STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157536	A. BUILDING 00 B. WING	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
METHODIST HOME CARE SERVICES	303 E 89TH AVENUE, SUITE A, ROOM 117 MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
G 0000 Bldg. 00	This visit was a complaint survey with 1 complaint. The survey visit took place 3/26/2021 to 3/31/2021. Complaint: IN00317648 - substantiated with related and unrelated findings. Facility ID: 003070 This deficiency report reflects State Findings cited in accordance with 410 IAC Article 17. Refer to State Form for additional State Findings. Quality Review Completed: 05/03/2021 Area 1	G 0000		
G 0572 Bldg. 00	484.60(a)(1) Plan of care Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the home health agency failed to ensure the medical plan of care was followed and individualized in 2 of 2 active clinical records. (#1, #3)	G 0572	**G572 #1 The Administrator and Quality/Educator counselled the staff involved in this patient's care and remediation was provided**	04/23/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	The findings include: 1. Record review on 3/31/2021, evidenced an agency policy titled, "Plan of Care", revised 06/2020, which stated, " ... POLICY: To establish guidelines that promotes [sic] appropriate care planning to ensure acceptable delivery of care. A. Every patient must have a written Plan of Care. This plan must be designed to meet the needs of the patient. The Plan of Care is developed from the physician's orders, and is developed and maintained by home care staff is consultation with the physician. The patient is encouraged to participate in the development and revision of the Plan of Care ... C. The Plan of Care must include the type of services to be provided and the frequency and duration of these services, including: ... 2. Specific procedures & treatments, including frequency & duration ... 14. Any safety measures to protect against injury ... E. The Plan of Care must be reviewed by the clinician and attending physician at least every 60 days, and more often if the patient's condition warrants. The clinician will promptly inform the physician of changes in patient's condition that indicates an alteration in the plan and the physician must agree to any changes in the plan of care ... G. All other drugs and treatments observed by the nurse on assessment will also be incorporated into the Plan of Care...." 2. Record review on 3/31/2021, evidenced an agency policy titled, "Clinical Records - Documentation", revised 06/2020, which stated, " ... POLICY: To establish guidelines for documentation in the clinical record that complies with professional standards and federal, state, and local laws. To present a true and accurate picture of the patient's status and the care provided. A clinical record must be maintained for each patient		**regarding correct order entries into the care plan and improved case communication using EPIC tools between field nurses on 4/15/2021. At the April staff meeting, field nurses were remediated for correct use of order entry in the care plan and reminded to consistently use EPIC case communication tool.** **A daily lab log was initiated in the office on 4/7/2021 to track all lab draws: Case manager to list labs on referral sheet, Case manager will list on white board all patients needing routine labs, Case manager will verify lab order when checking the SOC, ROC, or RCT. Field nurses will obtain labs and phone the case manager when dropping specimen off at the lab, Case manager will document using the lab log for tracking. When results are received and faxed to physician, it will be crossed off the log once complete. All field nurses were educated on 4/6/2021 using a handout on the process for obtaining labs and getting results** **All IV cases were audited after this finding to check for deficiencies. IV cases will be audited weekly. Once 100% compliance is achieved for 4 consecutive weeks, auditing will be done randomly to**	

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	in accordance with the accepted professional standards ... Each clinical record will contain the following elements ... 4. Documentation of all teaching and patient and family education provided ... Safety measures taken to protect the patient from harm and notes on the suitability of the environment for the care or services to be provided, when applicable ... 15. The patient's plan of care which is updated as needed and the patient's response to care, treatment and services 16. All relevant diagnostic and therapeutic procedures, treatments, and tests' and their results ... Clinical Documentation: 2. A clinical or visit note is to be used to document a contact with a patient that is written and dated by a clinician, and describes signs and symptoms, treatment and drugs administered, including any reactions of the patient, progress towards goals, and any changes in physical, emotional, or social conditions which may affect outcomes or response to care. During each home visit the patient's response to care against established goals will include but not be limited to: care, interventions, treatment, medications, teaching ... Visits notes should include any assessment findings, services rendered, instruction given, patient's progress, any physician contact or consultation, and care coordination with other disciplines...." 3. Clinical record review on 3/30/2021 for patient #1, with start of care 2/27/2021, certification period 2/27/2021 to 4/27/2021, primary diagnosis of Type 2 diabetes mellitus with foot ulcer (onset), evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 3/9/2021. This plan of care had a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, " ... Specimen sample ... Lab draw ... Start:		**monitor compliance. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur G 572 #2 The Administrator held a meeting with home health IT staff and EPIC –the EPIC representative was able to educate and guide Administrator on where to find the active POC on the EPIC hyperspace side to assist during a survey. It is entitled: "episode summary review"-located in "episode" under chart review. Currently, in the EPIC remote client, field staff are able to view the current up to date POC. G572 #3 The Administrator/Educator on 4/15/2021 counselled the staff involved in this patient's care and remediation was provided regarding correct order end date entry into the care plan-any time an order is to be held, the order needs to be end dated. In the April staff meeting, field nurses were remediated for correct use of order end date entry into the care plan and also reminded to consistently use case communication tools to explain**	

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	2/27/2021 ... Labs to be drawn on Monday and Thursday and results to be sent to [physician C] - labs include CBC / DIFF [complete blood count with differential], CMP [complete metabolic panel], ESR [erythrocyte sedimentation rate] WHILE ON IV [intravenous] ANTIBIOTICS...." Review on 3/30/2021, of the patient's electronic medical record (Epic) evidenced on 3/1/2021, the nurse drew CBC / DIFF, CMP, and CRP [c-reactive protein]. The nurse failed to draw an ESR. Clinical record review failed to evidence an order to draw for CRP. On 3/26/2021 at 11:30 a.m., the administrator indicated she did not know why the nurse drew CRP and not ESR. Review on 3/30/2021, of the patient's electronic medical record (Epic) evidenced on 3/15/2021 and 3/25/2021, the nurse drew CBC / DIFF, CMP, and CPK [creatine phosphokinase] During an interview on 3/26/2021 at 11:00 a.m., the administrator identified a physician order dated 2/27/2021 as the correct lab draw order, which indicated CBC / DIFF, CMP, and CPK to be drawn weekly while on antibiotics, and results sent to physician E. When queried, the administrator indicated this order was not present in the plan of care in "Epic hyperspace". She indicated it is something "IT" was working on to make the plan of care a "living document". No additional documentation was received. Clinical record review of nurse's notes and review of the patient's electronic medical record failed to evidence any labs were drawn on the week of 3/7/2021 to 3/13/2021. The skilled nurse failed to follow the medical plan of care.		**any changes that occur.** **A daily lab log was initiated in the office on 4/7/2021 to track all lab draws: Case manager to list labs on referral sheet, Case manager will list on white board all patients needing routine labs, Case manager will verify lab order when checking the SOC, ROC, or RCT. Field nurses will obtain labs and phone the case manager when dropping specimen off at the lab, Case manager will document using the lab log for tracking, when results are received and faxed to physician, it will be crossed off the log once complete. All field nurses were educated on 4/6/2021 using a handout on the process for obtaining labs and getting results.** **The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.** **G572 #4** **Administrator/Educator met with the involved staff on 4/15/2021 and counselled them on how to accurately end date a frequency in EPIC Remote Client. The end date must reflect the correct day of the**	

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	During an interview on 3/26/2021 at 11:02 a.m., the administrator indicated the patient was on IV antibiotics during that time and should have had labs drawn. Both the administrator and employee B, RN [registered nurse] reviewed the patient's medical record and indicated the nurse failed to draw any labs that week as ordered in the plan of care. Clinical record review of an agency document titled, "Home Health Certification And Plan of Care" for certification period 2/27/2021 to 4/27/2021, evidenced an area subtitled "Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)". This subtitled area stated, "SN [skilled nurse] 2/27/2021 to 2/27/2021(is this date right?) Yes, they wrote it like that because the first visit was at the end of the week: 1 visit every week for 1 week, 2/28/2021 to 3/27/2021: 3 visits every week for 4 weeks ...." Review of the patient's electronic medical record and clinical record review of the nurse's notes for the week of 3/7/2021 to 3/13/2021 evidenced only one SN visit. The week of 3/14/2021 to 3/20/2021 evidenced only one SN visit. The week of 3/21/2021 to 3/27/2021 evidenced only one SN visit. The skilled nurse failed to follow the medical plan of care as ordered by the primary care physician. During an interview on 3/31/2021 at 10:37 a.m., the administrator indicated a physician order was received on 3/25/2021, to change SN visit frequency to one visit per week. The agency failed to update the plan of care with this order. When queried, the administrator indicated the order was in Epic, but was not part of the plan of care found in Epic hyperspace. The administrator		**week that it occurred. At the April staff meeting, field nurses were remediated regarding accurate end dating of the frequency in the EPIC Remote client.** **Continue to monitor accurate frequency dates during quarterly review of 30 charts.** **A meeting with IT and EPIC was arranged and EPIC was able to educate Administrator on where to find the active Plan of Care on the hyperspace side: "episode summary review"-located in chart review and episode. In remote client, field staff has always been able to see the current Plan of Care , including orders and med list.** **The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur** **G572 #5 The Administrator/Educator counselled the nurse involved on 4/15/2021 regarding following lab orders for this patient and also placed the nurse in corrective action.**	

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	indicated the agency failed to provide 3 SN nursing visits per week for the weeks of 3/7/2021 to 3/13/2021 and 3/14/2021 to 3/20/2021. (Did you place the finding under revision to the plan of care as well?) Yes 4. Clinical record review on 3/29/2021 for patient #3, with start of care 2/18/2021, certification period 2/18/2021 to 4/18/2021, primary diagnosis of Covid-19 and secondary diagnoses including but not limited to Acute on chronic systolic (congestive) heart failure (exacerbation) and Hypertensive chronic kidney disease, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 3/3/2021. This plan of care had a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, " ... Specimen sample ... Lab draw ... Start: 2/18/2021 ... lab draw to be perform [sic] x2 [two times] weekly cbc with diff, cmp with results going to [physician C] and [infusion specialty pharmacy D]...." Clinical record review evidenced a group of documents, identified by the administrator as the nurse's visit notes. The nurse visit notes for the week of 3/7/2021 to 3/13/2021, failed to evidence two times lab draws were performed. The nurse visit notes for the week of 3/14/2021 to 3/20/2021, failed to evidence two times lab draws were performed. The skilled nurse failed to follow the medical plan of care as ordered by the primary care physician. Review of patient #3's electronic medical record (Epic) failed to evidence two lab draws were performed for the week of 3/7/2021 to 3/13/2021 and the week of 3/14/2021 to 3/20/2021.		**A daily lab log was initiated in the office on 4/7/2021 to track all lab draws: Case manager to list labs on referral sheet, Case manager will list on white board all patients needing routine labs, Case manager will verify lab order when checking the SOC, ROC, or RCT. Field nurses will obtain labs and phone the case manager when dropping specimen off at the lab, Case manager will document using the lab log for tracking, when results are received and faxed to physician, it will be crossed off the log once complete. All field nurses were educated on 4/6/2021 using a handout on the process for obtaining labs and getting results.** **The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur** **G572 #6 The Administrator/Quality met with the involved nurse on 4/15/2021 to council and remediate regarding correct use of care plan documentation and educating patient/caregiver. This nurse was issued a**	

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	During an interview on 3/31/2021 at 10:22 a.m., the administrator indicated the patient was supposed to have lab tests drawn twice weekly. When informed of the findings, the administrator and employee B reviewed the patient's electronic medical record. The administrator indicated the patient had nursing visits on 3/11/2021 and 3/18/2021 when the labs should have been drawn by the nurse. The record failed to evidence labs were drawn on 3/11/2021 and 3/18/2021. The administrator and employee B indicated the nurse failed to perform lab draws two times weekly for the week of 3/7/2021 to 3/13/2021 and the week of 3/14/2021 to 3/20/2021. The administrator stated, "I don't see anything to explain it". Clinical record review of an agency document titled, "Home Health Certification And Plan of Care" for certification period 2/27/2021 to 4/27/2021, evidenced an area subtitled "Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)". This subtitled area stated, " ... Disease Knowledge Deficit ... Absence or deficiency of knowledge in the placement of pacemaker ... Assess patient's understanding of disease process, management and complications ... Start: 2/18/2021 ... Patient / caregiver may have misconceptions about the disease that should be corrected. Identify baseline knowledge to help facilitate and establish a plan of care for patient and family education by week 2 ... Disease Management ... Instruct chronic renal disease ... Start: 2/18/2021 ... Instruct patient and Caregiver on disease management, including signs & symptoms, risk factors and lifestyle modifications ... Disease Management ... Instruct atrial fibrillation [an irregular heart rhythm] Start 2/18/2021 ... Instruct Patient and Caregiver on disease management, including signs & symptoms, risk factors and		**corrective action.** **At the April staff meeting, nurses was remediated on the correct use of the care plan interventions and correct documentation of goal progression** **Continue to monitor the documentation of educating patients/families during quarterly review of 30 charts** **Any staff found out of compliance were mandated to attend a "Demonstrate and return demonstration" of the correct method for checking interventions and progression to goals with live presentation/laptop/screen by the educator.** **The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur**	

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	lifestyle modifications ... Fluid Retention - HF [heart failure] ... Instruct fluid restrictions ... Start 2/18/2021 ... Restrict fluid intake to 1500 ml [milliliters] per day as instructed by your physician. Teach that fluids include: ice cubes, tea, coffee, juice, soup, gelatin, ice cream, sherbet, milk and soda ... Instruct to maintain daily log of HF [heart failure] signs and symptoms ... Start: 2/18/2021 ... Use HF notebook to instruct / coach the patient / caregiver: HF disease process, medications, reduced sodium in diet, reading & understanding food labels, daily log of signs & symptoms, exercising, and when to call Methodist HH [home health] and / or physician...." Clinical record review evidenced a group of documents, identified by the administrator as the nurse's visit notes. The nurse's visit notes were dated: 2/19/2021, 2/22/2021, 2/25/2021, 3/1/2021, 3/3/2021, 3/8/2021, 3/11/2021, 3/15/2021, 3/18/2021, 3/22/2021, and 3/24/2021. Each of these notes failed to evidence patient education for the placement of a pacemaker. Each of these notes failed to evidence patient education for chronic renal disease. Each of these notes failed to evidence patient education for atrial fibrillation. Each of these notes failed to evidence patient education for heart failure. Each of these notes failed to evidence the patient was on or educated about a fluid restriction. The skilled nurse failed to follow the medical plan of care as ordered by the primary care physician. During an interview on 3/31/2021 at 9:45 a.m., employee B, RN, indicated patient teaching should be documented in each visit. When informed of the findings, the administrator and employee B reviewed the electronic medical record for patient #3. The administrator stated, "There's none in the record. It should be in there." The			

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	administrator indicated if a patient was on a fluid restriction, it should be documented in a heart failure template or a narrative note within the nurse's notes. The administrator and employee B indicated the nurse's notes failed to evidence the fluid restriction. 17-13-1(a)			
G 0574 Bldg. 00	484.60(a)(2)(i-xvi) Plan of care must include the following The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or			

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	physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure the individualized plan of care included all services, safety measures, medications and treatments in 2 of 2 discharged patient records out of a total sample of 4 records reviewed (#2, #4) The findings include: 1. Record review on 3/31/2021, evidenced an agency policy titled, "Plan of Care", revised 06/2020, which stated, " ... POLICY: To establish guidelines that promotes [sic] appropriate care planning to ensure acceptable delivery of care. A. Every patient must have a written Plan of Care. This plan must be designed to meet the needs of the patient. The Plan of Care is developed from the physician's orders, and is developed and maintained by home care staff is consultation with the physician. The patient is encouraged to participate in the development and revision of the Plan of Care ... C. The Plan of Care must include the type of services to be provided and the frequency and duration of these services, including: ... 2. Specific procedures & treatments, including frequency & duration ... 5. Prescribed medications with dose, route, and frequency ... 14. Any safety measures to protect against injury ... E. The Plan of Care must be reviewed by the clinician and attending physician at least every 60 days, and more often if the patient's condition warrants. The clinician will promptly inform the physician of changes in patient's condition that indicates an alteration in the plan and the physician must agree to any changes in the plan of care ... G. All drugs and treatments ordered by the physician will be incorporated into the Plan of Care. All other	G 0574	**G574 #1 Administrator/Educator counselled the staff involved on 4/15/2021 regarding the importance of making sure all prn med orders include an indication for use. At the April staff meeting, field nurses were remediated regarding medication orders-order must include the indication for use on all prn medications** **Will continue to monitor correct documentation for prn meds/indication during quarterly review of 30 charts.** **The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur** **G574 #2 At the April staff meeting, the Administrator/Educator remediated staff on the necessity of reviewing the entire inpatient DC summary to gain insight into the plan for patient post hospitalization and importance of documenting DME use and compliance in their narrative** **Will continue to monitor DME documentation during quarterly review of 30 charts.**	04/23/2021

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	drugs and treatments observed by the nurse on assessment will also be incorporated into the Plan of Care. Any medication side-effects, drug allergies or adverse reactions, contra-indicated medications, will be evaluated by the clinician and will be reported to the physician...." 2. Record review on 3/32/2021 evidenced an agency policy titled, "Medication Administration and Oversight", revised 06/2020, which stated, " ... POLICY: Establish guidelines for the appropriate administration and management of medications for patients ... B. Medication orders: 1) Orders must include the drug name (generic or trade name), dose, route, and frequency of administration. 2) Medications orders must be clear and accurate. 3) The clinical record must contain the purpose for the medication's use. 4) All PRN [as needed] medication orders must specify the purpose for the medication's use...." 3. Clinical record review on 3/30/2021 for patient #2, with start of care 6/25/2019, certification period 6/25/2019 to 8/23/2019, primary diagnosis of Sepsis due to methicillin resistant Staphylococcus aureus (onset), evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 7/1/2019. The plan of care had a subcategory titled, "Medications: Dose / Frequency / Route (N)ew (C)hanged", which stated, " ... hydrocodone - acetaminophen (NORCO) [a narcotic pain medication] 7.5 - 325 MG [milligram] per tablet Take 1 tablet by mouth every 6 hours as needed for up to 7 days. Max daily Amount: 4 tablets. - Oral....". The plan of care failed to evidence the indication for usage of the medication. During an interview on 3/31/2021 at 12:46 p.m., the		**The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur** **G574 #3 Administrator/Educator counselled the staff involved on 4/15/2021 regarding the importance of making sure all prn med orders include an indication for use. At the April staff meeting, field nurses were remediated regarding medication orders-order must include the indication for use on all prn medications** **Will continue to monitor for correct documentation of PRN medications during quarterly review of 30 charts.** **The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur**	

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	157536	A. BUILDING 00 B. WING	03/31/2021

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	administrator indicated all medications ordered PRN [as needed] required an indication for usage. When informed of the findings, the administrator indicated the plan of care failed to include an indication for usage. 4. Clinical record review on 3/30/2021 for patient #4, with start of care 11/7/2020, certification period 11/7/2020 to 1/5/2021, primary diagnosis of encounter for other orthopedic aftercare, evidenced a document from facility A, titled "After Visit Summary", dated 11/4/2020. This document was identified by employee A as the instructions the patient received when discharged from the hospital. This document stated, " ... Your instructions: Soft cervical collar to be worn until December 1 - per [person B]...." Clinical record review evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", certification period 11/7/2020 to 1/5/2021, signed by the physician on 11/16/2020. The plan of care failed to evidence the patient was to wear a soft cervical collar During an interview on 3/31/2021 at 12:33 p.m., the administrator indicated the plan of care failed to evidence the patient was to wear a soft cervical collar. At 12:35 p.m., the administrator and employee B, RN reviewed the patient's electronic medical record and indicated clinical record failed to evidence use of a soft cervical collar. Clinical record review evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", certification period 11/7/2020 to 1/5/2021, signed			

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	by the physician on 11/16/2021. This plan of care evidenced a subcategory titled, "Medications: Dose / Frequency / Route (N)ew (C)hanged", which stated, " ... oxycodone - acetaminophen [a narcotic pain reliever] 7.5 - 325 MG [milligram] PO [by mouth] per tablet Take 1 tablet by mouth every 6 hours as needed for up to 14 days. Max Daily Amount: 4 tablets. - Oral (C)...." The plan of care failed to evidence the indication for usage of the medication. During an interview on 3/31/2021 at 12:46 p.m., the administrator indicated all medications ordered PRN [as needed] required an indication for usage. When informed of the findings, the administrator reviewed the plan of care and stated, "I can see it's not on there. It doesn't say pain." 17-13-1(a)(1)(B)(2(a)			
G 0576 Bldg. 00	484.60(a)(3) All orders recorded in plan of care All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review and interview, the home health agency failed to ensure the plan of care was revised to include all patient care orders, in 2 of 2 clinical records reviewed of patients with wounds. (#1, #2) The findings include: 1. Record review on 3/31/2021, evidenced an agency policy titled, "Plan of Care", revised 06/2020, which stated, " ... POLICY: To establish guidelines that promotes [sic] appropriate care planning to ensure acceptable delivery of care. A. Every patient must have a written Plan of Care. This plan must be designed to meet the needs of the patient. The Plan of Care is developed from	G 0576	G576 #1 The Administrator and Quality/Educator counselled the staff involved in this patient's care on 4/15/2021 and remediation was provided regarding correct order entries into the care plan and improved case communication using EPIC tools between field nurses. At the April staff meeting, all field nurses were remediated for correct use of order entry in the care plan and reminded to consistently use EPIC case communication tool. A daily lab log was initiated in the office on 4/7/2021 to track all lab	04/23/2021

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	the physician's orders, and is developed and maintained by home care staff is consultation with the physician. The patient is encouraged to participate in the development and revision of the Plan of Care ... C. The Plan of Care must include the type of services to be provided and the frequency and duration of these services, including: ... 1) Disciplines and frequency & duration of visits 2) Specific procedures & treatments, including frequency & duration ... 14. Any safety measures to protect against injury ... E. The Plan of Care must be reviewed by the clinician and attending physician at least every 60 days, and more often if the patient's condition warrants. The clinician will promptly inform the physician of changes in patient's condition that indicates an alteration in the plan and the physician must agree to any changes in the plan of care ... G. All other drugs and treatments observed by the nurse on assessment will also be incorporated into the Plan of Care. Any medication side-effects, drug allergies or adverse reactions, contra- indicated medications, will be evaluated by the clinician and will be reported to the physician...." 2. Record review on 3/31/2021, evidenced an agency policy titled, "Clinical Records - Documentation", revised 06/2020, which stated, " ... POLICY: To establish guidelines for documentation in the clinical record that complies with professional standards and federal, state, and local laws. To present a true and accurate picture of the patient's status and the care provided. A clinical record must be maintained for each patient in accordance with the accepted professional standards ... Each clinical record will contain the following elements ... 7. A complete Medication profile, allergies and sensitivities, vital signs, height and weight when appropriate. 15. The		draws: Case manager to list labs on referral sheet, Case manager will list on white board all patients needing routine labs, Case manager will verify lab order when checking the SOC, ROC, or RCT. Field nurses will obtain labs and phone the case manager when dropping specimen off at the lab, Case manager will document using the lab log for tracking, when results are received and faxed to physician, it will be crossed off the log once complete. All field nurses were educated on 4/6/2021 using a handout on the process for obtaining labs and getting results All IV cases were audited after this finding to check for deficiencies. IV cases will be audited weekly. Once 100% compliance is achieved for 4 consecutive weeks, auditing will be done randomly to monitor compliance. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur G576 #2 Administrator/Educator met with the involved staff on 4/15/2021 and counselled them on how to accurately end date a frequency. The end date must	

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	patient's plan of care which is updated as needed and the patient's response to care, treatment and services 16. All relevant diagnostic and therapeutic procedures, treatments, and tests' and their results...." 3. Clinical record review on 3/30/2021 for patient #1, with start of care 2/27/2021, certification period 2/27/2021 to 4/27/2021, primary diagnosis of Type 2 diabetes mellitus with foot ulcer (onset), evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 3/9/2021. This plan of care had a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)", which stated, " ... Specimen sample ... Lab draw ... Start: 2/27/2021 ... Labs to be drawn on Monday and Thursday and results to be sent to [physician C] - labs include CBC / DIFF [complete blood count with differential], CMP [complete metabolic panel], ESR [erythrocyte sedimentation rate] WHILE ON IV [intravenous] ANTIBIOTICS...." Review on 3/30/2021, of the patient's electronic medical record (Epic) evidenced on 3/15/2021 and 3/25/2021, the nurse drew CBC / DIFF, CMP, and CPK [creatine phosphokinase]. The ski During an interview on 3/26/2021 at 11:00 a.m., the administrator identified a physician order dated 2/27/2021 as the correct lab draw order, which indicated CBC / DIFF, CMP, and CPK to be drawn weekly while on antibiotics, and results sent to physician E. When queried, the administrator indicated this order was not present in the plan of care in "Epic hyperspace". She indicated it is something IT is working on to make the plan of care a "living document". No additional documentation was received.		reflect the correct day of the week that it occurred. At the April staff meeting, all nurses were remediated regarding accurate end dating of the frequency. Continue to monitor accurate dating to end frequency during quarterly review of 30 charts. A meeting with IT and EPIC was arranged and EPIC was able to educate Administrator on where to find the active POC on the hyperspace side: “episode summary review”-located in chart review and episode. In remote client, field staff has always been able to see the current POC , including orders and med list. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur G576 #3 During April staff meeting, Administrator/Educator reviewed with the nursing field staff and case managers regarding allergies being added to the allergy profile during the patient’s service period A meeting with IT and EPIC was arranged and EPIC was able to educate Administrator on where to find the active POC on the hyperspace side: “episode	

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	Clinical record review evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 3/9/2021. This plan of care had a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration)" of the plan of care also evidenced the order, "SN [skilled nurse] 2/27/2021 to 2/27/2021: 1 visit every week for 1 week, 2/28/2021 to 3/27/2021: 3 visits every week for 4 weeks ...." Review of the patient's electronic medical record and clinical record review of the nurse's notes for the week 3/7/2021 to 3/13/2021 evidenced only one SN visit. The week of 3/14/2021 to 3/20/2021 evidenced only one SN visit. The week of 3/21/2021 to 3/27/2021 evidenced only one SN visit. During an interview on 3/31/2021 at 10:37 a.m., the administrator indicated a physician order was received on 3/25/2021 to change SN visit frequency to one visit per week. The agency failed to update the plan of care with this order. When queried, the administrator indicated the order was in Epic, but was not part of the plan of care found in Epic hyperspace. The administrator indicated the agency failed to provide 3 SN nursing visits per week for the weeks of 3/7/2021 to 3/13/2021 and 3/14/2021 to 3/20/2021. Clinical record review evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 3/9/2021. Review of the plan of care evidenced a subcategory titled, "Medications: Dose / Frequency / Route....", which stated, " ... ceFAZolin Sodium-Dextrose [an IV antibiotic] 2 GM [gram] IV SOLR piggyback		summary review"-located in chart review and episode. In remote client, field staff has always been able to see the current POC, including orders and med/allergies list. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur **G576 #4** A meeting with IT and EPIC was arranged and EPIC was able to educate Administrator on where to find the active POC on the hyperspace side: "episode summary review"-located in chart review and episode. In remote client, field staff has always been able to see the current POC, including orders and med/allergies list.	

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	Inject 2 g [gram] into the vein every 8 hours for 40 days...." The plan of care also had a subcategory titled, "Allergies", which stated, "Vancomycin, Azithromycin". Review of the patient's electronic medical record evidenced an encounter note titled, "ED [emergency department]", dated 3/5/2021, electronically signed by physician F. This note stated, " ... On patient re-evaluation, reporting improvement in symptoms. Itching improved. No new symptoms. Pt [patient] instructed to d/c [discontinue] ancef [cefazolin]...." Review of the patient's electronic medical record evidenced a physician order dated 3/9/2021, signed by physician E, which stated, " ... Daptomycin (Cubicin) [an antibiotic] 700 mg [milligram] in sodium chloride 0.9% 50 mL [milliliter] IVPB [IV piggyback]...." Review of the patient's electronic medical record evidenced a document titled, "Office Visit", dated 3/22/2021, electronically signed by physician E. This note stated, " ... This man was on Cefazolin but developed allergic reaction and so it was discontinued and Daptomycin started...." Clinical record review evidenced the plan of care failed to reflect the patient's most recent medications and allergies. During an interview on 3/31/2021 at 10:39 a.m., the administrator indicated the agency failed to update the plan of care with the Cefazolin allergy. When queried, the administrator indicated the orders to discontinue Cefazolin and the new order for Daptomycin were not present in the plan of care in "Epic hyperspace". She indicated it is something IT is working on to make the plan of			

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	care a "living document". No additional documentation was received by end of survey dated 03/31/2021. 4. Clinical record review on 3/30/2021 for patient #2, with start of care 6/25/2019, certification period 6/25/2019 to 8/23/2019, primary diagnosis of Sepsis due to methicillin resistant Staphylococcus aureus (onset), evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 7/1/2019. The plan of care had a subcategory titled, "Medications...." This subcategory stated, " ... rifampin (Rifadin) [an oral antibiotic] 300 MG [milligram] capsule Take 1 capsule by mouth every 12 hours for 40 days. - Oral ... Vancomycin HCl in NACl [an IV antibiotic] 750-0.9 MG [milligram] / 150 ML [milliliter] SOLN [solution] PREMIX Inject 150 mLs into the vein every 12 hours for 40 days - Intravenous...." Clinical record review evidenced an agency document titled, "PROVIDER VERBAL ORDER", dated 6/27/2019, from physician G, signed by the nurse, which stated, " ... D/C [discontinue] Vancomycin. Daptomycin [an IV antibiotic] 6 mg [milligram] / kg [kilogram] (600 mg) IV Daily thru 8-4-19...." The plan of care failed to evidence a revision to include this medication change order. Clinical record review evidenced an agency document titled, "PROVIDER VERBAL ORDER", dated 7/8/2019, from physician G, signed by the nurse, which stated, " ... Hold Daptomycin until further orders. Hold po [by mouth] Rifampin...." The plan of care failed to evidence this medication change order. Review of the patient's electronic medical record evidenced a document, identified by the			

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	administrator as infusion clinic orders, dated 7/12/2019, from physician G, which stated, " ... Medication order ceftaroline fosamil (TEFLARO) 600 mg, sodium chloride 0.9% 100 mL...." Clinical record review evidenced an agency document titled, "Case Communication", dated 7/13/2021, signed by employee D, RN, which stated, " ... Communication Details Patient called and stated IV antibiotics was changed on Friday, initial dose of Teflaro 600 mg IV was given and [sic] infusion clinic. Patient was told at clinic that HH [home health] will be out on Saturday to educate on how to administer IV antibiotics, no communication was given to Homehealth. Writer done visit with patient and educated on new antibiotics and frequency of medication. Informed to call if any concerns arises, voiced understanding...." The plan of care failed to evidence the patient was taking Teflaro. During an interview on 3/31/2021 at 12:10 p.m., the administrator indicated the plan of care failed to evidence the patient's medication changes. The administrator stated, "I can't see it. I will talk to IT". 17-14-1(a)(1)(C)			
G 0590 Bldg. 00	484.60(c)(1) Promptly alert relevant physician of changes The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any 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. Based on record review and interview, the home health agency failed to ensure the skilled nurse notified the primary care physician of changes in a patient's condition that may require alteration of	G 0590	G590 Administrator/Educator counselled the involved nurse on 4/15/2021 and they were placed in corrective action	04/23/2021

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	the plan of care, in 1 of 1 clinical record reviewed with a change in the patient's condition. (#3) The findings include: Record review on 3/31/2021, evidenced an agency policy titled, "Clinical Records - Documentation", revised 06/2020, which stated, " ... POLICY: To establish guidelines for documentation in the clinical record that complies with professional standards and federal, state, and local laws. To present a true and accurate picture of the patient's status and the care provided. A clinical record must be maintained for each patient in accordance with the accepted professional standards ... Each clinical record will contain the following elements ... 10. Documentation of all relevant communication with the patient's physician 15. The patient's plan of care which is updated as needed and the patient's response to care, treatment and services ... 18. Documentation of all communication with the patient and physician regarding care, treatment and services and when there are changes in the patient's condition, psychosocial status, home environment ... 19. Evidence of interdisciplinary communication and care coordination ... Clinical Documentation: 2. A clinical or visit note is to be used to document a contact with a patient that is written and dated by a clinician, and describes signs and symptoms, treatment and drugs administered, including any reactions of the patient, progress towards goals, and any changes in physical, emotional, or social conditions which may affect outcomes or response to care. During each home visit the patient's response to care against established goals will include but not be limited to: care, interventions, treatment, medications, teaching ... Visits notes should include any assessment findings, services rendered, instruction given,		At the April staff meeting, all field nurses were remediated and educated regarding report of patient changes in condition and documenting notice to physician in case communication: Any significant change in a patient's condition must be reported to the physician by phone and also documented within the visit. A case communication needs to be created and sent to the case manager, the physician, and all disciplines on the case Continue to monitor accurate reporting on patient's condition change to the physician, case ,manager, and other disciplines in the home during quarterly review of 30 charts. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

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	patient's progress, any physician contact or consultation, and care coordination with other disciplines...." Record review evidenced an agency policy titled, "Care Coordination", revised 6/2020, which stated, " ... POLICY: To maintain liaison and communication among all care providers to ensure continuity, consistency, efficiency, and appropriateness of service delivery. A. Professional staff are responsible for coordinating services with the physician ... J. There will be ongoing communication between the professional staff and the patient's physician...." Clinical record review on 3/29/2021 for patient #3, with start of care 2/18/2021, certification period 2/18/2021 to 4/18/2021, primary diagnosis of Covid-19 and secondary diagnoses including but not limited to Acute on chronic systolic (congestive) heart failure (exacerbation) and Hypertensive chronic kidney disease ... evidenced a group of documents, identified by the administrator as the nurse's visit notes. The assessment dated 2/19/2021 stated, " ... Cardiovascular Within defined limits....". The nurse visit note assessment dated 2/22/2021, stated, " ... Cardiovascular Issues: lower extremity edema [swelling caused by excess fluid] Lower extremity edema ... left foot pitting [when swollen skin remains indented after being pressed]. Review of the clinical record failed to evidence the physician was notified of the change in the patient's condition. During an interview on 3/29/2021 at 6:02 p.m., Employee D, RN [registered nurse] indicated if there is a change in patient condition, the nurse should notify the physician and document in a case communication or narrative, in the nurse's			

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	note. During an interview on 3/31/2021 at 10:05 a.m., the administrator indicated the presence of pitting edema, not present on previous assessment, is a change in patient condition. The administrator indicated the clinical record failed to evidence the physician was notified of the change in the patient's condition. 17-13-1(a)(2)			
G 1024 Bldg. 00	484.110(b) Authentication 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 agency failed to ensure all clinical record entries were legible, clear, complete, and appropriately authenticated in 2 of 3 clinical records reviewed for patients receiving physical therapy services. (#2, #3) The findings include: 1. Record review on 3/31/2021, evidenced an agency policy titled, "Clinical Records - Documentation", revised 06/2020, which stated, " ... POLICY: To establish guidelines for documentation in the clinical record that complies with professional standards and federal, state, and local laws. To present a true and accurate picture of the patient's status and the care provided. A clinical record must be maintained for each patient	G 1024	G1024 #1 The Administrator/Educator counselled the staff involved on 4/15/2021. At the April staff meeting, nursing was remediated regarding original care plan corrections: Any Plan of Care interventions that may have been entered inaccurately at the SOC needs to be discussed with the case manager immediately (prior to POC being sent to physician for signature) so they can modified. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	04/23/2021

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	157536	A. BUILDING 00 B. WING	03/31/2021

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	in accordance with the accepted professional standards ... Each clinical record will contain the following elements ... 3. Routine and relevant visit notes with pertinent findings and the skill for the visit, and periodic summaries provided to they physician as applicable ... 9. Safety measures taken to protect the patient from harm and notes on the suitability of the environment for the care or services to be provided, when applicable ... Clinical Documentation: 2. A clinical or visit note is to be used to document a contact with a patient that is written and dated by a clinician, and describes signs and symptoms, treatment and drugs administered, including any reactions of the patient, progress towards goals, and any changes in physical, emotional, or social conditions which may affect outcomes or response to care. During each home visit the patient's response to care against established goals will include but not be limited to: care, interventions, treatment, medications, teaching ... Visits notes should include any assessment findings, services rendered, instruction given, patient's progress, any physician contact or consultation, and care coordination with other disciplines...." 2. Clinical record review on 3/30/2021 for patient #2, with start of care 6/25/2019, certification period 6/25/2019 to 8/23/2019, primary diagnosis of Sepsis due to methicillin resistant Staphylococcus aureus (onset), evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 7/1/2019. The plan of care had a subcategory titled, "Orders for Discipline and Treatments....", which stated, " ... Post-op care ... Instruct on fall prevention ... Start 6/25/2019 ... Instruct patient / caregiver in drain care...." Clinical record review evidenced an agency		G1024 #2 The Administrator/Educator counselled the staff involved on 4/15/2021 regarding the need to carefully review all care plan interventions that are chosen for accuracy . At the April staff meeting, remediation was completed with field nurses on carefully reviewing all care plan interventions that are chosen for accuracy. All care plan templates were reviewed by the Administrator/Educator for accuracy and were corrected in EPIC with the assistance of IT department. Following all future EPIC updates, the Administrator /Educator will review all care plan templates to be sure that any new updates have not affected the accuracy of the care plan templates The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

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	document titled, "OASIS [Outcome and Assessment Information Set] [a standardized assessment used in home health] Start of Care", dated 8/25/2019, signed by employee F, RN. This document had a subcategory titled, "Intervention Documentation", which stated, " ... Problem: Post-op care ... Goal: Care of wound drain Description: Patient / caregiver will demonstrate the ability to care for wound drains throughout episode of care. Intervention: Instruct on fall prevention Description: Instruct patient / caregiver in drain care...." The physical assessment failed to evidence the patient had a drain. Clinical record review evidenced a group of documents, identified by the administrator as the nurse's visit notes. The notes dated 6/26/2019 stated, " ... Goal: Care of wound drain Description: Patient / caregiver will demonstrate the ability to care for wound drains throughout episode of care. Intervention: Instruct on fall prevention Description: Instruct patient / caregiver in drain care...." The physical assessment on this note failed to evidence the patient had a drain. The nurse's notes dated 7/3/2019 and 7/4/2019 each stated, " ... Problem: Post-op care ... Goal: Care of wound drain Description: Patient / caregiver will demonstrate the ability to care for wound drains throughout episode of care. Intervention: Instruct on fall prevention Description: Instruct patient / caregiver in drain care.....". The physical assessment on each of these notes failed to evidence the patient had a drain. The nursing notes dated 6/27/2019, 7/1/2019, 7/3/2019, 7/8/2019, 7/9/2019, 7/11/2019, 7/13/2019, 7/15/2019, 7/18/2019, 7/22/2019, 7/25/2019, 7/29/2019, 8/1/2019 and 8/5/2019 each failed to evidence the patient had a drain.			

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	During an interview on 3/31/2021 at 12:13 p.m., the administrator indicated if a patient had a drain, it should be included in the physical assessment and in the nursing teaching and interventions. When queried, the administrator indicated patient #2 did not have a drain. When informed of the findings, the administrator reviewed the patient's electronic record (Epic) and stated, "Something's goofy. That's really strange. We'll have to call Epic." The administrator indicated the clinical record documentation was not clear. 3. Clinical record review on 3/29/2021 for patient #3, with start of care 2/18/2021, certification period 2/18/2021 to 4/18/2021, primary diagnosis of Covid-19, evidenced a group of documents, identified by the administrator as the nurse's visit notes. Each of the notes were signed by employee E, RN. These notes had a subcategory titled, "Communicable Disease Screening". This screening stated, " ... In the last month, have you been in contact with someone who was confirmed or suspected to have Coronavirus / COVID - 19? ...." The answers documented to this question were as follows: 2/18/2021 - yes, 2/19/2021 - no, 2/22/2021 - yes, 2/25/2021, 3/1/2021, 3/3/2021, 3/8/2021 - no, 3/11/2021 - yes, 3/15/2021, 3/18/2021, 3/22/2021, and 3/24/2021 - no. During an interview on 3/31/2021 at 10:12 a.m., the administrator indicated the Covid screening should be done by the clinician at the beginning of each visit. The administrator indicated the first question was to determine if the patient had been in contact with anyone potentially positive for Covid-19 in the past month. When informed of the findings, the administrator stated, "There are inconsistencies", and indicated the nurse's documentation was unclear.			

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	17-15-1(a)(7)			