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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/07/2022

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 Post Condition Revisit Survey for a Licensed State and Federal Home Health Agency (HHA) completed by the Indiana Department of Health (IDOH). Survey Dates: 1/5/2022, 1/6/2022, and 1/7/2022. Facility Number: IN005279 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings.	G0000		2022-01-28
N0000	Initial Comments This was a Post Condition Revisit Survey for a State and Federal Home Health Agency (HHA) Re-Licensure Survey completed by the Indiana Department of Health (IDOH). Survey Dates: 1/5/2022, 1/6/2022, and 1/7/2022. Facility Number: IN005279	N0000		2022-01-28

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. Survey Dates: 1/5/2022, 1/6/2022, and 1/7/2022. Facility Number: IN005279	E0000		2022-01-28
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. Based on observations, record review, and interview, the agency failed to evidence individualized emergency preparedness plans in the electronic medical record and patient s residence in 1 of 5 clinical records reviewed. (#5) The findings include:	E0017	Emergency Preparedness Plan Staff educated by Patient Care Coordinators to ensure atevery visit the patient has their emergency plan in the home 12/21/21 Quality Assurance began auditing 100% of charts ofadmissions to ensure a copy of the Emergency plan from the home is uploadedinto the chart 1/10/22. Patient Care Coordinators will visit two home health patients’homes per quarter to ensure all paperwork needed is in the home starting 1/1/22.	2022-01-26

	Review of agency policy, obtained 1/7/2022, updated 5/20/2021 titled, Comprehensive Patient Assessment in Disaster stated, Center for Hospice and Palliative Care will ensure all patients have an individualized plan of care in the event of an emergency. That plan will be included as part of the patient s comprehensive assessment. These would include, but not be limited to: Discussions about potential disasters that the patient may face within the home, such as fire hazards, flooding, tornados, and how and when a patient is to contact local emergency officials. Discussions may include patient, caregivers, patient representatives, or any person involved in the clinical care aspects to educate them on steps that can be taken to improve the patient s safety. Center for Hospice and Palliative Care employees will document that these discussions occurred and 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. Clinical record review on 1/6/2022, of patient #5, start of care 10/11/2021 failed to evidence an individualized emergency preparedness plan on file or in medical record. During a home visit on 1/6/2021 at 11:00 AM with patient #5 and RN K, review of the patient s home health folder failed to evidence an individualized emergency preparedness plan. During an interview 1/7/2022 at 1:44 PM, clinical manager B indicated that patient #5 was in an assisted living center and that they would use the assisted living s emergency preparedness plan. Clinical manager B agreed that patient #5 should have had her own individualized emergency preparedness plan at her home and in her clinical record.		Director of Nursing and Director of Quality Assuranceconducting re-education with Patient Care Coordinators and 100% audit ofcurrent Home Health charts 1/26/22. Results of this plan of correction will be monitored by theDirector of Nursing and Director of Quality assurance on an ongoing basis toensure deficiency is corrected and will not reoccur. Patient #5's Emergency plan was placed in patient room on1/14/22. Completion date 1/26/22	
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).	E0030	E0030 Emergency Preparedness Plan Emergency Preparedness book maintained at Mishawaka locationwas updated to include name and contact information for home health employeeson	2022-01-26

	[(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:] (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.		1/10/22. Executive Office Manager will send monthly reminders toupdate names and contact numbers for staff effective 12/1/21 to each office. Patient Care Coordinators will check each EmergencyPreparedness book quarterly to ensure it has been updated appropriatelybeginning first quarter 1/26/22. Results of this plan of correction will be monitored by the Directorof Nursing and Director of Quality Assurance on an ongoing basis to ensuredeficiency is corrected and will not reoccur Completion date 1/26/22	

*[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). Based on record review and interview, the agency failed to ensure a hard copy of all appropriate contact information was kept in the emergency preparedness manual to include employee information. The findings include: Review of an agency policy titled Names and Contact Information (E-0030) revised 11/10/21, stated, CHC [Center for Hospice Care] will maintain contact information for staff, entities providing services under arrangement, patients physicians, and other hospices and health care providers. The information will be posted on & Microsoft teams under Emergency Preparedness & Hard copies of employee phone numbers will be printed monthly by receptionists, the triage nurse, and the Hospice Inpatient Unit & The communication plan must include the name and contact information for the following: & CHC employees &. Record review on 1/7/22, of the agency's emergency preparedness manual, which was a binder of hard copy information, evidenced a tab titled "Contacts." Review of the content under this tab failed to evidence contact information for CHC employees. Review of the emergency preparedness manual failed to evidence contact information for CHC employees. During an interview on 1/7/22, at 12:53 PM, alternate clinical manager C indicated the employee contact information should be kept in the emergency preparedness binder, under the "Contacts" tab. Alternate Administrator A indicated the contact information for CHC employees should have been in the emergency preparedness binder.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j)	N0488	Discharge Planning Discharge/Transfer Policy updated by Director of Quality on1/10/22 to include 15-day notice before discharge.	2022-01-26

	Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review and interview, the home health agency failed to ensure they developed and maintained a 15 day discharge policy as required by the State of Indiana's rules and regulations for a home health agency.		Education on updated policy provided to Patient CareCoordinators on 1/10/22. Patient Care Coordinators educated staff on 15-day noticeduring IDT's and 1:1's week of 1/10/22. Quality Assurance begins audit to ensure 15-day noticedocumented in 100% of all home health discharges 1/10/22. Director of Nursing and Director of Quality Assurance conductingre-education with Patient Care Coordinators and 100% audit of current HomeHealth charts 1/26/22. Results of this plan of correction will be monitored by the Directorof Nursing and Director of Quality Assurance on an ongoing basis to ensuredeficiency is corrected and will not reoccur. Completion date 1/26/22	

	The findings include: Review of an undated agency policy titled Transfer/Discharge was indicated to be under revision but already implemented by the appropriate staff. This document stated, Policy: ... When a patient is no longer appropriate for services, a care team meeting is scheduled to review options for alternative care ... This can be initiated by either a team member or the patient or caregiver ... Support and assistance is given to the patient/caregiver in the explanation of resources in the decision making process ...." Review of the agency's discharge policy failed to evidence indication that a 15 day discharge notice would be given to patients. During an interview on 1/7/22, at 1:06 PM, alternate administrator A indicated the agency's policy for a discharge notice was 48 hours; Discharge should be discussed at the start of care and every visit after. The alternate administrator, clinical manager, and alternate clinical manager were informed of the 15 day discharge notice. Alternate administrator A indicated the agency will update the discharge policy.			
N0490	Q A and performance improvement 410 IAC 17-12-2(k) Rule 12 Sec. 2(k) A home health agency must continue, in good faith, to attempt to provide services during the fifteen (15) day period described in subsection (i) of this rule. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented. Based on record review and interview, the agency failed to ensure each patient received a 15 day discharge notice for 3 of 3 discharge records reviewed. (#1, #2, #3) The findings include:	N0490	Discharge Planning Discharge/Transfer Policy updated by Director of Quality Assuranceon 1/10/22 to include 15-day notice before discharge. Education on updated policy provided to Patient CareCoordinators on 1/10/22. Patient Care Coordinators educated staff on 15-day noticeduring IDT's and 1:1's week of 1/10/22. Quality Assurance begins audit to ensure 15-day noticedocumented in 100% of all	2022-01-26

	1. Review of an undated agency policy titled Transfer/Discharge was indicated to be under revision but already implemented by the appropriate staff. This document stated, Policy: ... When a patient is no longer appropriate for services, a care team meeting is scheduled to review options for alternative care ... This can be initiated by either a team member or the patient or caregiver ... Support and assistance is given to the patient/caregiver in the explanation of resources in the decision making process ...." Review of the agency's discharge policy failed to evidence indication that a 15 day discharge notice would be given to patients. 2. Clinical record review on 1/7/22, for patient #1, start of care 11/11/21, diagnosis of Congestive Heart Failure (CHF; a chronic condition where the heart does not pump blood adequately), evidenced a discharge date of 12/21/21. Record review evidenced an agency document titled "Skilled Nursing Visit" from 12/13/21, and was signed by Registered Nurse (RN) G. This document had an area subtitled "Narrative Notes" which stated, "... Discussed discharge plan and informed that [patient #1's physician] is aware and in agreement that if the patient is not homebound does not have a skilled nsg [nursing] need ... Plan to meet next week and finalize dc [discharge] plan ...." Review evidenced the patient received a 9 day discharge		home health discharges 1/10/22. Director of Nursing and Director of Quality Assuranceconducting re-education with Patient Care Coordinators 1/26/22. Results of this plan of correction will be monitored by the Directorof Nursing and Director of Quality Assurance on an ongoing basis to ensuredeficiency is corrected and will not reoccur. Patient #1 discharged 12/21/21 Patient #2 discharged 12/23/21 Patient #3 discharged 12/28/21 Completion date 1/26/22	

notice. Review failed to evidence the patient received a 15 day discharge notice as required by the State of Indiana.

3. Clinical record review on 1/7/22, for patient #2, start of care 10/25/21, diagnosis of Chronic Obstructive Pulmonary Disorder (COPD; a progressive lung disease that progressively worsens with everyday activities), evidenced a discharge date of 12/23/21.

Record review evidenced an agency document titled "Skilled Nursing Visit" from 12/17/21, and was signed by RN J. This document had an area subtitled "Narrative Notes" which stated, "... Discussed the referral for hospice and pt [patient] states 'I am just not ready for hospice right now yet' ...."

Review of an agency document titled "Miscellaneous Communication" dated 12/20/21, and signed by RN I. This document stated, "Call to [patient #2's physician] for d/c [discharge] order ... patient declines hospice services at this time.... " Review evidenced the patient did not receive a 15 day discharge notice as required by the State of Indiana.

During an interview on 1/7/22, at 1:06 PM, alternate administrator A indicated the agency's policy for a discharge notice was 48 hours; Discharge should be discussed at the

	start of care and every visit after. The alternate administrator, clinical manager, and alternate clinical manager were informed of the 15 day discharge notice. Alternate administrator A indicated the agency will update the discharge policy. 1. Clinical record review on 1/6/2022 of patient #3, start of care 11/3/2021, certification period 11/3/2021 - 1/1/2022, discharged 12/28/2021, evidenced a document titled "Skilled Nursing Visit Note" dated 12/21/2021, signed electronically by registered nurse H which stated, "Discussed plans for discharge as patient does not continue to qualify for continued Home Health Services as has no continued skilled nursing needs ... Patient agrees to discharge on 12/28/2021". Record review on 1/6/2022 for patient #3 evidenced a document signed electronically by registered nurse H, titled "Discharge Summary" which indicated patient was discharged 12/28/2021. Record review failed to evidence 15 day discharge notice from notification on 12/21/2021. 2. During an interview on 1/7/2022 at 1:04 PM, clinical manager B indicated that agency policy was 48 hour discharge notice to patients and agreed that patient's were not given 15 days notice prior to discharge. Clinical manager B indicated they would change the agency's policy to reflect 15 day notice.			
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.	G0564	Discharge Transfer Summary Nurse Practitioner provided Home Health discharge summaryand care planning education to clinical staff on 1/5/22, 1/6/22, 1/7/22, 1/13/22,1/27/22.	2022-01-27

	Based on record review and interview, the agency failed to ensure discharge or transfer summary contained sufficient information about current course of illness and treatment, post-discharge goals of care, and treatment preferences to ensure continuity of care in 4 of 4 patients who were transferred or discharged, from a total sample of 5 clinical records reviewed. (#1, #2, #3, #5) The findings include: .Clinical record review on 1/7/22, for patient #1, start of care 11/11/21, diagnosis of Congestive Heart Failure (CHF; a chronic condition where the heart does not pump blood adequately), evidenced a discharge date of 12/21/21. Record review evidenced an agency document titled "Discharge Summary" signed by Registered Nurse (RN) G. This document had areas subtitled "Allergies" and "Reason for Admission" which remained blank. Another area subtitled "Discharge Condition" stated "Alive ...." Review failed to evidenced the document contained all pertinent information for a smooth patient discharge/transfer. Review failed to evidence a complete discharge summary. .Clinical record review on 1/7/22, for patient #2, start of care 10/25/21, diagnosis of Chronic Obstructive Pulmonary Disorder (COPD; a progressive lung disease that progressively worsens with		Discharge/Transfer Policy updated by Director of Quality Assuranceon 1/10/22 to include 15-day notice before discharge. Procedure for completion of discharge or transfer summary completed1/11/22 Education on updated policy and new procedure provided toPatient Care Coordinators on 1/10/22 Patient Care Coordinators educated staff on 15-day noticeduring IDT's and 1:1's week of 1/10/22 Quality Assurance begins audit to ensure completeness ofdocumentation in 100% of all home health transfers or discharges 1/11/22 Discharge/Transfer Summary to be reviewed by Patient CareCoordinator for completeness before sending to facility and/or physician1/21/22 Results of this planof correction will be monitored by the Director of Nursing and Director ofQuality Assurance on an ongoing basis to ensure deficiency is corrected andwill not reoccur. Patient #1 discharged 12/21/21 Patient #2 discharged 12/23/21 Patient #3 discharged 12/28/21	

	everyday activities), evidenced a discharge date of 12/23/21. Record review of an agency document titled "Discharge Summary" signed by RN J. This document had areas subtitled "Reason for Admission" and "Discipline Orders" which remained blank. Review failed to evidenced the document contained all pertinent information for a smooth patient discharge/transfer. Review failed to evidence a complete discharge summary. The findings include: 1. Review of agency policy, obtained 1/7/2022, titled Hospitalizations stated, Purpose: To assure continuity of care in all settings, to determine the appropriate location for patient care, and to retain professional management responsibilities through the care team & Procedure: Notify the attending physician, Patient Care Coordinator, and pertinent team members of the patient s hospitalization & Complete the transfer OASIS . 2. Review of agency policy, revised November 2021 and obtained 1/7/2022, titled Discharge Criteria stated, &After the decision is made for		Patient #5 returned to services on 12/1/21 to CHC services Completion date 1/27/22	

discharge, the patient/caregiver will be notified. At the time of discharge, a Discharge Summary Note is completed, and if applicable a Discharge OASIS .

3. Clinical record review on 1/6/2022 for patient #5, start of care 10/11/2021, evidenced an agency document titled Transfer OASIS-D1 which indicated that patient #5 was transferred to an inpatient hospital on 11/26/2021. Record review evidenced resumption of care with home health agency 12/1/2021. No transfer summary was evidenced.

   During an interview on 1/7/2022 at 1:43 PM, clinical manager B indicated that the transfer summary for patient #5 who transferred 11/26/2021 did not get sent to the hospital before resumption of care 12/1/2021.

4. Clinical record review on 1/6/2022 for patient # 3, start of care 11/3/2021, certification period 11/3/2021 1/1/2022, discharge date 12/28/2021, evidenced an agency document titled

	which failed to evidence current labs, reason for admission, discharge condition, patient/family discharge instructions, and discipline orders. During an interview on 1/7/2022 at 1:55pm, clinical manager B was in agreeance that a complete discharge summary should have included labs, reason for admission, discharge condition, discharge instructions, and discipline orders.			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the agency failed to ensure coordination of care between therapy services and home health agency staff to ensure treatment effectiveness in 1 of 5 clinical records reviewed. (#4) The findings include: Review of agency policy, revised November 2021 and obtained 1/7/2022, titled Therapy Services stated, Purpose: To ensure that necessary therapies for patients care are available to patients & Policy: The Agency will make available physical therapy, occupational therapy, and speech language pathology services in a manner consistent with accepted standards of practice. Contracted agencies will be used. & The plan of care will be obtained from the specific therapist and the Agency will show incorporation it into ours & The initial	G0606	Quality Assurance will monitor 100% of all therapy notes toensure they are uploaded by the agreed upon date with the contracted agencybeginning 1/17/22 Quality Assurance will send weekly report to Patient CareCoordinators with list of patients currently receiving therapy beginning1/17/22 Patient Care Coordinators will discuss patients listed onreport at their next Home Health Care IDT's starting 1/17/22 Results of this plan of correctionwill be monitored by Director of Nursing and Director of Quality Assurance onan ongoing basis to ensure deficiency is corrected and will not reoccur. Patient #4's therapynotes were uploaded to the EMR on 1/6/22	2022-01-17

	evaluation will be received by the therapist within 5 business days of initial evaluation & QA [quality assurance] department will upload these reports to the patient s EMR [electronic medical record] & The therapist will be responsible for obtaining all orders and forwarding to QA to add to EMR . Clinical record review on 1/6/2022 for patient #4, start of care 12/30/2021, evidenced an agency document titled Communication Notes which contained a note created by registered nurse E, on 1/5/2021 at 3:06 PM. The note indicated that patient was evaluated for physical therapy on 12/31/2021, but notes had not yet been submitted. The note stated that physical therapy notes would be received in the next couple of days roughly . Record review on 1/6/2022 of an agency document titled Physical Therapy Evaluation signed by physical therapist F, indicated that date of physical therapy evaluation was 12/30/2021. Record review on 1/6/2022 of agency document titled Communication Notes indicated that on 1/6/2022 at 8:27 AM physical and occupational plan of care and notes were received by agency. Record review on 1/6/2022 of electronic medical record failed to evidence physical or occupational therapy frequency orders in the patient s medical record. During an interview on 1/7/2022 at 1:35 PM, alternate administrator A indicated that the contracted physical and occupational therapy services drop off the therapy notes and plans of care to the home health agency every Tuesday to ensure coordination of care. Alternate administrator A stated that the therapy agency failed to drop off the notes by Tuesday 1/4/2022, which resulted in a delay of ordering physical therapy and updating the patient s plan of care. Alternate administrator A indicated the contracted agency failed to follow agency policy for coordination of therapy services		Order received forfurther therapy for patient # 4 on 1/7/22 Completion: 1/17/22	

G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. Based on record review and interview, the agency failed to ensure completed transfer summary was sent within 2 business days of becoming aware of unplanned transfer in 1 of 4 clinical records reviewed. (#5) The findings include: Review of an undated agency policy, obtained 1/7/2022, titled Hospitalizations stated, Purpose: To assure continuity of care in all settings, to determine the appropriate location for patient care, and to retain professional management responsibilities through the care team & Procedure: Notify the attending physician, Patient Care Coordinator, and pertinent team members of the patient s hospitalization & Complete the transfer OASIS . Review of agency policy, revised November 2021 and obtained 1/7/2022, titled Discharge Criteria stated, & After the decision is made for discharge, the patient/caregiver will be notified. At the time of discharge, a Discharge Summary Note is completed, and if applicable a Discharge OASIS . Clinical record review on 1/6/2022 for patient #5, start of care 10/11/2021, evidenced an agency document titled Transfer OASIS-D1 which indicated that patient #5 was transferred to an inpatient hospital on 11/26/2021. No transfer summary was evidenced as being sent to ensure continuity of patient care. During an interview on 1/7/2022 at 1:43	G1022	Discharge transfer summary Completion date 1/17/22 Education was initially completed for transfer summaries on11/1/21. Education was further provided via the agency internallearning system on transfers summaries on 12/31/21 Nurse Practitioner provided Home Health discharge summaryand care planning education to clinical staff on 1/5/22, 1/6/22, 1/7/22,1/13/22, 1/27/22. Further education will be provided by Patient CareCoordinators at all Home Health IDT's to ensureunderstanding related to completing and sending of transfer summaries within 48hours by 1/28/22 Transfer summary to be reviewed by Patient Care Coordinatorfor completeness before sending to facility and/or physician 1/21/22. Director of Nursing and Director of Quality Assuranceconducting re-education with Patient Care Coordinators and 100% audit ofcurrent Home Health charts 1/26/22. Quality Assurance to audit all	2022-01-28

	PM, clinical manager B indicated the transfer summary for patient #5 who transferred 11/26/2021 did not get sent to the hospital within 2 business days of becoming aware of transfer.		Home Health transfersummaries to ensure completeness and facilitate sending a copy to facility andattending physician Results of this plan of correction will be monitored byDirector of Nursing and Director of Quality Assurance on an ongoing basis toensure deficiency is corrected and will not reoccur. Patient #5 returned to services on 12/1/21 to CHC services Completion date 1/28/22	
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 by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview the home health agency failed to ensure documentation was clear, legible, and appropriately dated and timed in 1 of 5 records reviewed. (#4) The findings include: Review of an agency policy obtained 1/7/2022, revised August 2013, titled "Dating of Medical Records" stated "Procedure: All services provided to Agency patients by CHC [Center for Hospice and Palliative Care] staff and contracted staff are documented in the medical record by the individual providing the service. Each original entry into the medical record will have an electronic date and time stamp, and include the electronic signature of the person providing the services." Clinical record review on 1/6/2022 for patient #4, start of care 12/30/2021,	G1024	Quality Assurance began auditing 100% of all therapy notesto ensure legibility on 12/13/21. Non-legible notes will be returned to thetherapy company immediately with a request for legible copy. Re-education to Quality Assurance department on 1/24/22 onlegibility requirements and returning of notes that are not legible. Case manager to review all therapy notes at Home Health IDT's to verify legibility 1/17/22 Alternate Administrator completed initial planning meetingwith contracted therapy CEO to transition paper therapy charts to electronic charting1/21/22 for primary contracted therapy company.	2022-01-26

	evidenced an agency document titled P.T. Eval [physical therapy evaluation] dated 12/30/2021. This handwritten document indicated physical therapy evaluation was completed on 12/30/2021. The short-term and long-term goals were illegible, the therapist s written name was illegible, treatment plan was illegible, functional assessment notes were illegible, environmental assessment was illegible, problems/safety were illegible, and document failed to evidence emergency contact s telephone number and upper extremity range of motion and strength. Clinical record review on 1/6/2022 evidenced a document titled Communication Notes, dated 1/5/2022, created by registered nurse E, stated, the patient was evaluated for PT on 12/31/2021 . During an interview on 1/7/2022 at 1:35 PM clinical manager B indicated that physical therapy notes were difficult to read in many sections and missing information. During an interview on 1/7/2022 at 1:41 PM, clinical manager B indicated the date of visit for patient #4 should have been documented at 12/30/2021 and the communication note was incorrect.		Completion of transition Feb 2022. Results of this plan of correction will be monitored by the Directorof Nursing and Director of Quality Assurance on an ongoing basis to ensuredeficiency is corrected and will not reoccur. Patient #4's originaltherapy notes were uploaded to the EMR on 1/6/22, therapy notes transcribed by theoriginal author and uploaded 1/26/22 Completion date 1/26/22	

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