 10/27/2021 at 10:53 AM, the alternate administrator, clinical director, and director of quality assurance C indicated they were unaware HHAs utilized volunteers during an emergency, thought the policy referred to hospice volunteers, and the plan was largely geared to the hospice component of the organization.			
E0030	Names and Contact Information 494.62(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(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 facilities]. The communication plan must include all of the following:]	E0030	The Director of Nursing, Director of Quality,and alternate Administrator updated the current Emergency Preparedness folderto include contact information for staff, other home health agencies, andpatient physicians in Microsoft teams. All staff have access to the EmergencyPreparedness Manual through the agencies Microsoft Teams drive along withprinted copy in each CHC site. The Emergency Preparedness Manual will be reviewed at thenext all staff meeting in February to ensure compliance and understanding ofall new updates.	2021-12-07

(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 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: (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). A policy with review date 5/20/2021, titled Names and Contact Information (E-0030)			

	information for ... entities providing services under arrangement, patients physicians, and other hospices and health care providers ... The communication plan must include the name and contact information for the following ... Hospice employees ... Entities providing services under agreement ... Patients physicians ... Other hospices .... The policy failed to evidence the plan must include contact information for the HHA s employees. During an interview on 10/20/2021 at 10:12 AM, the clinical director indicated physical therapy (PT), occupational therapy (OT), and speech therapy (SLP) was provided to the HHA under arrangement (contracted services). During a visit with HHA branch C on 10/27/2021 at 9:30 AM, patient care coordinator (PCC) O indicated they did not have a list of all patients physicians because they served such a broad geographic area. During this time, staff also provided other documents associated with the emergency preparedness plan, which failed to evidence contact information for entities who provided services under arrangement (therapies), or volunteers utilized during an emergency.			

	During an interview on 10/27/2021 at 10:53 AM, the alternate administrator, clinical director, and director of quality assurance C indicated the emergency preparedness communication plan failed to include the name and contact information for HHA staff was required, failed to evidence contact information for entities who provided services under arrangement (therapies), volunteers utilized during an emergency, and the plan was largely geared to the hospice component of the organization.			
E0031	Emergency Officials Contact Information 494.62(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(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 facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local	E0031	The Director of Nursing, Director of Quality, and alternateAdministrator updated the current Emergency Preparedness folder to includecontact information for Federal,State, tribal, regional, and local emergency officials. in Microsoftteams. All staff have access to theEmergency Preparedness Manuel through the agencies Microsoft Teams Drive alongwith printed copy in each CHC site. The Emergency Preparedness Manual will bereviewed at the next all staff meeting in February to ensure compliance and understandingof all new updates.	2021-12-07

	emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. A policy with review date 5/20/2021, titled Emergency Officials Contact Information (E-0031) stated ... will maintain contact information of Federal, State, tribal, regional, and local emergency officials .... The policy evidenced a list of officials, but failed to evidence the contact information for the listed officials. During an interview on 10/27/2021 at 10:53 AM, the alternate administrator, clinical director, and director of quality assurance C indicated the emergency preparedness communication plan submitted failed to include contact information for Federal, State, tribal, regional, local emergency preparedness staff, or other sources of assistance.			
E0033	Methods for Sharing Information	E0033	TheDirector of Nursing, Director of Quality, and alternate Administrator updatedthe current Emergency Preparedness manual to	2021-12-31

	491.12(c)(4) §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(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 facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). 1. A policy with review date		address communication strategies for sharing information with itspatients and staff as well as ensuring patients information is available toensure continuity of care in the event the patients care must betransferred. All nurses will haverequired education by 12/31/21.	

	5/20/2021, titled Methods for Sharing Information (E-0033) stated ... will share general patient information ... a copy of the patient s face sheet will be sent with an evacuated patient ... information will also be made readily available for patients being sheltered in place .... 2. A home visit observation was conducted with patient #7 on 10/21/2021 at 9:00 AM. During this time, the home folder was reviewed, which failed to evidence documentation of a patient specific emergency plan, a current plan of treatment with medications, or a patient face sheet. 3. A home visit observation was conducted with patient #6 on 10/22/2021 at 10:30 AM. During this time, the home folder was reviewed, which failed to evidence documentation of a patient specific emergency plan, a current plan of treatment with medications, or a patient face sheet. 4. A home visit observation was conducted with patient #5 on 10/22/2021 at 1:00 PM. During this time, the patient s caregiver indicated there were no HHA documents or folder present in the home. 5. During an interview on 10/27/2021 at 10:53 AM, the alternate administrator, clinical			

	assurance C indicated the emergency preparedness communication plan submitted failed to indicate the information that would be provided included the patients general condition or location.			
E0034	Information on Occupancy/Needs 494.62(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(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 facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. A policy with review date 5/20/2021, titled Sharing	E0034	TheDirector of Nursing, Director of Quality, and alternate Administrator updatedthe current Emergency Preparedness manual to address strategies for setting up an incident command center in theevent of a disaster involving one or more facilities. The plan also addressesother facilities that may house home health patients.	2021-12-07

	Occupancy/Needs (E-0034) stated ... Hospice Inpatient Unit patient information will be printed .... The policy failed to address anything about the HHA. During an interview on 10/27/2021 at 10:53 AM, the alternate administrator, clinical director, and director of quality assurance C indicated the policy titled Sharing Information on Occupancy/Needs (E-0034) included only information for the hospice, not the HHA component of the organization.			
E0042	Integrated EP Program 491.12(e) §416.54(e), §418.113(e), §441.184(e), §460.84(e), §482.15(f), §483.73(f), §483.475(e), §484.102(e), §485.68(e), §485.625(f), §485.727(e), §485.920(e), §486.360(f), §491.12(e), §494.62(e). (e) [or (f)]Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:] (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.	E0042	The Director of Nursing,Director of Quality, and alternate Administrator updated the current EmergencyPreparedness manual with an HVA for Mishawaka, LaPorte, Elkhart, and Plymouthsites.	2021-12-07

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program].

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:

(i) A documented community-based risk assessment, utilizing an all-hazards

approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

A document updated October 2021, titled Center for Hospice Care ... Emergency Preparedness Program included all of the agency s EPP policies and procedures.

The document failed to evidence the HHA designated itself as part of an integrated healthcare system, demonstrated that each separately certified facility within the system actively participated in the development of the unified and integrated EPP, was developed and maintained in a manner that took into account each separately certified facility's unique circumstances, patient

	populations, and services offered, demonstrated that each separately certified facility was capable of actively using the unified and integrated EPP and was in compliance, or included integrated policies and procedures that met regulatory requirements. During an interview on 10/27/2021 at 10:53 AM, the alternate administrator, clinical director, and director of quality assurance C indicated the HHA was part of an integrated healthcare system, agreed the HHA s EPP policies and procedures was based more on the corporation s hospice program, and some elements required for the HHA s compliance with the program were missing.			
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. 1. A policy revised 3/2017 titled Referral Intake Process stated ... The patient should be scheduled within 48 hours ... Failure to admit within 48 hours ... will be documented as to the reason and that the doctor was notified .... 2. A policy revised 7/2019 titled Initial Assessment .... stated ...	G0374	Accuracy of encoded OASIS data.¿ Education provided to Intake Coordinator and Admission Team Leader on 11/4/21. Education provided by Intake Coordinator to Referral Specialist on 12/9/21. Referral intake process policy updated 11/21/21¿to ensure patient SOC occurs within 48 hours of time of Physician order. Education provided by Intake Coordinator to Referral Specialist on 12/9/21.	2021-12-09

	within 48 hours .... 3. Record review for patient #1 was completed on 10/27/2021, start of care date 9/27/2021, for certification period 9/27/2021-11/25/2021. The clinical record evidenced the agency received a physician referral for home health on 9/22/2021, did not admit the patient until 9/27/2021, and failed to evidence the physician ordered home health services to begin on 9/27/2021. A document dated 9/22/2021 titled Referral Notes evidenced the patient was referred to the agency for skilled nursing and skilled therapy by nurse practitioner J. A document titled ... [patient] ... Communication Notes evidenced an entry dated 9/22/2021 which stated ... Received call back from Pt s [patient s] spouse ... offered Monday [9/27/2021, five days after referral] at 10:30 [for start of care assessment] ... which she accepted		Intake Coordinator or Admission Team Leader will¿audit all home health¿start of care dates for¿compliancy¿with updated policy for 90 days.¿ On 11/5/21 Quality Assurance Department started monitoring on an ongoing basis 10% of all HH admissions monthly. Results of this plan of correction will be monitored and reported to Quality Improvement Committee by Director of Nursing and Director of Quality Assurance on an ongoing basis to ensure deficiency is corrected and will not reoccur	

	A document dated 9/27/2021 titled SOC [start of care] OASIS-D1 [outcome and assessment information set] .... stated ... If the physician indicated a specific start of care ... date when the patient was referred for home health services, record the date specified ... 09/27/2021 .... During an interview on 10/27/2021 at 4:50 PM, the clinical manager and alternate administrator agreed the OASIS document date was not accurate, and the physician did not order the start of care to occur on 9/27/2021. 4. Record review for patient #6 was completed on 10/26/2021, start of care date 8/26/2021, for certification period 8/26/2021-10/24/2021. The clinical record evidenced the agency received a physician referral for home health on 8/19/2021, did not admit the patient until 8/26/2021, and failed to evidence the physician ordered home health services to begin on 8/26/2021. A faxed document received by the agency on 8/19/2021, signed by certifying physician H on 8/19/2021 titled Order which stated ... [discharge] 8/21/21 home w/ HHC [home health care] .... A document dated 8/26/2021			

	... If the physician indicated a specific start of care ... date when the patient was referred for home health services, record the date specified ... 8/26/2021 .... During an interview on 10/26/2021 at 11:00 AM, the alternate administrator indicated the clinical record failed to evidence the certifying physician ordered the start of care to occur on 8/26/2021. 5. Record review for patient #7 was completed on 10/21/2021, start of care date 8/14/2021, for certification period 8/14/2021-10/12/2021. The clinical record evidenced the agency received a physician referral for home health on 8/10/2021, did not admit the patient until 8/14/2021, and failed to evidence the physician ordered home health services to begin on 8/14/2021. A document titled ... [patient] ... Communication Notes evidenced an entry dated 8/10/2021 at 12:19 PM which stated ... I advised [certifying physician l] that we are booking about 1 week out for OT and maybe 2 for PT ... we can start for medication management right away .... A document titled ... [patient] ... Communication Notes evidenced an entry dated 8/10/2021 at 4:31 PM which			

	[home health] admit on 8/14 [2021] .... A document dated 8/14/2021 titled SOC OASIS-D1 .... stated ... If the physician indicated a specific start of care ... date when the patient was referred for home health services, record the date specified ... 8/14/2021 .... During an interview on 10/21/2021 at 1:00 PM, the alternate administrator confirmed the clinical record did not evidence the certifying physician ordered the start of care to occur on 8/14/2021, and the OASIS entry made was incorrect.			
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. 1. A policy revised 09/2017 titled Plan of Care: Physician Certification stated ... Each patient s needs should be	G0434	Participate inCare The week of 11/1/2021 verbal education provided on 484.50. Plan of Cares, medication profiles, andschedule were reviewed and updated and placed in patients' home as appropriate. Beginning week of 12/06/2021 an additional review of all current HomeHealth census electronic medical records was reviewed and updated when appropriate. PatientCare Coordinators will	2021-12-31

	continually assessed ... shall include ... frequency ... needed in order to meet the patient s/caregiver s needs .... 2. A policy revised 07/2019 titled Care Plan Establishment and Review stated ... must provide a written individualized plan of care ... occurs with the collaboration of ... patient and family ... planning appropriate responses to patient and family needs .... 3. A Centers for Disease Control and Prevention web-based site referenced on 10/27/2021, https://www.cdc.gov/diabetes/managing/managing-blood-sugar/a1c.html, stated ... The A1C test also known as the hemoglobin A1C or HbA1c test is a simple blood test that measures your average blood sugar levels over the past 3 months ... Higher A1C levels are linked to diabetes complications, so reaching and maintaining your individual A1C goal is really important if you have diabetes ... A normal A1C level is below 5.7% ... a level of 6.5% or more indicates diabetes .... 4. A home visit observation was conducted with patient #7 on 10/21/2021 at 9:00 AM with home health aide (HHA) H. The patient s spouse indicated the patient also received weekly nursing visits, physical therapy services, she never knew when they were coming, they did not		provide 1:1 education with all Home Health case managersbeginning week of 12/20/2021. Formaleducation will be presented to all Home Health nursing staff via CHC internaleducation system to be completed on or before 12/31/2021. Educationto include: · Orders · Physician Notification-Change of Conditions · Medication Profiles · Visit Schedules · Discharge / Transfer Planning PatientCare Coordinators will monitor Care Plans every two weeks at Inter-DisciplinaryMeetings with Case Managers to ensure plan of care is complete withpatient/caregiver needs on an ongoing basis. Results of this plan of correction will bemonitored and reported to Quality Improvement Committee by Director of Nursingon an ongoing basis to ensure deficiency	

	leave schedules for how often they would visit, and she wished the HHA would come twice weekly instead of once. Clinical record review was completed on 10/21/2021, start of care date 8/14/2021, for certification periods 8/14/2021-10/12/2021 and 10/13/2021-12/11/2021. The clinical record evidenced a PT evaluation was completed on 9/8/2021 with goals for future visits, but no other PT (physical therapy) visits were documented, and no OT (occupational therapy) evaluation was completed. The record failed to evidence the patient/caregiver was made aware or approved the changes to the services or frequencies they were provided. A document signed by certifying physician I on 10/12/2021 titled Home Health Care Certification and Plan of Care for certification period 8/14/2021-10/12/2021 evidenced HHA weekly for 7 weeks, and PT and OT services were ordered. A document signed by certifying physician I on 10/20/2021 titled Home Health Care Certification and Plan of Care for certification period 10/13/2021-12/11/2021 evidenced HHA weekly for 9 weeks, nursing visits weekly, and PT and OT services were ordered. A document titled [patient]		is corrected and will not reoccur. ClinicalRecord 5 10/27/2021Nursing visit with State Surveyor 11/1/2021Nursing visit completed, wound care completed, vitals, and comprehensiveassessment, reviewed. Medication profilereviewed with Patient and Caregiver. 11/3/2021Nursing communication with Caregiver: 11/3/2021Nursing visit completed, wound care completed, vitals, and focus of visit withCaregiver goals of care. 11/3/2021Nursing call to Primary Physician on change of condition 11/3/2021Communication with Primary Physician for new referral and orders. 11/4/2021Nurse communication with Caregiver 11/5/2021Nursing visit, wound care and labs Patientdeveloped fever and care was placed on hold as of 11/05/2021 as patient	

	Communication Notes evidenced an entry dated 8/14/2021 which stated ... They [patient/family] were informed that the PT/OT will be ordered but it might take a few weeks to get started .... The entry failed to evidence the patient/family approved of this delay in services ordered. An entry dated 10/18/2021 evidenced nursing visits changed to every other week, but failed to evidence the patient/family was notified or approved the change in nursing visit frequency. During an interview on 10/21/2021 at 1:00 PM, director of quality assurance C indicated she wasn t sure why the aide was only ordered weekly if the family requested twice per week. 5. A home visit observation was conducted with patient #6 on 10/22/2021 at 10:30 AM. During the visit, the patient drank a bottle of mountain dew (soft drink high in sugar, contraindicated for people with diabetes), family indicated the patient s blood sugar readings were out of control but getting better, she would like someone to teach the patient about diabetes management, diabetic diet, and how exercise affected blood sugar levels. When asked, RN (registered nurse) J indicated the visit was for recertification of services (review and modification of the plan of care) for the next		wasadmitted to hospital. Patientresumption of care 11/17/2021, patient discharged from CHC Home Health on11/24/2021 to hospice services. ClinicalRecord 6 Patientdischarged from CHC Home Health services on 11/07/2021. ClinicalRecord 7 Medication profile updated on10/22/2021 and 10/24/2021 with new order from Primary Care Physician. Week of 11/01/2021 updateddiscipline schedule, medication profile and plan of care taken to patients'home and placed in CHC folder. All PT notes received anduploaded to clinical record on 11/01/2021. 10/24/2021 Attending Physiciannotified unable to provide OT at this time and ordered received for PT only byPhysician. 10/25/2021 nursing visitconducted. All orders and medications reviewed with patient and spouse.	

	60-day period (10/25/2021-12/23/2021), she did not know what his most recent A1c level (a blood test to estimate average blood sugar levels over the past 2-3 months) was, and she would need to follow up with the patient s physician. A document received from director of quality assurance C on 10/26/2021 titled Discharge Summary evidenced the patient s A1c lab value was 12.4% (normal value is less than 7%) on 7/29/2021. A document signed by certifying physician H on 9/14/2021 titled Home Health Care Certification and Plan of Care for certification period 8/26/2021-10/24/2021 evidenced (but not limited to) the patient had diabetes with a foot ulcer (open wound), but was ordered a regular diet. A document signed/not dated by (the new) certifying physician K titled Home Health Care Certification and Plan of Care for certification period 10/25/2021-12/23/2021 evidenced (but not limited to) the patient had diabetes with a foot ulcer (open wound), and diet was as tolerated . The plan of care failed to evidence skilled nursing interventions that family requested for teaching of diabetes management, diabetic			

	blood sugar levels. 5. A home visit observation was conducted with patient #5 on 10/22/2021 at 1:00 PM. When asked what his goal(s) for the services received from the home care agency was, the patient indicated he wanted physical therapy (PT) services, and his goal was to get out of bed. When asked, RN Q indicated PT wasn t ordered upon start of care, and the quality assurance department took care of that. A document signed by certifying physician L on 10/13/2021 titled Home Health Care Certification and Plan of Care start of care date 10/7/2021, for certification period 10/7/2021-12/5/2021 failed to evidence PT was ordered, or the patient s goal was to get out of bed. 17-12-3(b)(2)(D)(i)(AA) 17-12-3(b)(2)(D)(i)(BB) 17-12-3(b)(2)(D)(ii)(AA) 17-12-3(b)(2)(D)(ii)(BB)			
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. 1. A policy revised 03/2017 titled	G0536	A reviewof all current medications	2021-12-31

	Medication Review stated ... A Drug Regimen Review comprehensive assessment must include a review of all medications the patient is currently taking ... will include a listing of the medications that the patient is taking ... shall include over-the-counter and herbal medications ... shall be labeled with ... all applicable information .... 2. A policy revised 07/2019 titled Medication Orders stated ... medications are documented in the patient s medical record and include ... Purpose (if PRN [as needed] and/or antibiotic) .... 3. A policy revised 10/2021 titled Initial Assessment of Patient, Family, Caregiver stated ... [RN] Instruct in actions, side effects, contraindications, and efficacy of current [medication] regime, examine any additional medications (prescribed or over-the-counter) which the patient may be taking .... During an interview on 10/26/2021 at 10:00 AM, director of quality assurance C indicated the policy titled Initial Assessment of Patient, Family, Caregiver represented the agency s policy for the comprehensive assessment. 4. An FDA (Federal Drug Administration) website, https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/021134s010lbl.pdf,		Theweek of 11/1/2021 verbal education provided on 484.55. Medication profiles reviewed and updated asappropriate. HomeHealth case managers will complete medication reconciliation at every nursingvisit. · Efficacy · Over-the counter drugs · Adverse reactions · Therapeutic blood levels PatientCare Coordinators will provide further 1:1 education with all Home Health casemanagers beginning week of 12/20/2021. Beginningweek of 12/20/2021 all current Home Health census will electronic medicalrecords reviewed and updated accordingly. Additionalformal education will be presented to all Home Health nursing staff viaCHC internal education system to be completed on or before 12/31/2021.	

	referenced on 10/27/2021, stated ... NITROSTAT ... At the onset of an attack, administer one tablet under the tongue ... One additional tablet may be administered every 5 minutes as needed. No more than 3 total tablets are recommended within a 15 minute period ... If chest pain persists after three tablets, seek prompt medical attention .... 5. An FDA (Federal Drug Administration) website, https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/017874s038lbl.pdf, referenced on 10/27/2021, stated ... For use longer than 3 days, remove current patch and place new patch behind other ear .... 6. Record review for patient #1 was completed on 10/27/2021, start of care date 9/27/2021, for certification period 9/27/2021-11/25/2021. A document printed on 10/21/2021 titled Medication Profile stated ... Nitrostat [medication used to relieve chest pain] ... 1 tab ... [under the tongue] ... every 5 minutes as needed ... scopolamine ... Apply ... topically every 72 hours .... During an interview on 10/27/2021 at 4:50 PM, the clinical manager indicated the medication profile should have included instructions to take no more than 3 doses for the nitrostat, to call 911 if chest pain was unrelieved, and the		Educationto include: · Insulin · Nitro-stat · Medication patches PatientCare Coordinators will monitor Medication Profiles against Care Plans every twoweeks at Inter-Disciplinary Meetings with Case Managers to ensure plan of careis complete with patient/caregiver needs on an ongoing basis. Results of this plan of correctionwill be monitored and reported to Quality Improvement Committee by Director ofNursing on an ongoing basis to ensure deficiency is corrected and will notreoccur. ClinicalRecord 1 Nitrostat Order written with 5rights of medication administration. Right drug, right dose, right time, rightroute and right person. Medicationprofile review conducted on 11/05/2021 during nursing visit with patient.Education provided to all CHC agency nurses on 12/31/2021 covering order writing. Patient discharged from	

	included instructions to rotate sites for each new patch applied, and ensure old patch was removed. 7. Record review for patient #2 was completed on 10/27/2021, start of care date 5/1/2020, for certification period 8/24/2021-10/22/2021. A document printed on 10/21/2021 titled Medication Profile evidenced (but not limited to) the patient took 1mg (milligram) of warfarin (a blood thinner requiring routine lab monitoring for therapeutic blood levels) daily. During an interview on 10/27/2021 at 5:15 PM, the clinical manager and director of quality assurance C indicated 1mg was the default dose on the patient s medication list, there were no lab results in the patient s medical record, and the current dose of warfarin the patient took was unknown. 8. Record review for patient #4 was completed on 10/27/2021, start of care date 3/11/2020, for certification period 9/2/2021-10/31/2021, and discharge date 9/25/2021, evidenced a document titled [patient] Communication Notes evidenced an entry dated 7/21/2021 which stated ... A lot of teaching is done with ... [family] ... about treating with sliding scale [insulin]		agency Home Health services on 11/12/2021. Clinical Record 2 PT/INR Vancomycin and multiple otherlab results for 10/11, 11/1,11/8,11/15,11/22, 11/29/2021 uploaded to patients'chart on 12/7/2021. Clinical Record 4 Patient discharged from CHC HomeHealth services on 9/25/2021. Clinical Record 6 Patient discharged from CHC HomeHealth services on 11/07/2021. On 10/26/2021 follow up withattending physician for orders. Orderreceived for sliding scale insulin and blood sugar checks on 11/01/2021 Clinical Record 7 Medication profile updated. Order clarificationreceived for Tylenol on 10/25/2021 and medication discontinued on 12/30/2021.	

	A document titled Home Health Care Certification and Plan of Care for certification period 9/2/2021-10/31/2021 evidenced (but not limited to) a primary diagnosis of diabetes with hyperglycemia (high blood sugar), skilled nursing for symptom management and education of uncontrolled blood sugars, and failed to evidence sliding scale insulin in the medication section of the plan of care. 9. Record review for patient #6 was completed on 10/26/2021, start of care date 8/26/2021, for certification period 8/26/2021-10/24/2021. A document dated and signed by LPN (licensed practical nurse) S on 8/27/2021 stated ... 6 units of insulin was administered per sliding scale order .... A home visit observation was conducted on 10/22/2021 at 10:30 AM with RN J. The surveyor and RN J both observed a hand-written post-it note in a plastic bag which evidenced sliding scale insulin instructions for administration. During this time, family confirmed the patient did take sliding scale insulin. A document printed on 10/20/2021 titled Medication Profile failed to evidence sliding scale insulin use or indications. During an interview on			

	10/26/2021 at 11:00 AM, the clinical manager confirmed there was no sliding scale for insulin on the medication profile or in the medical record. 10. Record review for patient #7 was completed on 10/21/2021, start of care date 8/14/2021, for certification period 8/14/2021-10/12/2021, evidenced a document dated 10/12/2021 titled Recert OASIS [outcome and assessment information set]-D1 .... stated ... now taking Tylenol 1000mg QID [4 times daily] .... A document printed on 10/20/2021 titled Medication Profile evidenced tylenol 500mg 3 times daily. The medication profile failed to evidence the updated dose and frequency. 17-14-1(a)(1)(B)			
G0560	Discharge Planning 484.58 Condition of Participation: Discharge planning. 1. A policy revised 2/2017 titled Discharge Criteria stated ... After the decision is made for discharge, the patient/caregiver will be notified .... During an interview on 10/27/2021 at 1:03 PM, the alternate administrator indicated the policy titled Discharge Criteria was the only discharge	G0560	CONDITIONALLEVEL TAG G0560 · Transfersummary draft policy created 11/01/21 · 11/02/2021 providednursing staff with detailed steps, policy, and procedure on transfersummary. Week of 12/13/2021 Patient Care Coordinators will providean additional review on handouts with all nursingstaff during IDT’s.	2021-12-22

	policy the agency had, and it did not include discharge planning needs. 2. A policy revised 10/2021 titled Initial Assessment of Patient, Family, Caregiver failed to evidence the comprehensive assessment must include discharge planning needs. During an interview on 10/26/2021 at 10:00 AM, the director of quality assurance indicated the policy titled Initial Assessment of Patient, Family, Caregiver represented the agency s policy for the comprehensive assessment. 3. Record review for patient #3 was completed on 10/27/2021, start of care date 5/19/2021, for certification period 5/19/2021-7/17/2021, discharge date 5/25/2021. A document dated 9/27/2021 titled SOC OASIS-D1 .... evidenced (but not limited to) the patient had cancer, would be going back to the hospital soon for 3 weeks for stem cell transplant, skilled nursing provided central line care (tube inserted into a vein for direct access to administer medications), taught family how to care for the central line, and stated ... Patient needs post discharge ... None at this time ... Discharge Plans ... When goals met or progress plateaus .... The		· 12/06/21 Initialassessment of patient, family, and caregiver policy updated to includedischarge planning goals at time of admission. · Admission Team Leader toreview and educate all admission nurses on updated policy week of 12/13/2021 · Education will be providedvia agency internal Learning system on discharge summary regulatory componentswith completion date by: 12/22/2021. MONITORING: 100% auditof documentation of discharge plan upon admission byAdmission team leader. Admission Team Leader willmonitor daily:100% of all charts for completeness of discharge goals for 30days, 90% of all charts must meet standards, they will then monitor 50 % of allcharts for 30days, if 90% of all charts meet standards, they will monitor 10%of all charts monthly on an ongoing basis for compliancy. Patient CareCoordinators to monitor 100% of patient discharge goals documentationfor 30 days, 90% of all charts must meet	

	discharge planning needs for care of the central line upon agency discharge. A document titled Prep Notes Communication evidenced an entry dated 5/20/2021 which stated ... anticipate discharge once acknowledgement of arrival at ... [hospital M] ... on Tuesday, May 25 .... The document also evidenced an entry dated 5/25/2021 which stated ... [verbal order] received from [physician N s] nurse to discharge patient ... is currently admitted to [hospital M] .... A document dated and signed by registered nurse (RN) T on 5/25/2021, and signed by physician N on 6/4/2021 titled Discharge Summary failed to evidence if the patient had any allergies, any pertinent lab values, the reason for the home care admission, the treatments received, presence of a central line, the last time her central line dressing was changed, or post-discharge goals of care. 4. Record review for patient #4 was completed on 10/27/2021, start of care date 3/11/2020, for certification period 9/2/2021-10/31/2021, discharge date 9/25/2021. Documents dated 9/2/2021, 9/9/2021, 9/13/2021, and 9/16/2021 titled Skilled Nursing Visit Note ... Follow Up Visit .... all stated ... Discharge Planning		standards. If 90% of charts meet compliancy standards, they will then monitor 50 % of all charts for 30dats, if 90% of allcharts meet standards, they will monitor 10% monthly of all charts on anongoing basis for compliancy. QA to audit 100% of allhome health discharge and transfer summaries to ensure completion of summaryand a copy sent to facility (when applicable) and physician for 30days. Current home healthcensus discharge planning to be reviewed by Patient Care Coordinators by 12/14/21. Any discharge planning updates requiredwill be implemented by 12/21/21. QAwill audit 10% of all home health charts quarterly on an ongoing basis toensure compliancy with discharge goals and summaries.	

	... Not addressed this visit .... A document dated and signed by RN J on 9/20/2021 titled Skilled Nursing Visit Note stated ... Description ... RN Phone call ... patient ... admitted to ... [hospital O] ... over the weekend ... [patient] had a fall and fractured her hip and ... taken to surgery .... A document dated and signed by registered nurse (RN) J on 9/28/2021, with no physician signature titled Discharge Summary failed to evidence if the patient had any allergies, any pertinent lab values, the reason for the home care admission, patient/family discharge instructions, or treatments received. During an interview on 10/27/2021 at 1:00 PM, the director of quality assurance indicated the agency had no policy regarding transfer summaries or transfers, they did not send a transfer summary for the patient on 9/20/2021, and they did not send transfer summaries when any patients were admitted into a hospital.			
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	G0572	Planof Care	2021-12-31

	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. 1. A document revised 07/2019 titled Care Plan Establishment and Review stated ... agency ... must provide a written individualized plan of care that identifies patient-specific measurable outcomes and goals ... established, periodically reviewed, and signed by the attending physician .... 2. Record review for patient #1 was completed on 10/27/2021, start of care date 9/27/2021. The record failed to evidence the patient received occupational therapy (OT) or speech language pathology (SLP) services as ordered on the plan of care, the plan of care was individualized and included patient-specific measurable outcomes and goals, or the physical therapy (PT) plan of care was reviewed by, approved by, or signed by the certifying physician. A document dated 9/27/2021 titled SOC [start of care] OASIS-D1 [outcome and assessment information set] .... evidenced the patient s self-stated goals/care preferences were to use alternative methods to help complete personal care with the		The week of 11/1/2021 verbal education provided on 484.60. PatientCare Coordinators will provide further 1:1 education with all Home Health casemanagers by 12/23/2021. Formaleducation will be presented to all Home Health nursing staff via CHC internaleducation system to be completed on or before 12/31/2021. Educationto include: · Patient SpecificMeasurable Outcomes · Patient Goals Beginningweek of 12/20/2021 all current Home Health census electronic medical records willbe reviewed and updated accordingly.	

	better pain management; and his pain goal was 2 (scale of 0-10, with 0= no pain, and 10= worst pain ever). A document titled Home Health Care Certification and Plan of Care for certification period 9/27/2021-11/25/2021, was signed by the certifying physician on 10/3/2021, with primary diagnosis amyotrophic lateral sclerosis (ALS, a fatal, degenerative disease affecting the brain and spinal cord, with progressively worse symptoms), and other diagnoses included history of prostate cancer (causes restricted urinary flow and/or difficulty urinating), atherosclerosis (deposit of plaque in the arteries causing blockage) of CABG (coronary artery bypass grafting- a procedure to improve poor blood flow to the heart) without chest pain, and high cholesterol. The document evidenced (but not limited to) orders for SLP (speech language pathologist), PT, and OT to evaluate, goals included optimal independence, stabilization of pulmonary (lung) status, optimal activity level achieved and maintained within baseline respiratory and energy parameters, pain level less than 3 (patient goal was less than 2), and failed to evidence patient-specific measurable outcomes/goals for the patient s primary diagnosis, high		Beginningof 11/1/2021 Patient Care Coordinators will monitor Care Plans every two weeksat Inter-Disciplinary Meetings with Case Managers to ensure plan of care are individualizedand include measurable outcomes on an ongoing basis. Therapy organization waseducation on the need to ascertain therapy orders from physician on 11/1/2021. On 12/13/2021 new procedures implemented by CHCquality assurance nurse to ensure therapy orders were obtained by certifying physician. Quality AssuranceDepartment will monitor on an ongoing basis 10% of therapy notes are uploadedin the electronic medical record on a monthly basis. A new therapy agency was contractedto ensure timely start of therapies 12/2021. Results of this plan of correctionwill be monitored and reported to Quality Improvement Committee by Director ofQuality Assurance and Director of Nursing on an ongoing basis to ensuredeficiency is corrected and will not reoccur.	

	cholesterol, heart disease, fall, skin and nutritional risks, baseline versus stabilized pulmonary status, baseline versus optimal activity level, baseline energy parameters, or the patient s self-stated goals/care preferences were to use alternative methods to help complete personal care with the assistance of family, and have better pain management. An untitled document dated 10/7/2021 evidenced a PT evaluation was completed on 10/7/2021, interventions and goals were established, and failed to evidence it was approved by, or signed by the certifying physician. During an interview on 10/27/2021 at 4:50 PM, the clinical manager confirmed the record failed to evidence SLP or OT evaluations/treatments were provided to the patient. 3. Record review for patient #2 was completed on 10/27/2021, start of care date 5/1/2020, for certification period 8/24/2021-10/22/2021, and 10/23/2021-12/21/2021. The record failed to evidence the plan of care was individualized, and included patient-specific measurable outcomes and goals. A document titled Home Health Care Certification and Plan of Care for certification period		Clinical Record 1 On 10/26/21, verbal order receivedfor therapy and documented in communication note. Home Health referral order forskilled nursing and therapy for musculoskeletal pain maintenance. Patient withphysical therapy evaluation and treatment on 10/07/2021. Verbal order for discharge receivedfrom Attending Physician on 11/09/2021, patient no longer having skilledneed. Patient discharged from HomeHealth services on 11/12/2021. Signeddischarge summary from Attending Physician received on 11/16/2021. Education provided to contractedtherapist on 11/01/2021 on the need to ascertain therapy orders from Attending Physicians. 12/13/2021 agency Quality Assurance Departmentimplemented new procedures on obtaining orders by certifying physician fortherapies. New therapy contract obtained 12/2021 to ensure timely start ofordered therapies. Education provided to all CHC nurses in 12/2021 on writingorders, along with patient specific care plans.	

	signed by the certifying physician on 8/27/2021, with primary diagnosis ischemic cardiomyopathy (significantly impaired left ventricular heart function), and other diagnoses of chronic heart failure, chronic lung disease with acute exacerbation (active symptoms), high blood pressure, hardening of the arteries without chest pain, bacterial infection causing other disease, high cholesterol, infected implanted device, depression, presence of LVAD (left ventricular assist device-implanted in the chest to help pump blood from the left ventricle of heart out to the rest of the body for patients who have reached end-stage heart failure), and rib fracture. The document failed to evidence measurable outcomes/goals related to weight, heart failure management, lung disease, high cholesterol, depression, or rib fracture.		Clinical Record 2 Record reviewed during IDT on 11/15/2021,12/03/2021 and 12/14/2021 for patient specific care plans. Care plan updated on 11/27/2021. PT/INR, Vancomycin, and multiple labresults for 10/11, 11/1,11/8,11/15,11/22, 11/29/2021 uploaded to patients' charton 12/7/2021. Clinical Record 3 Patient was discharged from CHC HomeHealth Services on 5/25/2021. ClinicalRecord 4 Patientdischarged from CHC Home Health services on 9/25/2021. ClinicalRecord 5 11/1/2021Nursing visit completed, wound care completed, vitals, and comprehensiveassessment, reviewed. Medication profilereview with Patient and Caregiver. 11/3/2021Nursing Communication with Caregiver:	

	A document dated 10/18/2021 titled Skilled Nursing Visit Note ... Home Health POC Recertification .... evidenced patient self-stated goals/care preferences included to maintain current level of personal care ability, and her perceived impact of current illness was decreased ability to perform instrumental activities of daily living (IADLs) such as house cleaning, and cooking. A document titled Home Health Care Certification and Plan of Care for certification period 10/23/2021-12/21/2021, not yet signed by the certifying physician, evidenced a primary diagnosis of ischemic cardiomyopathy, and other diagnoses of chronic heart failure, chronic lung disease with acute exacerbation, high blood pressure, hardening of the arteries without chest pain, bacterial infection causing other disease, high cholesterol, infected implanted device, depression, presence of LVAD, and rib fracture. The document failed to evidence measurable outcomes/goals related to weight, heart failure management, lung disease, high cholesterol, depression, or rib fracture. During an interview on 10/27/2021 at 5:15 PM, the alternate administrator and		11/3/2021Nursing visit completed, wound care completed, vitals, and focus of visit withCaregiver goals of care. 11/3/2021Nursing call to Primary Physician on change of condition 11/3/2021Communication with Primary Physician for new referral and orders. 11/4/2021Nurse communication with Primary Caregiver 11/5/2021Nursing visit, wound care and labs Patientdeveloped fever and care was placed on hold as of 11/05/2021 as patient wasadmitted to hospital. Patientresumption of care 11/17/2021, patient discharged from CHC Home Health on11/24/2021 to hospice services. ClinicalRecord 6 Patient discharged from CHC Home Healthservices on 11/07/2021. OT evaluation notes uploaded to chart from 10/28/2021. ClinicalRecord 7 PTnotes received and uploaded to patients' chart. Home Health	

	clinical manager confirmed the nurses failed to obtain ordered lab draws as ordered on the plan of care. 4. Record review for patient #3 was completed on 10/27/2021, start of care date 5/19/2021, for certification period 5/19/2021-7/17/2021, discharge date 5/25/2021. The record failed to evidence the patient received a social worker evaluation as ordered on the plan of care, or the plan of care was individualized and included patient-specific measurable outcomes and goals. A document dated 9/27/2021 titled SOC OASIS-D1 .... evidenced the patient s self-stated goals/care preferences were to receive stem cell transplant and it would cure her, she was a high risk for infection, she received daily heparin (blood thinner) flushes and weekly central line (tube inserted into a large vein for administration of fluids, medications) dressing changes to the right chest, bouts of diarrhea due to her treatment, and she would be going to the hospital soon for stem cell transplant. A document titled Home Health Care Certification and Plan of Care for certification period 5/19/2021-7/17/2021, signed by		was declined by patient, missed visit in EMR. Week of 9/19 physiciannotified and no changes. PTorders received on 10/24/2021, attending physician notified of PT evaluationand follow up visits. UpdatedHome Health orders received 12/16/2021 Weekof 11/01/2021 review of care plans in IDT began for patient specific measurablegoals.	

	6/4/2021, evidenced primary diagnosis of multiple myeloma (cancer) not in remission, and other diagnoses of intractable migraine with status migrainosus (severe and long-lasting form of migraine headache), high cholesterol, depression, and hypothyroidism. The document evidenced an order for a social worker to evaluate between dates 5/20/2021-5/23/2021 (the patient was discharged on 5/25/2021), and failed to evidence individualized measurable outcomes or goals for diarrhea, migraine and associated pain, high cholesterol, or depression. 5. Record review for patient #4 was completed on 10/27/2021, start of care date 3/11/2020, for certification period 9/2/2021-10/31/2021, discharge date 9/25/2021. The record failed to evidence the patient s most current A1c (a blood test to determine average blood sugar over the past 2-3 months), the plan of care was individualized or included patient-specific measurable outcomes and goals. A document titled Home Health Care Certification and Plan of Care for certification period 9/2/2021-10/31/2021, signed by the certifying physician on 10/5/2021, evidenced (but not limited to) a primary diagnosis of diabetes with hyperglycemia			

	(high blood sugar), and a 2200 calorie restricted diabetic diet. The document failed to evidence patient-specific measurable outcomes and goals for hyperglycemia or diabetic diet. During an interview on 10/27/2021 at 1:00 PM, the clinical manager indicated there should have been an intervention to review a blood sugar readings log, there was no A1c in the record, an A1c would be beneficial to determine a measurable outcome, and there was no evidence to measure if the patient followed a 2200 calorie diabetic diet. 6. Record review for patient #5 was completed on 10/26/2021, start of care date 10/7/2021, for certification period 10/7/2021-12/5/2021. The record failed to evidence the plan of care was individualized, or included patient-specific measurable outcomes and goals. A document dated 10/7/2021 titled SOC OASIS-D1 .... evidenced the patient had a stage 2 pressure sore (an open wound characterized by partial-thickness skin loss into but no deeper than the depth of the skin, and would include intact or ruptured blisters) on his lower back/buttock area, a venous stasis ulcer (a wound caused by decreased circulation) on the			

	size 16 french/10 cc (cubic centimeter) indwelling foley catheter, the patient had horrible pain, his pain goal was 2 , his self-stated goal was to have his wounds healed, less pain, and ability to complete personal care with minimal assistance; and was only eating about 50% of his meals. A document titled Home Health Care Certification and Plan of Care for certification period 10/7/2021-12/5/2021, signed by the certifying physician on 10/18/2021, evidenced (but not limited to) a primary diagnosis of osteomyelitis (infection into the bone) of the right ankle and foot, and other diagnoses included nonrheumatic aortic valve disorder (dysfunction of heart valve), chronic kidney disease, stage 2 (mild), atrial fibrillation (irregular heartbeats), presence of foley catheter, and high cholesterol. The document failed to evidence individualized measurable outcomes or goals related to ability to self-perform personal care (patient s personal goal), pain, prevention of skin breakdown, prevention of UTI or dehydration, dietary and fluid intake, or goals for heart and kidney disease, or high cholesterol. 7. Record review for patient #6 was completed on 10/26/2021,			

	start of care date 8/26/2021, for certification period 8/26/2021-10/24/2021. The record failed to evidence the patient received OT as ordered on the plan of care, the plan of care was individualized and included patient-specific measurable outcomes and goals, the PT plan of care was reviewed, approved, or signed by the certifying physician, or the SLP plan of care was reviewed, approved, or signed by the certifying physician. A document titled Home Health Care Certification and Plan of Care for certification period 8/26/2021-10/24/2021, signed by the certifying physician on 9/14/2021, evidenced primary diagnosis of multi-system degeneration of the autonomic nervous system/MSA (a neurodegenerative disorder that can cause a multitude of symptoms in any combination including impairments to balance, difficulty with movement, poor coordination, bladder dysfunction, sleep disturbances and poor blood pressure control), and other pertinent diagnoses included (but not limited to) parkinson s disease (a progressive nervous system disorder that affects movement), benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (condition in which an overgrowth of prostate tissue pushes against			

	the urethra and the bladder, blocking the flow of urine), high blood pressure, history of falling, fainting and collapse, traumatic bruising of the brain (due to fall), and diabetes with foot ulcer. The document also evidenced (but not limited to) orders for skilled nursing for wound care, PT, OT, and SLP to evaluate and treat, regular diet, and failed to evidence individualized interventions, measurable outcomes, or goals related to MSA, BPH, high blood pressure, or diabetic diet. A document dated 9/2/2021 titled PT eval [evaluation/plan of care] evidenced a PT evaluation was completed on 9/2/2021, interventions and goals were established, and failed to evidence it was reviewed, with, approved by, or signed by the certifying physician. A document dated 9/1/2021 titled Speech Therapy [SLP] Assessment evidenced a SLP evaluation was completed on 9/1/2021, interventions and goals were established, and failed to evidence it was reviewed with, approved by, or signed by the certifying physician. During an interview on 10/26/2021 at 11:00 AM, the alternate administrator indicated he couldn t find an OT evaluation in the record, the clinical director			

	there was not an OT evaluation in the record, and the clinical manager and alternate administrator confirmed the therapy evaluations failed to evidence the certifying physician was contacted to review or approve the therapy plans of care, and the evaluations were not signed by the certifying physician. 8. Record review for patient #7 was completed on 10/21/2021, start of care date 8/14/2021, for certification period 8/14/2021-10/12/2021, and 10/13/2021-12/11/2021. The record failed to evidence the patient received OT services, a PT evaluation was completed on 9/8/2021 with goals for future visits, but no other PT visits were made, no weekly home health aide (HHA) visits were made during the weeks of 9/5/2021 or 9/19/2021 as ordered on the plan of care, the plans of care were individualized and included patient-specific measurable outcomes and goals, or the PT plan of care was reviewed with, approved by, or signed by the certifying physician. titled Home Health Care Certification and Plan of Care for certification period 8/14/2021-10/12/2021, was signed by the certifying physician on 10/12/2021, with primary diagnosis chronic combined			

	(both left and right sided heart failure, resulting in inability for the heart to adequately pump blood to and from the heart), and other pertinent diagnoses of paroxysmal atrial fibrillation (a rapid, erratic heart rate that begins suddenly and then stops on its own within 7 days), hearing loss, history of prostate cancer, high cholesterol, fainting and collapse, obesity, nonrheumatic aortic valve stenosis (rigidity of heart/aortic valve not caused by rheumatoid arthritis), history of falling, and long term (current) use of anticoagulants (blood thinners). The document evidenced (but not limited to) orders for skilled nursing, HHA weekly beginning 8/22/2021, PT/OT to evaluate and treat, and failed to evidence individualized and patient-specific measurable outcomes and goals for heart failure, paroxysmal atrial fibrillation, hearing loss, history of prostate cancer, high cholesterol, fainting and collapse, obesity, nonrheumatic aortic valve stenosis, history of falling, or long-term use of anticoagulants.			

	An untitled document dated 9/8/2021 evidenced a PT evaluation was completed on 9/8/2021, interventions and goals were established, and failed to evidence it was approved by, or signed by the certifying physician. During an interview on 10/21/2021 at 1:00 PM, the director of quality assurance confirmed OT was not provided to the patient, and there were no additional PT visit notes in the record after the evaluation on 9/8/2021, which also included the certification period 10/13/2021-12/11/2021. 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;	G0574	Planof Care must include The week of 11/1/2021 verbal education provided on 484.60. HomeHealth case managers received additional education on plans of care and careplanning at Nurses meeting on 12/01/2021. State survey results received 12/3/2021 and focus on Plan of Caresthe week of 12/06/2021. All current Home Health census electronic medicalrecords were	2021-12-31

	(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. 1. A document revised 07/2019 titled Care Plan Establishment and Review stated ... agency ... must provide a written individualized plan of care that identifies patient-specific measurable outcomes and goals ... will include patient/family/caregiver needs including medical, nursing, functional ... psycho-social .... 2. A document revised 09/2017 titled Plan of Care: Physician Certification stated ... The plan of care shall include, but is not limited to ... An assessment of the patients [sic] needs and identification of services ... scope and frequency of services/disciplines needed in order to meet the patient s/caregiver s needs .... 3. A University of California, San Francisco web-based reference cited on 10/21/2021, https://www.ucsfhealth.org/medical-tests/mental-status-testing, indicated (but not limited to) mental status testing is done to check a person's thinking ability, to determine if any		reviewed and updated when appropriate. · All Diagnosis · Risk for Hospitalization · Patient SpecificInterventions PatientCare Coordinators will provide 1:1 education with all Home Health case managersbeginning week of 12/20/2021. Education to include: · Patient SpecificMeasurable Outcomes · Patient Goals Formaleducation will be presented to all Home Health nursing staff via CHC internaleducation system to be completed on or before 12/31/2021. Educationto include but not limited to: · Durable MedicalEquipment and Supplies · Physician Notification-Change of Conditions	

	problems are getting better or worse, a health care provider will ask a number of questions to determine orientation to self, place, time, ability to problem solve, comprehend, and react to normal circumstances. 4. Record review for patient #1 was completed on 10/27/2021, start of care date 9/27/2021, evidenced a document dated 9/27/2021 titled SOC [start of care] OASIS-D1 [outcome and assessment information set] .... , which evidenced the patient used heat for pain relief, was chairfast, had contractures (joint/tendon/ligament stiffness causing limited mobility), was a risk for skin breakdown due to bony prominences, immobility and inability to change positions, had chest pain with activity, a productive cough, utilized a CPAP/BiPAP (a machine that forces air into the lungs either continuously or intermittently while breathing), used a size 32 condom catheter (a urinary drainage device that is fitted over the penis to drain urine into a bag), had GERD (acid reflux), was symptomatic of depression, took an antidepressant, had a PEG (tube inserted into the stomach to administer nutrition, fluids, and/or medications), received scheduled intermittent tube feedings for nutrition, was a moderate nutritional risk, unable to take nutrients by mouth, fall		· Individualized Plans · Measurable Outcomes · Procedures · Visit Schedules · Discharge / TransferPlanning Additionalplan of care and care planning education/review to be completed by Patient CareCoordinators at IDT meeting week of 12/27/2021. On11/1/2021 Patient Care Coordinators will monitor Care Plans every two weeks at Inter-DisciplinaryMeetings with Case Managers to ensure plan of care are individualized andinclude measurable outcomes on an ongoing basis. Results of this plan of correctionwill be monitored and reported to Quality Improvement Committee by Director ofNursing on an ongoing basis to ensure deficiency is corrected and will notreoccur. Clinical Record 1	

	medications, used cough assist and oral suctioning, unable to transfer self, was dependent on another person for completion of personal care, and risk factor(s) for emergency department (ED) visit/hospital re-admission included the patient took 5 or more medications. A document titled Home Health Care Certification and Plan of Care for certification period 9/27/2021-11/25/2021, was signed by the certifying physician on 10/3/2021, with primary diagnosis amyotrophic lateral sclerosis (ALS, a fatal, degenerative disease affecting the brain and spinal cord, with progressively worse symptoms), and other diagnoses included history of prostate cancer (causes restricted urinary flow and/or difficulty urinating), atherosclerosis (deposit of plaque in the arteries causing blockage) of CABG (coronary artery bypass grafting- a procedure to improve poor blood flow to the heart) without chest pain, and high cholesterol. The document evidenced the patient s mental status was oriented , but failed to evidence what the patient was oriented to (person, place, time, situation); failed to evidence psychosocial (family dynamics/support, household needs) or cognitive status (comprehension and understanding); failed to		10/29/2021 skilled nursing visitreflects patient alert oriented times three. 11/05/2021 skilled nursing visitdocuments patient return demonstration of home exercises provided by physicaltherapy. 11/05/21 Physician office notifiedof request for order to discharge or continue Home Health services, orderreceived 11/09/2021 to discharge no longer skilled need. 11/10/2021 Physician notified ofpatient fall. No new orders received. 11/12/21 verbal order received todischarge patient no longer skilled need per physician. Home Health nurses received additional educationon 12/01/2021 for plans of care and care planning. State survey resultsreceived 12/3/2021 where all current Home Health census EMR’s were reviewed and updatedwhen appropriate. Clinical Record 2 Verbal education provided on11/01/2021 on 484.60. 484.60 G574 was found to include all clinical recordsreviewed during site visit. CHC agency provided education to include allcurrent	

	evidence other pertinent diagnoses of depression, GERD, presence of a PEG tube, or pain; failed to evidence functional limitations of inability to transfer self, dependent for personal care, and non-ambulatory; failed to evidence the safety measure of aspiration (ingestion of food, other objects, or fluids into the lung) precautions due to presence of a PEG tube and diagnosis of GERD or need for 24 hour care/supervision due to dependent status; failed to evidence all supplies the patient needed such as PEG tube supplies, CPAP/BiPAP equipment, mask, tubing, oral suctioning machine and supplies, or supplies to clean PEG insertion site; nutrition status failed to evidence the patient could take nothing by mouth; failed to evidence interventions for use of heat as pain mitigation, instructions to check PEG tube placement and how often, PEG insertion site care and precautions, indications and instructions for suctioning, indications and instructions for use of CPAP/BiPAP, or who administered medications, medication administration teaching, or verification of medication competency. 5. Record review for patient #2 was completed on 10/27/2021, start of care date 5/1/2020, for certification period		this deficiency Additional education providedon 12/01/2021. Record reviewed during IDT on 11/15/2021, 12/03/2021 and 12/14/2021for patient specific care plans. Patient discharged from Home Health serviceson 12/21/2021. On 11/1/2021 Patient/Caregiver candemonstrate aseptic performance of PICC procedures On 11/8/2021 Patient/Caregiver to monitor weight changesand any gains to report to Case Manager. On 11/15/2021 New Nurse Case Managerassigned to clinical record 2. Medication profile reviewed for changes. On 12/14/2021, patient in agreementwith upcoming discharge. Case Managercoordinated discharge plan with Primary Care Physician and Beacon outpatientinfusion. Clinical Record 3 Patient was discharged from CHC HomeHealth Services on 5/25/2021 Clinical Record 4	

	evidenced a document titled Home Health Care Certification and Plan of Care for certification period 8/24/2021-10/22/2021, signed by the certifying physician on 8/27/2021, with primary diagnosis ischemic cardiomyopathy (significantly impaired left ventricular heart function), and other diagnoses of chronic heart failure, chronic lung disease with acute exacerbation (active symptoms), high blood pressure, hardening of the arteries without chest pain, bacterial infection causing other disease, high cholesterol, infected implanted device, depression, presence of LVAD (left ventricular assist device-implanted in the chest to help pump blood from the left ventricle of heart out to the rest of the body for patients who have reached end-stage heart failure), and rib fracture. The document evidenced (but not limited to) the patient s mental status was oriented , interventions for lab draws, assessment for weight change, weekly PICC (a tube inserted into a vein for administration of fluids or medications) dressing change, teach family how to administer IV (intravenous) medications via PICC, how to flush PICC, but failed to evidence what the patient was oriented to; failed to evidence psychosocial or cognitive status; failed to		Patient discharged from CHC HomeHealth services on 9/25/2021. ClinicalRecord 5 11/1/2021Nursing visit completed, wound care completed, vitals, and comprehensiveassessment, reviewed. Medication profilereview with Patient and Caregiver. 11/3/2021Nursing Communication with Caregiver: 11/3/2021Nursing visit completed, wound care completed, vitals, and focus of visit withCaregiver goals of care. 11/3/2021Nursing call to Primary Physician on change of condition 11/3/2021Communication with Primary Physician for new referral and orders. 11/4/2021Nurse communication with Primary Caregiver 11/5/2021Nursing visit, wound care and labs Patientdeveloped fever and care was placed on hold as of 11/05/2021 as patient	

	syringes for flushing the PICC, type and frequency of labs to be drawn, current anticoagulant therapy lab values, current or desired weight, or last PICC dressing change and when next due to be changed. 6. Record review for patient #3 was completed on 10/27/2021, start of care date 5/19/2021, for certification period 5/19/2021-7/17/2021, discharge date 5/25/2021, evidenced a document dated 9/27/2021 titled SOC OASIS-D1 .... , which evidenced the patient was a high risk for infection, she received daily heparin (blood thinner) flushes and weekly central line (tube inserted into a large vein for administration of fluids, medications) dressing changes to the right chest, had bouts of diarrhea due to her treatment, and she would be going to the hospital soon for stem cell transplant.		wasadmitted to hospital. Patientresumption of care 11/17/2021, patient discharged from CHC Home Health on11/24/2021 to hospice services. Clinical Record 6 Patient discharged from CHC HomeHealth services on 11/07/2021. ClinicalRecord 7 Patients care planupdated 10/24/2021 and ongoing with patient specific measurable goals.	

	A document titled Home Health Care Certification and Plan of Care for certification period 5/19/2021-7/17/2021, signed by the certifying physician on 6/4/2021, evidenced primary diagnosis of multiple myeloma (cancer) not in remission, and other diagnoses of intractable migraine with status migrainosus (severe and long-lasting form of migraine headache), high cholesterol, depression, and hypothyroidism. The document evidenced (but not limited to) the patient s mental status was oriented , diet as tolerated , risk for ED visits/hospital re-admissions was none ; and failed to evidence what the patient was oriented to; failed to evidence psychosocial or cognitive status; failed to evidence supplies also included syringes for flushing the central line, specific instructions to flush the central line, or interventions to mitigate diarrhea, migraine and associated pain, high cholesterol (such a dietary choices), or depression. 7. Record review for patient #4 was completed on 10/27/2021, start of care date 3/11/2020, for certification period 9/2/2021-10/31/2021, discharge date 9/25/2021, evidenced a document titled Home Health Care Certification and Plan of Care for certification period			

	the certifying physician on 10/5/2021, which evidenced (but not limited to) a primary diagnosis of diabetes with hyperglycemia (high blood sugar), a 2200 calorie restricted diabetic diet, risk for ED visits/hospital re-admissions included history of falls or any fall with injury in the past 12 months, unintentional weight loss of a total of 10 or more pounds in the last 12 months, multiple hospitalizations (2 or more) in the past 6 months, multiple ED visits (2 or more) in the past 6 months, reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, currently taking 5 or more medications, and currently reports exhaustion. The document failed to evidence patient-specific interventions to mitigate high blood sugar, interventions to monitor and educate on maintaining a 2200 calorie diabetic diet, or specific interventions to address risks for ED visits/hospital re-admissions. During an interview on 10/27/2021 at 1:00 PM, the clinical manager indicated there should have been an intervention to review a blood sugar readings log, there was no A1c in the record, and there was no evidence to measure if the patient followed a 2200 calorie			

	diabetic diet. 8. Record review for patient #5 was completed on 10/26/2021, start of care date 10/7/2021, for certification period 10/7/2021-12/5/2021, evidenced a document dated 10/7/2021 titled SOC OASIS-D1 .... , which evidenced the patient had a stage 2 pressure sore (an open wound characterized by partial-thickness skin loss into but no deeper than the depth of the skin, and would include intact or ruptured blisters) on his lower back/buttock area, a venous stasis ulcer (a wound caused by decreased circulation) on the bottom of the right foot, had a size 16 french/10 cc (cubic centimeter) indwelling foley catheter that was last changed 9/30/2021, was due to be changed 10/30/2021, the patient had horrible pain, he had privately paid caregiver(s), he was non-weight-bearing, bedbound, had contractures, high risk for skin breakdown, bradycardia (slow heart rate), his urine was dark amber colored, incontinent of bowel, was a fall risk, home health aide was referred, and was only eating about 50% of his meals. A document titled Home Health Care Certification and Plan of Care for certification period 10/7/2021-12/5/2021, signed by the certifying physician on			

	limited to) a primary diagnosis of osteomyelitis (infection into the bone) of the right ankle and foot, and other diagnoses included nonrheumatic aortic valve disorder (dysfunction of heart valve), chronic kidney disease, stage 2 (mild), atrial fibrillation (irregular heartbeats), presence of foley catheter, and high cholesterol. The document also evidenced the patient s mental status was oriented , had a regular diet, foley catheter was to be changed monthly and as needed; and failed to evidence a diagnosis of pain, individualized interventions for mitigation of pain, prevention of skin breakdown, signs/symptoms of UTI or dehydration, methods to increase/monitor dietary and fluid intake, nutritional requirements to aid with wound healing, kidney disease or low cholesterol food choices, fall prevention, management/goals for heart and kidney disease, or high cholesterol, failed to include what the patient was oriented to, his psychosocial or cognitive status, or interventions to prevent ED visits or hospital re-admissions. 9. Record review for patient #6 was completed on 10/26/2021, start of care date 8/26/2021, for certification period 8/26/2021-10/24/2021, evidenced a document titled			

	and Plan of Care for certification period 8/26/2021-10/24/2021, signed by the certifying physician on 9/14/2021, which evidenced primary diagnosis of multi-system degeneration of the autonomic nervous system/MSA (a neurodegenerative disorder that can cause a multitude of symptoms in any combination including impairments to balance, difficulty with movement, poor coordination, bladder dysfunction, sleep disturbances and poor blood pressure control), and other pertinent diagnoses included (but not limited to) parkinson s disease (a progressive nervous system disorder that affects movement), benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (condition in which an overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine), high blood pressure, history of falling, fainting and collapse, traumatic bruising of the brain (due to fall), and diabetes with foot ulcer. The document also evidenced the patient s mental status was oriented , a regular diet, and failed to evidence what the patient was oriented to, his psychosocial or cognitive status, specific wound supplies, individualized interventions related to MSA, BPH, high blood pressure, diabetic diet,			

	skin breakdown, or interventions to prevent ED visits or hospital re-admissions. 10. Record review for patient #7 was completed on 10/21/2021, start of care date 8/14/2021, for certification period 8/14/2021-10/12/2021, evidenced a document titled Home Health Care Certification and Plan of Care for certification period 8/14/2021-10/12/2021, signed by the certifying physician on 10/12/2021, with primary diagnosis chronic combined systolic and diastolic heart failure (both left and right sided heart failure, resulting in inability for the heart to adequately pump blood to and from the heart), and other pertinent diagnoses of paroxysmal atrial fibrillation (a rapid, erratic heart rate that begins suddenly and then stops on its own within 7 days), hearing loss, history of prostate cancer, high cholesterol, fainting and collapse, obesity, nonrheumatic aortic valve stenosis (rigidity of heart/aortic valve not caused by rheumatoid arthritis), history of falling, and long term (current) use of anticoagulants (blood thinners). The document evidenced the patient s mental status was oriented, forgetful , low sodium diet, the patient was on a blood thinner, and failed to evidence what the patient was oriented to,			

	bleeding precautions due to taking a blood thinner, individualized and patient-specific measurable interventions for heart failure, paroxysmal atrial fibrillation, hearing loss, history of prostate cancer, high cholesterol, fainting and collapse, obesity, nonrheumatic aortic valve stenosis, history of falling, or long-term use of anticoagulants. 11. During an interview on 10/27/2021 at 6:30 PM, the alternate administrator, clinical manager, and director of quality assurance C confirmed the plans of care for the clinical records reviewed were not individualized, or satisfactory to meet regulatory requirements. 17-13-1(a)(1)(B) 17-13-1(a)(1)(C) 17-13-1(a)(1)(D)(i) 17-13-1(a)(1)(D)(ii) 17-13-1(a)(1)(D)(vii) 17-13-1(a)(1)(D)(viii) 17-13-1(a)(1)(D)(ix) 17-13-1(a)(1)(D)(x)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant	G0590	Promptlyalert relevant physician of changes	2021-12-20

	changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. A document revised date 07/2019 titled Physician and Care Team Review of Plan of Care stated ... Verbal communication will be given to the physician and documented accordingly in the patient s record indicating ... the physician was notified as frequently as the patient s conditions warrant ... plan of care is reviewed by the attending physician ... as often as the severity of the patient s condition requires ... a significant change in condition .... Record review for patient #4 was completed on 10/27/2021, start of care date 3/11/2020, for certification period 9/2/2021-10/31/2021, discharge date 9/25/2021, evidenced a document dated and signed by RN (registered nurse) J on 9/20/2021 titled Skilled Nursing Visit Note stated ... Description ... RN Phone call ... patient ... admitted to ... [hospital O] ... over the weekend ... [patient] had a fall and fractured her hip and ... taken to surgery .... The document failed to evidence the physician was notified. During an interview on 10/27/2021 at 2:03 PM, director of quality assurance C indicated family called 2 days after the patient fell to let the agency know, it happened over a		Theweek of 11/8/2021 Patient Care Coordinators received verbal education on484.60. 100%of all active patients charts on service as 10/27/2021 were reviewed for changeof condition and physicians were notified if applicable. PatientCare Coordinators will provide further 1:1 education with all Home Health casemanagers beginning week of 12/20/2021. Additionalformal education will be provided to all nurses on notification anddocumentation to attending physicians when there is any change of patientcondition the week of 12/20/21. Starting December, Patient Care Coordinatorswill review triage call logs for 90 days to ensure physicians were notifiedwith any patient changes as they occur.	

	hospital to a rehabilitation facility, and the record did not reflect the physician was notified of the change in condition. 17-13-1(a)(2)		Patient Care Coordinators willreview change of conditions, and physician notification process at bi-weeklyinter-disciplinary meeting. Results of this plan of correctionwill be monitored and reported to Quality Improvement Committee by Director ofNursing on an ongoing basis to ensure deficiency is corrected and will notreoccur. Clinical Record 4 Patient discharged from CHC HomeHealth services on 9/25/2021.	
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. 1. A home visit observation was conducted with patient #7 on 10/21/2021 at 9:00 AM. During this time, the home folder was reviewed, which failed to evidence documentation of a written home visit schedule. Also during this visit, the patient s spouse indicated the patient also received weekly nursing visits, physical therapy services, she never knew when they were coming, they did not leave schedules, and she wished the	G0614	Visit Schedule The week of 11/1/21 verbal education provided on 484.60. Patient Care Coordinators will provide 1:1 education with all home health case managers beginning week of 12/20/2021. Beginning week of 12/20/2021 all current home health census electronic medical records will be reviewed and updated accordingly. The week of 11/1/2021, all home health nurses have placed required visit schedule in patients CHC folder in home. Patient Care Coordinators will conduct 2 home health visits per quarter to audit that home visit schedule is in place. Results of this plan of correction will be monitored and reported to Quality Improvement Committee by Director of Nursing on an ongoing basis to ensure deficiency is corrected and will not reoccur.	2021-12-23

	HHA would come twice weekly instead of once. 2. A home visit observation was conducted with patient #6 on 10/22/2021 at 10:30 AM. During this time, the home folder was reviewed, which failed to evidence documentation of a written home visit schedule. 3. A home visit observation was conducted with patient #5 on 10/22/2021 at 1:00 PM. During this time, the patient s caregiver indicated there were no HHA documents or folder present in the home.			
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. A home visit observation was conducted with patient #7 on 10/21/2021 at 9:00 AM. During this time, the home folder was reviewed, which failed to evidence documentation of the patient s written medication schedule. 2. A home visit observation was conducted with patient #6 on 10/22/2021 at 10:30 AM. During this time, the home folder was reviewed, which failed to evidence documentation of the patient s written medication schedule, and RN (registered	G0616	Patient Medicationschedule/instructions The week of 11/1/2021 verbal education provided on 484.60. PatientCare Coordinators will provide additional 1:1 education with all Home Healthcase managers beginning week of 12/20/2021. Beginningweek of 12/20/2021 all current Home Health census electronic medical records willbe reviewed and updated accordingly.	2021-12-23

	nurse) J indicated she never provided patients with written medication schedules. 3. A home visit observation was conducted with patient #5 on 10/22/2021 at 1:00 PM. During this time, the patient s caregiver indicated there were no HHA documents or folder present in the home.		Theweek of 11/1/2021, all Home Health nurses have placed required currentmedication schedule and instructions in patients CHC folder inhome. PatientCare Coordinators will conduct 2 Home Health visits per quarter to audit thathome visit schedule is in place. Results of this plan of correctionwill be monitored and reported to Quality Improvement Committee by Director ofNursing on an ongoing basis to ensure deficiency is corrected and will notreoccur.	
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. 1. A home visit observation was conducted with patient #7 on 10/21/2021 at 9:00 AM. Home health aide (HHA) H applied a gait belt (a device put on a patient who has mobility issues to assist with transfers or walking) to the patient, assisted	G0618	Treatments andtherapy services The week of 11/1/2021 verbal education provided on 484.60.	2021-12-31

	provided personal care (shower, assistance with dressing). During this visit, the patient s spouse indicated the patient also received weekly nursing visits, and physical therapy services. When asked, she indicated there was no written home exercise plan/program (HEP) provided by the physical therapist (PT). The home folder was also reviewed, which failed to evidence documentation of the patient s HHA care plan (instructions for care the HHA provided), written HEP for therapy services, or any care/services provided by the nurse. 2. A home visit observation was conducted with patient #6 on 10/22/2021 at 10:30 AM. RN (registered nurse) J performed wound care to the patient s right foot. The foot was cleansed with saline, medical-grade honey was applied to the wound bed, calcium alginate (absorbent dressing) was applied, covered with a gauze wrap, and the foot was wrapped with an elastic bandage (ace wrap). Family indicated she did wound care when needed, the agency also provided speech, physical, and occupational therapies, but she did not have any written documentation for wound care or exercises they should do. During this time, the home folder		The week of 11/15/2021 Quality Assurance Department providededucation to Therapy company on the requirements to place home education plansin the home. PatientCare Coordinators will provide additional 1:1 education with all Home Healthcase managers beginning week of 12/20/2021. Beginningweek of 12/20/2021 all current Home Health census electronic medical records willbe reviewed and updated accordingly. AllHome Health nurses will ensure required documentation for therapyservices, along with any home education plans if applicable are in CHC folderin the home. PatientCare Coordinators will conduct 2 Home Health visits per quarter to audit thathome visit schedule is in place. Additionalformal education will be presented to all Home Health nursing staff via CHCinternal	

	was reviewed, which failed to evidence documentation of wound care instructions, or HEP for therapy services received. 3. A home visit observation was conducted with patient #5 on 10/22/2021 at 1:00 PM. RN P indicated the patient received nursing services for wound care and foley catheter care (a tube inserted into the bladder to drain urine). The patient s caregiver indicated there were no agency documents or folder present in the home.		education system to be completed on or before 12/31/2021. Results of this plan of correctionwill be monitored and reported to Quality Improvement Committee by Director ofNursing on an ongoing basis to ensure deficiency is corrected and will notreoccur.	
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager. 1. A home visit observation was conducted with patient #7 on 10/21/2021 at 9:00 AM. During the visit, the patient s home folder was reviewed, which failed to evidence documentation of the name and contact information of the agency s clinical manager. 2. A home visit observation was conducted with patient #6 on 10/22/2021 at 10:30 AM. During the visit, the patient s home folder was reviewed, which failed to evidence documentation of the name and contact information of the agency s clinical manager. 3. During an interview at a home visit on 10/22/2021 at 1:00 PM,	G0622	Name/Contactof Clinical Manager Theweek of 12/13/2021 Home Health nursing staff will place a business card forDirector of Nursing in all patients' folders in homes currentand future census. Directorof Quality Assurance confirmed 100% completion with Patient Care Coordinatorson 12/20/2021. The Patient/FamilyHandbook for Home Health has been updated with ability to addClinical Manager's contact information and will be distributed	2021-12-18

	patient #5's caregiver indicated there were no agency documents or folder present in the home.		oncecurrent supply is exhausted. PatientCare Coordinators will conduct 2 Home Health visits per quarter to audit that ClinicalManager's contact information is in the home. Results of this plan of correctionwill be monitored and reported to Quality Improvement Committee by Director ofNursing on an ongoing basis to ensure deficiency is corrected and will notreoccur.	
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. A policy revised 10/2021 titled Therapy Services stated ... ensure that necessary therapies ... are available to patients ... will be provided according to the plan of care .... 2. Record review for patient #1 was completed on 10/27/2021, start of care date 9/27/2021, for certification period 9/27/2021-11/25/2021, evidenced a document signed by certifying physician F on 10/3/2021 titled Home Health	G0710	Provide servicesin the plan of care The week of 11/1/2021 verbal education provided on 484.75 PatientCare Coordinators will provide additional 1:1 education with all Home Healthcase managers by 12/23/2021.	2021-12-31

	Care Certification and Plan of Care stated ... the following services are medically necessary for home health services ... Physical Therapy [PT] ... Speech Language Pathology [SLP] ... Occupational Therapy [OT] .... The clinical record failed to evidence SLP or OT services were provided. During an interview on 10/27/2021 at 4:50 PM, the clinical manager confirmed the clinical record failed to evidence documentation that SLP or OT services was provided to the patient. 3. Record review for patient #2 was completed on 10/27/2021, start of care date 5/1/2020, for certification period 8/24/2021-10/22/2021, evidenced a document signed by certifying physician G on 8/27/2021 titled Home Health Care Certification and Plan of Care evidenced (but not limited to) the patient had a PICC (a tube inserted into a vein in the upper arm to administer substances via blood) line, received intravenous (IV) vancomycin (an antibiotic which required routine laboratory monitoring for therapeutic level) daily, took warfarin (a blood thinner/anticoagulant which required routine laboratory monitoring for therapeutic level), and stated ... Orders ... Skilled Nursing [SN] ... PICC line		Additionalformal education will be presented to all Home Health nursing staff via CHCinternal education system to be completed on or before 12/31/2021. Educationto include but not limited to: · Individualized Plans · Measurable Outcomes · Procedures Beginningweek of 12/20/2021 all current Home Health census electronic medical records willbe reviewed and updated accordingly. On11/1/2021, Patient Care Coordinators will monitor Care Plans every two weeks at Inter-DisciplinaryMeetings with Case Managers to ensure plan of care are individualized andinclude measurable outcomes on an ongoing basis. Therapy organization waseducation on the need to ascertain therapy orders from physician on11/1/2021. On 12/13/2021 new procedures implemented by CHCquality assurance nurse to ensure	

	management ... and lab draws ... Assess anticoagulant therapy lab values .... A prescription document signed by physician F on 10/7/2021 titled Rx: [prescription] Skilled Nursing stated ... weekly lab work .... During an interview on 10/27/2021 at 5:15 PM, the clinical manager and director of quality assurance C confirmed the clinical record failed to evidence any laboratory results, and failed to evidence skilled nurses obtained blood samples for laboratory testing or monitored lab values for therapeutic blood levels. 4. Record review for patient #6 was completed on 10/26/2021, start of care date 8/26/2021, for certification period 8/26/2021-10/24/2021, evidenced a document signed by certifying physician H on 9/14/2021 titled Home Health Care Certification and Plan of Care evidenced (but not limited to) OT was ordered to evaluate and treat the patient. During an interview on 10/26/2021 at 11:00 AM, the alternate administrator indicated he could not find an OT evaluation in the patient s clinical record, and director of quality assurance C confirmed OT was not provided to the patient.		therapy orders were obtained by certifyingphysician. Quality AssuranceDepartment will monitor on an ongoing basis 10% of therapy notes are uploadedin the electronic medical record on a monthly basis. A new therapy agency was contractedto ensure timely start of therapies 12/2021. Results of this plan of correctionwill be monitored and reported to Quality Improvement Committee by Director ofQuality Assurance and Director of Nursing on an ongoing basis to ensuredeficiency is corrected and will not reoccur. ClinicalRecord 1 Home Health referral order for skilled nursingand therapy for musculoskeletal pain maintenance. Patient with physical therapy evaluation and treatment on10/07/2021. PT Notes uploaded to electronicmedical record on 10/11, 10/19, 10/21, and 10/25/2021. Signed discharge summary fromattending physician received on 11/16/2021. Verbal order for discharge receivedfrom attending physician on 11/09/2021, patient no longer having skilledneed. New therapy contract	

	5. Record review for patient #7 was completed on 10/21/2021, start of care date 8/14/2021, for certification period 8/14/2021-10/12/2021, evidenced a document signed by certifying physician I on 10/12/2021 titled Home Health Care Certification and Plan of Care evidenced (but not limited to) PT and OT services were ordered for safety due to high fall risk and recently starting an anticoagulant. The clinical record evidenced a PT evaluation was completed on 9/8/2021 with goals for future visits, but no other PT visits were documented, and no OT evaluation was completed. During an interview on 10/21/2021 at 1:00 PM, director of quality assurance C confirmed OT was not provided to the patient, and there were no additional PT visit notes in the record after the evaluation on 9/8/2021.		obtained12/2021 to ensure timely start of ordered therapies. Education provided to allCHC nurses in 12/2021 on writing orders, along with patient specific careplans. Patient discharged from Home Health services on 11/12/2021. Clinical Record 2 PT/INR, Vancomycin, and multipleother lab results for 10/11, 11/1,11/8,11/15,11/22, 11/29 uploaded to patients'chart on 12/7/2021. Clinical Record 6 Patient discharged from CHC HomeHealth services on 11/07/2021. OT evaluation notes uploaded to chart from 10/28/2021. ClinicalRecord 7 PT notes received and uploaded topatients' chart. PT orders received on 10/24/2021, attending physician notifiedof PT evaluation and follow up visits.	
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care;	G0718	Communication withphysicians Theweek of 11/8/2021 Patient Care Coordinators received	2021-12-20

	1. A policy revised 07/2019 titled Care Plan Establishment and Review stated ... must provide a written individualized plan of care ... which is established, periodically reviewed, and signed by the attending physician .... 2. A document revised date 07/2019 titled Physician and Care Team Review of Plan of Care stated ... Verbal communication will be given to the physician and documented accordingly in the patient s record indicating ... the physician was notified as frequently as the patient s conditions warrant ... plan of care is reviewed by the attending physician ... as often as the severity of the patient s condition requires ... a significant change in condition .... 3. Record review for patient #1 was completed on 10/27/2021, start of care date 9/27/2021, evidenced an untitled document dated 10/7/2021, which evidenced a PT (physical therapy/physical therapist) evaluation was completed on 10/7/2021, interventions and goals were established, and failed to evidence the PT communicated with the physician to review approve the PT plan of care, or the plan of care was signed by the certifying physician. During an interview on		verbal education on484.75. 100%of all active patients charts on service as 10/27/2021 were reviewed for changeof condition and therapy orders, and physicians were contacted as appropriate. PatientCare Coordinators will provide 1:1 education with all Home Health case managersbeginning week of 12/20/2021. Additionalformal education will be provided to all nurses on notification anddocumentation to attending physicians when there is any change of patientcondition the week of 12/20/2021. StartingDecember, Patient Care Coordinators will review triage call logs for 90 days toensure physicians were notified with any patient changes as they occur.	

	alternate administrator and clinical manager confirmed the record failed to evidence the therapist communicated with the physician. 4. Record review for patient #4 was completed on 10/27/2021, start of care date 3/11/2020, for certification period 9/2/2021-10/31/2021, discharge date 9/25/2021, evidenced a document dated and signed by registered nurse (RN) J on 9/20/2021 titled Skilled Nursing Visit Note , which stated ... Description ... RN Phone call ... patient ... admitted to ... [hospital O] ... over the weekend ... [patient] had a fall and fractured her hip and ... taken to surgery .... The document failed to evidence RN notified the physician. During an interview on 10/27/2021 at 2:03 PM, director of quality assurance C indicated family called 2 days after the patient fell to let the agency know, it happened over a weekend, she went from the hospital to a rehabilitation facility, and the record did not reflect the physician was notified. 5. Record review for patient #6 was completed on 10/26/2021, start of care date 8/26/2021, for certification period 8/26/2021-10/24/2021, evidenced a document dated 9/2/2021 titled PT eval		Patient Care Coordinators willreview change of conditions, and physician notification process at bi-weeklyinter-disciplinary meeting. 11/1/2021, therapyorganization was educated on the need to obtain therapy orders fromphysician. 12/13/21, new proceduresimplemented by CHC quality assurance nurse to ensure therapy orders wereobtained by certifying physician. Quality AssuranceDepartment will monitor on an ongoing basis 10% of therapy notes are uploadedin the electronic medical record on a monthly basis. A new therapy agency was contractedto ensure timely start of therapies 12/2021. Results of this plan of correctionwill be monitored and reported to Quality Improvement Committee by Director ofQuality Assurance and Director of	

	[evaluation/plan of care] , which evidenced a PT evaluation was completed on 9/2/2021, interventions and goals were established, and failed to evidence the PT communicated with the physician to review approve the PT plan of care, or the plan of care was signed by the certifying physician. A document dated 9/1/2021 titled Speech Therapy [SLP] Assessment evidenced a SLP evaluation was completed on 9/1/2021, interventions and goals were established, and failed to evidence the SLP communicated with the physician to review approve the SLP plan of care, or the plan of care was signed by the certifying physician. During an interview on 10/26/2021 at 11:00 AM, the clinical manager and alternate administrator confirmed the therapy evaluations failed to evidence the certifying physician was contacted to review or approve the therapy plans of care, and the evaluations were not signed by the certifying physician. 6. Record review for patient #7 was completed on 10/21/2021, start of care date 8/14/2021, for certification period 8/14/2021-10/12/2021, and 10/13/2021-12/11/2021, evidenced an untitled document dated 9/8/2021, which evidenced		ensuredeficiency is corrected and will not reoccur. Clinical Record 1 Education provided to contractedtherapist on 11/01/2021 on the need to ascertain therapy orders from physicians.12/13/2021 agency quality assurance department implemented new procedures onobtaining orders by certifying physician for therapies. State survey resultsreceived 12/3/2021 patient discharged from Home Health services on 11/12/2021. 10/29/2021 skilled nursing visitreflects patient alert and oriented times three. 11/05/2021 skilled nursing visitdocuments patient return demonstration of home exercises provided by physicaltherapy. 11/05/2021 Physician office notifiedof request for order to discharge or continue HH services, order received11/09/2021 to discharge no longer skilled need. 11/10/2021 Physician notified ofpatient fall. No new orders received. 11/12/2021 verbal order received to dischargepatient no longer skilled need per physician. Clinical Record 4	

	a PT evaluation was completed on 9/8/2021, interventions and goals were established, and failed to evidence the PT communicated with the physician to review approve the PT plan of care, or the plan of care was signed by the certifying physician. During an interview on 10/21/2021 at 1:00 PM, the alternate administrator, clinical manager, and director of quality assurance C confirmed the record did not evidence the therapist communicated with the physician. 17-14-1(a)(1)(G)		Patient discharged from CHC HomeHealth services on 9/25/2021. Clinical Record 6 Patient discharged from CHC HomeHealth services on 11/07/2021. 11/01/2021 therapy organization educated on theneed to obtain therapy orders from physicians. Quality assurance departmentwith new procedures to audit therapy orders from certifying physician. Clinical Record 7 10/24/2021 attending physiciannotified unable to provide OT at this time and ordered received for PT only. All PT notes received and uploadedto clinical records 11/01/2021, and therapy organization educated on the needto obtain therapy orders from physicians.	
G1024	Authentication 484.110(b) Standard: Authentication. 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	G1024	Authentication Therapy organization was educated on the need to submit legible therapy notes on 11/1/21. Quality assurance will¿begin¿auditing¿100% of	2021-12-13

	by a unique identifier, of a primary author who has reviewed and approved the entry. 1. Record review for patient #1 was completed on 10/27/2021, start of care date 9/27/2021, for certification period 9/27/2021-11/25/2021, evidenced an untitled document dated 10/7/2021, which evidenced a PT (physical therapy/physical therapist) evaluation was completed on 10/7/2021. The handwritten document of the assessment/treatment was largely illegible, the clinician s signature was illegible, and the document failed to evidence the clinician s name or title, or the time and duration of the visit. Untitled documents dated 10/8/2021, 10/12/2021, 10/13/2021, and 10/17/2021 evidenced PT visits were completed, the handwritten documents of the assessments/treatments were largely illegible, the clinician s signature was illegible, and the document failed to evidence the clinician s name or title, or the time and duration of the visit. During an interview on 10/27/2021 at 4:50 PM, the alternate administrator and clinical manager reviewed the handwritten therapy documents and indicated the documents were illegible, the clinician s name and title was not present on the documents, the signature		all therapy notes on 12/13/21 to ensure legibility and/or use of electronic version. Non-legible notes will be returned to Therapy company for re-submission. New therapy company has been contracted 12/2021, and after successful 90 days of partnership, therapy organization will migrate therapy team to CHC electronic medical records documentation. Results of this plan of correction will be monitored and reported to Quality Improvement Committee by Director of Quality Assurance and Director of Nursing on an ongoing basis to ensure deficiency is corrected and will not reoccur.	

	was illegible, and there were no times on the documents. 2. Record review for patient #6 was completed on 10/26/2021, start of care date 8/26/2021, for certification period 8/26/2021-10/24/2021, evidenced a document dated 9/2/2021 titled PT eval [evaluation/plan of care] , which evidenced a PT evaluation was completed on 9/2/2021. The handwritten document of the assessment/treatment was largely illegible, the clinician s signature was illegible, failed to evidence the clinician s name or title, the time and duration of the visit, and failed to evidence the sections titled posture/alignment, joints, upper and lower extremities, hip, knee, ankle, trunk/cervical (neck), motor function, muscle tone, wheelchair mobility, bed mobility, transfers, skilled treatment this visit, or communication was completed. Documents dated 9/10/2021, 9/14/2021, 9/16/2021, and 9/21/2021 titled THHS PT Progress Note evidenced visits were made by a PT assistant (PTA), the clinician s signature was illegible, the documents failed to evidence the clinician s name, or the time and duration of the visits. A document dated 9/1/2021 titled Speech Therapy [SLP]			

	evaluation was completed on 9/1/2021. The document failed to evidence the time and duration of the visit. During an interview on 10/26/2021 at 11:00 AM, the alternate administrator confirmed the visits should have the times on the visits, and the documents were hard to read. 3. Record review for patient #7 was completed on 10/21/2021, start of care date 8/14/2021, for certification period 8/14/2021-10/12/2021, evidenced an untitled document dated 9/8/2021, which evidenced a PT evaluation was completed on 9/8/2021. The document was illegible, the clinician s signature was illegible, the document failed to evidence the clinician s name or title, or the time and duration of the visit. 4. During an interview on 10/27/2021 at 6:30 PM, the alternate administrator reviewed the handwritten therapy documents and confirmed they were illegible, incomplete, failed to evidence the clinician s name or title, or the time and duration of the visits. 17-15-1(a)(7)			
N9999	Final Observations	N9999	50% of non-licensed employees	2022-01-31

	Based on record review and interview, the agency failed to develop and implement a written drug testing policy which included Indiana Code (IC) 16-27-2.5 (effective date 7/1/2017), failed to evidence the written policy and acknowledgement of receipt of policy was provided to employees prior to drug testing for 6 of 6 employee records reviewed whose hire date was on or after 7/1/2017 (A, B, J, U, W, X), and failed to evidence at least fifty percent (50%) of non-licensed employees were randomly drug screened annually for 5 of 5 home health aide (HHA) records reviewed (H, U, V, W, X). Findings include: 1. An agency policy revised 05/2020 titled "Pre-Employment Drug Screen" evidenced all prospective employees must complete a urine drug test screen, and failed to evidence it included IC 16-27-2.5 (effective date 7/1/2017).		will be randomlydrug screened by 01/31/2022. HR policy updated 12/13/21. Acknowledgement of receipt of written HumanResources policy will be completed by 12/31/21. Human Resources Manager will ensure on an ongoing basis to ensure deficiency is corrected and will not reoccur.	

2. A document titled Indiana Code, Section 8, IC 16-27-2.5, effective July 1, 2017: Chapter 2.5. Drug Testing of Employees stated

Sec. 0.5. This chapter does not apply to a home health employee licensed under IC 25.

Sec. 1. (a) After giving a job applicant written notice of the home health agency's drug testing policy, a home health agency shall require a job applicant who is seeking employment with the home health agency for a position that will have direct contact with a patient to be tested for the illegal use of a controlled substance.

(b) A home health agency may use a job applicant's:

(1) refusal to submit to a drug test; or

(2) positive test result from a drug test;

as a basis for refusing to hire the job applicant.

(c) If a job applicant is hired by the home health agency before the job applicant's results of the drug test are received, the hired individual may not have any contact with patients until the home health agency obtains results of the drug test that indicate that the individual tested

drug test results

indicate that the individual tested positive on the drug test, the home health agency shall discharge or discipline the individual. If the home health agency disciplines the individual, the individual may have no direct contact with a patient for at least six (6) months.

Sec. 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.

(c) A home health agency shall either discharge or discipline

with a minimum of a six (6) month suspension an employee who refuses to submit to a drug test.

Sec. 3. If an employee tests positive on a drug test, and the employee does not have a valid prescription for the substance for which the employee tested positive on the drug test, the home health agency shall have the results of the test verified by a confirmation test. The employee shall pay for the confirmation test.

If the positive test result is confirmed, the home health agency shall either discharge the employee or suspend the employee from coming into direct contact with patients for at least six (6) months after the date of the confirmation test result. An employee who has a valid prescription for the substance for which the employee

tested positive on a drug test may not be terminated or suspended under this subsection.

Sec. 4. A home health agency that:

	(1) discharges or disciplines an employee; or (2) refuses to hire a job applicant; because of a positive drug test result or a refusal to submit to a drug test is considered to have discharged, disciplined, or refused to hire the individual for just cause. Sec. 5. (a) A home health agency, when acting in good faith, is immune from civil liability for: (1) conducting employee drug testing in compliance with this chapter; or (2) taking an employee disciplinary action or discharging an employee in compliance with this chapter as a result of the employee drug testing. (b) Subsection (a) does not apply to actions that constitute gross negligence or willful or wanton misconduct.			

	3. Employee record review for the alternate administrator (employee A), hire date 9/14/2020, first patient contact not applicable, was completed on 10/27/2021, which failed to evidence documentation the employee received written notice and acknowledged receipt of the agency's drug policy, IC 16-27-2.5. 4. Employee record review for the clinical manager (employee B), hire date 9/28/2020, first patient contact not applicable, was completed on 10/27/2021, which failed to evidence documentation the employee received written notice and acknowledged receipt of the agency's drug policy, IC 16-27-2.5. 5. Employee record review for registered nurse (RN) J, hire date 6/7/2021, first patient contact 6/14/2021, was completed on 10/27/2021, which failed to evidence documentation the employee received written notice and acknowledged receipt of the agency's drug policy, IC 16-27-2.5. 6. Employee record review for HHA U, hire date 10/16/2017, first patient contact 10/17/2017, was completed on 10/27/2021, which failed to evidence documentation the employee received written notice and			

agency's drug policy, IC 16-27-2.5.

7. Employee record review for HHA W, hire date 2/24/2020, first patient contact 2/26/2020, was completed on 10/27/2021, which failed to evidence documentation the employee received written notice and acknowledged receipt of the agency's drug policy, IC 16-27-2.5.

8. Employee record review for HHA X, hire date 4/26/2021, first patient contact 4/28/2021, was completed on 10/27/2021, which failed to evidence documentation the employee received written notice and acknowledged receipt of the agency's drug policy, IC 16-27-2.5.

9. Employee record review for HHA H, hire date 10/3/2011, first patient contact 10/6/2011, was completed on 10/27/2021, which failed to evidence documentation the employee received written notice and acknowledged receipt of the agency's drug policy, IC 16-27-2.5, and failed to evidence a drug screen was administered at all since hire.

10. Employee record review for HHA V, hire date 6/20/2016, first patient contact 6/22/2016, was completed on 10/27/2021, which failed to evidence documentation the employee received written notice and acknowledged receipt of the agency's drug policy, IC 16-27-2.5, and failed to evidence

	a drug screen was administered at all since hire. 11. During an interview on 10/27/2021 at 3:10 PM, human resource manager F indicated she was hired in April of 2020, she implemented drug screening for all employees upon hire, and the agency did not perform random drug screen testing on at least 50% of non-licensed employees annually.			

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