STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157536	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/26/2022

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

(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
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102.Survey Dates: 1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/24/2022, 1/25/2022, and 1/26/2022Facility ID: 003070	E0000		
E0017	HHA Comprehensive Assessment in Disaster CFR(s): 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. This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the emergency preparedness plan was individualized to meet the needs of each patient at their location in the event of a potential disaster in 17 of 17 clinical records reviewed. (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17) The findings include: 1. Record review of an agency policy titled,	E0017		

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

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E0017	Continued from page 1 "Emergency Management Plan" revised June 2021, stated "I. Policy: Prepare for and manage and emergency and restore to the same operational capabilities as pre-emergency levels. To ensure that adequate patient services and staff safety are provided when emergency conditions do not allow normal access to or from patient's home … Phase Three – Response: Implementation of the Emergency Management Plan by management and response to the Emergency Management Plan by all staff … 3) Clinical staff will notify their home care case manager or designee to review patient caseloads. Case managers or their designees are responsible for patient triage ... A list of active patients and employees will be printed and distributed to administrative staff as needed for reference … They will review patient caseloads with clinical staff and establish visit priorities based on patient priority level 1, 2, 3, and four. Patients will be seen by staff as soon as the emergency is over or it is safe to do so. A list of active patients and employees will be printed and distributed to administrative staff as needed for reference … 5) Patients will be given emergency preparedness instructions upon home health admission and will be assured they will not be abandoned during an emergency … Emergency instructions given to a patient/ caregiver will be documented in the medical record. If patient needs to leave/ evacuate their home they are to call the Methodist home care office as soon as possible with their new location … 6) During and emergency event supervisory and/ or field staff will contact active patients to evaluate and assist within the patient arrangements concerning evacuation plans, if any …."2. During an observation on 1/21/2022, at 12:56 PM, of a home visit for patient #1, start of care 10/21/2021, the patient's home folder which contained information provided by the home health agency, was reviewed for required information. Review of the home folder failed to evidence an individualized emergency preparedness plan to include the required potential disaster plan and/or specific relocation information. Clinical record review on 1/26/2022, evidenced an agency document titled "SN [Skilled Nurse] OASIS [Outcome and Assessment Information Set] Recertification" electronically signed by RN [Registered Nurse] I on 12/17/2021. This document had an area subtitled "Emergency Plan" that stated "... In the event of an emergency, it is important to identify an emergency contact person, such as a relative, a friend, a neighbor or a roommate. At least one of these individuals should be someone	E0017		

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E0017	Continued from page 2 that would not be affected by an emergency in your community ...." The emergency contact listed was Person F. This section also stated "Mobility Considerations: unable to navigate stairs, wheelchair bound ... Equipment Considerations: access to phone ... Additional Resources: Emergency Preparedness Plan ...." Review evidenced the emergency contact listed was the patients primary caregiver, who would be affected by the same potential disaster as the patient. Review failed to evidence specific emergency preparedness information to include but not limited to emergency contact information, specific shelter information, and transportation needs.3. During an observation on 1/21/2022,at 2:51 PM, of a home visit for patient #2, start of care 7/14/2020, the patient's home folder which contained information provided by the home health agency, was reviewed for required information. Review of the home folder failed to evidence an individualized emergency preparedness plan to include the required emergency contact information, potential disaster plan and/or specific relocation information.Clinical record review on 1/26/2022, evidenced an agency document titled "SN OASIS Recertification" from 1/3/2022, by RN Q. This document had an area subtitled "Emergency Plan" that stated "Teaching provided patient/family to develop emergency plan ... In the event of an emergency, it is important to identify an emergency contact person, such as a relative, a friend, a neighbor or a roommate. At least one of these individuals should be someone that would not be affected by an emergency in your community ...." This section also stated "Police/Fire/Rescue: 911 ... Mobility Considerations: unable to navigate stairs ... Additional Resources: Emergency Preparedness Plan ...." Review failed to evidence an emergency contact listed. Review failed to evidence specific emergency preparedness information to include but not limited to emergency contact information, specific shelter information, and transportation needs. 4. During an observation on 1/25/2022, at 3:42 PM, of a home visit for patient #3, start of care 12/28/2021, the patient's home folder which contained information provided by the home health agency, was reviewed for required information. Review of the home folder failed to evidence an individualized emergency preparedness plan to include the required potential disaster plan and/or specific relocation information.Clinical record review on 1/26/2022, evidenced an agency document titled "SN OASIS	E0017		

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E0017	Continued from page 3 Start of Care" from 12/28/2022, by RN H. This document had an area subtitled "Emergency Plan" that stated "... In the event of an emergency, it is important to identify an emergency contact person, such as a relative, a friend, a neighbor or a roommate. At least one of these individuals should be someone that would not be affected by an emergency in your community ...." The emergency contact listed was Person A. This section also stated "Police/Fire/Rescue: 911 ... Mobility Considerations: bedbound ... Equipment Considerations: access to phone, oxygen is in use ... Additional Resources: Emergency Preparedness Plan ...." Review evidenced the emergency contact listed was the patients primary caregiver, who would be affected by the same potential disaster as the patient. Review failed to evidence specific emergency preparedness information to include but not limited to emergency contact information, specific shelter information, and transportation needs.5. Record review for patient #10 on 1/24/2022, evidenced an agency document titled "SN - OASIS Start of Care" electronically signed by registered nurse L on 9/23/2021, which stated, "Emergency Plan: ... Mobility Considerations: requires assistive device to ambulate, unable to navigate stairs ... Equipment Considerations: access to phone ... Additional Resources: Emergency Preparedness Plan ...." Review failed to evidence specific emergency preparedness information to include, but not limited to: specific shelter information, transportation needs, and an emergency contact who would not be affected by an emergency in the community. 6. During a home visit 1/20/2022, with patient #11, home health aide E, and clinical manager B, review of patient's home folder at 9:20 AM, failed to evidence an individualized emergency preparedness plan with specific relocation information or potential disaster plan.Record review for patient #11 on 1/20/2022, evidenced an untitled agency document which stated, "Emergency Plan ... Emergency Contact #: [Person B] ... Mobility Considerations: bedbound, unable to navigate stairs ... Equipment Considerations: access to phone ... Additional Resources: Emergency Preparedness Plan". Review evidenced Person B lived with the patient and acts as primary caregiver. Review failed to evidence specific emergency preparedness information to include, but not limited to: specific shelter information, transportation needs, and an emergency contact who would not be affected by an emergency in the community. 7. During a home visit 1/20/2022, with	E0017		

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E0017	Continued from page 4 patient #12, physical therapist K, and clinical manager B, review of patient's home folder at 1:15 PM, failed to evidence an individualized emergency preparedness plan with specific relocation information or potential disaster plan.Record review for patient #12, on 1/20/2022, evidenced an untitled agency document which stated, "Emergency Plan: ... Mobility Considerations: requires assistive device to ambulate ... High risk Medications: Anticoagulants ... Additional Resources: Emergency Preparedness Plan". Review failed to evidence specific emergency preparedness information to include, but not limited to: specific shelter information, transportation needs, and an emergency contact who would not be affected by an emergency in the community. 8. Clinical record review on 1/26/2022, for patient #4, start of care 12/18/2021, evidenced an agency document titled "SN OASIS Start of Care" from 12/18/2021, by RN H. This document had an area subtitled "Emergency Plan" that stated "... Police/Fire/Rescue: 911 ... Mobility Considerations: requires assistive device to ambulate … Equipment Considerations: access to phone, pacemaker / defibrillator ... Additional Resources: Emergency Preparedness Plan ...." Review failed to evidence specific emergency preparedness information to include but not limited to specific shelter information, and transportation needs. 9. Clinical record review on 1/26/2022,for patient #5, start of care 10/22/2021, evidenced an agency document titled "SN OASIS Recertification" from 12/21/2021, by RN Q. This document had an area subtitled "Emergency Plan" that stated ".... In the event of an emergency, it is important to identify an emergency contact person, such as a relative, a friend, a neighbor or a roommate. At least one of these individuals should be someone that would not be affected by an emergency in your community .... Police/Fire/Rescue: 911 ... Additional Resources: Emergency Preparedness Plan ...." Review failed to evidence an emergency contact listed. Review failed to evidence specific emergency preparedness information to include but not limited to emergency contact information, specific shelter information, and transportation needs. 10. Clinical record review on 1/26/2022,for patient #6, start of care 12/17/2021, evidenced an agency document titled "SN OASIS Start of Care" from 12/17/2021, by RN J. This document had an area subtitled "Emergency Plan" that stated "... Police/Fire/Rescue: 911 ... Equipment Considerations: access to phone ... High Risk	E0017		

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E0017	Continued from page 5 Medications: Narcotics ... Additional Resources: Emergency Preparedness Plan ...." Review failed to evidence specific emergency preparedness information to include but not limited to specific shelter information, and transportation needs. 11. Clinical record review on 1/26/2022, for patient #7, start of care 11/20/2021, evidenced an undated and unsigned agency document titled "Episode Information." This document had an area subtitled "Emergency Plan" that stated "... Police/Fire/Rescue: 911 ... Mobility Considerations: lives alone, requires assistive device to ambulate ... Equipment Considerations: access to phone, oxygen in use ... Additional Resources: Emergency Preparedness Plan ...." Review failed to evidence specific emergency preparedness information to include but not limited to specific shelter information, and transportation needs. 12. Clinical record review on 1/26/2022, for patient #8, start of care 11/19/2021, evidenced an agency document titled "Episode Information" which was undated and unsigned. This document had an area subtitled "Emergency Plan" that stated "... Police/Fire/Rescue: 911 ... Mobility Considerations: lives alone, requires assistive device to ambulate, unable to navigate stairs ... Additional Resources: Emergency Preparedness Plan ...." Review failed to evidence specific emergency preparedness information to include but not limited to specific shelter information, and transportation needs. 13. Clinical record review on 1/26/2022, for patient #9, start of care 10/14/2021, evidenced an undated and unsigned agency document titled "Episode Information." This document had an area subtitled "Emergency Plan" that stated "... Police/Fire/Rescue: 911 ... Mobility Considerations: bedbound, requires assistive device to ambulate ... Equipment Considerations: access to phone ... Additional Resources: Emergency Preparedness Plan ...." Review failed to evidence specific emergency preparedness information to include but not limited to specific shelter information, and transportation needs. 14. During a home visit on 1/21/2022, with patient #13, registered nurse J, and clinical manager B, review of patient's home instructions at 1:15 PM failed to evidence an individualized emergency preparedness plan with specific relocation information or potential disaster plan.Record review for patient #13 on 1/21/2022 evidenced an untitled agency document which stated, "Emergency Plan ... Mobility Considerations: requires assistive device to	E0017		

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E0017	Continued from page 6 ambulate, unable to navigate stairs ... Equipment Considerations: access to phone, pacemaker/defibrillator ... Additional Resources: Emergency Preparedness Plan". Review failed to evidence specific emergency preparedness information to include, but not limited to: specific shelter information, transportation needs, and an emergency contact who would not be affected by an emergency in the community.15. During a home visit 1/21/2022, with patient #14, registered nurse J, and clinical manager B, review of patient's home folder at 2:15 PM failed to evidence an individualized emergency preparedness plan with specific relocation information or potential disaster plan.Record review for patient #14 on 1/21/2022, evidenced an untitled agency document which stated, "Emergency Plan: Patient/family accepting of emergency plan ... Mobility Considerations: lives along ... Equipment Considerations: access to phone ... Additional Resources: Emergency Preparedness Plan". Review failed to evidence specific emergency preparedness information to include, but not limited to: specific shelter information, transportation needs, and an emergency contact who would not be affected by an emergency in the community. 16. Record review for patient #15 on 1/24/2022 evidenced an untitled agency document which stated, "Emergency Plan ... Mobility Considerations: requires assistive device to ambulate, unable to navigate stairs ... non weight bearing status ... Equipment Considerations: access to phone ... Additional Resources: Emergency Preparedness Plan". Review failed to evidence specific emergency preparedness information to include, but not limited to: specific shelter information, transportation needs, and an emergency contact who would not be affected by an emergency in the community. 17. Record review for patient #16 on 1/25/2022 evidenced an agency document titled "SN - OASIS Start of Care" electronically signed by registered nurse O on 2/15/2021, which stated, "Emergency Plan ... Mobility Considerations: requires assistive device to ambulate, wheelchair bound ... Equipment Considerations: access to phone ... Additional Resources: Emergency Preparedness Plan". Review failed to evidence specific emergency preparedness information to include, but not limited to: specific shelter information and transportation needs. 18. Record review for patient #17 on 1/25/2022 evidenced an agency document titled "SN - OASIS Start of Care" electronically signed by registered nurse I on	E0017		

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E0017	Continued from page 7 4/27/20, which stated, "Mobility Considerations: bedbound, wheelchair bound ... equipment considerations ... access to phone ... Additional Resources: Emergency Preparedness Plan". Review failed to evidence specific emergency preparedness information to include, but not limited to: specific shelter information and transportation needs.19. During an interview on 1/20/2022, at 9:20 AM, administrator A indicated the patient's individualized emergency preparedness plans were accessible electronically to agency staff. 20. During an interview 1/26/2022 at 11:51 AM, administrator A indicated the individualized emergency preparedness plans are in the patient's electronic medical record. Administrator A indicated patient's are instructed to call 911, and given general emergency instructions for fires, tornados, thunderstorms, and snow but have not planned the specific relocations indicating where each patient would go safely in the case of an emergency. Administrator A indicated emergency preparedness plans were not individualized for each patient.	E0017		
E0030	Names and Contact Information CFR(s): 416.54(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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians	E0030		

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E0030	Continued from page 8 (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.	E0030		

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E0030	Continued from page 9 (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).	E0030		

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E0030	Continued from page 10 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the emergency preparedness plan contained contact information for each employee for reference in the event of a potential emergency. The findings include: Record review of an agency policy titled, "Emergency Management Plan" revised June 2021, stated "I. Policy: Prepare for and manage and emergency and restore to the same operational capabilities as pre-emergency levels. To ensure that adequate patient services and staff safety are provided when emergency conditions do not allow normal access to or from patient's home … Phase One – Mitigation: … 2) Home Care will establish priorities of the potential emergencies identified in the hazard vulnerability analysis which will need to have mitigation, preparation, response and recovery activities undertaken and procedures developed. Disasters may include but not limited to: … e. Communication outage … g. Computer services unavailable for clinical or office system … Phase Three – Response: Implementation of the Emergency Management Plan by management and response to the Emergency Management Plan by all staff … 1) Command Structure: The Emergency Management Plan will be implemented upon the direction of the Command Center. The person receiving notification of an emergency will immediately notify the Home Care Manager or designee who will implement the Emergency Management Plan. Every employee is given an updated copy of the Emergency Command Structure if changes are applied and a current copy is kept in the On-call Binder. once staff receives notice of the emergency, all staff is to report to the home care office in person or via telephone to report their work availability status. 2) Corporate Policy will be followed as defined in the Methodist hospitals, Inc. Emergency Operations Plan … The Home Care Manager or designee will notify the command center as to the number and type of employees who are available for assignment ... Phase Four – Recovery: Actions that restore essential services and resume normal activities such as assessment of staff support and dealing with community reaction … 2) Staff is to report to the Home Care office by telephone or in person as soon as possible after the acute emergency has passed. Staff reporting in will be verified against the active employee list. Staff will be	E0030		

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E0030	Continued from page 11 assigned to assess current patients ... 5) Home Care will provide for alternate communication methods in the event of a communication failure such as two way radio equipment and/ or cell phones ….”Record review on 1/20/22, of the agency's emergency preparedness manual, which was a binder of hard copy information. Review of the content in the emergency preparedness binder failed to evidence contact information for home health agency’s employees. Review of the emergency preparedness manual failed to evidence contact information for all employees.During an interview on 1/20/22, at 9:20 AM, administrator A indicated the agency’s employee contact information was not in the binder at the time of review, but will include the it in emergency preparedness plan moving forward.	E0030		
G0000	INITIAL COMMENTS This was a Federal Re-certification, and State licensure survey for a home health agency, conducted by the Indiana Department of Health.Survey Dates: 1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/24/2022, 1/25/2022, and 1/26/2022Facility ID: 003070This deficiency report reflects State Findings cited in accordance with 410 IAC 17.Community Home Care Services, Inc. is precluded from providing its own home health aide training and competency evaluation for a period of two years from 01/26/2022 - 01/25/2024, due to being found out of compliance with Conditions of Participation 484.58 Discharge Planning. Quality Review Completed 02/23/22	G0000		
G0374	Accuracy of encoded OASIS data CFR(s): 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the OASIS [The Home Health Outcome and Assessment Information Set] data was accurate, complete, and reflected the patient’s status in 4 of 17 clinical records reviewed. (#10, #11, #16, #17)The findings include: 1. Review of an agency policy revised July 2021	G0374		

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G0374	Continued from page 12 and obtained 1/26/2022, titled “OASIS Information Reporting” stated “Policy: To define the parameters for OASIS data encoding and electronic transmission as required by the Medicare Conditions of Participation … B. After OASIS data is collected and completed by a qualified Clinician as part of the Comprehensive Assessment at the required time points, Methodist Home Care Services staff may take up to seven (7) calendar days to encode OASIS data into the EPIC computer software. During this time, any errors must be corrected. C. the encoded OASIS data must accurately reflect the patient’s status at the time of assessment. It is the responsibility of the home care to monitor the accuracy of the data and to ensure that the M0090 date falls within the correct time frame”.2. Clinical record review on 1/25/2022 for patient #10, start of care 9/23/2021, certification period 9/23/2021 - 11/21/2021, evidenced a primary diagnosis of multiple sclerosis [a nervous system disease that affects the brain and spinal cord]. Record review evidenced an agency document titled “SN [skilled nurse] – OASIS [The Home Health Outcome and Assessment Information Set] Start of Care” electronically signed by RN [registered nurse] L on 9/23/2021. This document contained a section titled “Mobility” in which sub-sections titled, “GG0170J – Mobility: Walk 50 feet with two turns; GG0179K – Mobility: Walk 150 feet; GG0170L – Mobility: Walking 10 feet on uneven surfaces; GG0170N – Mobility: 4 steps; and GG0170O – Mobility: 12” were all marked as “skipped”. This document failed to ensure OASIS data reflected patient’s status at the time of assessment.Record review for patient #10 evidenced an agency document titled “SN – OASIS Resumption of Care” electronically signed by RN L on 10/7/2021. Section titled “Actions/Narrative” stated “Patient requires assistance with transferring, uses a cane for ambulation”.Review of document titled “PT – Initial Evaluation” electronically signed by PT [physical therapist] M on 10/8/2021 evidenced a section titled “Homebound Status” which stated, “Other homebound reasons: confined to bed/chair, unable to ambulate”. This document evidenced a section titled “Actions/Narrative” which stated, “Patient stated unable to get into motorized wheelchair as mom don’t know how to use it [SIC]… strength in RLE [right lower extremity] is poor – as patient unable to move it at all … Patient transferred from bed to wheelchair using Hoyer lift … Discharge patient as patient is at max rehab at this time.” Record review failed to	G0374		

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G0374	Continued from page 13 ensure OASIS data accurately represented patient's mobility status at the time of assessment.Review of document titled "SN [skilled nurse] – OASIS [Home Health Outcome and Assessment Information Set] Resumption of care", electronically signed by registered nurse L on 10/7/2021, evidenced section titled "Mobility" in which sub-sections titled, "GG0170J – Mobility: Walk 50 feet with two turns; GG0179K – Mobility: Walk 150 feet; GG0170L – Mobility: Walking 10 feet on uneven surfaces; GG0170N – Mobility: 4; and GG0170O – Mobility: 12 steps" were all marked as "skipped". This document failed to ensure OASIS data completely and accurately reflected patient's status at time of assessment. Review of document titled "SN [skilled nurse] – OASIS [Home Health Outcome and Assessment Information Set] Discharge", dated 10/28/2021 and electronically signed by registered nurse L 11/17/2021, evidenced section titled "Mobility" in which sub-sections titled, "GG0170J – Mobility: Walk 50 feet with two turns; GG0179K – Mobility: Walk 150 feet; GG0170L – Mobility: Walking 10 feet on uneven surfaces; GG0170N – Mobility: 4 steps; and GG0170O – Mobility: 12 steps" were all marked as "skipped". This document failed to ensure OASIS data was complete and accurately reflected patient's status at time of the assessment.Review of document titled "SN [skilled nurse] – OASIS [Home Health Outcome and Assessment Information Set] Discharge", dated 10/28/2021, and electronically signed by registered nurse L on 11/17/2021, evidenced a sub-section titled "M2410 0 Inpatient Facility – To which inpatient facility has the patient been admitted?" which stated, "N/A – No inpatient facility admission". Sub-section titled "M2420 – Discharge Disposition – Where is the patient after discharge from your agency?" stated, "Patient remained in the community [without formal assistive services]". Sub-section titled "Discharge Instructions" stated, "discharge to inpatient rehab". Document failed to accurately represent patient's discharge location at time of assessment.During an interview 1/26/2022 at 1:30 PM, administrator A indicated OASIS discharge summary for patient #10, gave an unclear picture of location patient was discharged to, and was an error. Administrator A stated registered nurse L "did not update" the discharge summary to accurately reflect patient's mobility status at time of assessment and the "complex assessment was inaccurate". Administrator A indicated mobility sections on OASIS documents should not have been skipped, and they would instruct staff to make sure all sections are completed.3. Clinical record	G0374		

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G0374	Continued from page 14 review on 1/20/2022 for patient #11, start of care 8/10/2021, certification period 12/8/2021 - 2/5/2022, evidenced a primary diagnosis of multiple sclerosis [a nervous system disease that affects the brain and spinal cord].Record review evidenced an agency document titled “Home Health Certification and Plan of Care” electronically signed by registered nurse I 12/6/2021 which stated, “Medications: Dose/Frequency/Route … Zolpidem [for sleep] 5 MG [milligrams] by mouth nightly … baclofen [for muscle spasms] 10 MG tablets, take 3 tablets by mouth 2 times daily … Ascorbic Acid [vitamin C] 500 MG by mouth daily … trazodone [for depression] 100 MG by mouth nightly … oxybutynin [for urinary incontinence] 5 MG by mouth daily … Calcium-Vitamin D-Vitamin K [for osteoporosis] 2 tablets by mouth 2 times daily … Probiotic Product [for digestion] take 1 capsule by mouth daily … linaclotide [for constipation] 145 MCG [micrograms] by mouth as needed for constipation … lisinopril [for blood pressure] 20 MG by mouth daily … rifaximin [antibiotic] 550 MG by mouth twice daily … bisacodyl [for constipation] 10 MG by mouth daily … lactulose [for constipation] 20 G [grams] by mouth 3 times daily … nystatin powder [for skin infection] 100,000 G topically 2 times daily to bilateral breasts and groin, sacrum, and peri area … Triamcinolone Acetonide [for skin rash] 1 applicator topically two times daily near skin folds”. Clinical record review 1/20/2022 for patient #11, evidenced an agency document titled “SN [skilled nurse] - OASIS [Home Health Outcomes and Assessment Information Set] Transfer w/o DC [discharge]” electronically signed by registered nurse N on 12/14/2021. Document stated, “Medications … M2016 – Patient/Caregiver Drug Education Intervention- At the time of, or at any time since the most recent SOC/ROC [start of care/resumption of care] assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur? NA [not applicable] – Patient not taking any drugs”. Record review failed to evidence accurate documentation in OASIS regarding patient’s medications.During an interview 1/26/2022 at 12:02 PM, administrator A stated the OASIS [Home Health Outcomes and Assessment Information Set] documentation stating patient was not taking any drugs, “was an error”. Administrator A stated they would educate staff on proper documentation of	G0374		

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G0374	Continued from page 15 OASIS data.4. Clinical record review on 1/25/2022 for patient #16, start of care 12/15/2021, certification period 12/15/2021 - 2/12/2022, evidenced a primary diagnosis of malignant neoplasm of prostate [prostate cancer].Record review evidenced an agency document titled “SN [skilled nurse] - OASIS [Home Health Outcomes and Assessment Information Set] Start of Care” electronically signed by registered nurse O on 12/15/2021. Document evidenced a section titled “Mobility” in which sub-sections titled, “GG0170J – Mobility: Walk 50 feet with two turns; GG0179K – Mobility: Walk 150; GG0170L – Mobility: Walking 10 feet on uneven surfaces; GG0170N – Mobility: 4 steps; and GG0170O – Mobility: 12 steps” were all marked as “skipped”. This document failed to include necessary documentation of patient's mobility status to accurately reflect patient's status. 5. Clinical record review on 1/25/2022 for patient #17, start of care 4/27/2020, certification period 12/18/2021-2/15/2022, evidenced a primary diagnosis of neuromuscular dysfunction of bladder [when a person lacks bladder control due to brain, spinal cord or nerve problems].Record review evidenced an agency document titled “SN [skilled nurse] – OASIS [Home Health Outcome and Assessment Information Set] Recertification” electronically signed by registered nurse I 12/14/2021. This document evidenced a section titled “Mobility” in which sub-sections titled, “GG0170J – Mobility: Walk 50 feet with two turns; GG0179K – Mobility: Walk 150; GG0170L – Mobility: Walking 10 feet on uneven surfaces; and GG0170N – Mobility: 4 steps” were all marked as “skipped”. This document failed to include necessary documentation of patient's mobility status to accurately reflect patient's status. During an interview on 1/26/2022 at 1:40 PM, Administrator A indicated OASIS [Home Health Outcomes and Assessment Information Set] was incomplete and inaccurate due to sections that were marked “skipped”. Administrator A indicated OASIS data should have all sections filled in to be complete.	G0374		
G0436	Receive all services in plan of care CFR(s): 484.50(c)(5) Receive all services outlined in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview,	G0436		

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G0436	Continued from page 16 the home health agency failed to ensure patients received all services outlined in the plan of care in 3 of 12 active records reviewed. (#11, #12, #17)The findings include: 1. Review of an agency policy obtained 1/26/2022, revised August 2021, titled “Plan of Care” stated, “Policy: … K. Staff providing services under arrangement or contract must participate in the development of the Plan of Care, deliver services according to the Plan, and notify the physician of any changes in the patient’s condition, per home care policy”.2. Review of an undated agency document 1/26/2022, titled "Home Health Care Patient Bill of Rights" stated, "Patients/Representatives have the right to: Participate in, and be informed about, and consent or refuse care in advance of and during treatment with respect to: ... The care to be furnished, based on the comprehensive assessment ... The frequency of visits ... Any changes in the care to be furnished ... Receive all services outlined in the plan of care".3. Clinical record review for patient #11, start of care 8/10/2021, certification period 12/8/2021 - 2/5/2022, evidenced a primary diagnosis of multiple sclerosis [a nervous system disease that affects the brain and spinal cord].Clinical record review for patient #11 evidenced an untitled agency document which stated, “Care Plan … Aide … Visits: … 3 visits every week for 8 weeks-12/12/2021 to 2/5/2022, 1 visit every week for 1 week-1/2/2022 to 1/8/2022, 2 visits every week for 4 weeks-1/9/2022 to 2/5/2022”.Clinical record review for patient #11, evidenced an agency document titled “Home Health Certification and Plan of Care” electronically signed by registered nurse I 12/6/2021, which stated, “Certification Period: From 12/8/21 To: 2/5/2022 ... Orders for Discipline and Treatments … Aide: …12/12/2021 to 2/5/2022: 3 visits every week for 8 weeks”.During a home visit for patient #11 on 1/20/2022 at 9:00 AM, person B stated patient #11 was supposed to get 3 aide visits a week, but the home health agency changed aide visit frequency to 2 visits a week due to short staffing, even when patient #11 and caregiver did not want to decrease visit frequency. Person B stated they needed 3 aide visits a week for patient #11. Agency failed to provide 3 visits a week to patient #11, as ordered on plan of care.During an interview 1/18/2022 at 9:38 AM, administrator A stated, "due to having only 1 home health aide," the agency had called each patient and cut visits from 3 times a week to	G0436		

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G0436	Continued from page 17 1 or 2 times a week when possible and held off on taking referrals if the agency couldn't handle the additional patients.During an interview 1/26/2022 at 11:50 AM, administrator A indicated the agency had increased patient #11's visits to 3 times a week again after home visit on 1/20/2022.4. Clinical record review on 1/20/2022 for patient #12, start of care 1/11/2022, certification period 1/11/2022 - 3/11/2022, evidenced a primary diagnosis of encounter for other orthopedic aftercare [care after hip surgery]. Record review for patient #12 evidenced an agency document titled "Home Health Certification and Plan of Care", for certification period 1/11/2022 - 3/11/2022, which stated, "Orders for Discipline and Treatments … PT [physical therapy]: … Each Visit … Assess patient's incision at every visit and document on the WLDA [wounds, lines, drains, and airways] … Measure incision weekly and document on the WLDA".Record review for patient #12 evidenced an untitled agency document which stated, "Wound Assessment … Incision Hip Lateral; Right". This document failed to evidence any incision measurements during home visits on 1/11/2022, 1/13/2022, 1/15/2022, 1/18/2022, and 1/19/2022.Observation of a home visit was conducted on 1/20/2022 for patient #12. This home visit was conducted with physical therapist K and clinical manager B. At 1:00PM, physical therapist K failed to be observed assessing and measuring the patient's right hip incision. The surveyor failed to observe any measurement of the patient's right hip incision by time of exit at 1:47 PM.During an interview on 1/26/2022 at 12:10 PM, administrator A indicated the physical therapist is responsible for assessing patient #12's incision every visit. Administrator A stated the physical therapist had not documented measurement of incision weekly as ordered. 5. Clinical record review for patient #17, start of care 4/27/20, certification period 12/8/2021 - 2/5/2022, evidenced a primary diagnosis of neuromuscular dysfunction of bladder [when a person lacks bladder control due to brain, spinal cord or nerve problems].Clinical record review for patient #17 evidenced an agency document titled "Home Health Certification and Plan of Care", for certification period 12/8/2021 - 2/5/2022, electronically signed by registered nurse I on 12/14/2021. This document stated, "Orders for Discipline and Treatments: … Change catheter … Perform latex change every month using 16 French cath [catheter] with 5ml [milliliter] balloon".Record review evidenced an untitled	G0436		

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G0436	Continued from page 18 agency document which indicated patient had a Foley catheter placed 10/15/2021 by registered nurse I, and was removed 12/1/2021 by registered nurse I. Document indicated that there were 47 days between catheter changes. Agency failed to ensure patient #17 received catheter change monthly as ordered in plan of care.During an interview on 1/26/2022 at 1:16 PM, administrator A stated plan of care orders should be followed, and patient #17's Foley catheter should have been changed before 47 days.	G0436		
G0454	HHA can no longer meet the patient's needs CFR(s): 484.50(d)(1) The transfer or discharge is necessary for the patient's welfare because the HHA and the physician or allowed practitioner, who is responsible for the home health plan of care agree that the HHA can no longer meet the patient's needs, based on the patient's acuity. The HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHA's capabilities; This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure they arranged an appropriate transfer to another healthcare entity that could meet the needs of the patient in 1 of 7 home visits conducted. (#11)The findings include: Review of an agency policy obtained 1/26/2022, revised August 2021, titled "Patient Rights & Responsibilities" stated, "Rights of patients … include: … M. Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to: … the care to be furnished, based on the comprehensive assessment … the frequency of visits ... expected outcomes of care, including patient-identified goals, and anticipated risks and benefits … any factors that could impact treatment effectiveness … any changes in the care to be furnished".Review of an agency policy obtained 1/26/2022, revised August 2021, titled "Discharge & Transfer" stated, "11. The HHA [home health agency] and physician responsible for the plan of care agree that the patient's needs can no longer be met by the HHA based on the patient's acuity. The HHA must arrange a safe and	G0454		

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G0454	Continued from page 19 appropriate transfer to other care entities when the needs of patient exceed the HHA's capabilities".Clinical record review 1/20/2022 for patient #11, start of care 8/10/2021, certification period 12/8/2021 - 2/5/2022, evidenced a primary diagnosis of multiple sclerosis [a nervous system disease that affects the brain and spinal cord].Clinical record review for patient #11 evidenced an untitled agency document which stated, "Care Plan … Aide … Visits: … 3 visits every week for 8 weeks-12/12/2021 to 2/5/2022, 1 visit every week for 1 week-1/2/2022 to 1/8/2022, 2 visits every week for 4 weeks-1/9/2022 to 2/5/2022".Clinical record review for patient #11, evidenced an agency document titled "Home Health Certification and Plan of Care", for certification period 12/8/2021 - 2/5/2022, electronically signed by registered nurse I 12/6/2021, which stated, "Orders for Discipline and Treatments … Aide: …12/12/2021 to 2/5/2022: 3 visits every week for 8 weeks".Observation during a home visit for patient #11 on 1/20/2022 at 9:00 AM, person B stated patient #11 was supposed to get 3 aide visits a week, but the home health agency changed aide visit frequency to 2 visits a week due to short staffing, even when patient #11 and caregiver did not want to decrease visit frequency. Person B indicated they needed 3 aide visits a week for patient #11. Agency failed to offer other resources or additional interventions to resolve caregiver's request. Interview failed to evidence home health agency had arranged appropriate transfer to other care entities when needs of the patient exceeded the agency's capabilities.During an interview 1/18/2022 at 9:38 AM, administrator A stated, "due to having only 1 home health aide," the agency had called each patient and cut visits from 3 times a week to 1 or 2 times a week when possible and held off on taking referrals if the agency couldn't handle the additional patients.During an interview 1/26/2022 at 11:50 AM, administrator A stated the agency had increased patient #11's visits to 3 times a week again after home visit on 1/20/2022.	G0454		
G0560	Discharge Planning CFR(s): 484.58 Condition of Participation: Discharge planning. This CONDITION is NOT MET as evidenced by:	G0560		

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G0560	Continued from page 20 Based on record review and interview, the home health agency failed to develop and implement an effective discharge planning process for the agency. The agency failed to ensure they sent discharge summaries with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences for 5 of 5 discharge records reviewed. (#7, #8, #9, #10, #15) (see tag 564) The agency failed to assist patients in selecting post-acute care providers using quality measures data and resource use measures in 2 of 2 transfer records reviewed. (#7, #10) (see tag G562)Standard level tags were also cited (G562, G564) under this condition. This practice had the potential to affect all agency patients.The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR §484.58: Discharge planning.	G0560		
G0562	Discharge Planning CFR(s): 484.58(a) Standard: Discharge planning. An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. This STANDARD is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure an effective discharge process, failed to assist patients/caregivers in selecting post-acute care providers and failed to share data on quality measures with patients during discharge process for 2 of 2 patients transferred to an emergency department (ED), from a total of 5 discharged clinical records reviewed. (#7, #10)The findings include:	G0562		

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

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G0562	Continued from page 21 1. Review of an agency policy obtained 1/26/2022, revised August 2021, titled, “Discharge & Transfer” stated “Policy: At the time of admission the clinician will begin planning for the patient’s discharge. Discharge plans will be documented in the plan of care. The patient/legal representative will participate in planning for discharge or transfer. The staff will notify the patient/legal representative of reasons for discharge and changes in the plan as they affect the discharge plans. Staff will educate the patient and/or family in self-care, management of medical and health needs, use of community resources, available alternatives, and other appropriate information. Verbal discharge instructions will be provided … The patient/ legal representative or other individual responsible for the patient’s care will be given at least fifteen calendar day notice before services are discontinued … Transfer: transfer to another organization will occur when appropriate and the patient meets discharge criteria. Home care and attending physician will be responsible for the patient during the transfer process. The receiving organization and patient’s physician will be provided with all relevant written or verbal information including: 1) reason for transfer 2) patient’s physical and pertinent psychological status 3) current needs necessitating intervention 4) summary of the care and services provided 5) progress towards achieving identified goals 6) all medication, instructions and/or referral information provided to the patient 7) advance directive information … Discharge/Transfer Summary: A completed discharge summary will be 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 within five business days of the patient discharge … A completed transfer summary will be sent to the health care facility within two business days of a planned transfer, if the patient’s care will immediately continue in a health care facility. A completed transfer summary will be sent within two business days to the health care facility and/or responsible health care provider upon becoming aware of an unplanned transfer”.2. Clinical record review on 1/24/2022 for patient #10, start of care 9/23/2021, discharged 10/28/2021, evidenced a primary diagnosis of multiple sclerosis (exacerbation), [a nervous system disease that affects the brain and spinal cord].Record review	G0562		

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G0562	Continued from page 22 1/24/2022 for patient #10 evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 9/23/2021 - 11/21/2021, electronically signed by registered nurse L on 9/20/2021. Document stated “Discharge Plans … At discharge patient will remain at home, with physician follow-up, live with family member”.Review on 1/24/2022 of agency document titled “OASIS Start of Care” electronically signed by registered nurse L on 9/23/2021 contained section titled “Mobility GG0170” which stated “Roll Left and Right … Discharge Goal: Independent … Sit to Lying … Discharge Goal: Setup or clean-up assistance … Lying to Sitting on Side of Bed … Discharge Goal: Setup or clean-up assistance … Chair/Bed-to-chair Transfer … Discharge Goal: Supervision or touching assistance".Review on 1/24/2022 of agency document titled “Case Communication” electronically signed by registered nurse L on 11/17/2021 stated, “Spoke with patient mother, informed that patient is in an inpatient rehab [rehabilitation] facility … Patient discharged from home health services”.Record review on 1/24/2022 evidenced an agency document titled “Discharge” electronically signed by registered nurse L on 11/17/2021. Document stated, “Reason for Discharge: Patient in rehab facility … Alterations in the Plan of Care: no … Date of Last Home Visit: 10/28/2021”.Review on 1/24/2022 of agency document titled “SN-OASIS Discharge” electronically signed by registered nurse L on 10/28/2021 and 11/17/2021 stated “Plan for next visit: 11/19/2021”. Document failed to evidence discharge to rehabilitation facility had been discussed in advance with patient.Review on 1/24/2022 of agency document titled “SN-OASIS Discharge” electronically signed by registered nurse L on 10/28/2021 and 11/17/2021 stated “Goal Status on Discharge: Goals met”.Review on 1/24/2022 of agency document titled “SN-OASIS Discharge” electronically signed by registered nurse L on 10/28/2021 and 11/17/2021 contained section titled “Mobility GG0170” which stated “Roll Left and Right … Discharge Performance: Supervision or touching assistance … Sit to Lying … Discharge Performance: Partial/moderate assistance … Lying to Sitting on Side of Bed … Discharge Performance: Partial/moderate assistance … Chair/Bed-to-chair Transfer … Discharge Performance: Partial/moderate assistance”. Document failed to evidence goals were met at discharge.Record review failed to evidence actual date that patient #10 transferred to inpatient rehab. Record review failed to evidence that	G0562		

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G0562	Continued from page 23 agency had assisted patient #10 with selecting post-acute care provider. Record review failed to evidence the agency had provided patient with quality measures data and resource use data to select inpatient rehabilitation facility.During an interview on 1/26/2022 at 1:34 PM, administrator A indicated the agency did not find out about patient #10 being transferred to inpatient rehabilitation until registered nurse L contacted patient about setting up a visit on 11/17/2021. Administrator A stated they did not know what day patient #10 had transferred to inpatient rehabilitation. Administrator A indicated agency did not assist patient in selecting the inpatient rehabilitation facility or provide quality measures/resource use measures data for patient.3. Clinical record review on 1/26/2022, for patient #7, start of care 11/20/2021, certification period 11/20/2021 - 1/18/2022, diagnoses include but were not limited to sepsis [potentially life-threatening infection], pneumonia [infection that inflames one or both lungs, and may be filled with fluid], evidenced an agency document titled, “Case Communication” from 12/21/2021, and signed by RN R. This document had an area subtitled “Communication Notes” which stated “Topic discussed: Re-admission inpatient hospitalization … Communication details: Patient was discharged from [Entity I] on 12-17-21. Methodist HHC [home health care] received a ROC [resumption of care]/order on 12-20-21. Patient re-admitted to [Entity I] ED Inpatient on 12-21-21 with shock, sepsis, hypotension [low blood pressure], and possible pneumonia ….” Review evidenced the patient was discharged from Entity I on 12/27/2021. Review of the clinical record failed to evidence a discharge summary. Review failed to evidence the disposition of the patient. Review failed to evidence Entity I or the patient’s physician received a discharge summary of the patient’s pertinent information.During an interview on 1/26/2022, at 12:31 PM, administrator A stated that in this situation, the patient "must have fallen off the board" and indicated the case manager failed to follow up with the patient's status as a result.	G0562		
G0564	Discharge or Transfer Summary Content CFR(s): 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical	G0564		

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G0564	Continued from page 24 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to send discharge summaries containing pertinent medical information, goals of care, and treatment preferences to receiving facility or practitioner in 5 of 5 closed clinical records reviewed. (#7, #8, #9, #10, #15)The findings include: 1. Review of an agency policy obtained 1/26/2022, revised August 2021, titled, “Discharge & Transfer” stated “Policy: At the time of admission the clinician will begin planning for the patient’s discharge. Discharge plans will be documented in the plan of care. The patient/legal representative will participate in planning for discharge or transfer. The staff will notify the patient/legal representative of reasons for discharge and changes in the plan as they affect the discharge plans … Transfer: transfer to another organization will occur when appropriate and the patient meets discharge criteria. Home care and attending physician will be responsible for the patient during the transfer process. The receiving organization and patient’s physician will be provided with all relevant written or verbal information including: 1) reason for transfer 2) patient’s physical and pertinent psychological status 3) current needs necessitating intervention 4) summary of the care and services provided 5) progress towards achieving identified goals 6) all medication, instructions and/or referral information provided to the patient 7) advance directive information … Discharge/Transfer Summary: A completed discharge summary will be 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 within five business days of the patient discharge … A completed transfer summary will be sent to the health care facility within two business days of a planned transfer if the patient’s care will immediately continue in a health care facility. A completed transfer summary will be sent within two business days to the health care facility and/or responsible health	G0564		

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G0564	Continued from page 25 care provider upon becoming aware of an unplanned transfer".2. Clinical record review on 1/24/2022 for patient #10, start of care 9/23/2021, certification period 9/23/2021 - 11/21-2021 , evidenced a primary diagnosis of multiple sclerosis (exacerbation), [a nervous system disease that affects the brain and spinal cord].Clinical record review 1/24/2022 for patient #10 evidenced agency document titled "Case Communication" electronically signed by registered nurse L on 11/17/2021 which stated, "Spoke with patient mother, informed that patient is in an inpatient rehab [rehabilitation] facility … Patient discharged from home health services".Record review on 1/24/2022 evidenced an agency document titled "Discharge" electronically signed by registered nurse L on 11/17/2021. Document stated, "Reason for Discharge: Patient in rehab [rehabilitation] facility … Alterations in the Plan of Care: no … Date of Last Home Visit: 10/28/2021". Record review failed to evidence agency had sent a discharge summary or transfer summary to inpatient rehab facility. During an interview on 1/26/2022 at 11:34 AM, administrator A stated, "discharge summaries get entered the date of the last home visit". During an interview on 1/26/2022 at 1:34 PM, administrator A indicated the agency did not find out about patient #10 being transferred to inpatient rehab until registered nurse L contacted patient about setting up a visit on 11/17/2021. Administrator A indicated the agency had not updated discharge plan to meet patient discharge needs. Administrator A stated they did not know what day patient #10 had transferred to inpatient rehab. Administrator A stated they did not know if discharge summary/transfer summary had been sent to inpatient rehab facility.3. Clinical record review on 1/24/2022 for patient #15, start of care 9/9/2021, certification period 9/9/2021 - 11/7/2021, evidenced a primary diagnosis of orthopedic aftercare following surgical amputation [care after amputation]. Clinical record review for patient #15 evidenced an agency document titled, "Case Communication" electronically signed by physical therapist K on 9/28/2021 which stated, "Patient admitted to the hospital due to wound infection".Record review evidenced an agency document titled, "Case Communication" electronically signed by registered nurse J on 9/29/2021 which stated, "Patient admitted to inpatient".Record review evidenced an agency document dated 10/1/2021, titled, "Case Communication" electronically signed by registered	G0564		

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G0564	Continued from page 26 nurse C, which stated, “patient transferred to ... [Hospital E] ... for surgery”.Record review evidenced an agency document which was titled “SN [skilled nurse]-OASIS [Home Health Outcome and Assessment Information Set] Transfer w/o DC [discharge]” electronically signed by registered nurse C on 10/4/2021. Review failed to evidence a discharge summary was completed or sent to hospital. Record review Record review failed to evidence patient treatment preferences, goals of care, and relevant medical information were sent to the hospital upon transfer. Record review failed to evidence any discharge OASIS was completed. Record review failed to evidence agency follow-up with patient regarding discharge planning after hospital admission.During an interview on 1/26/2022 at 11:34 AM Administrator A stated, “discharge summaries get entered the date of the last home visit”.During an interview on 1/26/2022 at 11:32 AM, administrator A indicated agency did not know whether patient #15 was still in hospital or had returned home. Administrator A indicated a discharge summary was not completed, and if a patient does not return to agency after hospital discharge, a discharge summary should be completed.4. Clinical record review on 1/26/2022, for patient #7, start of care 11/20/2021, diagnoses include but were not limited to sepsis [potentially life-threatening infection], pneumonia [infection that inflames one or both lungs, and may be filled with fluid], evidenced an agency document titled, “Home Health Certification and Plan of Care” for certification period 11/20/2021 – 1/18/2022, which was electronically signed by the physician on 12/31/2021. This document had an area subtitled “21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)” that stated “PT [physical therapist]: … 11/24/2021 to 12/18/2021: 2 visits every week for 4 weeks … SN [skilled nurse]: … 11/21/2021 to 12/18/2021: 2 visits every week for 4 weeks. Review evidenced PT and SN services was ordered for this patient. Record review of an agency document titled “Case Communication” from 12/16/2021, and signed by RN [Registered Nurse] R. This document had an area subtitled “Communication Notes” which stated “Topic discussed: Inpatient Hospitalization … Relationship to patient: home care staff … Communication details: Patient switched from observation to inpatient on 12-15-21 at [Entity I] ….” Record review of an agency document titled “SN – OASIS Transfer w/o [without] DC [discharge]” which was signed by RN R on 12/16/2021. Review of	G0564		

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G0564	Continued from page 27 the clinical record evidenced the patient went to the emergency department (ED) on 12/12/2021, and was placed on an observation status until 12/15/2021, when Entity I made placed the patient on an inpatient status. Record review of an agency document titled “Case Communication” from 12/21/2021, and signed by RN R. This document had an area subtitled “Communication Notes” which stated “Topic discussed: Re-admission inpatient hospitalization … Communication details: Patient was discharged from [Entity I] on 12-17-21. Methodist HHC [home health care] received a ROC [resumption of care]/order on 12-20-21. Patient re-admitted to [Entity I] ED Inpatient on 12-21-21 with shock, sepsis, hypotension [low blood pressure], and possible pneumonia ….” Review evidenced the patient was discharged from Entity I on 12/27/2021. Review of the clinical record failed to evidence a discharge summary. Review failed to evidence the disposition of the patient. Review failed to evidence Entity I or the patient’s physician received a discharge summary of the patient’s pertinent information.During an interview on 1/26/2022, at 11:33 AM, administrator A indicated if a patient was transferred as "Transfer without discharge" without a ROC, the case manager would discharge when they find out the patient would not come back or is placed at another agency/facility.5. Clinical record review on 1/26/2022, for patient #8, start of care 11/19/2021, primary diagnosis post total knee replacement evidenced an agency document titled, “Home Health Certification and Plan of Care” for certification period 11/19/2021 – 1/17/2022, which was electronically signed by the physician on 12/9/2021. This document had an area subtitled “21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)” that stated “PT: … 11/21/2021 to 12/4/2021: 3 visits every week for 2 weeks … SN: … 11/24/2021 to 1/15/2021: 2 visits every week for 8 weeks ..." Another area subtitled "Goals" stated "Potential for post-op [operative] complications ... Patient/caregivers will verbalize understanding of post-op care including infection control, prevention of deep vein thrombosis [blood clots], prevention of constipation and patient specific precautions throughout the service period ...."Record review of an agency document titled “Case Communication” from 11/24/2021, and signed by RN L. This document had an area subtitled “Communication Notes” which stated “… PT on hold until further notice ….” Review evidenced the patient's surgical wound had been draining more than normal for the total knee	G0564		

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G0564	Continued from page 28 replacement surgery. Review evidenced PT was put on hold, and SN services started on 11/24/2021. Record review of an agency document titled “SN - OASIS Discharge” signed by RN L, on 12/7/2021. This document had an area subtitled "Discharge Plans" which stated "Reason for Discharge: Goals met ... Discharge from: Nursing ... Alterations in the Plan of Care: No ...." Review evidenced the patient was discharged from SN services. Review evidenced an alteration in the plan of care. Review failed to evidence the patient was discharged from PT. Review failed to evidence PT goals were met as ordered on the plan of care. Review failed to evidence accurate documentation of patients progress towards PT goals at the time discharge.6. Clinical record review on 1/26/2022, for patient #9, start of care 10/14/2021, primary diagnosis post total knee replacement evidenced an agency document titled, “Home Health Certification and Plan of Care” for certification period 11/19/2021 – 1/17/2022, which was electronically signed by the physician on 10/13/2021. Record review of an agency document titled “Case Communication” from 11/27/2021, and signed by RN I. This document had an area subtitled “Communication Notes” which stated “Communication details: On-call service called to report that the patient was admitted into hospice for further care ….” Review of this document evidenced the patient was transferred to hospice services on 11/27/2021.Record review of an agency document titled "SN - OASIS Discharge" which was signed by RN P on 12/6/2021. This document had an area subtitled "Actions/Narrative" that stated "SN received message patient transferred to Hospice care and to discharge from Methodist home care service.... " Review of this document evidenced the patient was discharged on 12/6/2021. Review evidenced the patient was discharged from the home health agency 10 days after transfer to Hospice care. Review failed to evidence the hospice agency received a discharge summary within 48 hours as required. 7. During an interview on 1/26/2022, at 11:30 AM, administrator A indicated the process to follow a patient admitted to the ED consisted of the case manager to follow up on the patient's status to establish if the patient will be an inpatient status in the hospital. 8. During an interview on 1/26/2022, at 11:35 AM, administrator A indicated a discharge summary would be sent to the physician when the discharge order is put in and received. The administrator indicated the discharge assessment is the last visit in the home.	G0564		

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G0564 G0572	Plan of care CFR(s): 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 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the plan of care's frequency and duration was followed by every discipline as ordered by the physician for 1 of 7 patients where a home visit was conducted, from a total of 12 active records reviewed. (#3) Record review of an agency policy titled "Plan of Care" revised August 2021, stated "Policy: ... To establish guidelines that promotes 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 in consultation with the physician ...." Clinical record review on 1/26/2022, for patient #3, start of care 12/28/2021, primary diagnosis congestive heart failure (CHF, chronic condition in which the heart does not pump blood as well as it should), evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 12/28/2021 - 2/25/2022, and electronically signed by the patient’s physician on 1/16/2022. This document had an area subtitled “21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)” which stated “… SN [skilled nurse] … 1/2/2022 to 1/15/2022: 2 visits every week for 2 weeks ….”Record review of agency documents titled “SN Home Visit” evidenced SN visits were conducted on 1/4/2022, 1/6/2022, and 1/12/2022. Review failed to evidence missed visit documentation for the second week of visits.	G0564 G0572		

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G0572	Continued from page 30 Review failed to evidence SN visits were conducted twice a week for 2 weeks, as ordered by the physician on the plan of care. Review failed to evidence a missed visit note or physician notification. Review failed to evidence the patient's need were met as indicated in the agency's policy. During an interview on 1/26/2022, at 11:18 AM, administrator A indicated the process to follow a missed visit was to document in the clinical record the reason for the missed visit and send to the patient's physician.	G0572		
G0574	Plan of care must include the following CFR(s): 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; (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	G0574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157536	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/26/2022

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

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G0574	Continued from page 31 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. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the individualized plan of care included all medications and treatments, safety measures to protect against injury, and the frequency and duration of treatments in 5 of 12 active clinical records reviewed. (#5, #6, #11, #13, #16)The findings include: 1. Review of an agency policy obtained 1/26/2022, revised August 2021, titled “Plan of Care” stated, “Policy: … 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 in consultation with the physician … 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 … 3) Specific modalities & amount of therapy services … 4) PRN (as needed) visits with a specified number and reason … 5) Prescribed medications with dose, route, and frequency … 6) Over-the-counter medications which staff will administer and/or pour … 7) Mental status … 8) Goals & Prognosis … 9) Rehabilitation Potential …. 10) Discharge Plan … 11) Functional Limitations … 12) Activities permitted … 13) Nutritional requirements … 14) Any safety measures to protect against injury … 15) Instruction for timely discharge or referral and any other appropriate items … G. All drugs and treatments ordered by the physician will be incorporated into the Plan of Care. All other drugs and treatments observed by the nurse on assessment will also be incorporated into the Plan of Care”.2. Clinical record review on 1/20/2022 for patient #11, start of care 8/10/2021, certification period 12/8/2021-2/5/2022, evidenced a primary diagnosis of multiple sclerosis [a nervous system disease that affects the brain and spinal cord].Clinical record review for patient	G0574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157536	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/26/2022

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G0574	Continued from page 32 #11 evidenced a document titled “Home Health Certification and Plan of Care” for certification period 12/8/2021 - 2/5/2022, electronically signed by registered nurse I 12/6/2021 which stated, “Medications: Dose/Frequency/Route … Zolpidem [for sleep] 5 MG [milligrams] by mouth nightly … baclofen [for muscle spasms] 10 MG tablets, take 3 tablets by mouth 2 times daily … Ascorbic Acid [vitamin C] 500 MG by mouth daily … trazodone [for depression] 100 MG by mouth nightly … oxybutynin [for urinary incontinence] 5 MG by mouth daily … Calcium-Vitamin D-Vitamin K [for osteoporosis] 2 tablets by mouth 2 times daily … Probiotic Product [for digestion] take 1 capsule by mouth daily … linaclotide [for constipation] 145 MCG [micrograms] by mouth as needed for constipation … lisinopril [for blood pressure] 20 MG by mouth daily … rifaximin [antibiotic] 550 MG by mouth twice daily … bisacodyl [for constipation] 10 MG by mouth daily … lactulose [for constipation] 20 G [grams] by mouth 3 times daily … nystatin powder [for skin infection] 100,000 G topically 2 times daily to bilateral breasts and groin, sacrum, and peri area … Triamcinolone Acetonide [for skin rash] 1 applicator topically two times daily near skin folds”.Observation of a home visit was conducted on 1/20/2022 at 8:45 AM for patient #11. The home visit was conducted with home health aide E and clinical manager B. At 9:00 AM, caregiver B provided patient #11’s home medications for review. Review of patient’s home medications evidenced baclofen [for muscle spasms] 10 MG [milligram] tablets, take 3 tablets by mouth 2 times a day; oxybutynin [for urinary incontinence] 5 MG by mouth daily; and Methenamine Hippurate [for urinary tract infection] 1 G [gram] by mouth 2 times daily. Observation failed to evidence that plan of care contained complete and accurate medication list compared to medications patient taking at home.During an interview 1/26/2022 at 11:53 AM, administrator A indicated the plan of care medication list was not accurate or updated with all of patient’s medications.3. Clinical record review on 1/21/2022 for patient #13, start of care 12/26/2021, certification period 12/26/2021 - 2/23/2022, evidenced a primary diagnosis of pleural effusion [a buildup of fluid between the tissues that line the lungs and the chest]. Record review evidenced an unsigned agency document titled “Outpatient Medications on the Plan of Care” which listed the following medications: “aspirin [to prevent blood clots] 81 MG [milligram] chewable tablet - take 240 MG by mouth daily; bumetanide [for swelling] 2 MG PO [by	G0574		

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G0574	Continued from page 33 mouth] tablet; carvedilol [for blood pressure] 25 MG tablet - take one tablet by mouth twice daily with meals; glipizide [for blood sugar] 10 MG tablet - take 10 MG by mouth 2 times daily before meals; hydrocodone-acetaminophen [for pain] 5-325 MG per tablet - take 1 tablet by mouth every 8 hours as needed for pain; losartan [for blood pressure] 100 MG tablet - take one tablet by mouth once daily; lovastatin [for cholesterol] 40 MG PO tablet - take 40 MG by mouth nightly; Melatonin [for sleep] 1 MG capsule - take 1 tablet by mouth nightly x1; metolazone [for swelling] 2.5 MG PO tablet - take 2.5 MG by mouth; Novolin [for blood sugar] 70/30 100 unit/ML [milliliter] SC [subcutaneous] suspension - 2 times daily; pantoprazole [for stomach acid] 40 MG PO tablet - take 40 mg by mouth; warfarin [for blood clots] 2.5 MG PO tablet – take 1 tablet by mouth daily".Observation of a home visit was conducted on on 1/21/2022 at 1:00 PM for patient #13. The home visit was conducted with registered nurse J and clinical manager B. Review of patient's home medications at 1:15 PM, evidenced the following medications not included in plan of care: "finasteride[for prostate] 5 MG [milligram] by mouth daily, potassium chloride [electrolyte] 20 milliequivalent by mouth twice a day, Flomax [for prostate] 0.4 MG by mouth daily, colestipol [for cholesterol] 1 gram by mouth daily, gabapentin [for nerve pain] 300 MG by mouth three times a day, and Jardiance [for diabetes] 10 MG by mouth daily".During this home visit on 1/21/2022 a review of patient's home medications was conducted at 1:15 PM. Review failed to evidence patient was taking the following medications which were listed on the plan of care: aspirin [to prevent blood clots] 240 MG by mouth daily, hydrocodone-acetaminophen [for pain] 5-325 MG by mouth every 8 hours as needed for pain, losartan [for blood pressure] 100 MG tablet by mouth daily, melatonin [for sleep] 1 MG by mouth nightly, and pantoprazole [for stomach acid] 40 MG by mouth.Review of patient #13's home medications evidenced patient was taking carvedilol [for blood pressure] 6.25 MG by mouth twice a day, and glipizide [for blood sugar] 5 MG by mouth twice a day, which differed from dosage on plan of care.During an interview 1/26/2022 at 12:11 PM, administrator A indicated the plan of care medication list did not include all medications patient was taking, and plan of care should list all medications patient is taking.Clinical record review 1/21/2022 for patient #13 evidenced an agency document titled "Home Health Certification	G0574		

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G0574	Continued from page 34 and Plan of Care" for certification period 12/26/2021 - 2/23/2022, electronically signed by registered nurse J 12/26/2021. This document contained a section titled "Safety Measures" which failed to ensure bleeding precautions were in effect for a patient taking blood thinners.During an interview 1/26/2022 at 12:14 PM, administrator A indicated bleeding precautions should be listed as safety measures for patients taking blood thinners.4. Clinical record review for patient #16, start of care, 12/15/2021, certification period 12/15/2021-2/12/2022, evidenced a primary diagnosis of malignant neoplasm of prostate [prostate cancer]. Record review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 12/15/2021 - 2/12/2022, electronically signed 12/10/2021 by registered nurse O, which stated, "Orders for Discipline and Treatments … PT [physical therapy] 12/16/2021 to 12/18/2021: 1 visit every week for 1 week … 12/19/2021 to 1/15/2022: 2 visits every week for 4 weeks … SN [skilled nursing] 12/15/2021 to 1/8/2022: 2 visits every week for 4 weeks". Document failed to evidence current treatment frequency and visit schedule ordered through end of certification period 2/12/2022.Clinical record review of an untitled agency document evidenced section titled "Care Plan" which stated, "Aide … Visits …. 1 visit every week for 1 week … 1/9/2022 to 1/15/2022 … 2 visits every week for 3 weeks … 1/16/2021 to 2/5/2022 … PT … Visits … 2 visits every week for 3 weeks … 1/16/2022 to 2/5/2022 … SN … Visits … 2 visits every week for 4 weeks … 1/9/2022 to 2/5/2022". Record review failed to evidence plan of care was updated with correct frequency and duration of visits.During an interview on 1/26/2022 at 1:02 PM, administrator A indicated the plan of care for patient #16 did not match the current frequency and duration of visits ordered. Administrator A stated the plan of care should be updated with recertification and start of care. Administrator A stated computer system didn't automatically update plan of care with current orders.5. Clinical record review on 1/26/2022, for patient #5, start of care 10/22/2021, diagnoses include but were not limited to an unspecified open wound of the right and left arms, evidenced an agency document titled, "Home Health Certification and Plan of Care" for certification period 12/21/2021 – 2/18/2022, which was electronically signed by the physician on 12/20/2021. This document had an area subtitled "10. Medications: Dose/Frequency/Route (N)ew	G0574		

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G0574	Continued from page 35 (C)hanged" which remained blank. Review of the plan of care failed to evidence the patient's medications were listed and individualized on the plan of care as required.6. Clinical record review on 1/26/2022, for patient #6, start of care 12/17/2021, a pertinent diagnosis included but was not limited to an abscess of the breast, evidenced an agency document titled, “Home Health Certification and Plan of Care” for certification period 12/17/2021 – 2/14/2022, which was electronically signed by the physician on 12/30/2021. This document had an area subtitled “10. Medications: Dose/Frequency/Route (N)ew (C)hanged” that stated “Ginseng [supplement] 250 MG [milligrams] PO [by mouth] CAPS [capsules] Take by mouth – Oral … Turmeric [supplement] PO Take by mouth – Oral … Lactobacillus (Probiotic Acidophilus PO) Take by mouth – Oral … Vitamin E PO Take by mouth – Oral ….” Review of this document failed to evidence the dosage/amount and frequency of all medications listed. Review failed to evidence the plan of care was individualized as required, to show specific medication instructions. 7. During an interview on 1/26/2022, at 11:27 AM, administrator A indicated name, dosage, route, time, and strength should be included in medication orders and instructions.17-13-1(a)(1)(D)(iii)17-13-1(a)(1)(D)(x)17-13-1(a)(1)(D)(ix)	G0574		
G0590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) 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. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to alert the physician to changes in the patient’s condition or needs that suggest the plan of care should be altered in 2 of 12 active records reviewed. (#5, #11)The findings include: 1. Review of an agency policy obtained 1/26/2022, revised August 2021, titled “Plan of Care” stated, “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	G0590		

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G0590	Continued from page 36 warrants. The clinician will promptly inform the physician of changes in the patient's condition that indicates and alteration in the plan and the physician must agree to any changes in the plan of care … F. Effectiveness of the Plan of Care will be documented on visit notes at the time each nurse or therapist visits the patient".2. Review of a reliable website source, the American Heart Association (www.heart.org) stated "Blood pressure categories ... Hypertension Stage 2 ... Hypertension Stage 2 is when blood pressure consistently ranges at 140/90 mm Hg [millimeters of Mercury] or higher. At this stage of high blood pressure, doctors are likely to prescribe a combination of blood pressure medications and lifestyle changes ... Your blood pressure numbers and what they mean ... Your blood pressure is recorded as two numbers: ... Systolic blood pressure (the first number) - indicates how much pressure your blood is exerting against your artery walls when the heart beats ... Diastolic blood pressure ... (the second number) - indicates how much pressure your blood is exerting against your artery walls while the heart is resting between beats ...."3. Review of an agency policy obtained 1/26/2022, revised September 2021, titled "Wound, Ostomy and Continence Care" stated, "… The following criteria will be used to identify surgical incisions, vascular ulcers, skin tears or any other type of break in skin integrity: 1. Partial Thickness – Loss of epidermis and possible partial loss of dermis 2. Full Thickness – Tissue destruction extending through the dermis to involve the subcutaneous level and possible muscle/bone … Wound documentation is completed at every patient visit. Documentation to include: Assessment of wound, peri wound assessment, closure, drainage amount, drainage description, non-staged wound description, wound odor, wound cleansing, dressing/treatment, dressing change, dressing status at beginning of visit,, wound length – width- depth – tunneling – undermining in centimeters, describe wound margins … Wound measurements will be taken at least once a week on Mondays … or when significant wound change occurs … Wounds will be documented in the visit documentation under wounds, lines, drains, and airways".4. Record review on 1/20/2022 for patient #11, start of care 8/10/2021, certification period 12/8/2021 - 2/5/2022, evidenced a primary diagnosis of multiple sclerosis [a nervous system disease that affects the brain and spinal cord].Observation of a home visit was conducted on 1/20/2022 at 8:45 AM for patient #11. Home visit	G0590		

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G0590	Continued from page 37 was conducted with home health aide E and clinical manager B. During the home visit, the surveyor observed a darkened, scabbed area of skin was to the top of patient's left foot, about the size of a quarter.Record review for patient #11, start of care 8/10/2021, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 12/8/2021 - 2/5/2022, electronically signed by registered nurse I 12/6/2021, which stated, “Orders for Discipline and Treatments … Aide: … Inspect skin for signs of pressure or irritation. Report any observed or patient reported concerns to RN [registered nurse] … Progress was made in the following areas: wounds healed … Wound Care and Measurements: none”.Record review for patient #11 evidenced an agency document titled “SN [skilled nurse]-OASIS [Home Health Outcome and Assessment Information Set] Resumption of Care” electronically signed by registered nurse J 12/25/2021, which stated, “Integumentary … Issues: dry skin, rash”. Record review failed to evidence documentation of darkened area to top of left foot and subsequent notification of physician.During an interview 1/26/2022 at 11:25 AM, administrator A stated "wounds should get documented every visit". Administrator A described a wound as any skin alterations or open areas.During an interview 1/26/2022 at 11:55 AM, administrator A indicated a scab should have been added to the plan of care, and the aide should have notified the registered nurse, "which would then trigger a skilled nurse home visit to assess patient’s skin and notify physician of changes in the patient’s status". Administrator A stated physician should have been notified of alterations in patient #11’s skin integrity.5. Clinical record review on 1/26/2022, for patient #5, start of care 10/22/2021, diagnosis included but was not limited to an primary hypertension (high blood pressure), evidenced an agency document titled, “SN - Home Visit" from 12/27/2021, and signed by RN [Registered Nurse] Q. This document had an area subtitled "Vitals" which stated "BP [Blood Pressure] ... 149/91 ...." Review evidenced the patient's blood pressure indicated hypertension. Review failed to evidence physician notification.Record review evidenced an agency document titled, “SN - Home Visit" from 12/31/2021, and signed by RN Q. This document had an area subtitled "Vitals" which stated "BP ... 146/92 ...." Review evidenced the patient's blood pressure indicated stage 2 hypertension. Review failed to evidence physician notification. Record	G0590		

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G0590	Continued from page 38 review evidenced an agency document titled, “SN - Home Visit" from 1/5/2022, and signed by RN Q. This document had an area subtitled "Vitals" which stated "BP ... 148/96 ...." Review evidenced the patient's blood pressure indicated stage 2 hypertension. Review failed to evidence physician notification. Record review evidenced an agency document titled, “SN - Home Visit" from 1/7/2022, and signed by RN Q. This document had an area subtitled "Vitals" which stated "BP ... 153/94 ...." Review evidenced the patient's blood pressure indicated stage 2 hypertension. Review failed to evidence physician notification. Record review evidenced an agency document titled, “SN - Home Visit" from 1/12/2022, and signed by RN Q. This document had an area subtitled "Vitals" which stated "BP ... 148/94 ...." Review evidenced the patient's blood pressure indicated stage 2 hypertension. Review failed to evidence physician notification. Record review evidenced an agency document titled, “SN - Home Visit" from 1/19/2022, and signed by RN Q. This document had an area subtitled "Vitals" which stated "BP ... 133/98 ...." Review evidenced the patient's blood pressure indicated stage 2 hypertension. Review failed to evidence physician notification.Record review evidenced an agency document titled, “SN - Home Visit" from 1/21/2022, and signed by RN Q. This document had an area subtitled "Vitals" which stated "BP ... 146/100 ..." Another area subtitled "Actions/Narrative" stated "... discussed with the pt [patient] the need to monitor [his/her] blood pressure; requested that [he/she] start to pay more attention to [his/her] diet/salt intake; and requested that [he/she] get a blood pressure cuff for the home; pt currently does not take any medications for [his/her] blood pressure ...." Review evidenced the patient's blood pressure indicated stage 2 hypertension. Review failed to evidence physician notification. During an interview on 1/26/2021, at 11:21 AM, administrator A indicated vital sign parameters would be individualized by the patient's physician. The administrator also indicated there was not a policy for general vital sign parameter guidelines.17-13-1(a)(2)	G0590		
G0604	Integrate all orders CFR(s): 484.60(d)(2) Integrate orders from all physicians or allowed practitioners involved in the plan of care to assure the coordination of all services and	G0604		

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G0604	Continued from page 39 interventions provided to the patient. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure coordination of all services and interventions by integrating all orders from physicians in the plan of care in 1 of 5 discharge clinical records reviewed. (#10)The findings include: Review of an agency policy obtained 1/26/2022, revised August 2021, titled “Plan of Care” stated, “Policy: … 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 in consultation with the physician … B. Prior to the initial assessment visit, a verbal or written order is needed from the attending physician. This may come in the form of a referral. The clinician will complete the Plan of Care for certification and recertification of the patient. The Plan of Care must have physician approval. 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 … 3) Specific modalities & amount of therapy services … 4) PRN (as needed) visits with a specified number and reason … 5) Prescribed medications with dose, route, and frequency … 6) Over-the-counter medications which staff will administer and/or pour … 7) Mental status … 8) Goals & Prognosis … 9) Rehabilitation Potential …. 10) Discharge Plan … 11) Functional Limitations … 12) Activities permitted … 13) Nutritional requirements … 14) Any safety measures to protect against injury … 15) Instruction for timely discharge or referral and any other appropriate items … G. All drugs and treatments ordered by the physician will be incorporated into the Plan of Care. All other drugs and treatments observed by the nurse on assessment will also be incorporated into the Plan of Care”.Clinical record review on 1/24/2022 for patient #10, start of care 9/23/2021, certification period 9/23/2021 - 11/21/2021, discharged 10/28/2021, evidenced a primary diagnosis of multiple sclerosis (exacerbation), [a nervous system disease that affects the brain and spinal cord].Clinical record review for patient #10 evidenced an untitled agency document, which	G0604		

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(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
G0604	Continued from page 40 stated, “Episode Referral … Referral Instructions … Notes copied from referral order (MD [medical doctor] D 9/22/2021): Please evaluate for admission to Home health … Disciplines requested: PT [physical therapy]/OT [occupational therapy]/RN [registered nurse]/Aide …”.Clinical record review for patient #10 evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 9/23/2021 - 10/28/2021, electronically signed by registered nurse L on 9/30/2021, and medical doctor D on 9/23/2021, which stated, “Face to Face Attestation … Medically necessary services you are ordering: Skilled Nursing, Physical Therapy, Occupational Therapy and Home health tech …”. Document failed to evidence physical therapy, occupational therapy, or home health aide services were ordered or provided to patient by home health agency as ordered by medical doctor D.During an interview 1/26/2022 at 1:26 PM, administrator A indicated QA [quality assurance] C, case manager, or registered nurse on patient #10's case should have reviewed the referral order from the physician and made sure the plan of care integrated all requested services including physical therapy, occupational therapy, and home health aide.17-12-2(h)	G0604		
G0608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to coordinate care delivery to meet the patient’s needs and involve the patient in coordination of care activities in 3 of 5 discharged clinical records reviewed. (#7, #9, #10)The findings include: 1. An agency policy obtained 1/26/2022, revised August 2021, titled “Plan of Care” stated, “…J. The patient will be informed in advance of any changes in the Plan of Care before the change is made. The patient has the right to participate in planning the care or treatment in advance of such care”. 2. An agency policy titled “Therapists/MSW [medical social worker] Responsibilities” obtained 1/26/2022, revised July 2021, stated, “Policy: …	G0608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157536	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/26/2022

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G0608	Continued from page 41 Patients will be admitted to therapy (physical therapy, occupational therapy, speech therapy) and Medical Social Work service by written referral from licensed physicians … All patients will be evaluated and will be accepted for home care if there is potential for progress. Treatment will be discontinued when functional goals are met".3. Clinical record review on 1/24/2022 for patient #10, start of care 9/23/2021, certification period 9/23/2021 - 11/21/2021, evidenced a primary diagnosis of multiple sclerosis (exacerbation), [a nervous system disease that affects the brain and spinal cord]. Record review on 1/24/2022 for patient #10 evidenced an agency document titled "SN [skilled nurse] - OASIS [Home Health Outcome and Assessment Information Set] Resumption of Care" electronically signed by registered nurse L on 10/7/2021. This document stated, "Lying to sitting on Side of Bed: … Discharge Goal … Setup or clean-up assistance … Sit to Stand: … Discharge Goal … Supervision or touching assistance … Chair/Bed-to-chair Transfer: … Discharge Goal … Supervision or touching assistance".Record review on 1/24/2022 for patient #10 evidenced an agency document titled "PT [physical therapy] – Initial Evaluation" electronically signed by PT [physical therapist] M on 10/8/2021. A section titled "Actions/Narrative" stated, "Patient was seen today for initial evaluation. Patient was sitting at edge of bed with mom present. Patient stated unable to get into motorized wheelchair as mom don't know how to use it [SIC] … muscle strength in RLE [right lower extremity] is poor – as patient is unable to move it at all. Performed therapy exercises in form of passive range of motion for both lower extremities. Patient transferred from bed to wheelchair using Hoyer lift … Discharge patient as patient is at max rehab [rehabilitation] at this time." Document failed to evidence that goals of care plan were met. Review failed to evidence if patient agreed to physical therapy discharge plan and if physician was notified.Record review on 1/24/2022 evidenced an agency document titled "Case Communication" electronically signed by registered nurse L on 10/28/2021, which stated, "Patient requested to be re-evaluated by PT, patient stated she feels like her first PT evaluation wasn't correct. Writer placed PT order at this time. Writer educated patient on multiple sclerosis signs and symptoms and progression of disorder. Patient stated she understands, but she was ambulating before she got Covid." Record review failed to evidence the agency had coordinated	G0608		

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G0608	Continued from page 42 therapy services to meet patient needs.Record review 1/24/2022 evidenced an agency document titled “Case Communication” electronically signed by registered nurse L on 11/17/2021, which stated, “Spoke with patient mother, informed that patient is in an inpatient rehab [rehabilitation] ... Patient discharged from home health services.”. Record review failed to evidence patient had been involved in care coordination of care to meet needs and goals.During an interview on 1/26/2022 at 1:29PM, administrator A stated, “the physical therapist should have included a re-evaluation in the initial therapy evaluation since patient had just gotten out of the hospital and could have been weaker because of acute illness.” Agency failed to coordinate physical therapy services and include the patient in coordination of care. Agency failed to accurately document patient’s potential for rehabilitation progress.4. Clinical record review on 1/26/2022, for patient #7, start of care 11/20/2021, diagnoses include but were not limited to sepsis [potentially life-threatening infection], pneumonia [infection that inflames one or both lungs, and may be filled with fluid], evidenced an agency document titled, “SN – OASIS Transfer w/o [without] DC [discharge]” which was signed by RN R on 12/16/2021. Review of the clinical record evidenced the patient went to the emergency department (ED) on 12/12/2021, and was placed on an observation status until 12/15/2021, when Entity I placed the patient on an inpatient status. Record review of an agency document titled “Case Communication” from 12/21/2021, and signed by RN R. This document had an area subtitled “Communication Notes” which stated “Topic discussed: Re-admission inpatient hospitalization … Communication details: Patient was discharged from [Entity I] on 12-17-21. Methodist HHC [home health care] received a ROC [resumption of care]/order on 12-20-21. Patient re-admitted to [Entity I] ED Inpatient on 12-21-21 with shock, sepsis, hypotension [low blood pressure], and possible pneumonia ….” Review evidenced the patient was discharged from Entity I on 12/27/2021. Review of the clinical record failed to evidence a discharge summary. Review failed to evidence the disposition of the patient. Review failed to evidence Entity I or the patient’s physician received a discharge summary of the patient’s pertinent information.During an interview on 1/26/2022, at 11:33 AM, administrator A indicated if a patient was transferred as "Transfer without discharge" without a ROC, the case manager would discharge when they find out	G0608		

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G0608	Continued from page 43 the patient would not come back or is placed at another agency/facility.5. Clinical record review on 1/26/2022, for patient #9, start of care 10/14/2021, primary diagnosis post total knee replacement evidenced an agency document titled, “Home Health Certification and Plan of Care” for certification period 11/19/2021 – 1/17/2022, which was electronically signed by the physician on 10/13/2021. Record review of an agency document titled “Case Communication” from 11/27/2021, and signed by RN I. This document had an area subtitled “Communication Notes” which stated “Communication details: On-call service called to report that the patient was admitted into hospice for further care ….” Review of this document evidenced the patient was transferred to hospice services on 11/27/2021.Record review of an agency document titled "SN - OASIS Discharge" which was signed by RN P on 12/6/2021. This document had an area subtitled "Actions/Narrative" that stated "SN received message patient transferred to Hospice care and to discharge from Methodist home care service.... " Review of this document evidenced the patient was discharged on 12/6/2021. Review evidenced the patient was discharged from the home health agency 10 days after transfer to Hospice care. Review failed to evidence the hospice agency received a discharge summary within 48 hours as required. Review failed to evidence care coordination was conducted with the receiving agency to meet the needs of the patient, per agency policy.6. During an interview on 1/26/2022, at 11:30 AM, administrator A indicated the process to follow a patient admitted to the ED consisted of the case manager following up to either schedule a ROC assessment or if the patient would be admitted to the hospital as an inpatient status. 7. During an interview on 1/26/2022, at 12:50 PM, administrator A indicated the clinicians should be documenting what happened after transfer. The administrator stated "It looks like the patient fell off" and indicated the documentation needs closure for when, where, and why the patient was discharged.17-12-2(g)17-14-1(a)(1)(F)17-14-1(c)(6)	G0608		
G0614	Visit schedule CFR(s): 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.	G0614		

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G0614	Continued from page 44 This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure every patient was provided with the required written visit schedule consistent with the patient's plan of care for 7 of 7 patients for which a home visit was conducted. (#1, #2, #3, #11, #12, #13, #14) The findings include: 1. Record review of an agency policy titled “Patient Rights & Responsibilities” revised August 2021, stated, “Policy: To inform the patient/ legal representative, in writing, of his/her rights as a patient of Home Care in advance of furnishing care, and ensure Home Care personnel promote and protect the patient’s rights while providing service … A. A written Statement of Rights and Responsibilities will be given to each patient/representative during the Initial Assessment Visit, which outlines the patient’s regarding services performed by Home Care. Patients must be notified in writing of their rights and obligations in advance of furnishing care ... 2) Information regarding Plan of Treatment as authorized by the physician, opportunity to participate in developing the Plan, the right to refuse treatment, the right to make informed decisions about their care ... 6) Notice of the disciplines that will be providing services and proposed frequency of visits ... E. The patient will be supplied with a copy of their current plan of care ... M. Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to: ... The disciplines that will furnish the care ... The frequency of visits ….” 2. During an observation of a home visit on 1/21/2022, at 12:33 PM, for patient #1, start of care 10/21/2021, with Registered Nurse (RN) I to observe care. At 12:56 PM, failed to evidence a visit schedule written for skilled nurse (SN) services. Review failed to evidence a visit schedule to include the frequencies of every discipline providing services in to the patient. Review failed to evidence the patient had the required written visit schedule in the patient's home.During an interview on 1/21/2022, 12:54 PM, person F indicated staff has a basic set schedule and will call the day before a visit and adjust	G0614		

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G0614	Continued from page 45 times/days as needed. 3. During an observation of a home visit on 1/21/2022, at 2:32 PM, for patient #2, start of care 7/14/2020, with RN Q to observe routine wound care provided by the skilled nurse. At 2:51 PM, the patient's home folder was reviewed. Review failed to evidence a visit schedule to include the frequencies of the skilled nurse. Review failed to evidence the patient had the required written visit schedule in the patient's home.During an interview on 1/21/2022, 2:56 PM, person G indicated staff will contact person H for visits, but there is pretty much an ongoing set schedule. 4. During an observation of a home visit on 1/25/2022, at 2:59 PM, for patient #3, start of care 12/28/2022, with Occupational Therapist (OT) D to observe a routine occupational therapy session. At 3:42 PM, the patient's home folder was reviewed. Review failed to evidence a visit schedule for OT services. Review failed to evidence a visit schedule to include the frequencies of every discipline providing services in to the patient. Review failed to evidence the patient had the required written visit schedule in the patient's home.During an interview on 1/25/2022, 3:39 PM, person A indicated staff will call or text message the day before a visit. Person A also indicated the visit schedule is usually the same, unless there are doctor appointments that interfere. 5. Observation of a home visit was conducted on 1/20/2022 for patient #11, to observe a routine home health aide visit. At 9:20 AM, the patient's home folder was reviewed. Review failed to evidence a visit schedule to include the frequencies of every discipline providing services to the patient. Review failed to evidence the patient had the required written visit schedule in the patient's home. 6. Observation of a home visit was conducted on 1/20/2022 for patient #12 to observe a routine physical therapy session. At 1:15 PM the patient's home folder was reviewed. Review failed to evidence a visit schedule to include the frequencies of every discipline providing services to the patient. Review failed to evidence the patient had the required written visit schedule in the patient's home. 7. Observation of a home visit was conducted on	G0614		

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G0614	Continued from page 46 1/21/2022 for patient #13 to observe a routine skilled nurse visit and drain the Pleurx catheter. At 1:15 PM, patient #13 stated that he did not know where his home folder was located. Observation failed to evidence a visit schedule to include the frequencies of every discipline providing services to the patient. Observation failed to evidence the patient had the required written visit schedule in the patient's home. 8. Observation of a home visit was conducted on 1/21/2022 for patient #14 to observe a routine skilled nurse visit and change a wound dressing. At 2:15 PM, the patient's home folder was reviewed. Review failed to evidence a visit schedule to include the frequencies of every discipline providing services to the patient. Review failed to evidence the patient had the required written visit schedule in the patient's home. 9. During an interview 1/26/2022 at 11:51 AM, administrator A stated the staff should be updating a white board included in the patient's home folder with visit schedule including name of staff, frequency of visits, and discipline types.	G0614		
G0616	Patient medication schedule/instructions CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure patients written instructions provided to patient's included all medication instructions including medication name, dosage, and frequency of administration for 6 of 7 patients where a home visit was conducted. (#2, #3, #11, #12, #13, #16)The findings include: 1. Review of an agency policy titled “Patient Rights & Responsibilities” revised August 2021, stated, “Policy: To inform the patient/ legal representative, in writing, of his/her rights as a patient of Home Care in advance of furnishing care, and ensure Home Care personnel promote and protect the patient’s rights while providing	G0616		

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G0616	Continued from page 47 service … A. A written Statement of Rights and Responsibilities will be given to each patient/representative during the Initial Assessment Visit, which outlines the patient's regarding services performed by Home Care. Patients must be notified in writing of their rights and obligations in advance of furnishing care ... 2) Information regarding Plan of Treatment as authorized by the physician, opportunity to participate in developing the Plan, the right to refuse treatment, the right to make informed decisions about their care ... E. The patient will be supplied with a copy of their current plan of care ... M. Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to: ...The care to be furnished based on the comprehensive assessment …. " 2. Review of an agency policy obtained 1/26/2022, revised August 2021, titled "Medication Administration and Oversight" stated, "Policy: … A. … The clinical record must contain physician orders for all medications prescribed for the patient … B. Medications orders: 1) Orders must include the drug name (generic or trade name), dose, route, and frequency of administration … 4) All PRN [as needed] medication orders must specify the purpose for the medication's use … 11) The clinician will inform the physician of any concerns related to medications and will document any physician contact or orders … C) Staff will teach the patient and/or caregiver and document the following in the clinical record: 1) Name and description of medication including any medication dosage change or newly prescribed medication … F) …. If a verbal order is taken for a new medication or medication dosage changed, there needs to be a computer check of possible interactions. The Case Manager will notify the physician as applicable".3. During an observation of a home visit on 1/21/2022, at 2:32 PM, for patient #2, start of care 7/14/2020, with RN Q to observe routine wound care provided by the skilled nurse. At 2:51 PM, the patient's home folder was reviewed for required information provided by the home health agency. Review failed to evidence a required medication schedule in the patient's home to include but not limited to the name, dosage, and route.4. During an observation of a home visit on 1/25/2022, at 2:59 PM, for patient #3, start of care 12/28/2022, with Occupational Therapist (OT) D to observe a routine occupational therapy session. At 3:42 PM, the patient's home folder was reviewed for the required provided information by	G0616		

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G0616	Continued from page 48 the home health agency. Review failed to evidence the required medication schedule in the patient's home to include but not limited to the name, dosage, and route.5. Observation of a home visit was conducted on 1/20/2022 for patient #11 with home health aide E, to observe a routine home health aide visit. At 9:00 AM, patient's home medications were reviewed. Review of patient's home medications evidenced baclofen [for muscle spasms] 10 MG [milligram] tablets, take 3 tablets by mouth 2 times a day; oxybutynin [for urinary incontinence] 5 MG by mouth daily; and Methenamine Hippurate [for urinary tract infection] 1 G [gram] by mouth 2 times daily.During home visit with patient #11, a document was observed in the home folder, which was titled "Outpatient Medications on the Plan of Care" and stated, "baclofen [for muscle spasms] 10 MG [milligram] tablets, take 1 tablet by mouth 2 times daily… bisacodyl [for constipation] 10 MG by mouth daily … Calcium-Vitamin D-Vitamin K [for osteoporosis] 2 tablets by mouth 2 times daily … Enoxaparin Sodium [for blood clots] inject 0.4 milliliters in the skin daily … linaclotide [for constipation] 145 MCG [micrograms] by mouth as needed for constipation … lisinopril [for blood pressure] 20 MG by mouth daily … nystatin powder [for skin infection] 100,000 G [gram] topically 2 times daily to bilateral breasts and groin, sacrum, and peri area … oxybutynin [for urinary incontinence] 5 MG by mouth daily … Probiotic Product [for digestion] take 1 capsule by mouth daily … rifaximin [antibiotic] 550 MG by mouth twice daily … Triamcinolone Acetonide [for skin rash] 1 applicator topically two times daily near skin folds". Observation failed to evidence that medication list provided to patient was accurate and included all medications patient was taking. During an interview 1/26/2022 at 11:53 AM, administrator A indicated home medication list should be a complete and accurate list of medications patient is currently taking. Administrator A indicated patient #11's medication list should have been updated by the nurse.6. Observation of a home visit was conducted on 1/20/2022 for patient #12, to observe a routine physical therapy session. At 9:00 AM, the patient's home folder was reviewed. which evidenced a document titled "Outpatient Medications on the Plan of Care" which stated, "Calcium Carb-Cholecalciferol [for calcium and vitamin D levels] 600 tablets by mouth once daily … lisinopril-hydrochlorothiazide [for blood pressure] 10-12.5 MG [milligram] 1 tablet by mouth	G0616		

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G0616	Continued from page 49 as needed". Document failed to evidence correct dosage of Calcium Carb-Cholecalciferol. Document failed to evidence indication for taking lisinopril-hydrochlorothiazide as needed. During an interview on 1/26/2022 at 11:27 AM, administrator A stated, "a complete medication order includes medication name, dose, route, frequency, and PRN [as needed] orders should include the indication". Administrator A stated patient #12's lisinopril-hydrochlorothiazide order should have included the PRN indication. During an interview 1/26/2022 at 12:06 PM, administrator A stated the Calcium Carb-Cholecalciferol dosage of 600 tablets was incorrect and was entered in error. 7. Clinical record review on 1/21/2022 for patient #13, start of care 12/26/2021, evidenced a primary diagnosis of pleural effusion [A buildup of fluid between the tissues that line the lungs and the chest]. Record review evidenced an unsigned agency document titled "Outpatient Medications on the Plan of Care" which listed the following medications: "aspirin [to prevent blood clots] 81 MG [milligram] chewable tablet - take 240 MG by mouth daily; bumetanide [for swelling] 2 MG PO [by mouth] tablet; carvedilol [for blood pressure] 25 MG tablet - take one tablet by mouth twice daily with meals; glipizide [for blood sugar] 10 MG tablet - take 10 MG by mouth 2 times daily before meals; hydrocodone-acetaminophen [for pain] 5-325 MG per tablet - take 1 tablet by mouth every 8 hours as needed for pain; losartan [for blood pressure] 100 MG tablet - take one tablet by mouth once daily; lovastatin [for cholesterol] 40 MG PO tablet - take 40 MG by mouth nightly; Melatonin [for sleep] 1 MG capsule - take 1 tablet by mouth nightly x1; metolazone [for swelling] 2.5 MG PO tablet - take 2.5 MG by mouth; Novolin [for blood sugar] 70/30 100 unit/ML [milliliter] SC [subcutaneous] suspension - 2 times daily; pantoprazole [for stomach acid] 40 MG PO tablet - take 40 mg by mouth; warfarin [for blood clots] 2.5 MG PO tablet – take 1 tablet by mouth daily". Record review failed to evidence frequency of medication administration for bumetanide, metolazone, and pantoprazole.Observation of a home visit was conducted on 1/21/2022 for patient #13, to observe a routine skilled nurse visit, and wound care. At 1:15 PM, patient's home medications were reviewed. Review of patient's home medications evidenced the following medications not included in medication list: "finasteride[for prostate] 5 MG [milligram] by mouth daily, potassium chloride [electrolyte] 20 milliequivalent by mouth twice a day, Flomax [for	G0616		

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(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
G0616	Continued from page 50 prostate] 0.4 MG by mouth daily, colestipol [for cholesterol] 1 gram by mouth daily, gabapentin [for nerve pain] 300 MG by mouth three times a day, and Jardiance [for diabetes] 10 MG by mouth daily". Review of patient's home medications failed to evidence patient was taking the following medications which were listed on the medication list: aspirin [to prevent blood clots] 240 MG by mouth daily, hydrocodone-acetaminophen [for pain] 5-325 MG by mouth every 8 hours as needed for pain, losartan [for blood pressure] 100 MG tablet by mouth daily, melatonin [for sleep] 1 MG by mouth nightly, and pantoprazole [for stomach acid] 40 MG by mouth. Review of patient's home medications evidenced patient was taking carvedilol [for blood pressure] 6.25 MG by mouth twice a day, and glipizide [for blood sugar] 5 MG by mouth twice a day, which differed from dosage on medication list. At 1:00 PM registered nurse J failed to be observed updating or assessing patient's home medications. The agency failed to assess the patient's medications by time of exit at 1:45 PM.During an interview 1/26/2022 at 11:27 AM, administrator A stated, "a complete medication order includes medication name, dose, route, frequency, and PRN [as needed] orders should include the indication". Administrator A stated regarding keeping medication list up to date, "the nurse looks at each bottle, each medication, and checks the order with what is listed in the medication list and adds any new medication to the medication list". Administrator A indicated the nurse should review patient's medications each visit. Administrator A indicated patient #13's medication list was inaccurate and incomplete. 8. Clinical record review on 1/25/2022 for patient #16, start of care 12/15/2021, certification period 12/15/2021 - 2/12/2022, evidenced a primary diagnosis of malignant neoplasm of prostate [prostate cancer]. Review evidenced an untitled agency document which stated, "Outpatient Current Medications as of 1/26/2022 … tramadol [for pain] 50 MG [milligrams] PO [by mouth] tablet …. Take 50 MG by mouth every 6 hours as needed". Record review failed to ensure PRN [as needed] medication order included a purpose for taking the medication.During an interview on 1/26/2022 at 11:27 AM, administrator A stated, "a complete medication order includes medication name, dose, route, frequency, and PRN [as needed] orders should include the indication".	G0616		
G0618	Treatments and therapy services	G0618		

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G0618	Continued from page 51 CFR(s): 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. This ELEMENT is NOT MET as evidenced by: Based on observation and interview, the home health agency failed to ensure a copy of ordered therapy and treatments furnished by the agency was kept in every patients home for 2 of 7 patient home visits. (#3, #11) The findings include: 1. Record review of an agency policy titled "Patient Rights & Responsibilities" revised August 2021, stated, "Policy: To inform the patient/ legal representative, in writing, of his/her rights as a patient of Home Care in advance of furnishing care, and ensure Home Care personnel promote and protect the patient's rights while providing service … A. A written Statement of Rights and Responsibilities will be given to each patient/representative during the Initial Assessment Visit, which outlines the patient's regarding services performed by Home Care. Patients must be notified in writing of their rights and obligations in advance of furnishing care ... 2) Information regarding Plan of Treatment as authorized by the physician, opportunity to participate in developing the Plan, the right to refuse treatment, the right to make informed decisions about their care ... 6) Notice of the disciplines that will be providing services and proposed frequency of visits ... E. The patient will be supplied with a copy of their current plan of care ... M. Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to: ... The care to be furnished, based on the comprehensive assessment ... Establishing and revising the Plan of Care ... The disciplines that will furnish the care ... The frequency of visits …."2. During an observation of a home visit on 1/25/2022, at 2:59 PM, for patient #3, start of care 12/28/2022, with Occupational Therapist (OT) D to observe a routine occupational therapy session. At 3:42 PM, the patient's home folder was reviewed for the required provided information by the home health agency. Review failed to evidence the required plan of care or copy of ordered therapies and treatments in the	G0618		

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G0618	Continued from page 52 patient's home.3. Observation of a home visit was conducted on 1/20/2022 for patient #11 to observe a routine home health aide visit. At 9:20 AM patient's home folder was reviewed. Review failed to evidence the required plan of care or copy of ordered therapies and treatments in the patient's home.During an interview 1/26/2022 at 11:54 AM, administrator A indicated patient's should have the most up to date plan of care in their homes.	G0618		
G0710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview the agency failed to ensure services were provided as ordered in the plan of care in 7 of 12 active clinical records reviewed. (#1, #2, #5, #11, #12, #13, #17)The findings include: 1. Review of an agency policy obtained 1/26/2022, revised August 2021, titled “Plan of Care” stated, “K. Staff providing services under arrangement or contract must participate in the development of the Plan of Care, deliver services according to the Plan, and notify the physician of any changes in the patient’s condition, per home care policy”.2. Review of agency’s physical therapist job description, obtained 1/20/2022, evidenced a section titled “Principal Duties and Responsibilities (Essential Functions)” which stated, “Evaluates patients muscle strength, ROM [range of motion], endurance, balance, pain, skin integrity and overall function level”.3. Clinical record review for patient #11, start of care 8/10/2021, certification period 12/8/2021 - 2/5/2022, evidenced a primary diagnosis of multiple sclerosis [a nervous system disease that affects the brain and spinal cord].Clinical record review for patient #11 evidenced an untitled agency document which stated, “Care Plan … Aide … Visits: … 3 visits every week for 8 weeks-12/12/2021 to 2/5/2022, 1 visit every week for 1 week-1/2/2022 to 1/8/2022, 2 visits every week for 4 weeks-1/9/2022 to 2/5/2022”.Clinical record review for patient #11, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 12/8/2021 -	G0710		

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G0710	Continued from page 53 2/502022, electronically signed by registered nurse I 12/6/2021, which stated, “Orders for Discipline and Treatments … Aide: …12/12/2021 to 2/5/2022: 3 visits every week for 8 weeks”.Observation of a home visit was conducted on 1/20/2022 for patient #11 to observe a routine home health aide visit. At 9:00 AM, person B stated that patient #11 was supposed to get 3 aide visits a week, but "the home health agency changed aide visit frequency to 2 visits a week due to short staffing", even when patient #11 and caregiver did not want to decrease visit frequency. Person B stated patient #11 needed 3 aide visits a week.During an interview 1/18/2022 at 9:38 AM, administrator A stated, "due to having only 1 home health aide", the agency had called each patient and cut visits from 3 times a week to 1 or 2 times a week when possible and held off on taking referrals if the agency couldn’t handle the additional patients.During an interview 1/26/2022 at 11:50 AM, administrator A stated the agency had increased patient #11’s visits to 3 times a week again after home visit on 1/20/2022.4. Clinical record review on 1/20/2022 for patient #12, start of care 1/11/2022, certification period 1/11/2022 - 3/11/2022, evidenced a primary diagnosis of encounter for other orthopedic aftercare [care after hip surgery]. Record review for patient #12 evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 1/11/2022 - 3/11/2022, which stated, “Orders for Discipline and Treatments … PT [physical therapy]: … Each Visit … Assess patient’s incision at every visit and document on the WLDA [wounds, lines, drains, and airways] … Measure incision weekly and document on the WLDA”.Record review for patient #12 evidenced an agency document which administrator A referred to as the "episode" which stated, “Wound Assessment … Incision Hip Lateral; Right”. This document failed to evidence any incision measurements during home visits on 1/11/2022, 1/13/2022, 1/15/2022, 1/18/2022, and 1/19/2022.Observation of a home visit was conducted on 1/20/2022 for patient #12 to observe a routine physical therapy session. At 1:00 PM, physical therapist K failed to be observed assessing and measuring patient's right hip incision. The agency failed to measure the right hip incision by time of exit at 1:47 PM.During an interview on 1/26/2022 at 12:10 PM, administrator A indicated the physical therapist is responsible for assessing patient #12’s incision every visit. Administrator A stated physical therapist had not documented measurement	G0710		

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G0710	Continued from page 54 of incision weekly as ordered. 5. Clinical record review on 1/21/2022 for patient #13, start of care 12/26/2021, certification period 12/26/2021 - 2/23/2022, evidenced a primary diagnosis of pleural effusion [a buildup of fluid between the tissues that line the lungs and the chest]. Record review for patient #13 evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 12/26/2021 - 2/23/2022, which stated, “Orders for Discipline and Treatments SN[skilled nurse]: … Document the drainage volume and character …Drain Pleurx Catheter frequency TWO TIMES WEEKLY”. Record review on 1/21/2022 for patient #13 evidenced an agency document titled “SN [skilled nurse] -Home Visit” electronically signed by registered nurse J 1/11/2022. This document stated, “Additional Narrative … Patient seen for visit … Pleurx drained per MD’s orders and dressing change provided patient tolerated well”. Record review failed to evidence documentation of volume or characteristics of pleural fluid drained during visit on 1/11/2022.During an interview 1/26/2022 at 12:17 PM, administrator A stated "Pleurx catheter should have been drained every visit, and documented the volume, color, and catheter site assessment”. Administrator A indicated that the nurse had not documented the volume, color, or catheter site assessment on 1/11/2022.6. Clinical record review for patient #17, start of care 4/27/20, certification period 12/18/2021 - 2/5/2022, evidenced a primary diagnosis of neuromuscular dysfunction of bladder [when a person lacks bladder control due to brain, spinal cord or nerve problems].Clinical record review for patient #17 evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 12/18/2021 - 2/5/2022, electronically signed by registered nurse I on 12/14/2021. This document stated, “Orders for Discipline and Treatments: … Change catheter … Perform latex change every month using 16 French cath [catheter] with 5ml [milliliter] balloon”.Record review evidenced an agency document referred to as the "episode" by administrator A, which indicated patient had a Foley catheter placed 10/15/2021 by registered nurse I, and was removed 12/1/2021 by registered nurse I. Document indicated that there were 47 days between catheter changes. Agency failed to ensure patient #17 received catheter change monthly as ordered in plan of care.During an interview on 1/26/2022 at 1:16 PM, administrator A indicated plan of care orders should be followed,	G0710		

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G0710	Continued from page 55 and patient #17's Foley catheter should have been changed before 47 days.7. Clinical record review on 1/26/2022, for patient #2, start of care 7/14/2020, diagnosis includes but not limited to a pressure ulcer of the sacral (region of the sacrum; a flat triangular bone in the lower back formed from fused vertebrae and sits between two hip bones) region, evidenced an agency document titled, "Home Health Certification and Plan of Care" for certification period 1/5/2022 – 3/5/2022, which was electronically signed by the physician on 1/18/2022. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "... Infection Prevention - Catheter ... Instruct in urinary tract prevention infection ... Learning/Teaching Needs ... SN [skilled nurse] to visit to teach patient/caregiver in care of urethral catheter ...." Record review of agency documents titled "SN - Visit Note" signed by RN (Registered Nurse) Q failed to evidence documentation of foley catheter care and patient/caregiver education for the following dates: 1/7/2022, 1/10/2022, and 1/14/2022. Review failed to evidence the SN provided all services in the plan of care as ordered by the physician.8. Clinical record review on 1/26/2022, for patient #1, start of care 10/21/2021, diagnoses include but were not limited to a non-pressure ulcer of the left foot and chronic kidney disease (CKD, an incurable condition where the kidneys deteriorate and lose the function of eliminating wastes in the body), evidenced an agency document titled, "Home Health Certification and Plan of Care" for certification period 12/20/2021 – 2/17/2022, which was electronically signed by the physician on 1/19/2022. This document had an area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" that stated "... Aide: ... Aide catheter care ... Cleanse skin and catheter tubing with soap and water ... SN ... Infection Prevention - Catheter ... Instruct in urinary tract infection prevention ... SN to visit to teach patient/caregiver in care of urethral catheter ...." Review evidenced the patient has a foley catheter in place for bladder elimination.Record review of an agency document titled, "SN - Visit Note" from 1/12/2022, and signed by RN I. This document had an area subtitled "LDA [lines, drains, airway] and Wound Assessment" which failed to evidence documentation for an assessment of the foley catheter. Review failed to evidence instruction, demonstration and/or teaching provided at every visit. Review	G0710		

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G0710	Continued from page 56 failed to evidence the SN provided all services in the plan of care as ordered by the physician.9. During an interview on 1/26/2022, at 11:19 AM, administrator A indicated if a patient had foley catheter, the SN should assess every visit, including but not limited to color, site, drainage, and patency.10. Clinical record review on 1/26/2022, for patient #5, start of care 10/22/2021, diagnoses include but were not limited to an unspecified open wound of the right and left arms, evidenced an agency document titled, “Home Health Certification and Plan of Care” for certification period 12/21/2021 – 2/18/2022, which was electronically signed by the physician on 12/20/2021. This document had an area subtitled “21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)” that stated "... Wound Care Therapy ... Cleanse wound to the RIGHT AXILLARY [underarm] with peroxide; pat dry; apply bactroban [antibiotic to treat skin infections] ointment to the wound bed; cover with dry dressing.....change dressing 3x [times] weekly ... Cleanse wound to the LEFT AXILLARY with peroxide; pat dry; apply bactroban ointment to the wound bed; cover with dry dressing.....change dressing 3x [times] weekly ...."Record review of agency documents titled "SN - Visit Note" which were signed by RN Q. These documents failed to evidence documentation of wound care for the right and left axillaries on 12/31/2021 and 1/12/2022.17-14-1(a)(1)(H)	G0710		
G0716	Preparing clinical notes CFR(s): 484.75(b)(6) Preparing clinical notes; This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure all skilled professional prepared clinical documentation with accurate patient information for 1 of 4 patients observed during a skilled nurse visit, from a total of 12 active records reviewed. (#2) The findings include: Record review of an agency policy titled "Clinical Records - Documentation" revised July 2021, stated "Policy: To establish guidelines for documentation in the clinical record that complies with	G0716		

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G0716	Continued from page 57 professional standards and federal, state, and local laws. To present a true and accurate picture of the patient's status and the care provided ... Clinical Documentation: It is the responsibility of all authorized disciplines (RN's [registered nurse's] ...) to document accurately on patient charts and records, on each visit to the home and include all pertinent information regarding patient care, treatment, and progress ... 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 ...." Clinical record review on 1/26/2022, for patient #2, start of care 7/14/2020, diagnosis includes but not limited to a pressure ulcer of the sacral (region of the sacrum; a large, flat triangular bone in the lower back formed from fused vertebrae and sits between two hip bones) region, evidenced an agency document titled, “Home Health Certification and Plan of Care” for certification period 1/5/2022 – 3/5/2022, which was electronically signed by the physician on 1/18/2022. This document had an area subtitled “21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)” that stated "SN [skilled nurse]: ... Wound Care Therapy ... Instruct wound care ... Sacrum: Cleanse with Normal Saline, apply opticell [an absorbent dressing with gelling fibers to protect the wound from damaged or infected tissue] to wound bed, cover with dry dressing or foam dressing 3x [times] weekly ...." During an observation of a home visit on 1/21/2022, RN [Registered Nurse] Q performed routine wound care for patient #2. At 2:45 PM, RN Q turned the patient to their left side, pulled down the patient's brief, and removed a soiled dressing from the patients sacral area. The wound appeared about a dime sized, beefy red, surrounded by a few inches of pink skin in diameter. RN Q changed the sacral wound dressing as ordered in the plan of care; cleansed with normal saline, patted dry, removed soiled gloves, sanitized hands, donned new gloves, and applied dressing to sacral area. Record review of agency documents titled "SN - Home Visit" signed by RN [Registered Nurse] Q, evidenced an area subtitled "LDA and Wound Assessment." This section evidenced the wound care being documented under "Pressure Ulcer ... Coccyx [tailbone; small triangular bone at the base of the spinal column] ...." for the following dates: 1/7/2022, 1/10/2022, 1/14/2022, 1/17/2022, and 1/21/2022. Review evidenced an order for wound care to the sacral area. Review	G0716		

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G0716	Continued from page 58 evidenced documentation of wound care to the coccyx. Review failed to evidence documentation of sacral wound care as ordered on the plan of care. Review failed to evidence the skilled nurse documented to present a true and accurate picture of the patient's status per agency policy.During an interview on 1/26/2022, at 11:20 AM, clinical manager B indicated the sacrum is located above (superior) to the coccyx.During an interview at 1/26/2022, at 11:44 AM, administrator A indicated the order was for wound care to the sacrum, documentation should also indicate care was provided to the sacrum. 17-14-1(a)(1)(E)	G0716		
G0768	Competency evaluation CFR(s): 484.80(c)(1)(2)(3) Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure every home health aide (HHA) had an annual competency evaluation as described in the agency's policy for 2 of 2 HHA	G0768		

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G0768	Continued from page 59 personnel records reviewed. (HHA E, HHA F) The findings include: 1. Record review of an agency policy titled, “Home Health Tech Training & Evaluation” revised October 2021, stated “I. Policy: to develop and implement an ongoing training program for Home Health Techs (HHT) that fulfills the requirements specified in the Conditions of Participation and ensures that individuals who perform home health tech duties meet the competency requirements ... A. The Home Health Tech Must meet the personnel qualifications as defined in the Medicare Conditions of Participation (484.4) … Competency will be verified at the time of hire through a written and practical test ... C. Competency Evaluation: The qualified instructor will evaluate a Home Health Tech’s competency initially at the time of hire, and annually thereafter, and will observe performance of at least: 1) reading and recording temperature, pulse, respirations, & blood pressure … 2) appropriate & safe techniques in personal hygiene … 3) safe transfer techniques and ambulation … 4) normal range of motion and positioning … 5) other areas through written or oral examination or observation ... G. Ongoing Education: All Home Health Techs will receive no less than twelve (12) hours of mandatory in service training within a 12 month period. Compliance monitoring will be done on a quarterly basis. The in-service may occur while an HHT is furnishing care to patients … H. Home Health Tech will be evaluated on an annual basis reflecting practical skills, documentation, communication techniques and reliability. The annual review will be conducted per home health policy ….”2. Record review of an agency policy titled “Continuing Education & Meetings” revised August 2021, stated, “Policy: To encourage each staff member to keep updated in his or her skills and knowledge base and to remain informed about issues in the department in which they work … B. The Methodist Hospitals will provide various educational opportunities to enhance professional practice. Home Health Techs will be provided with 12 hours of education yearly within the department … E. Requirements are as follows: … 3) Annual Mandatory Hospital Competencies ….”3. Record review of an agency policy titled, “Home Health Tech Competency & Supervision” revised August 2021, stated “I. Policy: To ensure the Home Health Tech (HHT) is competent in skills and performance provides care according to the assignment, homecare standards, rules, and regulations ... C. Documentation of	G0768		

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(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
G0768	Continued from page 60 competency will be maintained in the personnel file. Competency through supervisory home visits will be evaluated as part of the annual performance review. Review will include status of practical skills, documentation, communication techniques, and reliability … E. An orientation program is provided to inform HHT's of the expectations and responsibilities detailed in their job descriptions. Orientation will include: 1) ongoing education requirements ….”4. Personnel record review on 1/19/2022, for Home Health Aide (HHA) F, evidenced a start date of 9/16/2019, and a document titled, "HHT In-Service Education 2019" which was unsigned and undated. Review failed to evidence HHA F received the 12 hours of in-service training for 2020 and 2021, that discussed the required subjects per the agency policy. 5. Personnel record review on 1/19/2022, for HHA E, evidenced a start date f 10/15/2001. Record review failed to evidence of documentation for the required in-service and competency training. Review failed to evidence HHA E received the 12 hours of in-service training for 2020 and 2021, that discussed the required subjects per the agency policy. 6. During an interview on 1/19/2022, at 2:16 PM, administrator A indicated since the beginning of the Covid-19 pandemic, staffing had been difficult and was unable to bring the home health aides in to the office of in-service training. 17-14-1(l)(1)(A)	G0768		
G1022	Discharge and transfer summaries CFR(s): 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. This ELEMENT is NOT MET as evidenced by:	G1022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157536	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/26/2022

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G1022	Continued from page 61 Based on record review and interview, agency failed to send transfer summaries within two business days of becoming aware of planned transfer and failed to complete and send discharge summaries in 3 of 5 discharge records reviewed. (#7, #10, #15)The findings include: 1. Review of an agency policy obtained 1/26/2022, revised August 2021, titled, “Discharge & Transfer” stated “Policy: At the time of admission the clinician will begin planning for the patient’s discharge. Discharge plans will be documented in the plan of care. The patient/legal representative will participate in planning for discharge or transfer. The staff will notify the patient/legal representative of reasons for discharge and changes in the plan as they affect the discharge plans. Staff will educate the patient and/or family in self-care, management of medical and health needs, use of community resources, available alternatives, and other appropriate information. Verbal discharge instructions will be provided … The patient/ legal representative or other individual responsible for the patient’s care will be given at least fifteen calendar day notice before services are discontinued … Transfer: transfer to another organization will occur when appropriate and the patient meets discharge criteria. Home care and attending physician will be responsible for the patient during the transfer process. The receiving organization and patient’s physician will be provided with all relevant written or verbal information including: 1) reason for transfer 2) patient’s physical and pertinent psychological status 3) current needs necessitating intervention 4) summary of the care and services provided 5) progress towards achieving identified goals 6) all medication, instructions and/or referral information provided to the patient 7) advance directive information … Discharge/Transfer Summary: A completed discharge summary will be 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 within five business days of the patient discharge … A completed transfer summary will be sent to the health care facility within two business days of a planned transfer, if the patient’s care will immediately continue in a health care facility. A completed transfer summary will be sent within two business days to the health care facility and/or	G1022		

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G1022	Continued from page 62 responsible health care provider upon becoming aware of an unplanned transfer".2. Clinical record review on 1/24/2022 for patient #10, start of care 9/23/2021, certification period 9/23/2021 - 11/21/2021, discharged 10/28/2021, evidenced a primary diagnosis of multiple sclerosis (exacerbation), [a nervous system disease that affects the brain and spinal cord].Clinical record review on 1/24/2022 for patient #10 evidenced agency document titled "Case Communication" electronically signed by registered nurse L on 11/17/2021 which stated, "Spoke with patient mother, informed that patient is in an inpatient rehab [rehabilitation] facility … Patient discharged from home health services".Record review on 1/24/2022 evidenced an agency document titled "Discharge" electronically signed by registered nurse L on 11/17/2021. Document stated, "Reason for Discharge: Patient in rehab facility … Alterations in the Plan of Care: no … Date of Last Home Visit: 10/28/2021". Record review failed to evidence agency had sent a discharge summary or transfer summary to inpatient rehab facility.During an interview on 1/26/2022 at 11:34 AM, administrator A stated, "discharge summaries get entered the date of the last home visit". During an interview on 1/26/2022 at 1:34 PM, administrator A stated they did not know what day patient #10 had transferred to inpatient rehab. Administrator A indicated the OASIS discharge had been entered 11/17/2021 but dated 10/28/2021 to align with last home visit completed. Administrator A stated they did not know if discharge summary was sent to inpatient rehabilitation center.3. Clinical record review on 1/24/2022 for patient #15, start of care 9/9/2021, certification period 9/9/2021 - 11/7/2021, evidenced a primary diagnosis of orthopedic aftercare following surgical amputation [care after amputation] Review evidenced an agency document titled, "Case Communication" electronically signed by physical therapist physical therapist K on 9/28/2021 which stated, "Patient admitted to the hospital due to wound infection".Record review evidenced an agency document titled, "Case Communication" electronically signed by registered nurse J on 9/29/2021 which stated, "Patient admitted to inpatient".Record review evidenced an agency document dated 10/1/2021, titled, "Case Communication" electronically signed by registered nurse C, which stated, "patient transferred to ... [Hospital E] ... for surgery".Record review evidenced an agency document which was transmitted	G1022		

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G1022	Continued from page 63 titled “SN[skilled nurse]-OASIS [Home Health Outcome and Assessment Information Set] Transfer w/o DC [discharge]” electronically signed by registered nurse C on 10/4/2021. Review failed to evidence a discharge summary was completed or sent to hospital.During an interview on 1/26/2022 at 11:34 AM, administrator A stated, “discharge summaries get entered the date of the last home visit”.During an interview on 1/26/2022 at 11:32 AM, administrator A indicated agency did not know whether patient #15 was still in hospital or had returned home. Administrator A indicated discharge summary was not completed, and that if patient becomes inpatient in hospital, agency is supposed to complete discharge summary.4. Clinical record review on 1/26/2022, for patient #7, start of care 11/20/2021, diagnoses include but were not limited to sepsis [potentially life-threatening infection], pneumonia [infection that inflames one or both lungs, and may be filled with fluid], evidenced an agency document titled, “Record review of an agency document titled “Case Communication” from 12/21/2021, and signed by RN R. This document had an area subtitled “Communication Notes” which stated “Topic discussed: Re-admission inpatient hospitalization … Communication details: Patient was discharged from [Entity I] on 12-17-21. Methodist HHC [home health care] received a ROC [resumption of care]/order on 12-20-21. Patient re-admitted to [Entity I] ED [emergency department] Inpatient on 12-21-21 with shock, sepsis, hypotension [low blood pressure], and possible pneumonia ….” Review evidenced the patient was discharged from Entity I on 12/27/2021. Review of the clinical record failed to evidence a discharge summary. Review failed to evidence the disposition of the patient. Review failed to evidence Entity I or the patient’s physician received a discharge summary of the patient’s pertinent information.During an interview on 1/26/2022, at 12:50 PM, administrator A the clinicians should be documenting what happened after transfer. The administrator stated "It looks like the patient fell off" and indicated the documentation needs closure for when, where, and why the patient was discharged.17-15-1(a)(6)	G1022		