STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157048	A. BUILDING B. WING	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERIM HEALTHCARE OF SOUTH BEND	605 W EDISON RD STE H, MISHAWAKA, IN, 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health (IDOH) in accordance with Condition of Participation for Home Health Agencies (HHAs): 42 CFR §484.102. Survey Dates: 2/14, 2/15, 2/16, 2/21, 2/22, 2/23, 2/24, 2/25, 2/28, 3/1, 3/2, and 3/3 (2022) Facility Number: IN006118 Provider Number: 157048 Current Census: 121 At this Emergency Preparedness survey, Interim Healthcare of South Bend was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR §484.102.	E0000	The governing body reviewed the statement of deficiencies and has approved the plan of correction.	2022-04-22
N0000	Initial Comments This was a State Home Health Agency (HHA)	N0000	The governing body reviewed the statement of deficiencies and has approved the plan of correction.	2022-04-22

	Department of Health (IDOH). Survey Dates: 2/14, 2/15, 2/16, 2/21, 2/22, 2/23, 2/24, 2/25, 2/28, 3/1, 3/2, and 3/3 (2022) Facility Number: IN006118 Provider Number: 157048 Current Census: 121 Refer to Federal form for additional State findings.			
G0000	This was a fully extended Federal and State Home Health Agency (HHA) Recertification/Re-Licensure survey completed by the Indiana Department of Health (IDOH). An immediate jeopardy (IJ) was called on 03/02/2022. The administrator was notified on 03/02/2022 at 2:44 PM, regarding an IJ cited at Conditions of Participation 42 CFR §484.55: Comprehensive Assessment of Patients; and 42 CFR §484.60: Care Planning, Coordination of Services, and Quality of Care. The IJ was not abated upon exit on 3/3/2022, due to all tasks/interventions evidenced on the agency s IJ removal plan, submitted on 3/3/2022, would not be completed until 3/9/2022. Survey Dates: 2/14, 2/15, 2/16, 2/21, 2/22, 2/23, 2/24, 2/25, 2/28, 3/1, 3/2, and 3/3 (2022) Facility Number: IN006118 Provider Number: 157048 Current Census: 121	G0000	The governing body reviewed the statement of deficiencies and has approved the plan of correction.	2022-04-22

	Based on the Condition-level deficiencies during the 03/03/2022 survey, Interim Healthcare of South Bend was subject to a fully extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 7/27/21. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, Interim Healthcare of South Bend is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for the two years beginning 03/03/2022 and continuing through 03/03/2024 for being found out of compliance with the Conditions of Participation: 42 CFR §484.55: Comprehensive Assessment of Patients; 42 CFR §484.60: Care Planning, Coordination of Services, and Quality of Care; §484.70: Infection Prevention and Control; §484.58: Discharge Planning; and §484.80: Home Health Aide Services. These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings. Quality Review Completed 04/05/2022			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable	N0488	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will audit all active charts to ensure discharge notice is given 15 days prior to discharge and discharge summaries are sent within 5 business days of discharge. 2. The Administrator/Director of Health Care Services or Chief Clinical Officer will reeducate clinicians regarding discharge planning occurs throughout the episode. Education will also include the requirement of 15-day notice prior to discharge and documentation that the notice was given except when patient elects discharge, transfers to inpatient facility with discharge, transfers care to Hospice or is discharged for cause per policy. 3. The Administrator/Director of Health Care Services will run the Visits by Status Report daily on business days for any open discharge visits and follow up with clinician to complete. 4. The Administrator/Director of Health Care Services will audit discharge and transfer Oasis daily to ensure compliance with notification to	2022-04-15

	reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review and interview, the agency s discharge policy failed to include notice of discharge of services must be provided to the patient, the patient s legal representative, or other individual responsible for the patient s care, at least 15 days before the services are stopped; and failed to provide at least 15 days notice of discharge from services for 3 of 3 planned discharged records reviewed (#4, 5, 11), and 1 of 1 active records reviewed with an upcoming, planned discharge date (#12). Findings include: 4. Record review for patient #11 was completed on 3/3/2022, start of care date 01/27/2022, discharge date 2/18/2022, for certification period 01/27/2022 03/27/2022. Record review evidenced a document dated and signed by RN		physician(s) within 5 business days of patient discharge from services and transfers within 2 days of being informed of transfer. 5. Monitoring: 100% of the clinical notes and discharge/transfer assessment with discharge will be reviewed for 30 days to show at least 15-day notice was provided prior to discharge. If 100% clinical compliance is not confirmed, 100% of clinical documentation will be reviewed for an additional 30 days until all clinical documentation is 100% compliant for a 30-day timeframe. 6. Once 100% compliance of providing discharge notice no later than 15 days prior to discharge and discharge summaries are sent within 5 business days and transfer summaries are sent with 2 days, 25% of discharge and transfer summaries and clinical visit notes will be audited quarterly. If at any time the agency falls out of compliance reeducation will be provided to clinicians and number 5 and 6 above will be repeated. 7. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI quarterly and communicated with the Governing Body 8. Completion date: 4/15/2022 and ongoing.	

indicated which indicated a section titled Discharge Planning . The section had choices (check boxes) to indicate N/A (not applicable, (or) if discharge planning was discussed, who it was discussed with (a space to enter a name), and if patient received discharge notice per agency policy. The document failed to indicate discharge notice was given, and stated ... Discharge Planning ... [box checked] N/A ....

A document dated and signed by RN I on 2/16/2022, titled Missed Visit , stated ... Type of Visit: ... SN [skilled nurse] DC [discharge] Planning Visit ... Reason ... Doctor-Clinic Appointment ....

A document dated and signed by RN I on 2/18/2022 titled OASIS [outcome and assessment information set] ... Discharge stated ... patient and caregiver notified of the discharge today ....

During an interview on 2/25/2022 at 1:21 PM, family indicated 2/18/2022 was the last day RN I saw the patient, RN I informed her it was her last day during that visit, the wound was closed, and told her to continue to treat the wound for 2 weeks.

During an interview on 2/28/22 at 3:10 PM, when queried to describe the discharge process, administrator/clinical manager A indicated a discharge planning visit was scheduled in the EMR (electronic medical record), the following visit was the discharge visit, and discharge planning was ongoing. When queried how much notice must be given prior to discharge, administrator/clinical manager A indicated she didn t know off the top of her head, and she thought it was 24 48 hours.

5. Record review for patient #12 was completed on 3/3/2022, start of care date 1/12/2022, for certification period 1/12/2022 3/12/2022. Record review evidenced documents dated and signed by RN I on 2/18/2022, and 2/24/2022, titled Skilled Nurse Visit , which indicated a section titled Discharge Planning . The section had choices (check boxes) to indicate N/A (not applicable, (or) if discharge planning was discussed, who it was discussed with (a space to enter a name), and if patient received discharge notice per agency policy. Both documents failed to indicate discharge notice

was given, and stated ... Discharge Planning ... [box checked] N/A ....

During an interview on 2/28/2022 at 3:30 PM, the patient s EMR was observed with administrator/clinical manager A, which indicated a nursing visit titled SN [skilled nursing] DC [discharge] Planning Visit was scheduled to occur on 3/4/2022, and a visit titled OASIS ... Discharge was scheduled to occur on 3/7/2022. When queried if the agency planned to discharge the patient on 3/7/2022, administrator/clinical manager A indicated they were. When queried where the record documented the patient was given notice of intent to discharge, administrator/clinical manager A indicated it would be given during the discharge planning visit scheduled just before the discharge.

1. Review of an agency policy obtained 2/22/2022, revised 4/2/2021, titled Discharge from Home Care stated, & Interim HealthCare informs the patient/client, the patient s representative (if any) in a timely manner of the need to plan for discharge from home care & Interim HealthCare discharges patient/clients when the patient s/client s goals are met, death occurs, the patient/client no longer meets Interim HealthCare s admission criteria or the patient/client refuses services, or elects to be transferred or discharged, or the Office ceases to operate &.

Agency failed to develop and implement a 15 day discharge notice policy.

2. Clinical record review for patient #4 was completed on 3/3/2022, start of care 5/19/2021, certification period 5/19/2021 6/15/2021. Review evidenced patient's last home visit was on 6/15/2021, but failed to evidence any discharge notice was given to patient or caregiver.

During an interview on 2/21/2022 at 2:09 PM, administrator/clinical manager A stated, when queried why no discharge notice or summary was noted, "... you are correct, no discharge notification or summary was noted for patient ... we should have put in a discharge summary for this patient ... the payor only approved this patient for 1 skilled nurse visit, so we used that for the start of care visit ... the nurse didn't go back to discharge the patient because of this ...."

	3. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced patient #5's last home visit was on 5/11/2021, and patient died on 5/12/2021 in the care of hospice. Review evidenced a faxed document from hospice K dated 4/28/2021, titled "Referral Intake". Review evidenced an agency document electronically signed by alternate clinical manager C on 4/29/2021, titled "Skilled Nurse Visit" which stated, "... Discharge Planning ... N/A [not applicable] ...." Record review evidenced an agency document electronically signed by person E (former scheduler) dated 5/12/2021, titled "Missed Visit" which stated, "... Family and hospice staff provided care ...." Record review evidenced an agency document electronically signed by alternate clinical manager C, dated 5/13/2021, titled "Missed Visit" which stated, "... [hospice K] is providing skilled nursing care ...." Record review failed to evidence any discharge notice was given to patient or caregiver. During an interview on 2/28/2022 at 11:50 AM, administrator/clinical manager A indicated the home health agency hadn't given any discharge notice, because she didn't know if the agency was aware of the hospice referral.			
G0510	Comprehensive Assessment of Patients 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the	G0510	Governing body immediately updated regarding issued IJ 1. Investigative results were reviewed with RN J on 3/7/22. Based on the results of the investigation, the following actions were taken. Terminated	2022-03-09

	homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. An immediate jeopardy (IJ) related to the comprehensive assessment and re-assessment of patients was cited on 3/2/2022 at 2:44 PM. Based on observation, record review, and interview, the agency failed to ensure the registered nurse (RN) completed a full physical assessment with complete assessment of lower legs, feet/toes on a patient diagnosed with diabetes, diabetic foot ulcer to (R) heel (open wound due to a combination of factors, such as lack of feeling in the foot, poor circulation, foot deformities, irritation (such as friction or pressure), trauma, as well as duration of diabetes), traumatic wound (physical injury of sudden onset and severity which requires immediate medical attention) to left plantar foot, edema, and cellulitis (a deep infection of the skin caused by bacteria). The patient indicated neither leg wrap (right or left) was removed since his last wound clinic appointment on 01/31/2022. By RN J's own admission, she indicated she was unaware of the left foot wound, and did not assessed the left foot subsequent to wound clinic M's dressing/leg wrap applied on 01/31/2022. The last comprehensive assessment performed by RN J was 02/01/2022. Patient #10 was affected. This practice had the potential to affect all agency patients with wounds, and/or patients with the potential/risk for wounds. Additionally, the registered nurse (RN) failed to conduct the initial assessment visit within 48 hours of referral (See tag G514); failed to ensure the comprehensive assessment was completed no later than 5 calendar days after the start of care (See tag G520); included the patient s current health, psychosocial, functional, and/or cognitive status (See tag G528); the patient's discharge planning needs (See tag G534); an accurate list of all medications the patient currently used, which included dose, route, frequency, and/or indications for use (See tag G536); was updated/revised, to include the administration of the OASIS (outcome and assessment information set) as frequently as the patient s condition warranted (See tag G544); or was completed within the last 5 days of every 60 day certification period (See tag G546). This practice had the potential to affect all agency patients.		03/07/2022, reported misconduct/unsafe clinical practices to Indiana State Board of Nursing 03/08/2022 and Michigan State 03/09/2022 Board of Nursing, and reported to Office of Inspector General on 03/09/2022 for fraudulent medical record entries and fabricating documentation for visits not performed. 2. Alternate Administrator/Alternate Nursing Supervisor made Nursing Visit to patients' home 3/2/202. The visit included a complete assessment, including analysis of the assessment, which was documented in the clinical record, full review of the plan of care, and medication review. The physician was updated on current patient status and the clinician secured a new physician order for frequency of services, medication discrepancies, and wound care. The clinician attempted to initiate additional services to ensure patient's safety in home as well as ADL care. Patient refused Occupational Therapy and Home Health Aide after multiple offers. Patient was seen by the wound clinic on 3/9/22, per Physician recommendation. a. Report was made to adult protective services and child protective on 3/3/22 3. Patients seen by RN J were seen by the end of day 3/4/22, with wound care patients being seen by the end of day 3/3/22. Nursing visits were performed by the Administrator/Director of Health Care Services, Alternate Administrator/Alternate Nursing Supervisor and Chief Clinical Officer. The visit included the following: complete assessment and an analysis of the assessment was documented in the clinical record, full review of plan of care for accuracy, medication review, and complete skin assessment was done including assessment of wounds if any and for presence of new wounds. Notification to MD if necessary additional orders were identified. 4. The Chief Clinical Officer assessed the Administrator/Director of Health Care Services' knowledge and provided additional training to Administrator/Director of Health Care Services on the following: Completed 03/04/2022 including review of completed clinical records thoroughly to ensure sound clinical practices are documented and patient current condition is accurate. Ensuring individuals are admitted to	

	Findings include: Faxed documents in the patient s clinical record from wound clinic M evidenced a fax cover sheet, dated 1/31/2022 at 12:27 PM, which stated ... Wound assessments and orders for today, 1/31/2022 ... change dressings/wraps ... on Monday 2/7/22 ... due to [wound clinic physician H] being out of the office that day, and the normal Wednesday and Friday. Patient to RTC [return to clinic] on 2/14 [2022] .... An additional document was included, dated 1/31/2022, titled Office Visit (for wound clinic M), which stated ... here for new wound left foot and chronic wound right heel. Patient has visiting nurses applying collagen and ace wraps for swelling ... Wound care nurse noted on his initial evaluation today that there was a shell of a pistachio nut embedded into the plantar [bottom of] left foot. Therefore he has a new wound today on his left foot ... Full thickness ulceration right heel ... new ulceration from foreign body left foot but [sic] signs of infection ... Chronic lymphedema [condition in which extra lymph fluid builds up in tissues and causes swelling] ... Advised the patient never to go barefoot ... Physician orders ... Apply collagen [dressings derived from usually cow or pig collagen, a crucial role in the wound healing process], foam ... apply 3M 2 layer lite [a 2 layer compression system wrap, not the same as ace wrap] ... Home care to change dressing and wrap on Monday, Wednesday and Friday ... float heels to reduce pressure .... Record review for patient #10 was completed on 3/3/2022, start of care date 12/7/2021, for certification period 2/5/2022 4/5/2022. Record review evidenced a document dated and signed by registered nurse (RN) J on 2/1/2022, titled ... Recertification [comprehensive reassessment] , which indicated the patient needed help with management of medications, had a decreased adherence to treatment plan, inadequate support network, lived with family and had little assistance with care, had a diabetic ulcer, non-pitting edema (swelling that does not leave pits in the skin after pressure is applied) to both lower legs, needed help with showering, but had no willing/able caregiver, vital signs parameters for when to notify the physician included fasting blood sugar level greater than 250, random blood sugar level greater than 350, the patient took toujeo solostar (insulin) to manage diabetes, and the patient had no pain. The document failed to evidence the patient had decaying/missing teeth, ate only 1 meal daily,		home care only if the needed care/service can be provided by an appropriately qualified individual. 5. Administrator/Director of Health Care Services and Chief Clinical Officer educated Case Managers/Clinical Managers and staff who conduct the comprehensive assessment on how to accurately conduct and complete thorough documentation of comprehensive assessment and as well as when it must be done including following: a. At the Start of Care and completed no later than 5 days after the Start of Care b. Within the last 5 days of every sixty days for recertification. c. Within 48 hours of the patient returning from an inpatient stay. d. When a patient exhibits a significant change in condition e. When the patient discharges from services 6. Administrator/Director of Health Care Services and Chief Clinical Officer conducted In-Service training for all nursing staff by 3/8/22. Training included the following: a. Wound Care . Assessment of patient to identify, the type, stage (if applicable), and size of all wounds present. ii. Assessment of additional wounds on every visit. iii. Assess a patient's level of pain and need to pre-medicate for pain before wound care. iv. Proper removal of old dressings to protect patient from additional skin breakdown/new wounds. v. Thorough documentation of all wounds present during the visit, including full wound care assessment for each wound present as well as standard of nursing practice to measure wound at minimum weekly. vi. Conduct wound care according to documented Physician’s orders. vii. Communicating with Physician regarding any changes in condition, including new wounds. b. Pain Assessment . Assess pain history, location, intensity, and pain characteristics	

	used a cane to ambulate, a cushion in his/her wheelchair, how often the patient checked his/her blood sugar level, his/her homebound status, progress toward goals upon reassessment, his/her primary caregiver, or discharge planning needs based upon wound management/healing, assistance with medication management, transportation needs, personal care needs, or nutritional needs; and failed to indicate RN J assessed the patient had compression dressings on both legs/feet, assessed for presence of pedal pulses (pulses in the feet, indicated for presence of lower extremity edema), identified or measured the wound identified by wound clinic M on 1/31/2022 on the patient s left plantar (bottom) foot, assessed measurements/description of the patient s wound on the right foot, or assessed any additional open skin areas/wounds. A home visit was observed on 3/1/2022 at 10:30 AM, with the patient and registered nurse (RN) J. RN J was not present upon surveyors arrival. Observed the patient seated on a wheelchair cushion (on the wheelchair), in his/her bedroom, with both lower extremities wrapped with compression wraps, approximately 3-4 inches below the knees, distal to toes. The toes on both feet were exposed, with multiple draining wounds visible. Both legs were swollen above the wraps, and their toes were swollen. The patient had decaying/missing teeth, was alert and oriented, and able to answer questions appropriately. On 3/1/2022 at 10:37 AM, the patient indicated they had a medical history of diabetes with neuropathy (nerve damage which causes numbness, tingling, and pain), and wounds; he/she took their own blood glucose 1 time per day, since he/she only ate once per day, usually when someone could make some food for them, and it was generally after 7:00 PM; he/she drank coffee and had oatmeal for breakfast sometimes; their blood sugars ran about 160 , and their doctor didn t care as long as they were below 200 ; he/she took 18 units of Levemir (a type of insulin to treat diabetes) daily. On 3/1/2022 at 10:40 AM, the patient indicated they haven t been seen at wound clinic M for several weeks, since they didn t have transportation; his/her left leg and foot bandage hasn t been changed for 3 weeks, the right leg and foot hasn t been changed for 2 3 weeks, and this was because RN J wanted them left in place to heal ; the home health nurse was		ii. Pain relief measures and how often they are used iii. Effectiveness of pain relief measures and follow-up for ineffective pain management Iiii. Assess the need to premedicate prior to wound care c. Documentation Practices . Creating an accurate, patient specific plan of care including documentation of all patients problems and wounds identified during the comprehensive assessment. ii. Completion of all documentation in the comprehensive assessment within 5 days of start of care and or 5 days following resumption of care or recertification of care. iii. Addressing all components required on the plan of care iv. Documentation of interventions identified on the Patient Plan of Care v. Documentation of the Communication with Physician regarding any changes in condition vi. Documentation of Physician orders and ensuring the physician order flows to the plan of care. vii Standards of Nursing Practice d. Identification and reporting guidelines for abuse and neglect: . Adult Protective Services ii. Child Protective Services e. Medication reconciliation . During the comprehensive assessment ii. On each skilled visit f. Patient Bill of Rights g. Maintaining patients' dignity. 7. The Administrator/Director of Health Care Services, Alternate Administrator/Alternate Nursing Supervisor, and Chief Clinical Officer re-competency tested each clinician by 3/7/2022 for proper wound care using wound care supervisory visit checklist. 8. All wound care patients and patients at risk for skin breakdown, as evidenced by the Braden Scale and/or diagnosis, were seen by end of day 3/8/22. 9. Steps to prevent it from reoccurring	

	supposed to be visiting 2 times per week, but sometimes she only come once because of staffing, and the last time the nurse came was last Tuesday (2/22/2022); he/she was in the hospital/nursing home (skilled nursing facility (SNF) N) in November (2021) for wound infection and swollen legs, he/she had a wound vac on right heel at that time, they left SNF N on 12/1/2021, and home health care services started the next week (12/7/2021). When queried if a delay was requested to the start of home health services, the patient indicated they did not. The record failed to evidence the patient received a timely comprehensive assessment. A document dated and signed by administrator/clinical manager A on 12/3/2021, and signed by physician I on 12/15/2021, titled Physician Order indicated an order was received on 12/7/2021 (7 days after the agency received an order for home health services), with an effective date of 12/3/2021, and stated ... Start of Care Date ... 12/7/21 per patient request .... A skilled nursing facility (SNF) N document dated and signed by physician R (SNF N attending physician) 11/30/2021, titled November 2021 Physician Order Sheet stated ... Order ... Discharge home with home health ... PT [physical therapy], Nurse, Bath Aide [home health aide] .... On 3/1/2022, at 10:50 AM, the patient indicated he/she didn t know where the home folder from the agency was located, and indicated they were frustrated that they were denied Medicaid for the second time (in December 2021), and, at that time, the patient was working with entity O (Indiana Area Agency on Aging, which provides services to seniors and persons with disabilities). The record failed to evidence the patient s need for social worker services. On 3/1/2022, at 10:53 AM, the patient indicated they used a wheelchair, and a cane sometimes to walk. He/she indicated they tried to elevate their legs at night while sleeping. During this time, the surveyors observed medications in a patient belongings bag, and they were reviewed/reconciled with the patient. The patient confirmed they only took the following medications: Levemir 18 U (units) daily, Atenolol 25 mg (milligrams) daily, Atorvastatin 40 mg daily, Ropinirole 0.5 mg daily, and Furosemide		a. Continue review of 100% of comprehensive assessments and physician orders for accuracy and ensuring quality standards are upheld. 100% of the comprehensive assessments and physician orders will be reviewed for 30 days. If 100% clinical compliance is not confirmed, 100% of clinical documentation will be reviewed for an additional 30 days. Assessments and orders will continue to be reviewed at 100% until all clinical documentation is 100% compliant for a 30-day timeframe. 10. Once 100% compliance has been upheld for a 30-day timeframe, assessments, and physician orders will continue to be reviewed by Administrator/Director of Health Care Services for clinical compliance quarterly for 95% compliance. If compliance falls below 95% within the quarter, clinical documentation will be reviewed with the plan outlined in points above in point 9. a. On-site supervisory visits will be scheduled with nursing staff, no less than quarterly, with the Administrator/Director of Health Care Services, alternate nursing supervisor, or Chief Clinical Officer throughout 2022, then no less than every six months thereafter. 11. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body.	

	40mg daily. They indicated they have not taken potassium chloride, aspirin, zinc, toujeo, multivitamins, florastor, or metronidazole since their discharge from skilled nursing facility (SNF) N in December of 2021. On 3/1/2022, at 10:56 AM, the patient indicated their pain was currently about 4-5 (out of 10, with 0 = no pain, and 10 = worst pain ever), last night it was 10 , and when queried if he/she took any pain medications, he/she stated, ... My doctor [physician I] doesn t believe in that .... , and indicated physician I wanted them to go to the pain management place , but the patient didn t want to. On 3/1/2022, at 11:06 AM, when queried how many wounds patient had, RN J stated, I don t know ... there s not a number ... it s hard to tell how many wounds because they all blend together ... one kind of goes into the other ... mainly [his/her] right leg ... we wrapped the left leg mainly for swelling ... no open wound on left leg .... When queried when the last time wound care was performed, RN J indicated she performed wound care on Friday (2/25/2022) (the patient earlier during this home visit indicated her last home visit was Tuesday, 2/22/2022). When queried how often she measured wounds, RN J indicated the agency measured wounds weekly. When queried what the current wound care orders for this patient were, RN J indicated the wound orders were to wash with normal saline and rewrap. The comprehensive reassessment performed by RN J on 2/1/2022 and all subsequent clinical visit notes (previous to 3/1/2022) evidenced only 1 wound on the patient s right heel, and failed to evidence any other wound(s). On 3/1/2022, at 11:15 AM, RN J was observed unwrapping the second layer of the wound dressing, which was saturated with brown, purulent drainage, with very foul odor. RN J pulled the dry gauze batting wrap off the leg and foot. The dressing was stuck to several areas, including the right heel, top of right foot, and lateral right foot. RN J pulled the dry dressing off without soaking it first with saline. The patient s right lateral (outside) foot started bleeding and dripping on the floor while RN J pulled the dressing off. RN J then moistened additional stuck pieces of dressing with normal saline after the patient began bleeding, and pulled them off with moistened gauze.			

On 3/1/2022, at 11:20 AM, the right lower leg was observed. Skin from the knee down to the ankle was scaly, flaking, red, shiny in some areas, and swollen; the right foot and ankle were red, thickened, flaky, and swollen; the top of the right foot and toes evidenced copious amounts of macerated (wet, soggy, pale in color, due to excessive moisture) tissue and purulent greenish, yellow, foul-smelling drainage.

Wounds observed during this visit to the right lower extremity included, but were not limited to, the following:

right 3rd toe with darkened area approximately 1x2 cm (centimeters), surrounding skin thickened, yellow, flaky, macerated, drainage was yellow/green, and purulent, and all toes were stuck together from old/current drainage;

right external lateral foot was brown/yellow in color, active bleeding, an open area approximately 2 x 10 cm, surrounding skin was thickened, yellow, flaky, and macerated;

top of right foot over the center evidenced an open area, was bright red, moist, macerated, with greenish yellow drainage, measured approximately 4 x 4 inches in, surrounding skin was macerated, flaky, yellow, and red;

bottom of the right heel evidenced a dark area next to a gray/light pink open area with full thickness (damage past all layers of skin), approximately 1 x 1 cm, surrounding skin was thickened, flaky, dry, cracking, yellow;

right interior lateral calf was dark red/purple in color, an open area approximately 2x2 cm, and surrounding skin was red, flaky, swollen;

and, posterior (backside) right calf evidenced 2 or more scabbed areas approximately 1x1 cm each, surrounded by red, swollen, flaky skin.

On 3/1/2022, at 11:35 AM, RN J failed to clean or assess between the patient s toes as she performed care to the right foot/leg, and failed to assess the bottom of the foot or the posterior (back of) leg.

On 3/1/2022, at 11:45 AM, RN J removed a black nylon stocking from the left leg, which was placed by wound clinic 1/31/2022, per both the patient and RN J s testimony. The black nylon had a large amount of thick, brown exudate

	(drainage) on it. The patient s toes were visible, and all had skin sloughing (falling) off, were moist, yellow, and macerated. The left great toe had a nickel sized area of black necrosis (dead tissue) to the tip. RN J removed the second layer of wrap from the left leg and foot, which was saturated with foul smelling drainage on he/she left lateral foot and left heel. The dressing stuck to the outside of the foot. RN J did not use saline to remove the dressing. During this time, RN J stated, ... it s not as bad as I expected .... (when she observed the left leg and foot). The leg was red, swollen, had large dent in back from the wrap, and had flaky, scaly skin from knee to toes. RN J used moistened gauze to rip off the dry dressing stuck to the left lateral foot, wiped macerated skin from the top of the left foot, which made it bleed. RN J stated ... that s why it s bleeding .... . The patient yelled in pain more than once, and indicated he/she could feel when she pulled his/her skin off. When she moved to address the foot, the patient indicated he/she couldn t feel it. RN J stated, ... there s no open area ... (in regard to left lateral foot), and surveyor pointed out open wound to RN J on the patient s left lateral foot. RN J continued to debride (remove skin/tissue) from the leg and foot with gauze. Wounds observed during this visit to the left lower extremity included, but were not limited to, the following: Top of left foot had no intact skin, presence of slough, maceration, was moist, red, bleeding, had a yellow area, approximately 4x4 inches, surrounding skin was macerated, yellow, and thickened; another small area was noted approximately 1x1cm to the center of this wound that was red, bleeding, and deeper into the tissue; left toes were mostly without skin, macerated, had greenish/yellow drainage, pink wound beds, and were stuck together due to current/old drainage; left great toe tip was black, necrotic, about the size of a nickel; left external lateral foot evidenced an open area approximately 1x10 cm with brown, yellow, purulent, foul smelling drainage, and surrounding skin was thickened, brown, and yellow; left heel evidenced an open area approximately 3x3cm, dark red, shiny, moist, open wound;			

plantar interior left ball of foot: darkened area, thickened, hard scabbed skin, approximately 1x1 cm;

left anterior (front) shin evidenced an approximately 1x1cm brown scabbed area;

and, posterior calf evidenced multiple open, draining areas.

On 3/1/2022, at 12:00 PM, observed both of the patient s fronts of thighs, just above the knees, which were red, the patient indicated this was new, and they were sore. RN J did not indicate she would report this to a physician, and failed to assess/palpate (touch) the areas, or the skin under their clothing/shorts.

On 3/1/2022 at 12:20 PM, RN J assessed the patient s pain after wound care was completed. The patient indicated it was a 9 in his right leg last night, and indicated he/she was crying last night because pain was so bad.

On 3/1/2022 at 12:25 PM, RN J failed to assess the patient s buttocks, posterior legs, and plantar surfaces of both feet. Upon prompting by surveyors, RN assessed patient s buttocks, which appeared red/purple, but blanchable, and patient had stool residue in his/her underwear, RN J failed to offer the patient assistance for personal care, or change their undergarments. During this time, the patient indicated they hadn t showered in a couple weeks, that they went to the sink to wash their self up, and he/she had a shower chair. When queried if the agency ever offered a home health aide to assist with bathing, the patient indicated they were not. The comprehensive reassessment RN J performed on 2/1/2022, evidenced the patient needed help with personal care, but failed to evidence home health aide services was offered to the patient on 2/1/2022, or during any subsequent nursing visit prior to today s visit (3/1/2022).

The home visit was completed at 12:37 PM. During this visit, RN J failed to assess the patient s respiratory, cardiac, genitourinary, gastrointestinal, or other skin areas; did not assess what the patient s blood sugar level was, or if the patient checked it; did not measure any wounds; and did not reconcile the patient s medications.

During an interview with RN J on 3/1/2022 at 12:40 PM, when queried how often she assessed the patient s heart, lung, and bowel sounds, RN J indicated she assessed them every other week or so , and indicated it was because the patient was always fine.

Documents received on 2/15/2022, dated and signed by RN J on 2/8/2022, 2/11/2022, and 2/15/2022, titled Skilled Nurse Visit , all indicated the patient had pitting edema (swelling that leaves pitting/dents in the skin after pressure is applied, indicative of fluid retention in the underlying tissues) to both lower legs, and 1 wound to the right heel; and failed to evidence RN J assessed for pedal pulses; or identified, treated or measured the wound identified by wound clinic M on 1/31/2022, on the patient s left plantar foot. The documents also failed to indicate the presence of any other wounds on the patient s legs, feet, or toes.

A document in the patient s clinical record from wound clinic M dated 1/31/2022, titled Office Visit (for wound clinic M), stated ... here for new wound left foot and chronic wound right heel. Patient has visiting nurses applying collagen and ace wraps for swelling ... Wound care nurse noted on his initial evaluation today that there was a shell of a pistachio nut embedded into the plantar [bottom of] left foot. Therefore he/she has a new wound today on [his/her] left foot ... Full thickness ulceration right heel ... new ulceration from foreign body left foot but [sic] signs of infection ... Chronic lymphedema [condition in which extra lymph fluid builds up in tissues and causes swelling] ....

A document received on 3/3/2022, dated 3/2/2022, but not yet signed by RN C, titled Skilled Nurse Visit evidenced the patient s blood pressure was 176/110 (blood pressure below 120/80 is considered normal), both legs had pitting edema, and multiple new wounds were assessed. The document indicated RN C suspected the presence of infection to wounds, physician I was notified, who instructed the patient to go to the emergency department (ED) for evaluation, and the patient indicated he/she didn t want to go and wait 5-6 hours. RN C also assessed the patient was unable to open his/her medication bottles with childproof lids due to neuropathy and provided/filled a 7 day pill planner.

	During an interview on 3/3/2022 at 2:13 PM, RN C was queried to describe the home nursing visit with patient #10 on 3/2/2022. RN C indicated she was still working on completing the visit note, as it was overwhelming, the patient was in very poor condition, and she was unaware of the severity of his/her wounds. During an interview on 3/3/2022 at 1:29 PM, while discussion of the IJ occurred, person P (chief operations officer, owner) indicated the findings during the surveyors home visit with this patient warranted the calling of an IJ. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR §484.55: Comprehensive Assessment of Patients. 17-14-1(a)(1)(A) 17-14-1(a)(1)(B) 17-15-1(a)			
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the registered nurse failed to conduct the initial assessment within 48 hours of referral for 3 of 14 records reviewed (#2, 10, 11). Findings include: 4. Record review for patient #10 was completed	G0514	1. The Administrator/Director of Healthcare Services or Chief Clinical Officer will reeducate clinicians and intake coordinator on: 2. Comprehensive assessment and admission, if appropriate, will be initiated within 48 hours from referral unless there is a physician specific start of care date, in which case the start of care will be on that date. 3. Addressing all disciplines in referral order. 4. If outside the 48-hour window due to patient's request, clinicians must document the reason and who was informed, including physician. Clinicians will call for a new verbal order for specific start of care date if requested by the patient and why. 5. The Administrator/Director of Health Care Services will collaborate with the Intake Coordinator on the following: a. The Administrator/Director of Health Care Services will review all referrals with focus on referral date, discharge date and/or physician ordered specific start of care date, and disciplines ordered. b. The Administrator/Director of Health Care	2022-04-15

	on 3/3/2022, start of care date 12/7/2021, for certification period 2/5/2022 4/5/2022. Record review evidenced a faxed document received by the agency on 11/30/2021 from skilled nursing facility (SNF) N, titled November 2021 Physician Order Sheet , which was dated and signed on 11/30/2021 by physician R (Physician at SNF N). The document stated ... Discharge home with home health ... PT [physical therapy], Nurse, Bath Aide .... A document dated and signed by administrator/clinical manager A on 12/3/2021, and physician I (certifying physician) on 12/15/2021, titled Physician Order stated ... Order date ... 12/7/2021 ... Effective Date ... 12/3/2021 ... Start of care 12/7/2021 per patient request .... The order was received 7 days after the referral date, effective date 3 days after the referral, and the record failed to indicate any communication was documented between the patient and agency on or prior to 12/7/2021, requesting the delay in the start of care. On 3/1/2022 at 10:45 AM, the patient indicated he/she left SNF N on 12/1/2021, and Interim (agency) came about a week later. When queried if he/she requested a delay to begin home care services, he/she indicated he/she did not. 5. Clinical record review for patient #11 was completed on 3/3/2022, start of care date 01/27/2022, discharge date 2/18/2022, for certification period 01/27/2022 03/27/2022. Record review evidenced a faxed hospital T document was scanned into the agency s EMR (electronic medical record) on 1/21/2022, dated 1/19/2022, titled Office-Clinic Notes , which indicated a referral was made with home care orders for wound care at home, and stated ... refer for Home care wound care to eval and treat .... A document dated and signed by administrator/clinical manager A on 1/24/2022, and physician U (certifying physician) on 1/25/2022, titled Physician Order stated ... Order date ... 01/27/2022 ... Effective Date ... 01/24/2022 ... Agreed upon start of care date 1/27/2022 .... The order was received 6 days after the referral was received, with an effective date 3 days after the referral was received, and the record failed to indicate any communication occurred between the agency and patient/family		Services will coordinate acceptance or denial of the referral with focus on ability to complete the initial comprehensive assessment visit within 48 hours. c. The agency will have written or verbal order for start of care before the initial visit occurs. 6. The Administrator/Director of Health Care Services will assess 100% of referrals for 3 months with combined use of BI analytics tool for 100% compliance. 7. Once 100% compliance is achieved for three consecutive months, the Administrator/Director of Health Care Services will review 25% of referrals quarterly for continued 100% compliance. If at any time the agency falls out of 100% compliance, the Administrator/Director of Health Care Services will reeducate clinicians and intake coordinator on performing assessment within 48 hours and agency will revert to original ongoing monitoring plan as outlined in above steps 3 and 4. 8. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body. 9. Completion date: 04/15/2022 and ongoing.	

to indicate who agreed on the start of care date, or why the start of care was delayed.

During an interview on 2/25/2022 at 1:21 PM, when queried if family or the patient requested the home care services to start on 1/27/2022, family indicated the doctor ordered the home care (wound care) during his appointment on 1/19/2021, family waited like a good week before they called me , and indicated she never said she wanted to wait until the 27th (1/27/2021) to start home care.

17-14-1(a)(1)(A)

1. Record review evidenced an agency policy obtained 2/14/2022, revised 4/2/2021, titled Initial Comprehensive Assessment which stated, & Policy & An initial comprehensive assessment of an individual is conducted & within 48 hours of referral for home care/service(s), or & within 48 hours of the individual s return home, or & on the physician s or allowed practitioner s & ordered start of care date & The initial comprehensive assessment determines the individual s immediate need for care/services, the appropriateness of home care, and the type of care/service to be provided & Initial comprehensive assessments are conducted in accordance with applicable law and regulation by designated, qualified employees in the location where the referred individual will receive care/service &.

2. Clinical record review for patient #2 was completed on 3/3/2022, start of care 4/27/2020, for certification period reviewed 12/8/2021 2/15/2022. Review evidenced an agency document electronically signed by registered nurse N on 12/16/2021, titled Home Health Certification and Plan of Care which listed a primary diagnosis of hereditary hypogammaglobulinemia (an immune system disease in which the body does not produce enough antibodies).

Review evidenced a referral for home care services from entity V, faxed on 3/27/2020. This document stated, & New patient enrollment for home IVIG (intravenous immunoglobulin) infusions & Next infusion to start 4/1/2020 &.

Record review evidenced an agency document electronically signed by registered nurse N on 4/27/2020, titled Pediatric SOC [start of care] , which stated, & Visit Date: 4/27/2020 & this is

	his first Home Infusion &. Agency failed to ensure initial assessment visit was completed on the physician ordered start of care date. 3. During an interview on 2/28/2022 at 2:50 PM, when queried about why start of care dates were delayed, administrator/clinical manager A stated, & we talk to who is making the referral, let them know that we can t start their care until this date & the person on the other end says, okay I ll ask the patient if that s okay &.			
N0518	Patient Rights 410 IAC 17-12-3(e) Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on record review and interview, the agency failed to distribute written information to its patients concerning its policies on advance directives, or the current Indiana Department of Health (IDOH) Advance Directives brochure, last updated November 2018. Findings include: Review of the agency admission packet/home folder received on 2/14/2022 failed to evidence written information concerning the agency's policies on advance directives, or the current IDOH Advance Directives Brochure, revised November, 2018. During an interview and review of the agency's	N0518	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will provide training for all clinicians and clinical record assistants regarding ensuring the home health agency informs and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. 2. Nursing staff will hand deliver The Indiana Department of Health Advance Directives Brochure (current copy revised 11/2018) to call current patients by 4/22/2022. 3. All current premade admission folders will be updated with current Advance Directive Brochure as stated above by	2022-04-22

	home folder on 2/14/2022 at 4:22 PM, administrator/clinical manager A indicated the IDOH information packet was dated 2013, and she was going to update the packet. Review of an agency document obtained 2/14/2022, revised 2018, titled Homecare Admission Consent Form stated, & Patient rights on advance directives & I certify that I have been instructed about, received a copy of, and understand the patient Rights on Advance Directives that was explained to me orally by a representative of Interim Healthcare & I certify that I have received any State specific information/documentation concerning advance directives &.		4/22/2022. 3. Monitoring: The Administrator/Director of Health Care Services will review 100% of the premade admission booklets for 30 days for evidence of Indiana Department of Health Advance Directives Brochure (current copy revised 11/2018) is in each packet. Admission packets will be reviewed until 100% compliance is maintained for 30 days. The Administrator/Director of Health Care Services or designee will make random home visits monthly for the remainder of 2022 to verify written Indiana Department of Health Advance Directives Brochure (current copy revised 11/2018) is present in home folder. 4. Once 100% compliance with admission packets containing correct brochure stated above, and 100% of home visits finds correct brochure in home folder, 25% of admission packets will be reviewed quarterly. If at any time the agency falls out of compliance, reeducation will be provided to clinicians regarding documentation of providing written schedule in patient's home and steps 3 and 4 above will be repeated. 5. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI	

			quarterly and communicated with the Governing Body	
G0520	5 calendar days after start of care 484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on record review and interview, the registered nurse failed to ensure the comprehensive assessment was completed no later than 5 calendar days after the start of care date for 5 of 11 initial comprehensive assessments reviewed (#3, 5, 6, 11, 12). Findings include: 5. Record review for patient #3 was completed on 3/3/2022, start of care date 11/13/2021, transfer date 11/16/2021, for certification period 11/13/2021 1/11/2022. Record review evidenced a document was dated and signed by RN J on 11/13/2021 titled ... Start of Care [comprehensive assessment] . The agency s EMR (electronic medical record) was reviewed on 2/25/2022 at 12:20 PM, which evidenced a tab titled Schedule Event Logs (this tab reflected when a document was created, quality assurance reviewed, modified, and subsequently completed). The EMR indicated the initial comprehensive assessment was completed on 11/22/2021 (9 days after the start of care), not 11/13/2021, and the plan of care was created on 11/22/2021. 6. Record review for patient #11 was completed on 3/3/2022, start of care date 1/27/2022, discharge date 2/18/2022, for certification period 1/27/2022 3/27/2022. Record review evidenced a document was dated and signed by RN I on 1/27/2022 titled ... Start of Care . During an interview on 2/15/2022 at 3:18 PM,	G0520	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will audit all start of care comprehensive assessments to ensure clinician has completed within five days from start of care date. Any incomplete assessments will be completed by day 5. This will be accomplished by review of EMR's Visit by Status Report. 2. Administrator/Director of Health Care Services or Chief Clinical Officer will reeducate clinicians regarding start of care comprehensive assessments must be completed within 5 calendar days after the start of care. 3. Administrator/Director of Health Care Services will run Visit by Status Report in the EMR daily showing incomplete assessments and monitor to ensure Start of Care Assessments are completed within 5 days. 4. Monitoring: 100% of the SOC Comprehensive Assessments will be reviewed for completion within 5 days of start of care for 30 days. If 100% clinical compliance is not confirmed, 100% of start of care comprehensive assessments will be reviewed for an additional 30 days until 100% is achieved for 30 days. 5. If at any time the agency falls out of 100% compliance, the Administrator/Director of Health Care Services will reeducate clinicians and intake coordinator on completion of compressive assessments within 5 days of start of care and agency will revert to original ongoing monitoring plan as outlined in above steps 4 and 5. 6. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body. 7. Completion date: 04/15/2022 and ongoing.	2022-04-15

certification period 1/27/2022 3/27/2022 was requested, and was received from administrator/clinical manager A at 3:51 PM. When queried why the start of care comprehensive assessment wasn t completed, administrator/clinical manager A indicated it had to be sent back to RN I to make corrections, there was an issue with the wound care, where to add the wound on the document, the nurse forgot to add the wound to the document, they were waiting for the nurse to fix it, and there could not be a plan of care generated until the comprehensive assessment was completed.

The agency s EMR was reviewed on 2/25/2022 at 12:27 PM, which evidenced a tab titled Schedule Event Logs . The EMR indicated the comprehensive assessment was completed on 2/15/2022 at 4:04 PM (19 days after the start of care), not 1/27/2022, and the plan of care was created on 2/15/2022.

7. Record review for patient #12 was completed on 3/3/2022, start of care date 1/12/2022, for certification period 1/12/2022 3/12/2022. Record review evidenced a document was dated and signed by RN I on 1/12/2022 titled ... Start of Care

The agency s EMR was reviewed on 2/25/2022 at 12:30 PM, which evidenced a tab titled Schedule Event Logs . The EMR indicated the comprehensive assessment was completed on 1/21/2022 (9 days after the start of care), not 1/12/2022.

8. During an interview on 02/23/2022 at 2:51 PM, when queried how the plan of care was developed, administrator/clinical manager A indicated it was generated (in the EMR) from the comprehensive assessment, and it couldn t be generated until after the comprehensive assessment was completed.

9. During an interview on 2/28/2022 at 3:30PM, when queried why comprehensive assessments/reassessments were authenticated/electronically signed by the RNs on the same day the visit occurred, instead of being dated/signed as completed after any quality assurance/modifications to the documents were made (as evidenced in the EMR task/event logs), administrator/clinical manager A indicated she didn t know why the

documents were signed earlier than they were completed, she couldn t answer that, and she d have to investigate it more. Upon survey exit, nothing further was submitted.

1. Record review evidenced an agency policy obtained 2/14/2022, revised 4/2/2021, titled Initial Comprehensive Assessment which stated, & Policy & An initial comprehensive assessment of an individual is conducted & a) within 48 HOURS of referral for home care/service (s), or b) within 48 HOURS of the individual s return home, or c) on the physician s or allowed practitioner s ordered start of care date & The comprehensive assessment is completed in a timely manner, consistent with the patient s immediate needs, but no later than five calendar days after the start of care &.

2. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Home Health Certification and Plan of Care which stated, & start of care & 12/7/2020 &.

The agency s EMR (electronic medical record) for patient #5 was reviewed on 2/28/2022, which evidenced a tab titled Schedule Task Logs . This tab reflected when a document was created, modified, and completed. This tab evidenced a non OASIS [outcome and assessment information set] SOC [start of care, comprehensive assessment] completed by alternate clinical manager C on 1/23/2021 at 3:26 PM for start of care 12/7/2020. Agency failed to complete the comprehensive assessment within 5 days of start of care date.

3. Record review was completed on 3/3/2022 for patient #6, start of care date 3/15/2021, certification period 5/13/2021 7/11/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 5/10/2021, titled Home Health Certification and Plan of Care which stated, & start of care & 3/15/2021 &.

The agency s EMR (electronic medical record) for patient #6 was reviewed on 2/28/2022, which evidenced a tab titled Schedule Task Logs . This tab evidenced a non OASIS [outcome and assessment information set] SOC [start of care,

	registered nurse N on 5/13/2021 at 7:44 PM for start of care 3/15/2021. Agency failed to complete the comprehensive assessment within 5 days of start of care date. 4. During an interview on 2/28/2022 at 3:30 PM, when queried why comprehensive assessments/reassessments were authenticated/electronically signed by the nurses on the same day the visit occurred, instead of being dated/signed as completed after any quality review/modifications to the documents were made (as evidenced in the EMR task/event logs), administrator/clinical manager A indicated she didn t know why the documents were signed earlier than they were completed, she couldn t answer that, and she d have to investigate it more.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on observation, record review, and interview, the registered nurse (RN) failed to ensure the comprehensive assessment/reassessment included the patient s current health and/or psychosocial status for 12 of 14 records reviewed (#1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13). Findings include: 10. Record review for patient #1 was completed on 3/3/2022, start of care date 8/24/2021, for certification period 12/22/2021 2/19/2022. Record review evidenced a document dated and signed by registered nurse (RN) I on 12/20/2021 titled ... Recertification [comprehensive reassessment] , indicated the patient had three, stage 3 pressure related wounds (Full thickness through all layers of skin, but not to muscle) to sacrum (lower back), left and right hips, was paralyzed from the waist down (cannot move lower extremities, feel pain/discomfort, or voluntarily evacuate bladder/bowel without assist) , Braden scale risk indicated the patient had no sensory deficit which would limit ability to	G0528	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will audit all Comprehensive assessments to ensure accurate patient findings are documented per Interim policy on “Initial Comprehensive Assessment” and “Follow up Comprehensive Assessment” 2. The Administrator/Director of Health Care Services or Chief Clinical Officer will reeducate clinicians on: a. Completion of the Comprehensive Assessments and documentation must include current health, psychosocial, functional, and cognitive status. b. Follow-up Comprehensive Assessment of the patient to determine the patient’s response to the care/services provided, as well as the continued appropriateness of such care/services. c. Accurate and thorough comprehensive assessments and specifics related to each section with emphasis on, but not limited to specifics indicated below: d. Reviewing all referral information to include all pertinent diagnoses and medical history. e. Reviewing all discharge information prior to resumption of care and addressing all new and current problems thoroughly. f. Accurately reflecting patients' prognosis (ex. good, fair, poor).	2022-04-22

	occasionally moist, was 16 (low risk for skin breakdown), no problems were identified with genitourinary system (the organs of the reproductive system and the urinary system), no problems with the gastrointestinal system (tract or passageway of the digestive system that leads from the mouth to the anus) and was paralyzed from the waist down. The document failed to indicate problems with genitourinary system included urinary retention, problems with the gastrointestinal system included decreased ability/inability to defecate due to paralysis, problems with musculoskeletal system included atrophy (muscle wasting) of both legs/feet, and the patient was a high risk for skin breakdown due to current open wounds, paralysis, and skin was constantly moist from wound drainage. A home visit was observed on 2/16/2022 at 11:55 AM, with the patient and RN C. The patient presented lying in his bed, and his athletic shorts were soaked with drainage from his wounds. His legs and feet had no voluntary movement, and both legs/feet were atrophic. The patient indicated he self-performed intermittent urinary catheterization to drain urine. When queried if he performed a regular bowel program, the patient indicated he always wanted to, but was never taught while he was in rehab (prior to agency admission for home health services), and would like to learn how to do a bowel program. 11. Record review for patient #3 was completed on 3/3/2022, start of care date 11/13/2021, transfer date 11/16/2021, for certification period 11/13/2021 1/11/2022. Record review evidenced a document dated and signed by RN J on 11/13/2021 titled ... Start of Care [comprehensive assessment] , which indicated the patient had a postsurgical incision with steri-strips (thin adhesive bandages often used by surgeons as a backup to dissolvable stitches or after regular stitches are removed), unable to take in nutrients by mouth/orally, and presence of a g-tube (a tube inserted in the abdomen directly to the stomach for administration of nutrition, fluids, and/or medications). The document failed to indicate how old the incision was, the appearance of the g-tube insertion site, size/type of g-tube, when the g-tube was inserted, how often the patient received g-tube feedings, or the type of feeding she received. 12. Record review for patient #10 was completed on 3/3/2022, start of care date 12/7/2021, for certification period 2/5/2022		g. Address psychosocial needs and any supportive assistance. h. Accurate pain assessment including current and historical pain rating i. Complete skin assessment documented including any wounds. j. Accurately documenting Braden Scale as evidenced by supporting documentation in the record (i.e., incontinence, mobility, friction). k. Addressing oxygen under respiratory status and adding oxygen to plan of care including medication list. l. Accurate assessment of blood sugar testing, ranges, etc. in endocrine section. m. Accurate assessment of cardiac status complications (I.e., edema, pedal pulses, abnormal heart rate, orthostatic hypotension). n. Accurate assessment and documentation of GI/GU status including but not limited to; last BM, addressing if patient on dialysis, type, and placement of dialysis catheter or if patient has catheter and type as well as urination status of patient who is receiving dialysis. o. Nutritional status addressed including any supplements (i.e., protein shakes) and identifying nutritional risks. Nutritional drinks must be on Medication record. Tube feedings must be on Medication record including how often. p. Accurate assessment and documentation of cognitive/neuro status. q. Documentation of any musculoskeletal abnormalities including but limited to contracture, paralysis, weakness, mobility, etc. r. Completion of fall assessment. s. Include all DME (Durable Medical Equipment) and other supplies. t. Indicate location of any IV, PICC, central line sites and specifics regarding type of catheter. 3. Monitoring: 100% of the SOC Comprehensive Assessments will be reviewed for completion within 5 days of start of care for 30 days. If 100% clinical compliance is not confirmed, 100% of start of care comprehensive assessments will be reviewed for an additional 30 days until 100% is achieved for 30 days. 4. If at any time the agency falls out of 100% compliance, the Director of Health Care Services will reeducate clinicians on initial and follow up comprehensive assessments for	

	4/5/2022. Record review evidenced a document dated and signed by registered nurse (RN) J on 2/1/2022, titled ... Recertification [comprehensive reassessment] , which indicated the patient had 1 diabetic ulcer, non-pitting edema (swelling that does not leave pits in the skin after pressure is applied) to both lower legs, The document failed to evidence the patient had decaying/missing teeth, ate only 1 meal daily, used a cane to ambulate, how often the patient checked his/her blood sugar level, type and assistance received for medication management, transportation needs, personal care needs, or nutritional needs; and failed to indicate RN J assessed the patient had compression dressings on both legs/feet, assessed for presence of pedal pulses (pulses in the feet, indicated for presence of lower extremity edema), identified or measured the wound identified by wound clinic M on 1/31/2022 on the patient s left plantar (bottom) foot, assessed measurements/description of the patient s wound on the right foot, or assessed any additional open skin areas/wounds. Faxed documents in the patient s clinical record from wound clinic M evidenced dated 1/31/2022, titled Office Visit (for wound clinic M), which stated ... here for new wound left foot and chronic wound right heel. Patient has visiting nurses applying collagen and ace wraps for swelling ... Wound care nurse noted on his initial evaluation today that there was a shell of a pistachio nut embedded into the plantar [bottom of] left foot. Therefore he has a new wound today on his left foot ... Full thickness ulceration right heel ... new ulceration from foreign body left foot but [sic] signs of infection ... Chronic lymphedema [condition in which extra lymph fluid builds up in tissues and causes swelling] ... Advised the patient never to go barefoot ... Physician orders ... Apply collagen [dressings derived from usually cow or pig collagen, a crucial role in the wound healing process], foam ... apply 3M 2 layer lite [a 2 layer compression system wrap, not the same as ace wrap] ... Home care to change dressing and wrap on Monday, Wednesday and Friday ... float heels to reduce pressure .... A home visit was observed on 3/1/2022 at 10:30 AM, with the patient and registered nurse (RN) J. RN J was not present upon surveyors arrival. Observed the patient seated on a wheelchair cushion (on the wheelchair), in his/her bedroom, with both lower extremities wrapped with compression wraps, approximately 3-4 inches below the knees, distal to toes. The toes on both feet were exposed, with multiple draining		thorough completion and agency will revert to original ongoing monitoring plan as outlined in above steps step 3 and 4. 5. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body. 6. Completion date 4/22/2022 and ongoing.	

wounds visible. Both legs were swollen above the wraps, and their toes were swollen. The patient had decaying/missing teeth, was alert and oriented, and able to answer questions appropriately.

On 3/1/2022 at 10:37 AM, the patient indicated they had a medical history of diabetes with neuropathy (nerve damage which causes numbness, tingling, and pain), and wounds; he/she took their own blood glucose 1 time per day, since he/she only ate once per day, usually when someone could make some food for them, and it was generally after 7:00 PM; he/she drank coffee and had oatmeal for breakfast sometimes; their blood sugars ran about 160 , and their doctor didn t care as long as they were below 200 ; he/she took 18 units of Levemir (a type of insulin to treat diabetes) daily.

On 3/1/2022, at 10:50 AM, the patient indicated he/she didn t know where the home folder from the agency was located, and indicated they were frustrated that they were denied Medicaid for the second time (in December 2021), and, at that time, the patient was working with entity O (Indiana Area Agency on Aging, which provides services to seniors and persons with disabilities). The clinical record failed to evidence the patient s need for social worker services.

On 3/1/2022, at 10:53 AM, the patient indicated they used a wheelchair, and a cane sometimes to walk. He/she indicated they tried to elevate their legs at night while sleeping. During this time, the surveyors observed medications in a patient belongings bag, and they were reviewed/reconciled with the patient. The patient confirmed they only took the following medications: Levemir 18 U (units) daily, Atenolol 25 mg (milligrams) daily, Atorvastatin 40 mg daily, Ropinirole 0.5 mg daily, and Furosemide 40mg daily. They indicated they have not taken potassium chloride, aspirin, zinc, toujeo, multivitamins, florastor, or metronidazole since their discharge from skilled nursing facility (SNF) N in December of 2021.

On 3/1/2022, at 11:06 AM, when queried how many wounds patient had, RN J stated, I don t know ... there s not a number ... it s hard to tell how many wounds because they all blend together ... one kind of goes into the other ... mainly [his/her] right leg ... we wrapped the left

leg mainly for swelling ... no open wound on left leg .... When queried when the last time wound care was performed, RN J indicated she performed wound care on Friday (2/25/2022) (the patient earlier during this home visit indicated her last home visit was Tuesday, 2/22/2022). When queried how often she measured wounds, RN J indicated the agency measured wounds weekly. When queried what the current wound care orders for this patient were, RN J indicated the wound orders were to wash with normal saline and rewrap. The comprehensive reassessment performed by RN J on 2/1/2022 and all subsequent clinical visit notes (previous to 3/1/2022) evidenced only 1 wound on the patient s right heel, and failed to evidence any other wound(s).

On 3/1/2022, at 11:45 AM, RN J removed a black nylon stocking from the left leg, which was placed by wound clinic 1/31/2022, per both the patient and RN J s testimony. During this time, RN J stated, ... it s not as bad as I expected .... (when she observed the left leg and foot). The leg was red, swollen, had large dent in back from the wrap, and had flaky, scaly skin from knee to toes. The patient yelled in pain more than once, and indicated he/she could feel when she pulled his/her skin off. When she moved to address the foot, the patient indicated he/she couldn t feel it. RN J stated, ... there s no open area ... (in regard to left lateral foot), and surveyor pointed out open wound to RN J on the patient s left lateral foot.

During an interview with RN J on 3/1/2022 at 12:40 PM, when queried how often she assessed the patient s heart, lung, and bowel sounds, RN J indicated she assessed them every other week or so , and indicated it was because the patient was always fine.

13. Record review for patient #11 was completed on 3/3/2022, start of care date 01/27/2022, discharge date 2/18/2022, for certification period 01/27/2022 03/27/2022. Record review evidenced a document dated and signed by RN I on 1/27/2022 titled ... Start of Care , which indicated the patient s primary diagnosis was a pressure ulcer to the left buttock, stage 2 (partial-thickness skin loss into but no deeper than the layers of the skin, includes intact or ruptured blisters), but failed to evidence the description of the wound, surrounding skin, measurements, presence of drainage, or signs/symptoms of infection.

During an interview on 2/15/2022 at 3:51 PM, when queried where the description of the wound was located on the comprehensive assessment, administrator/clinical manager A indicated the nurse forgot to add the wound to the document.

14. Record review for patient #12 was completed on 3/3/2022, start of care date 1/12/2022, for certification period 1/12/2022 3/12/2022. Record review evidenced a document dated and signed by RN I on 1/12/2022 titled ... Start of Care indicated the patient had dizziness/lightheadedness, orthostatic hypotension (a form of low blood pressure that happens when standing up from sitting or lying down), but failed to evidence the patient s blood pressures were assessed from sitting to standing position.

15. Record review for patient #13 was completed on 3/3/2022, start of care date 12/16/2021, for certification period 12/16/2021 2/13/2022. Record review evidenced a document dated and signed by RN N on 12/16/2021 titled ... Start of Care indicated the patient had pain, and had a central venous catheter (CVC- a tube that doctors place in a large vein in the neck, chest, groin, or arm to give fluids, blood, or medications or to do medical tests quickly); and failed to indicate the location or quality of the pain, how the pain was mitigated, or the location and description of the CVC.

During an interview on 2/28/2022 at 3:48 PM, when queried where the location and description of the patient s pain was located on the comprehensive assessment, administrator/clinical manager A indicated it was not there.

17-14-1(a)(1)(A) and (B)

1. Review of an agency policy obtained 2/14/2022, revised 4/2/2021, titled Initial Comprehensive Assessment stated, Policy & The comprehensive assessment is completed to accurately reflect the individual s status at the time of the assessment & Define the scope of an initial comprehensive assessment of each referred individual, including their current health status, their appropriateness for home care as well as their medical, nursing, rehabilitative,

social, and discharge planning needs &.

2. Record review evidenced an agency policy obtained 2/22/2022, revised 1/12/2018, titled Follow-Up Comprehensive Assessment which stated, & Interim HealthCare employees periodically conduct a comprehensive follow-up assessment of the patient/client to determine the patient s/client s response to the care/services provided, as well as the continued appropriateness of such care/services & The comprehensive assessment is completed to accurately reflect the patient s status at the time of the assessment & Define &.

3. A web-based site referenced on 2/15/2022, https://www.in.gov/health/files/Braden_Scale.pdf , titled BRADEN SCALE For Predicting Pressure Sore Risk stated ... SEVERE RISK: Total score 9 ... HIGH RISK: Total score 10-12 ... MODERATE RISK: Total score 13-14 ... MILD RISK: Total score 15-18 ....

4. Clinical record review for patient #4 was completed on 3/3/2022, start of care 5/19/2021, certification period 5/19/2021 6/15/2021. Record review evidenced a referral document for home care titled, Referral Order which stated, & Reason for Referral: Home health aide x2 weeks po [post-operative] surgery on 5/18/2021 &.

Review evidenced an agency document electronically signed by registered nurse N on 5/19/2021, titled Non Oasis [outcome and assessment information set] SOC [start of care, comprehensive assessment] which failed to evidence the carpal tunnel surgery which was listed on referral information.

Review of a fax on 2/22/2022 from clinic BB, titled Encounters and Procedures signed by physician CC on 5/28/2021, stated, & 10 days s/p [status post] right basilar thumb reconstruction & on 5/18/2021 & also 3 ½ months s/p revision left thumb reconstruction & She reports continued pain and has noticed drainage from her incision &.

Review evidenced an agency document electronically signed by registered nurse N on 5/19/2021, titled Non Oasis [outcome and

comprehensive assessment] which stated, & Integumentary Status & Pink/WNL [within normal limits] & Dry &. Comprehensive assessment failed to include patient s surgical incision.

The start of care/comprehensive assessment failed to assess patient s GI (gastro-intestinal) status and failed to assess patient s diet.

During an interview on 2/21/2022 at 2:02 PM, when queried about what information should be included on the comprehensive assessments, administrator A stated, &I would expect to have all patient diagnosis, surgeries, and pertinent information listed & I would expect to see the recent surgery for [patient #4] on the comprehensive assessment &.

5. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review of a document faxed on 2/23/2022 by entity K, evidenced a document titled Hematology & Medical Oncology Phone Visit Note which was electronically signed by physician DD on 1/21/2021. This document stated, & Plan: & Unfortunately there are not many options available for him & I did explain we could continue on transfusional support as we have been, but we could also consider Hospice for him as well & He is not willing to commit to Hospice at this point, but was willing to think about it & we will plan on continuing with frequent blood checks as well as transfusional support as needed &.

Record review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Non Oasis [outcome and assessment information set] Recertification [comprehensive re-assessment] which stated, & Prognosis & Good &. Comprehensive assessment failed to accurately reflect patient s prognosis.

Review of an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled HHA [home health aide] Care Plan stated, & change depends &.

Record review evidenced an agency document

manager C on 4/1/2021, titled Non Oasis [outcome and assessment information set] Recertification [comprehensive re-assessment] which stated, & Braden Scale & Moisture & Rarely Moist Skin is usually dry, linen only requires changing at routine intervals & Friction & Shear ... No Apparent Problem Moves in Bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair &Total : 19 & Integumentary Status & need to use rolled towel under edge of hip left right to change position every 2-3 hours when not walking & Sits in recliner 24/7 except when walks or uses commode & GU [genitourinary] & Frequency &. Comprehensive assessment failed to accurately reflect patient s incontinence and failed to include an accurate Braden Scale.

The recertification/comprehensive assessm stated, & Integumentary Status & Needs to increase protein & Will drink protein shakes daily instead of every other day & Nutritional Health Screen & Without reason, has lost more than 10 lbs, in the last 3 months & Has open decubitus, ulcer, burn or wound & Has an illness/condition changed the type/amount of food eaten & Takes3 or more prescribed or OTC [over the counter] medications a day & Frequently has diarrhea or constipation & Over/under weight by 10% & Enter Physician s Orders or Diet Requirements & Regular &. Comprehensive assessment failed to accurately depict patient s nutritional status and protein shakes taken.

During an interview on 2/28/2022 at 10:12 AM, administrator/clinical manager A indicated if prognosis was good on a comprehensive assessment they would expect to see some improvement in patient s goals. Administrator/clinical manager A stated at 11:15 AM regarding patient #5 s Braden Scale, & it s an error & I would not expect to see skin is dry on the Braden if patient wears depends & It should be also listed as incontinence on the recert [recertification] &. At 11:16 AM, Administrator/clinical manager A indicated protein shakes should be listed on the comprehensive assessment.

6. Clinical record review was completed on 3/3/2022 for patient #6, start of care date 3/15/2021, certification period 5/13/2021 7/11/2021. Record review evidenced an agency document electronically signed by alternate clinical manager C on 5/10/2021, titled Non Oasis [outcome and assessment information

re-assessment] which stated, & Pain & Intermittent & Aching & Knees & 0=No Pain & Arthritis pain in knees with ambulation & Musculoskeletal & Joint Pain & Knees &. recertification failed to indicate why patient's pain rating was "0" and indicated patient had pain in knees. A section titled Fall Assessment was not completed. Comprehensive assessment failed to accurately depict patient s current or historical pain rating and failed to accurately reflect patient s fall assessment risk.

During an interview on 2/21/2022 at 2:02 PM, when queried about what information should be included on the comprehensive assessments, administrator/clinical manager A stated, &I would expect to have all patient diagnosis, surgeries, pain assessments, and pertinent information listed & should be all filled out &.

7. Clinical record review was completed on 3/3/2022 for patient #7, start of care 1/14/2003, for certification period 6/8/2021 8/6/2021. Record review evidenced an agency document electronically signed by alternate clinical manger C on 6/3/2021, titled Oaisis [sic] [outcome and assessment information set] D-1 Recert [comprehensive re-assessment] which stated, & Endocrine Interventions & Skilled Nurse to monitor blood sugars with visits &. No blood glucose reading was evidenced on comprehensive assessment.

Recertification/comprehensive assessment stated, & GU [genitourinary] & Suprapubic catheter & Last Changed 3/23/2021 &. Comprehensive assessment failed to accurately depict when patient s catheter was last changed.

Recertification/comprehensive assessment stated, & GI [gastrointestinal] & Last BM [bowel movement] & 4/5/2021 &. Comprehensive assessment failed to accurately depict patient s gastrointestinal status.

During an interview 2/23/2022 at 1:31 PM, administrator/clinical manager A indicated the comprehensive assessment was completed in error, and stated, & last BM and catheter change are not correct &.

8. Clinical record review was completed on 3/3//2022, for patient #8, start of care 6/23/2008,

certification period reviewed 12/13/21 2/10/2022. Review evidenced an agency document electronically signed by alternate clinical manager C on 12/10/2021, titled Non Oasis [Outcome and assessment information set] Recertification [comprehensive re-assessment] which stated, & Pain & Continuous & Burning & back/tail bone area & 0= No Pain &. Comprehensive assessment failed to accurately depict patient s pain level and intensity.

Recertification/comprehensive re-assessment stated, & Integumentary Status & 6cm x 5 cm areas with stage 2 pressure ulcers 2x1 2cmx1 at gluteal area & Wound 1 & Sacral area & Length 2cm & Width 1cm & Depth .25 cm &. Comprehensive assessment failed to accurately reflect how many wounds patient had, or their locations.

Recertification/comprehensive re-assessment stated, & History of blood clots year of SCI [spinal cord injury] with GreenField filter placement & Comprehensive assessment failed to list blood clots or filter placement in diagnosis or surgical history sections.

Recertification/comprehensive re-assessment stated, & Nutritional Health Screen & Protein shakes daily & Physician s Orders or Diet Requirements & No Concentrated Sweets &. Comprehensive assessment failed to accurately reflect type of protein shakes, or patient s nutritional status.

Recertification/comprehensive re-assessment stated, & Supplies &. This section was not completed, and failed to list hospital bed, wheelchair, hoyer lift, etc.

During an interview on 2/21/2022 at 2:02 PM, when queried about what information should be included on the comprehensive assessments, administrator/clinical manager A stated, &I would expect to have all patient diagnosis, surgeries, interventions, and pertinent information listed &.

During an interview on 2/28/2022 at 9:20 AM, administrator/clinical manager A indicated whatever supplies are in home being used, grab bars, raised toilet seat, hospital bed, wound supplies, lift chair, wheelchair, and any type of

listed on the comprehensive assessment.

During an interview 3/2/2022 at 1:18 PM, administrator/clinical manager A stated, & If we are addressing pain, yes & we should include instructions to mitigate pain, pain levels, pain goals, and add to care plan & when queried about documentation of pain on comprehensive assessments.

9. Clinical record review was completed on 3/3/2022 for patient #9, start of care 1/31/2022, certification period 1/31/2022 3/31/2022. Record review evidenced an agency document electronically signed by registered nurse J on 1/31/2022, titled OASIS [outcome and assessment information se]) -D1 Start of Care [comprehensive assessment] which stated, & Genitourinary Assessment & No Problems identified &. Comprehensive assessment failed to indicate if patient urinates normally, or if she received dialysis.

Start of care/comprehensive assessment stated, & Endocrine/hematological Assessment & Diabetes & Blood Sugars Performed By: Patient & Patient checks blood sugar twice daily; she isn t taking any insulin since discharge per PCP [primary care provider] &. Comprehensive assessment failed to evidence any blood glucose measurements were recorded.

Start of care/comprehensive assessment stated, & Potential Risk for Infection Assessment & IV [intravenous]/venous access device & poor hydration & Poor mobility & poor nutrition &. Comprehensive assessment failed to specify what type, location, and assessment of patient s dialysis access catheter.

Start of care/comprehensive assessment stated, & Potential Risk for Infection Assessment & poor hydration & poor nutrition & Nutrition assessment & No problems identified &. Nutritional Requirements & Heart healthy & No concentrated sweets &. Comprehensive assessment reflected contradicting nutritional status.

Start of care/comprehensive assessment stated, & Respiratory Assessment & Dyspnea & Oxygen use, intermittent LPM 1 Via Nasal

	to include oxygen in durable medical equipment section. Observation of a home visit for patient #9 was conducted 2/22/2022 at 3:30 PM, to observe a routine physical therapy visit. During the visit, the surveyor observed the patient had a right subclavian dialysis catheter, which was not included on comprehensive assessment. Observation failed to evidence any oxygen in use, which was listed on comprehensive assessment. During an interview on 3/2/2022 at 1:05 PM, administrator/clinical manager A stated, & yes, the dialysis catheter should be assessed and included & when asked if she would expect to see a dialysis catheter listed and assessed on comprehensive assessment. At 1:20 PM, administrator/clinical manager A stated, & If they re on oxygen then yes, should have it listed & when asked if a comprehensive assessment should include all patient s medical equipment.			
G0534	Patient's needs 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview, the registered nurse failed to ensure the comprehensive assessment/reassessment included all of the patient's discharge planning needs for 3 of 4 discharge records reviewed (#4, 5, 6). Findings include:	G0534	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will audit all Comprehensive assessments and clinical notes for accurate and thorough documentation of Patient’s needs. 2. The Administrator/Director of Health Care Services or Chief Clinical Officer will reeducate clinicians on Comprehensive Assessment, discharge planning, and patient/caregiver response to care including: a. Completing assessment must accurately reflect the individual's status at the time of the assessment including their current health status, their appropriateness for home care as well as their medical, nursing,	2022-04-22

	1. Review of an agency policy obtained 2/14/2022, revised 4/2/2021, titled Initial Comprehensive Assessment stated, Policy & The comprehensive assessment is completed to accurately reflect the individual s status at the time of the assessment & Define the scope of an initial comprehensive assessment of each referred individual, including their current health status, their appropriateness for home care as well as their medical, nursing, rehabilitative, social, and discharge planning needs &. 2. Record review evidenced an agency policy obtained 2/22/2022, revised 1/12/2018, titled Follow-Up Comprehensive Assessment which stated, & Interim HealthCare employees periodically conduct a comprehensive follow-up assessment of the patient/client to determine the patient s/client s response to the care/services provided, as well as the continued appropriateness of such care/services & The comprehensive assessment is completed to accurately reflect the patient s status at the time of the assessment &. 3. Clinical record review for patient #4 was completed on 3/3/2022, start of care 5/19/2021, certification period 5/19/2021 6/15/2021. Review of an agency document electronically signed by registered nurse N on 5/19/2021 titled Home Health Certification and Plan of Care , listed a primary diagnosis of unilateral primary osteoarthritis of first carpometacarpal joint right hand (arthritis of the right thumb). This document stated, & Orders for Discipline and Treatments: HHA (home health aide) Frequency: 3 hours a day x 14 days & HHA to assist with ADL s (activities of daily living) & IADL s (instrumental activities of daily living) per HHA care plan &. Review evidenced an agency document electronically signed by registered nurse N on 5/19/2021, titled Non Oasis [outcome and assessment information set] SOC [start of care, comprehensive assessment] which stated, & Discharge Plans & Self care &. Comprehensive assessment failed to include the patient s discharge planning needs such as community resources, education on ADL s (activities of daily living), incision care, or pain management. A phone interview was conducted patient #4 on 2/14/2022 at 5:45 PM. Patient #4 refused a home health aide, and for one week, did not receive any home health aide services from this		rehabilitative, social and discharge planning needs. b. Assessment and documentation of the patient's/client's response to the care/services provided, as well as the continued appropriateness of such care/services. c. Discharge planning including: . Discharge Planning, including assessment for support or resources at discharge and assistance to obtain services. ii. Discharge Planning is ongoing from the start of care. iii. Discharge planning needs should include specific educational needs. iv. Completion of transfer/discharge summary. 3. Monitoring: 100% of clinical visit notes and transfer/discharge summaries will be reviewed for completion and accuracy for 30 days. If 100% clinical compliance is not confirmed, 100% of clinical notes and transfer/discharge summaries will be reviewed for an additional 30 days until 100% is achieved for 30 days. 4. If at any time the agency falls out of 100% compliance, the Administrator/Director of Health Care Services will reeducate clinicians on discharge planning is ongoing and must be documented and completion of transfer/discharge transfers must	

	agency, and at the end of May, the agency sent a different caregiver. Patient #4 stated the agency did not offer any help with finding other service providers or resources. Patient #4 indicated she called her insurance company and they helped her find another home health agency to provide care. During an interview on 2/21/22 at 2:10 PM, administrator/clinical manager A stated, &you are correct, there is no discharge notification or summary noted & we should have put in a discharge summary for this patient & when asked about discharge information for patient #4. During an interview on 2/28/2022 at 2:50 PM, administrator/clinical manager A stated, &We put in a discharge planning visit, and the next visit is discharge. Discharge planning is ongoing & when asked how discharge planning works. 4. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Home Health Certification and Plan of Care . This document listed a primary diagnosis of myelodysplastic syndrome (group of diseases marked by disruption of production of blood cells). This document stated, & Prognosis & Good & Orders for Discipline and Treatments & SN [skilled nurse] frequency: 2 visits /week x 9 weeks & HHA [home health aide] Frequency: 2-4 hrs [hours] 1-2x/day 6 days/week x 9 weeks & Physical Therapy 2 v/week (visits per week) x9 weeks (for 9 weeks) & Skilled nurse overall assessment. TPR [temperature, pulse, respirations] B/P [blood pressure] Orthostatic B/P & Assess skin & apply Foam border dressing to sacral area twice a week and as needed & HHA to assist with personal care, incontinent care, and ADL s [activities of daily living] per plan of care &. Record review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Non Oasis [outcome and assessment information set] Recertification [comprehensive re-assessment] which stated, & Rehabilitation Potential & Ongoing care Medically Fragile & DC Plan:		be completed. The agency will also revert to the original ongoing monitoring plan as outlined above in steps step 3 and 4. 5. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body 6. Completion Date: 4/22/2022	

to assume care safely &. Discharge planning needs failed to include who would complete wound care, who would assist patient with ADL s, who would monitor vitals, and any therapy discharge needs.

During an interview on 2/28/2022 at 10:45 AM administrator/clinical manager A indicated the comprehensive assessment should include discharge planning needs pertinent to the patient s status, and she did not know whether the agency was aware of hospice referral, and the referral should be in patient s clinical record if they were aware of referral. She also indicated that if patient was receiving hospice care, the agency should have put in a discharge planning visit/discharge summary or continued care with hospice.

5. Clinical record review was completed on 3/3/2022 for patient #6, start of care date 3/15/2021, certification period 5/13/2021 7/11/2021, evidenced an agency document electronically signed by alternate clinical manager C on 5/10/2021, titled Home Health Certification and Plan of Care which evidenced a primary diagnosis of heart failure. This document stated, & Orders for Discipline and Treatments & HHA (home health aide) frequency: & HHA 1-2 hours 2 x a week for bathing x 9 weeks & HHA to assist with personal care, incontinent care, and ADL s (activities of daily living) per POC (plan of care) under supervision of an RN (registered nurse) &.

Record review evidenced an agency document electronically signed by alternate clinical manager C on 5/10/2021, titled Non Oasis [outcome and assessment information set] Recertification [comprehensive re-assessment] which stated, & Discharge Plans & Client to be discharged to the care of & self care & Discharge when goals met &. Discharge planning needs failed to include any education needs about heart failure, who would assist patient with bathing, or activities of daily living.

Record review evidenced an agency document electronically signed by person D (former scheduler) on 5/24/2021, titled Missed Visit which stated, & Client Hospitalized & 5/23 &. No other documentation was found for patient #6. No discharge summary or transfer summary was noted. No other visits were documented as completed after hospital admission. No follow-up from agency was noted. Comprehensive

	assessment failed to include accurate discharge needs for this patient. During an interview on 1/21/2022 at 2:34PM administrator/clinical manager A stated, & Oasis patients all get transfer summaries & No transfer summary was completed for this patient &. Administrator A indicated comprehensive assessments should include patient s specific discharge needs. 17-14-1(a)(1)(B)			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the registered nurse (RN) failed to ensure the patient s medication profile included an accurate list of all medications the patient currently used, which included dose, route, frequency, and/or indications for use, for 4 of 14 records reviewed (#3, 7, 10, 14). Findings include: 6. Record review for patient #3 was completed on 3/3/2022, start of care date 11/13/2021, transfer date 11/16/2021, for certification period 11/13/2021 1/11/2022. Record review evidenced a document dated and signed by RN C on 11/13/2021, titled SN [skilled nurse] Teaching/Training Visit , which indicated the patient used albuterol (aerosolized/inhaled medication to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and/or chest tightness). The document failed to evidence the dose, frequency, or indications for use of albuterol. A document dated and signed by RN J on 11/13/2021 titled Home Health Certification and	G0536	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will audit all client records to ensure the patient's medication profile includes an accurate list of all medications the patient is currently using including dose, route, frequency, and indication for use. If discrepancies are found, Physician will be notified, and medication orders will be clarified and corrected. 2. The Administrator/Director of Health Care Services or Chief Clinical Officer will reeducate clinicians on assessment of medications patients currently taking and documenting medication on Medication profile as well as the following: a. Assessing drug interactions and reporting any major drug interactions to the physician including date, time and who was notified at the physician's office. b. Completing medication review at each nursing visit. c. Upholding patient rights, which include right patient, right drug, right dose, right route, and right time of administering medications including instructions regarding safe and effective use of mediation, name and description of medication, dosage, route, potential side effects, and duration of drug therapy. d. The medication profile should contain all medications in the home including any over the counter medications. e. All as needed medications must include an indication for use. f. Any medication discrepancies, changes, and noncompliance will be reported to the physician and case manager with an updated order to reflect noted changes or discrepancies. g. Complete home visit with RN case managers	2022-04-15

	Plan of Care failed to evidence albuterol was listed on the medication profile. During an interview on 02/23/2022 at 2:51 PM, when queried if albuterol was on the plan of care or medication profile, administrator/clinical manager A indicated she didn t see it on there. 7. Record review for patient #10 was completed on 3/3/2022, start of care date 12/7/2021, for certification period 2/5/2022 4/5/2022. Record review evidenced an agency document signed and dated by RN J on 2/1/2022, and physician I (certifying, primary care physician) on 2/7/2022, titled "Home Health Certification and Plan of Care", for certification period 2/5/2022 - 4/5/2022. This document indicated the patient s medications included metronidazole (an antibiotic), atenolol (to treat high blood pressure), lasix (a diuretic to treat fluid retention), potassium chloride (supplement), ropinirole (to treat restless leg syndrome), toujeo max solostar (insulin to treat diabetes), zinc sulfate (supplement), aspirin, furosemide (generic for Lasix- duplicate entry), a multivitamin, and florastor (probiotic for gut health). The medication list failed to include the patient took Levemir (injectable medication used to treat diabetes). A home visit was observed on 3/1/2022 at 10:30 AM with the patient and RN J. RN J was not present upon surveyors arrival. At 10:53 AM, the surveyors observed medications in a patient s belongings bag, and they were reviewed/reconciled with the patient. The patient confirmed he/she only took the following medications: Levemir 18 U (units) daily, Atenolol 25 mg (milligrams) daily, Atorvastatin 40 mg daily, Ropinirole 0.5 mg daily, and Furosemide 40mg daily. He/she indicated he/she has not taken potassium chloride, aspirin, zinc, toujeo, multivitamins, florastor, or metronidazole since his/her discharge from skilled nursing facility (SNF) N in December of 2021. 17-14-1(a)(1)(B)		compliance. Completed 3/8/2022. 3. Monitoring: 100% of medication profiles will be reviewed for accurate list of medications for 30 days. If 100% compliance is not achieved, 100% medication profiles will be reviewed for an additional 30 days until 100% compliant for a 30-day timeframe. 4. If at any time the agency falls out of 100% compliance, the Administrator/Director of Health Care Services will reeducate clinicians on medication profiles need to reflect all medications. The agency will also revert to the original ongoing monitoring plan as outlined above in steps step 3 and 4. 5. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body 6. Completion date: 4/15/2022 and ongoing.	

	1. Review of an agency policy obtained 2/14/2022, revised 4/2/2021, titled Initial Comprehensive Assessment stated, Policy & The standardized assessment includes the elements as stated in the content of the following documents & Start of Care Skilled Adult Assessment & and the Medication Profile &. 2. Record review evidenced an agency policy obtained 2/22/2022, revised 1/12/2018, titled Follow-Up Comprehensive Assessment which stated, & The standardized assessment includes the elements as stated in the content of the following documents & Follow up/Resumption of Care Skilled Adult Assessment & Follow Up Comprehensive Assessment & and update the Medication Profile form &. 3. Record review evidenced an agency policy obtained 3/2/2022, revised 12/21/2021, titled Medications which stated, & Interim HealthCare ensures that they have the right patient, right drug, right dose, right route and right time prior to administering any medications & the designated qualified nurse provides the patient/caregiver with medication instructions that include at a minimum & Safe and effective use of medication & Name and description of the medication & Dosage, route of administration, and duration of drug therapy &. 4. Clinical record review was completed on 3/3/2022 for patient #7, start of care 1/14/2003. Record review evidenced an unsigned agency document titled Medication Profile which stated, & Care Period: 2/3/2022 4/3/2022 & Active Medications & Januvia [for blood sugar] 100 mg [milligrams] oral tablet 1-tab, daily by mouth & Motrin [anti-inflammatory] 800 mg oral tablet, 1-tab-daily as needed by mouth & Mucinex allergy [helps thin mucous] 1-tab every 6 hrs [hours] as needed by mouth &. Medication profile failed to evidence an indication for as needed Motrin and Mucinex and failed to evidence insulin. Observation of a home visit was conducted on 2/21/2022 at 9:30 AM for patient #7, to observe home health aide (HHA) P completing a routine HHA visit. During the home visit, patient #7 indicated he takes insulin 10 units in the morning if his blood sugar is above 150. Patient stated, & I only take Januvia if my blood sugar is high &.			

non-compliance with medications, indications for taking medications as needed, and failed to include insulin on medication profile.

During an interview on 2/23/2022 at 1:15 PM, administrator/clinical manager A stated, & [medication list] usually comes over with referral signed by physician & when queried about how the nurses compile the patient s medication list. When asked about what a complete medication order would include, administrator/clinical manager A stated, & what med is, dose, how often, specific times, route &. When asked about what should be included in a PRN (as needed) medication order, administrator/clinical manager A stated, & medication dose, route, how often like every 4 hours, schedule, and what it s for & if it s for pain &.

5. Clinical record review was completed on 3/3/2022, for patient #14, start of care 4/22/2020. Record review evidenced an unsigned agency document titled Medication Profile which stated, & Care Period: 2/17/2022 4/17/2022 & Active Medications &. Medication profile failed to evidence a medication called amlodipine (blood pressure medication).

Observation of a home visit for patient #14 was conducted on 2/21/2022 at 10:30 AM to observe a routine home health aide visit. During the home visit, a prescription, dated 1/21/2022, prescribed by physician EE, was observed on the patient s kitchen table for amlodipine (blood pressure medication) 10 mg (milligrams) daily by mouth. At 11:07 AM, patient #14 indicated amlodipine was not a new medication, but the doctor increased the dosage 1/21/2022 to 10 mg.

During an interview on 2/14/2022 at 10:12 AM, administrator/clinical manager A stated, when queried how medications are updated, & we update medication list in [electronic medical record] with medication bottles & send electronic order or call the doctor s office and verify verbally & we get orders for over-the-counter medications & every visit the nurses check the medication list &. At 10:17 AM, administrator/clinical manager A indicated that drug regimen review is performed in the electronic medical record software, and it automatically checks for medication interactions. Administrator/clinical manager A stated at 10:17 AM, & for therapy only cases, the therapist

	medical record and checks for interactions & when queried how drug regimen reviews are performed in therapy only cases. During an interview 3/2/2022 at 1:26 PM, administrator/clinical manager A stated, &they need to add it to medication list and verify the prescription with bottle & when queried about how nurses make sure the medication profile is accurate and includes new medications.			
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on observation, record review, and interview, the registered nurse (RN) failed to ensure the comprehensive assessment was updated and revised (including the administration of the OASIS outcome and assessment information set) for 3 of 3 records reviewed with patients who experienced a significant change in condition (#3, 5, 10). Findings include: 5. Record review for patient #3 was completed on 3/3/2022, start of care date 11/13/2021, transfer date 11/16/2021, for certification period 11/13/2021 1/11/2022. Record review evidenced a document dated and signed by administrator/clinical manager A on 11/15/2021 at 11:40 AM, titled Communication Note , which stated ... Daughter called and informed RN that patient fell last nigh transferring self ... RN spoke to daughter and informed daughter that patient requested only 1 skilled nurse visit per week when care was started. RN will be calling NP [nurse practitioner] regarding patient .... The record failed to evidence a skilled nursing comprehensive reassessment visit was offered or performed as a result of the patient s fall.	G0544	1. Investigative results were reviewed with RN J on 3/7/22. Based on the results of the investigation, the following actions were taken. Terminated 03/07/2022, reported misconduct/unsafe clinical practices to Indiana State Board of Nursing 03/08/2022 and Michigan State 03/09/2022 Board of Nursing, and reported to Office of Inspector General on 03/09/2022 for fraudulent medical record entries and fabricating documentation for visits not performed. 2. Alternate Administrator/Alternate Nursing Supervisor made Nursing Visit to patients' home 3/2/2022 visit included a complete assessment, including analysis of the assessment, which was documented in the clinical record, full review of the plan of care, and medication review. The physician was updated on current patient status and the clinician secured a new physician order for frequency of services, medication discrepancies, and wound care. The clinician attempted to initiate additional services to ensure patient's safety in home as well as ADL care. Patient refused Occupational Therapy and Home Health Aide after multiple offers. Patient was seen by the wound clinic on 3/9/22, per Physician recommendation. 3. Report was made to adult protective services and child protective services on 3/3/2022.	2022-04-15

	A document dated and signed by physical therapist (PT) K on 11/15/2021 at 2:00 PM, titled Communication Note , indicated when physical therapist (PT) K arrived at the patient s home, family indicated the patient was going to hospital FF via private vehicle with a bad bruise on leg . A document dated and signed by RN J on 11/16/2021, titled ... Transfer , indicated the patient was admitted to the hospital FF. During an interview on 2/23/2022 at 2:51 PM, when queried if a nurse performed a skilled nursing visit after the patient fell on 11/15/2021, administrator/clinical manager A indicated there was not. When queried to describe the agency s protocol for falls, or if the agency had a policy on falls, administrator/clinical manager A indicated it was a case-by-case basis, and was unsure if there was a policy. A document received on 2/24/2022 at 1:47 PM titled Occurrence Log evidenced an entry dated 11/16/2021, which indicated the patient fell and was admitted to the hospital. 6. Record review for patient #10 was completed on 3/3/2022, start of care date 12/7/2021, for certification period 2/5/2022 4/5/2022. Record review evidenced a document dated and signed by RN J on 2/1/2022, titled ... Recertification [comprehensive reassessment] , which indicated the patient had 1 wound- a diabetic ulcer (a wound caused by complications of diabetes) on the right heel. The document failed to evidence presence of any additional open skin areas/wounds. A faxed document in the patient s clinical record from wound clinic M, dated and received by the agency on 1/31/2022, titled Office Visit (for wound clinic M), stated ... here for new wound left foot and chronic wound right heel. Patient has visiting nurses applying collagen and ace wraps for swelling ... Wound care nurse noted on his initial evaluation today that there was a shell of a pistachio nut embedded into the plantar [bottom of] left foot. Therefore he has a new wound today on his left foot ... Full thickness ulceration right heel ... new ulceration from foreign body left foot but [sic] signs of		4. Patients seen by RN J were seen by the end of day 3/4/22, with wound care patients being seen by the end of day 3/3/22. Nursing visits were performed by the Administrator/Director of Health Care Services, Alternate Administrator/Alternate Nursing Supervisor and Chief Clinical Officer. The visit included the following: complete assessment and an analysis of the assessment was documented in the clinical record, full review of plan of care for accuracy, medication review, and complete skin assessment was done including assessment of wounds if any and for presence of new wounds. Notification to MD if necessary additional orders were identified. 5. The Chief Clinical Officer assessed the Administrator/Director of Health Care Services' knowledge and provided additional training to Administrator/Director of Health Care Services on the following: Completed 03/04/2022 including review of completed clinical records thoroughly to ensure sound clinical practices are documented and patient current condition is accurate. Ensuring individuals are admitted to home care only if the needed care/service can be provided by an appropriately qualified individual. 6. The Administrator/Director of Health Care Services or Chief Clinical Officer will lead training sessions as well as conduct real-time reviews of charts, follow up assessments, and plans of care to ensure updates are made to plan of care as frequently as patient condition warrants due to major decline, improvement, but no less frequently then every 60 days. 7. The Administrator/Director of Health Care Services or Chief Clinical Officer will educate clinicians on the following: a. Updating the plan of care with changes in condition and or at minimum every 60 days to reflect accurate patient status. b. Reporting change of condition with Director of Health Care Services to ensure follow-up was completed and to assess for changes necessary to patient plan of care including the need for other disciplines. c. Notifying MD and obtaining order to make extra home visits as needed for fall or change in condition to assess for injury or new care needs. d. Filling out occurrence reports for falls or sentinel events and conducting a root-cause analysis. 8. Monitoring: 100% of the visit notes and follow-up assessments for 30 days. If 100% clinical compliance is not confirmed, 100% of clinical documentation will be reviewed for an	

	infection ... Chronic lymphedema [condition in which extra lymph fluid builds up in tissues and causes swelling] .... A home visit was observed on 3/1/2022 at 10:30 AM, with the patient and RN J. RN J was not present upon surveyors arrival. Observed the patient seated on a wheelchair cushion (on the wheelchair), in his/her bedroom, with both lower extremities wrapped with compression wraps, approximately 3-4 inches below the knees, distal to toes. The toes on both feet were exposed, with multiple draining wounds visible. Both legs were swollen above the wraps, and the toes were swollen. The patient was alert and oriented, and able to answer questions appropriately. On 3/1/2022 at 10:40 AM, the patient indicated he/she hasn t been seen at wound clinic M for several weeks, since they didn t have transportation; his/her left leg and foot bandage hasn t been changed for 3 weeks, the right leg and foot hasn t been changed for 2 3 weeks, and this was because RN J wanted them left in place to heal . On 3/1/2022, at 10:56 AM, the patient indicated his/her pain was currently about 4-5 (out of 10, with 0 = no pain, and 10 = worst pain ever), last night it was 10 , and when queried if he/she took any pain medications, he/she stated, ... My doctor [physician I] doesn t believe in that .... , and indicated physician I wanted them to go to the pain management place , but the patient didn t want to. On 3/1/2022, at 11:06 AM, when queried how many wounds patient had, RN J stated, I don t know ... there s not a number ... it s hard to tell how many wounds because they all blend together ... one kind of goes into the other ... mainly [his/her] right leg ... we wrapped the left leg mainly for swelling ... no open wound on left leg .... When queried when the last time wound care was performed, RN J indicated she performed wound care on Friday (2/25/2022). The comprehensive reassessment performed by RN J on 2/1/2022, and all subsequent clinical visit notes (as of 3/1/2022) evidenced only 1 wound on the patient s right heel, failed to evidence any other wound(s), and failed to evidence a comprehensive reassessment was performed for the significant change in condition.		additional 30 days until all clinical documentation is 100% compliant for a 30-day time frame. 9.If at any time the agency falls out of 100% compliance, the Administrator/Director of Health Care Services will reeducate clinicians on comprehensive assessment as outlined above and the agency revert to the original ongoing monitoring plan as outlined above in step 8. 10. Survey results, quality record reviews, supervisory visits and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body. 11. Completion date: 04/15/2022 and ongoing	

On 3/1/2022, at 11:20 AM, the right lower leg was observed. Skin from the knee down to the ankle was scaly, flaking, red, shiny in some areas, and swollen; the right foot and ankle were red, thickened, flaky, and swollen; the top of the right foot and toes evidenced copious amounts of macerated (wet, soggy, pale in color, due to excessive moisture) tissue and purulent greenish, yellow, foul-smelling drainage.

Wounds observed during this visit to the right lower extremity included, but were not limited to, the following:

right 3rd toe with darkened area approximately 1x2 cm (centimeters), surrounding skin thickened, yellow, flaky, macerated, drainage was yellow/green, and purulent, and all toes were stuck together from old/current drainage;

right external lateral foot was brown/yellow in color, active bleeding, an open area approximately 2 x 10 cm, surrounding skin was thickened, yellow, flaky, and macerated;

top of right foot over the center evidenced an open area, was bright red, moist, macerated, with greenish yellow drainage, measured approximately 4 x 4 inches in, surrounding skin was macerated, flaky, yellow, and red;

bottom of the right heel evidenced a dark area next to a gray/light pink open area with full thickness (damage past all layers of skin), approximately 1 x 1 cm, surrounding skin was thickened, flaky, dry, cracking, yellow;

right interior lateral calf was dark red/purple in color, an open area approximately 2x2 cm, and surrounding skin was red, flaky, swollen;

and, posterior (backside) right calf evidenced 2 or more scabbed areas approximately 1x1 cm each, surrounded by red, swollen, flaky skin.

On 3/1/2022, at 11:45 AM, RN J removed a black nylon stocking from the left leg, which was placed by wound clinic 1/31/2022, per both the patient and RN J s testimony. The black nylon had a large amount of thick, brown exudate (drainage) on it. The patient s toes were visible, and all had skin sloughing (falling) off, were moist, yellow, and macerated. The left great toe had a nickel sized area of black necrosis (dead tissue) to the tip. RN J removed the second layer of wrap from the left leg and foot, which was saturated with foul smelling drainage on his/her left lateral foot and left heel. The

dressing stuck to the outside of the foot. RN J did not use saline to remove the dressing. During this time, RN J stated, ... it s not as bad as I expected .... (when she observed the left leg and foot). The leg was red, swollen, had large dent in back from the wrap, and had flaky, scaly skin from knee to toes. RN J used moistened gauze to rip off the dry dressing stuck to the left lateral foot, wiped macerated skin from the top of the left foot, which made it bleed. RN J stated ... that s why it s bleeding .... . The patient yelled in pain more than once, and indicated he/she could feel when she pulled his/her skin off. When she moved to address the foot, the patient indicated he/she couldn t feel it. RN J stated, ... there s no open area ... (in regard to left lateral foot), and surveyor pointed out open wound to RN J on the patient s left lateral foot. RN J continued to debride (remove skin/tissue) from the leg and foot with gauze.

Wounds observed during this visit to the left lower extremity included, but were not limited to, the following:

Top of left foot had no intact skin, presence of slough, maceration, was moist, red, bleeding, had a yellow area, approximately 4x4 inches, surrounding skin was macerated, yellow, and thickened; another small area was noted approximately 1x1cm to the center of this wound that was red, bleeding, and deeper into the tissue;

left toes were mostly without skin, macerated, had greenish/yellow drainage, pink wound beds, and were stuck together due to current/old drainage;

left great toe tip was black, necrotic, about the size of a nickel;

left external lateral foot evidenced an open area approximately 1x10 cm with brown, yellow, purulent, foul smelling drainage, and surrounding skin was thickened, brown, and yellow;

left heel evidenced an open area approximately 3x3cm, dark red, shiny, moist, open wound;

plantar interior left ball of foot: darkened area, thickened, hard scabbed skin, approximately 1x1 cm;

left anterior (front) shin evidenced an approximately 1x1cm brown scabbed area;

and, posterior calf evidenced multiple open, draining areas.

On 3/1/2022 at 12:20 PM, RN J assessed the patient s pain after wound care was completed. The patient indicated it was a 9 in his right leg last night, and indicated he/she was crying last night because pain was so bad.

A document received on 3/3/2022, dated 3/2/2022, but not yet signed by RN C, titled Skilled Nurse Visit evidenced the patient s blood pressure was 176/110, both legs had pitting edema, and multiple new wounds were assessed. The document indicated RN C suspected the presence of infection to wounds, physician I was notified, who instructed the patient to go to the emergency department (ED) for evaluation, and the patient indicated he/she didn t want to go and wait 5-6 hours. RN C also assessed the patient was unable to open his/her medication bottles with childproof lids due to neuropathy, and provided/filled a 7-day pill planner. The home health agency failed to ensure a comprehensive assessment was performed due to changes in the patient s condition.

During an interview on 3/3/2022 at 2:13 PM, RN C was queried to describe the home nursing visit with patient #10 on 3/2/2022. RN C indicated she was still working on completing the visit note, as it was overwhelming, the patient was in very poor condition, and she was unaware of the severity of his/her wounds.

17-14-1(a)(1)(B)

1. Record review evidenced an agency policy obtained 2/22/2022, revised 1/12/2018, titled Follow-Up Comprehensive Assessment which stated, & The patient/client is reassessed: & When there is evidence of an unanticipated major decline or improvement in the patient s/client s condition that results in a substantial change to the plan of care/service plan &. No less frequently than every 60 days & unless there is a & Significant change in condition & Major decline unanticipated onset or exacerbation of signs and symptoms (e.g., sudden onset of SOB [shortness of breath] reported or SOB increasing in reports across shifts) &.

2. Review of an agency policy obtained 3/2/2022, revised 1/13/2018, titled Occurrences and Sentinel Events stated, & Occurrence: Any act or omission in the provision of care or services that is not consistent with acceptable,

	routine patient care or client services, and has the reasonable potential to result in an adverse outcome for the patient/client & The Administrator/Manager or designee receives and investigates any report of an occurrence or sentinel event & the Administrator/Manager or designee documents the report including the date of the report and the reported nature of the occurrence or sentinel event & The Administrator/Manager or designee contacts the employee most familiar with the occurrence or sentinel event and he/she documents the reported facts of the occurrence in the patient/client record including any physician or allowed practitioner contact & or other type of intervention & The administrator/manager or designee ensures that the responsible family members or other caregivers are advised of the occurrence & The Administrator/Manager or designee & Conducts a root cause analysis & Reports the findings of the investigation to their risk manager & Maintains the documentation of the circumstances or root cause analysis in the quality improvement files & The Administrator/Manager communicates any occurrences and sentinel events, as well as results of any root cause analyses to the governing body/owner &. 3. A web-based site referenced on 3/3/2022, https://www.hopkinsmedicine.org/gec/series/wound_care.html#assessment, titled Wound and Pressure Ulcer Management stated, & Pressure Ulcer Staging & Stage I - Intact skin with non-blanchable redness of a localized area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area & Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister & Stage III - Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining/tunneling & Stage IV - Full thickness skin loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling & Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed & (Suspected Deep) Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler			

as compared to adjacent tissue. (NPUAP 2/07) & Class & There are a number of classification and grading systems used in wound care but the simplest method uses the terms partial thickness or full thickness & Partial thickness wound (PTW): damage to epidermis and/or dermis only & Full thickness wound (FTW): damage to subcutaneous layer or deeper &.

4. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Home Health Certification and Plan of Care . This document listed a primary diagnosis of myelodysplastic syndrome (group of diseases marked by disruption of production of blood cells). This document stated, & Prognosis & Good & Orders for Discipline and Treatments & SN [skilled nurse] frequency: 2 visits /week x 9 weeks & HHA [home health aide] Frequency: 2-4 hrs [hours] 1-2x/day 6 days/week x 9 weeks & Physical Therapy 2 v/week (visits per week) x9 weeks (for 9 weeks) & Skilled nurse overall assessment. TPR [temperature, pulse, respirations] B/P [blood pressure] Orthostatic B/P & Assess skin & apply Foam border dressing to sacral area twice a week and as needed & HHA to assist with personal care, incontinent care, and ADL s [activities of daily living] per plan of care &.

Record review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Non Oasis [outcome and assessment information set] Recertification [comprehensive re-assessment] which included the following diagnoses: Myelodysplastic syndrome (group of diseases marked by disruption of production of blood cells), anemia (low blood count), Orthostatic hypotension (low blood pressure when changing positions), thrombocytopenia (low platelet count), osteoarthritis, right knee (arthritis of right knee), spinal stenosis, cervical region (narrowing of the spinal canal in the area of the neck), history of falling, pressure ulcer of sacral region, stage 2 (partial thickness wound, loss of epidermis or dermis).

Recertification/comprehensive re-assessment stated, & Vital Signs & respiration 16 & Weight & 210 lbs [pounds] & Pulse 76 Radial & Blood Pressure 98/60 Right Sitting & Pain & 0=No Pain & Respiratory & Lung Sounds & CTA [clear to auscultation] & Hgb [hemoglobin, a part of red blood cells that carries oxygen] 8 usually after

transfusion dur to myelodysplastic syndrome & Oriented to: Person & Place & Time & Oriented & Forgetful & Improved over all strength past 60 days & Moves with more strength & gluteal fold areas have red 1cm x 1 cm areas and 0.25 area scabs areas surface skin loss, no drainage & Stands/walks q2hrs [every 2 hours] & report pain level >5 to MD [physician] &.

Record review evidenced an agency document electronically signed by licensed practical nurse T on 4/5/2021, titled Skilled Nurse Visit which stated, & patient is lethargic today & BP [blood pressure] sitting is 94/60. BP sitting 72/48 [sic] & Patient has become more weak and needs an assist of 1 to 2 for transfers & Patient becomes SOB [short of breath] with any activity including standing up &.

Record review evidenced an agency document electronically signed by licensed practical nurse T on 4/12/2021, titled Skilled Nurse Visit which stated, & BP sitting is 92/54, standing 88/50 & He is lethargic &.

Record review evidenced an agency document electronically signed by alternate clinical manager C on 4/19/2021, titled Skilled Nurse Visit which stated, & Difficult to clean as he cannot stand for very long. Had 2 PRBC s [packed red blood cells] last Friday 5 hgb [hemoglobin] &.

Record review evidenced an agency document electronically signed by CNA (certified nurse aide) U on 4/25/2021, titled New Home Care HHA which stated, & He s getting weaker and weaker &.

Record review evidenced an agency document electronically signed by licensed practical nurse T on 4/26/2021, titled Skilled Nurse Visit which stated, & Client is lethargic & He has become more forgetful recently & Has difficulty standing up and needs an assist of 2 & has 2+ pitting edema to RLE [right lower extremity] and 3+ pitting edema to LLE [left lower extremity] & BP sitting is 90/52, standing 72/44 & small open area noted to coccyx measuring 0.25cm x 0.25 cm & The skin on inner buttocks is raw &.

Record review evidenced an agency document

	4/26/2021, titled PT [physical therapy] which stated, & did very little despite repeated tries very tired and/or not concentrating well &. Record review evidenced an agency document electronically signed by physical therapist K on 4/28/2021, titled PT [physical therapy] which stated, & patient was not able to stand for more than a few seconds at a time with walker and assist & recommended getting hospital bed because patient no longer able to use commode & may not be able to stand each time for future PT sessions &. Record review evidenced an agency document electronically signed by alternate clinical manager C on 4/29/2021, titled Skilled Nurse Visit which stated, & He now has edema 2+ & flanks & Declining slowly & Sitting B/P [blood pressure] 86/54 & After standing 30 seconds, then sat B/P 72/45 & Hgb 5 most weeks & A month ago he started physical decline & this decline has continued each week & transfers 2 people max assist & He is not able to walk safely & weight 185 lbs approximately & upper gluteal crease stage 2 & 2 cm slit 0.25 depth serous scant drainage & Left gluteal 1cm stage 2 5cm w 6 cm of dark pink to purple skin & Left upper thigh 2 stage 2 1 cm diameters open skin & Right thigh upper has 1 2cm x 2cm .2cm depth area skin serous drainage & Right gluteal has 2cm area and 1cm area skin loss also & Also dark pink to purple from pressure &. Agency failed to update the comprehensive assessment based on a major decline in patient s condition during certification period 4/6/2021 5/12/2021. During an interview on 2/28/2021 at 10:12 AM, administrator/clinical manager A indicated if patient was not improving, the agency would re-assess the patient, update the plan of care, and notify the clinical manager and the doctor of any changes in patient s condition. Agency failed to notify physician of patient #5 s decline and failed to update comprehensive assessment during certification period 4/6/2021 5/12/2021.			
G0546	Last 5 days of every 60 days unless:	G0546	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will audit all recertification assessments to ensure clinician	2022-04-15

	484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. Based on record review and interview, the registered nurse (RN) failed to ensure the comprehensive reassessment was completed within the last 5 days of every 60-day certification period for 3 of 9 comprehensive reassessments reviewed (#1, 7, 8). Findings include: 5. Record review for patient #1 was completed on 3/3/2022, start of care date 8/24/2021, for certification period 12/22/2021 2/19/2022. Record review evidenced a document was dated and signed by RN I on 12/20/2021 titled ... Recertification [comprehensive reassessment] . The agency s EMR (electronic medical record) was reviewed on 2/25/2022 at 12:15 PM, which evidenced a tab titled Schedule Event Logs (this tab reflected when a document was created, quality assurance reviewed, modified, and subsequently completed). The EMR indicated the comprehensive reassessment was completed on 12/29/2021 (on the 68th day), not 12/20/2021 (59th day), and the plan of care was created on 12/29/2021. 6. During an interview on 02/23/2022 at 2:51 PM, when queried how the plan of care was developed, administrator/clinical manager A indicated it was generated (in the EMR) from the comprehensive assessment, and it couldn t be generated until after the comprehensive assessment was completed. 7. During an interview on 2/28/2022 at 3:30PM, when queried why comprehensive assessments/reassessments were authenticated/electronically signed by the RNs		has completed within the last 5 calendar days of the certification period. 2. Administrator/Director of Health Care Services will run Visit by Status Report daily on business days and follow up with any clinician who has open comprehensive assessments. 3. The Administrator/Director of Health Care Services or Chief Clinical Officer will reeducate clinicians regarding all recertification assessments must be completed within the last 5 calendar days from end of certification period and reeducate clinician on timely submission of assessment. 4. Monitoring: 100% of the recertification assessments will be reviewed to ensure assessment was completed in the last 5 days of the 60-day certification period for 30 days. If 100% clinical compliance is not confirmed, 100% of recertification assessments will be reviewed for an additional 30 days until 100 % compliance is achieved for 30 days. Once compliance is achieved, 25% of records will be quarterly. If at any time the agency falls out of compliance reeducation will be provided to clinicians and number 4 will be repeated. 5. Survey results, quality record reviews, supervisory visits and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body. 6. Completion date: 04/15/2022 and ongoing	

	being dated/signed as completed after any quality assurance/modifications to the documents were made (as evidenced in the EMR task/event logs), administrator/clinical manager A indicated she didn t know why the documents were signed earlier than they were completed, she couldn t answer that, and she d have to investigate it more. Upon survey exit, nothing further was submitted. 17-14-1(a)(1)(B) 1. Record review evidenced an agency policy obtained 2/22/2022, revised 1/12/2018, titled Follow-Up Comprehensive Assessment which stated, & Interim HealthCare employees periodically conduct a comprehensive follow-up assessment of the patient/client to determine the patient s/client s response to the care/services provided, as well as the continued appropriateness of such care/services & The patient/client is reassessed: & When there is evidence of an unanticipated major decline or improvement in the patient s/client s condition that results in a substantial change to the plan of care/service plan & No less frequently than every 60 days beginning with the start of care date unless there is a: & Beneficiary elected transfer & Significant change in condition; or & Discharge and return to the same agency during the 60 day episode & For patients whose payment source is Medicare fee for service, Medicare Advantage &. Medicaid fee for service or Medicaid HMO/managed care subject to OASIS (outcome and assessment information set) assessment requirements the follow-up assessment is completed within the last 5 days of the episode &. 2. Clinical record review was completed on 3/3/2022 for patient #7, start of care 1/14/2003, for certification period 6/8/2021 8/6/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 6/15/2021, titled Home Health Certification and Plan of Care . The agency s EMR (electronic medical record) for patient #7 was reviewed on 2/28/2022, which evidenced a tab titled Schedule Task Logs . This tab evidenced an Oaisis [sic] D-1 Recert [comprehensive re-assessment] completed by alternate clinical manager C on 2/12/2022 at 9:37 PM for certification period 12/5/2021 2/2/2022. Agency failed to perform a comprehensive assessment the last 5 days of a 60 day period.			

	3. Clinical record review was completed on 3/3/2022, for patient #8, start of care 6/23/2008, certification period reviewed 12/13/21 2/10/2022. Review evidenced an agency document electronically signed by alternate clinical manager C on 12/10/2021, titled Home Health Certification and Plan of Care . The agency s EMR (electronic medical record) for patient #8 was reviewed on 2/28/2022, which evidenced a tab titled Schedule Task Logs . This tab evidenced a Non Oasis Recertification [comprehensive re-assessment] completed by alternate clinical manager C on 2/13/2022 at 3:11 PM for certification period 12/13/21 2/10/2022. Agency failed to perform a comprehensive assessment the last 5 days of a 60 day period. 4. During an interview on 2/23/2022 at 1:24PM, administrator/clinical manager A stated, regarding when comprehensive assessments should be completed, & we complete comprehensive assessments within 5 days of certification period end & the nurses complete the recertification &.			
G0562	Discharge Planning 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. Based on record review and interview the agency failed to develop and implement an effective discharge planning process.	G0562	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will update the current Interim discharge policy to include Indiana Regulation that a 15-calendar day notice is given prior to home health care stopping services. The 15-day calendar day notice does not apply when: a. The health, safety, or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. b. The patient refuses the home health agency's services. c. The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge. d. The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the	2022-04-15

	Findings include: Record review evidenced an agency policy obtained 2/22/2022, revised 4/2/2021, titled, Discharge from Home Care which stated, & Interim HealthCare informs the patient/client, the patient s representative (if any) in a timely manner of the need to plan for discharge form home care & Interim HealthCare discharges patients when the patient s/client s goals are met, death occurs, the patient/client no longer meets Interim HealthCare s admission criteria or the patient/client refuses services, or elects to be transferred or discharged & Upon discharge from Interim HealthCare, a summary of the patient s/client s status is completed, and the summary is sent to the primary physician or allowed practitioner & or other health care professional who will be responsible for providing care and service to the patient after discharge (if any) within 5 business after the patient s discharge & the comprehensive assessment is completed to accurately reflect the patient s status at the time of discharge &. Policy failed to indicate the discharge notice timeframe given to patients and failed to indicate required contents of discharge summary. During an interview 2/14/2022 at 10:30 AM, administrator/clinical manager A indicated the agency gives patients 24 48 hours discharge notice for noncompliance and for routine discharges, the agency discusses discharge plans with the patient and the physician 1 week in advance. During an interview on 2/28/2022 at 3:00 PM, administrator/clinical manager A stated, when queried about the agency s discharge planning process, & we put in a discharge planning visit, and the next visit the patient is discharged & discharge planning is ongoing &. Administrator/clinical manager A indicated she was not sure how much notice was required to give to patients before discharging, but she thought it was 24 48 hours.		patient following discharge. 2 The Administrator/Director of Health Care Services or Chief Clinical Officer will educate all clinicians on updated discharge policy to ensure patient has at least 15-day notice of discharge prior to services being stopped. The 15-day calendar day notice does not apply when: a. The health, safety, or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. b. The patient refuses the home health agency's services. c. The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge. d. The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. 3. The Administrator/Director of Health Care Services will conduct weekly case conference meetings with clinicians. An active roster of patients will be reviewed so staff are able to ensure the patient has at least 15 calendar day notice prior to stopping services. 4. Monitoring: 100% of the upcoming discharges will be reviewed weekly by the Director of Health Care Services or designee with clinicians and the discharge planning visit will be set and assigned employee will give the notice of discharge following regulation of at least 15 calendar days before. Upcoming discharge planning will be reviewed for 30 days to show at least 15-day notice was provided prior to discharge. If 100% clinical compliance is not confirmed, 100% of clinical documentation will be reviewed for an additional 30 days until all clinical documentation is 100% compliant for a 30-day timeframe. 5. Once 100% compliance of providing discharge notice no later than 15 calendar days prior to discharge then 25% of upcoming discharges will be audited quarterly. If at any time the agency falls out of compliance reeducation will be provided to clinicians and number 4 and 5 above will be repeated. 6. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI quarterly and	

			communicated with the Governing Body 7. Completion date: 4/15/2022 and ongoing.	
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the agency failed to send all necessary medical information pertaining to the patient's current course of treatment and illness, post-discharge goals of care, and treatment preferences to the receiving facility or healthcare practitioner in 4 of 5 discharge records reviewed (#4, #5, #6, #11). Findings include: 6. Record review for patient #11 was completed on 3/3/2022, start of care date 01/27/2022, discharge date 2/18/2022, for certification period 01/27/2022 03/27/2022. Record review evidenced a document dated and signed by RN I on 2/18/2022 titled OASIS [outcome and assessment information set] ... Discharge stated ... patient and caregiver notified of the discharge today .... During an interview on 2/25/2022 at 1:21 PM, family indicated 2/18/2022 was the last day RN I saw the patient, RN I informed her it was her last day during that visit, the wound was closed, and told her to continue to treat the wound for 2 weeks. During an interview on 2/25/2022 at 1:57 PM, when queried if the office received a discharge summary on or after 2/18/2022, person RR (office staff) at physician U s office stated Not that I m seeing ... nothing after 2/17 [2022] .... When queried what was sent on 2/17/2022, person RR indicated their office received a faxed plan of care from the agency on 2/17/2022 at 6:04 AM, and physician U signed it the same day. 1. Record review evidenced an agency policy	G0564	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will review active patients charts to ensure all patients with discharge and transfer summaries pending audit are done daily to ensure they are sent to physician and or receiving facility within 2 days of being made aware of transfer and within 5 business days of discharge which includes summary of patient status at transfer and or discharge. 2. The Administrator/Director of Health Care Services or Chief Clinical Officer will reeducate clinicians regarding need to ensure all necessary medical information pertaining to the patient's current course of illness and treatment post discharge goals of care, and treatment preferences to receiving facility health care practitioner to ensure the safe and effective transition of care. 3. The Administrator/Director of Health Care will run the Visits by Status Report daily on business days for any open discharge and transfer assessments and follow up with clinician to complete. 4. All transfer and discharge summaries will be sent to receiving facility and physician no more than 2 days from being made aware of the transfer and discharge summaries will be sent to the receiving facility and or who is assuming care within 5 business days including coordination of care to Hospice. 5. Monitoring: 100% of clinical notes and transfer/discharge summaries for 30 days. If 100% clinical compliance is not confirmed, 100% of transfer/discharges will be reviewed for an additional 30 days, until all documents are 100% complaint for 30 days. 6. Once 100% compliance of providing transfer/discharge summaries are sent to facility effective transition of care, 25% of discharge and transfer summaries will be reviewed quarterly. If at any time the agency falls out of	2022-04-15

	obtained 2/22/2022, revised 4/2/2021, titled Transfer to an Inpatient Facility which stated, & A transfer summary is sent within two (2) business days of a planned transfer if the patient s care will be immediately continued in a health care facility & A transfer summary that is sent within two (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 & The DHCS [director healthcare services] or designee provides all necessary medical information pertaining to the patient s current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or physician or allowed practitioner & to ensure the safe and effective transition of care &. 2. Record review evidenced an agency policy obtained 2/22/2022, revised 4/2/2021, titled, Discharge from Home Care which stated, & Interim HealthCare informs the patient/client, the patient s representative (if any) in a timely manner of the need to plan for discharge form home care & Interim HealthCare discharges patients when the patient s/client s goals are met, death occurs, the patient/client no longer meets Interim HealthCare s admission criteria or the patient/client refuses services, or elects to be transferred or discharged & Upon discharge from Interim HealthCare, a summary of the patient s/client s status is completed, and the summary is sent to the primary physician or allowed practitioner & or other health care professional who will be responsible for providing care and service to the patient after discharge (if any) within 5 business after the patient s discharge & the comprehensive assessment is completed to accurately reflect the patient s status at the time of discharge &. 3. Clinical record review for patient #4 was completed on 3/3/2022, start of care 5/19/2021, certification period 5/19/2021 6/15/2021. Review of an agency document electronically signed by registered nurse N on 5/19/2021 titled Home Health Certification and Plan of Care , listed a primary diagnosis of unilateral primary osteoarthritis of first carpometacarpal joint right hand (arthritis of the right thumb). This document stated, & Orders for Discipline and Treatments: HHA [home health aide] Frequency: 3 hours a day x 14 days & HHA to assist with ADL s [activities of daily living] & IADL s [instrumental activities of daily living] per HHA care plan &.		compliance reeducation will be provided to clinicians and number 5 and 6 above will be repeated. 7. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI quarterly and communicated with the Governing Body 8. Completion date: 4/15/2022 and ongoing.	

	Record review evidenced patient s last home HHA visit was on 6/15/2021. No discharge summary was evidenced. During an interview on 2/21/22 at 2:09 PM, administrator/clinical manager A stated, when queried about discharge summary, & no discharge notification or summary was noted for [patient #4] & we should have put in a discharge summary for this patient &. 4. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Home Health Certification and Plan of Care which stated, & start of care & 12/7/2020 &. This document listed a primary diagnosis of myelodysplastic syndrome (group of diseases marked by disruption of production of blood cells). Record review evidenced patient s last home visit was on 5/11/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 5/12/2021, titled Missed Visit which stated, & [hospice K] is providing skilled nursing care &. No discharge or transfer summary evidenced. During an interview on 2/28/2022 at 11:57 AM, administrator/clinical manager A stated, when queried about discharge summary, & we should have put in a discharge summary for patient &. 5. Clinical record review was completed on 3/3/2022 for patient #6, start of care date 3/15/2021, certification period 5/13/2021 7/11/2021, evidenced an agency document electronically signed by alternate clinical manager C on 5/10/2021, titled Home Health Certification and Plan of Care which stated, & start of care & 3/15/2021 &. This document evidenced a primary diagnosis of heart failure. This document stated, & Orders for Discipline and Treatments & HHA [home health aide] frequency: & HHA 1-2 hours 2 x a week for bathing x 9 weeks & HHA to assist with personal care, incontinent care, and ADL s [activities of			

	supervision of an RN [registered nurse] &. Review evidenced patient s last home health aide visit was on 5/16/2021. Review evidenced an agency document electronically signed by person D (former scheduler) on 5/24/2021, titled Missed Visit which stated, & Client Hospitalized & Hosp [sic] [hospital] adm [admit] 5/23 &. Record review failed to evidence a transfer or discharge summary. During an interview on 1/21/2022 at 2:34 PM, administrator/clinical manager A stated, when asked about patient #6 s transfer or discharge summary, & No transfer summary was completed for this patient & we would have to send it manually & I would have to check if we do transfer summaries on non-Oasis patients &.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. An immediate jeopardy (IJ) related to the comprehensive assessment of patients, care planning, quality of care, and care coordination was identified on 3/2/2022 at 2:44 PM.	G0570	1. Investigative results were reviewed with RN J on 3/7/22. Based on the results of the investigation, the following actions were taken. Terminated 03/07/2022, reported misconduct/unsafe clinical practices to Indiana State Board of Nursing 03/08/2022 and Michigan State 03/09/2022 Board of Nursing, and reported to Office of Inspector General on 03/09/2022 for fraudulent medical record entries and fabricating documentation for visits not performed 2. Alternate Administrator/Alternate Nursing Supervisor made Nursing Visit to patients' home 3/2/202. The visit included a complete assessment, including analysis of the assessment, which was documented in the clinical record, full review of the plan of care, and medication review. The physician was	2022-03-09

	Based on observation, record review, and interview, the home health agency failed to ensure a plan of care for certification period 2/5/2022 - 4/5/2022 included an order from wound clinic M, dated 1/31/22, which indicated wound care was to be provided by the agency 3 times per week to 1 known wound on left foot, and 1 known wound on right heel (cleanse with saline, apply collagen, foam, and wrap with compression dressing). A comprehensive assessment dated 2/1/2022 indicated wound clinic M wanted patient to receive 3 visits per week; nurse indicated she couldn t do 3 visits per week due to caseload, failed to contact wound clinic, and did not see patient 3 times per week. The patient indicated both dressings had not been removed since 1/31/22. This caused a detrimental effect to the patient. This finding affected patient #10, and had the potential to affect all agency patients with wounds, and/or patients with the potential/risk for wounds. Findings include: Record review for patient #10 was completed on 3/3/2022, start of care date 12/7/2021, for certification period 2/5/2022 4/5/2022. Record review evidenced an agency document signed and dated by RN J on 2/1/2022, and physician I (certifying, primary care physician) on 2/7/2022, titled "Home Health Certification and Plan of Care", for certification period 2/5/2022 - 4/5/2022. This document indicated skilled nursing was ordered twice weekly for 8 weeks, the patient s medications included metronidazole (an antibiotic), atenolol (to treat high blood pressure), lasix (a diuretic to treat fluid retention), potassium chloride (supplement), ropinirole (to treat restless leg syndrome), toujeo max solostar (insulin to treat diabetes), zinc sulfate (supplement), aspirin, furosemide (generic for Lasix- duplicate entry), a multivitamin, and florastor (probiotic for gut health); and stated ... Orders ... Skilled nurse [SN] ... to perform complete physical assessment with each visit with emphasis on wound care ... assess other co-morbidities including diabetes and other conditions ... notify physician immediately of any potential problems ... Nursing ... All necessary interventions ... as follows ... Instruct dietary, hydration measures and medication management ... wound care management based on physician orders ... SN to administer insulin sliding scale per physician orders as follows: [enter sliding scale order - blank] ... Instruct ... on Diabetic Footcare precautions ... at risk for falls ... PT [physical therapy] ... to assess ... to instruct ... Wound		clinician secured a new physician order for frequency of services, medication discrepancies, and wound care. The clinician attempted to initiate additional services to ensure patient's safety in home as well as ADL care. Patient refused Occupational Therapy and Home Health Aide after multiple offers. Patient was seen by the wound clinic on 3/9/22, per Physician recommendation. a. Report was made to adult protective services and child protective on 3/3/22 3. Patients seen by RN J were seen by the end of day 3/4/22, with wound care patients being seen by the end of day 3/3/22. Nursing visits were performed by the Administrator/Director of Health Care Services, Alternate Administrator/Alternate Nursing Supervisor and Chief Clinical Officer. The visit included the following: complete assessment and an analysis of the assessment was documented in the clinical record, full review of plan of care for accuracy, medication review, and complete skin assessment was done including assessment of wounds if any and for presence of new wounds. Notification to MD if necessary additional orders were identified. 4. The Administrator/Director of Health Care Services or Chief Clinical Officer will educate clinicians on the following: a. Updating the plan of care with changes in condition and or at minimum every 60 days to reflect accurate patient status. b. Reporting change of condition to Director of Health Care Servcices to ensure follow up is completed c. Notifying physician and obtaining order to make extra home visits as needed for fall or change in condition. c. Completion of occurrence report for falls or sentinel events as well as reporting incidents to Director of Health Care Services to assess root cause analysis. 5. The Chief Clinical Officer assessed and provided additional training with Administrator/Director of Health Care Services 03/04/2022 a. Review of assessment documentation for accuracy and sound clinical practices. Auditing clinical notes for thoroughness and evidence of documentation towards interventions, goals, and discharge planning. b. Ensuring individuals are admitted to home care only if the needed care/service can be provided by an appropriately qualified individual. 6. The Administrator/Director of Health Care Services or Chief Clinical Officer educated Case	

	care orders ... to Right heel ... Cleanse/irrigate wound with sterile saline, apply non-adherent dressing, 4x4s [4 inch by 4-inch gauze pads]. Cover and secure with gauze wrap ... Other Physicians On The Case ... [physician H, at wound clinic M] .... This document failed to evidence the wound or orders for the left foot identified by wound clinic M on 1/31/2022, the order to see the patient on 2/7/2022, ordered nursing frequency of 3 times per week, or the current wound care treatment orders (per physician H on 1/31/2022), the correct list of all medications the patient used, interventions for a high nutritional risk due to tooth decay/missing teeth, and only eating 1 meal daily, or the physician's order for frequency of blood glucose monitoring. Faxed documents in the patient s clinical record from wound clinic M evidenced a fax cover sheet, dated 1/31/2022 at 12:27 PM, which stated ... Wound assessments and orders for today, 1/31/2022 ... change dressings/wraps ... on Monday 2/7/22 ... due to [wound clinic physician H] being out of the office that day, and the normal Wednesday and Friday. Patient to RTC [return to clinic] on 2/14 [2022] .... An additional document was included, dated 1/31/2022, titled Office Visit (for wound clinic M), which stated ... here for new wound left foot and chronic wound right heel. Patient has visiting nurses applying collagen and ace wraps for swelling ... Wound care nurse noted on his initial evaluation today that there was a shell of a pistachio nut embedded into the plantar [bottom of] left foot. Therefore he has a new wound today on his left foot ... Full thickness ulceration right heel ... new ulceration from foreign body left foot but [sic] signs of infection ... Chronic lymphedema [condition in which extra lymph fluid builds up in tissues and causes swelling] ... Advised the patient never to go barefoot ... Physician orders ... Apply collagen [dressings derived from usually cow or pig collagen, a crucial role in the wound healing process], foam ... apply 3M 2 layer lite [a 2 layer compression system wrap, not the same as ace wrap] ... Home care to change dressing and wrap on Monday, Wednesday and Friday ... float heels to reduce pressure .... A home visit was observed on 3/1/2022 at 10:30 AM with patient #10 and registered nurse (RN) J. RN J was not present upon surveyors arrival. Observed patient #10 seated in a wheelchair in his/her bedroom, with both lower extremities wrapped with compression wraps, approximately 3-4 inches below the knees, distal to toes. Toes on both feet were exposed. Both legs were		Managers who conduct comprehensive assessments on how to thoroughly assess and complete documentation accurately as well as when it must be done including following: a. At the Start of Care and completed no later than 5 days after the Start of Care b. Within the last 5 days of every sixty days for recertification. c. Within 48 hours of the patient discharge from an inpatient stay. d. When a patient exhibits a significant change in condition e. When the patient discharges from services 7. The Administrator/Director of Health Care Services or Chief Clinical Officer will conduct In-Service training for all nursing staff by 3/8/22. Training includes the following: a. Wound Care i. Assessment of patient to identify types, stage (if applicable), and size of all wounds present. ii. Assessment of additional wounds on every visit. iii. Assess patient's level of pain and need to pre-medicate for pain during wound care. iv. Proper removal of old dressings to protect from additional skin breakdown and worsening of pain. v. Proper documentation of all wounds present during the visit, including full wound assessment for each wound present. vi. Conduct wound care according to documented Physician’s orders. vii. Communicating with Physician regarding any changes in condition, including new wounds. b. Pain Assessment i. Assess pain history, location, intensity, and pain characteristics ii. Pain relief measures iii. Effectiveness of pain relief measures iv.. Need to premedicate prior to wound care and or treatments. c. Documentation Practices . Developing an accurate, patient specific plan of care addressing all patient problems and wounds identified during the comprehensive	

	swollen above the wraps, and his/her toes were swollen. The patient had tooth decay/missing teeth. The patient was alert and oriented, and able to answer questions appropriately. On 3/1/2022 at 10:37 AM, the patient indicated he/she had a medical history of diabetes with neuropathy (nerve damage which causes numbness, tingling, and pain), and wounds; he/she took his/her blood glucose 1 time per day, since he/she only ate once per day, usually when someone could make him/her some food, and it was generally after 7:00 PM; he/she drank coffee and had oatmeal for breakfast sometimes; his/her blood sugars ran about 160 , and his/her doctor didn t care as long as they were below 200 ; he/she took 18 units of Levemir daily. On 3/1/2022 at 10:40 AM, the patient indicated he/she hasn t been to wound clinic M for several weeks, since he/she didn t have transportation; his/her left leg and foot bandage hasn t been changed for 3 weeks, the right leg and foot hasn t been changed for 2 3 weeks, and this was because RN J wanted them left in place to heal ; the home health nurse was supposed to be out to see him/her 2 times per week, but sometimes she only came once because of staffing, and the last time the nurse came was last Tuesday (2/22/2022); he/she was in the hospital/nursing home (skilled nursing facility (SNF) N) in November (2021) for wound infection and swollen legs, he/she left SNF N on 12/1/2021, and home health care services started the next week (12/7/2021). The plan of care signed by RN J on 2/1/2022, evidenced orders for skilled nursing twice weekly, but stated, "... [patient] reports going to wound clinic yesterday. This nurse looked at paper sent home with [patient] ... [person H, wound clinic physician] is requesting that Interim visit client MWF [Monday, Wednesday, Friday] to change dressings. This nurse explained to [patient] that it isn t possible to see [him/her] 3x/wk [3 times per week] due to case load ... will follow up with wound clinic .... The plan of care failed to evidence orders to leave the patient s dressings on for 3 weeks to let them heal, and the patient s record failed to evidence RN J coordinated with wound clinic M for clarification of visit frequency. On 3/1/2022 at 10:53 AM, the patient indicated he/she used a wheelchair, and sometimes used a cane to walk. He/she indicated he/she tried to elevate his/her legs at night while sleeping. During this time, the surveyors observed		assessment. ii. Documentation of the comprehensive assessment iii. Addressing all elements required on the plan of care iv. Documentation of interventions identified on the Patient Plan of Care v. Documentation of the Communication with Physician regarding any changes in condition vi. Documentation of Physician orders ensuring the physician order flows to the plan of care. d. Identification and reporting guidelines for abuse and neglect: i. Adult Protective Services ii. Child Protective Services e. Medication reconciliation i. During the comprehensive assessment ii. On each skilled visit f. Patient Bill of Rights 8. The Administrator/Director of Health Care Services, Alternate Administrator/Alternate Nursing Supervisor, and Chief Clinical Officer re-competency tested each clinician by 3/7/2022 for proper wound care using wound care supervisory visit checklist. 9. All wound care patients and patients identified at risk by Braden scale or diagnosis for skin breakdown, were seen by end of day 3/8/22 10. Steps to prevent it from reoccurring a. Continued evaluation of clinical documentation to ensure quality standards are upheld on a routine basis. 100% of the clinical documentation will be reviewed for 30 days. If 100% clinical compliance is not confirmed, 100% of clinical documentation will be reviewed for an additional 30 days. Clinical documentation will continue to be reviewed at 100% until all clinical documentation is 100% compliant for a 30-day timeframe. b. Once 100% compliance has been met for a 30-day timeframe, all Assessments and Physician orders will continue to be evaluated for clinical compliance quarterly for 95% compliance. If compliance falls below 95% within the quarter, clinical documentation will be reviewed with the plan outlined in point c. On-site supervisory visits will be scheduled	

	medications in a patient belongings bag, and they were reviewed/reconciled with the patient. The patient confirmed that he/she only took the following medications: Levemir 18 U (units) daily, Atenolol 25 mg (milligrams) daily, Atorvastatin 40 mg daily, Ropinirole 0.5 mg daily, and Furosemide 40mg daily. When queried about other medications listed on the agency's current plan of care, he/she indicated he/she has not taken potassium chloride, aspirin, zinc, toujeo, multivitamins, florastor, or metronidazole since his discharge from skilled nursing facility (SNF) N in December of 2021. On 3/1/2022 at 10:56 AM, the patient indicated his/her pain was currently about 4-5 (out of 10, with 0 = no pain, and 10 = worst pain ever), last night it was 10 , and when queried if he/she took any pain medications, he/she stated, ... My doctor [physician I] doesn t believe in that .... , and indicated physician I wanted him/her to go to the pain management place , but he/she didn t want to. The plan of care failed to evidence interventions to mitigate pain. On 3/1/2022 at 11:06 AM, when queried how many wounds patient had, RN J stated, I don t know ... there s not a number ... it s hard to tell how many wounds because they all blend together ... one kind of goes into the other ... mainly [his/her] right leg ... we wrapped the left leg mainly for swelling ... no open wound on left leg .... When queried when the last time wound care was performed, RN J indicated she performed wound care on Friday (2/25/2022), and the patient indicated her last home visit was Tuesday (2/22/2022). When queried how often she measured wounds, RN J indicated the agency measured wounds weekly. When queried what the current wound care orders for this patient were, RN J indicated the wound orders were to wash with normal saline and rewrap. RN J failed to indicate or perform wound treatment based on wound clinic M s order dated 1/31/2022. On 3/1/2022 at 11:15 AM, after the first layer of the right leg was unwrapped by RN J, surveyors observed the second layer, which was saturated with brown, purulent drainage, with very foul odor. RN J pulled the dry gauze batting wrap off the leg and foot. The dressing was stuck to several areas, including the right heel, top of right foot, and lateral right foot. RN J pulled the dry dressing off without soaking it first, which would prevent/reduce risk of traumatic injury to underlying skin/tissue. The patient s right lateral		the Director of Health Care Services or alternate Director of Health Care Services. or Chief Clinical Officer effective immediately throughout 2022, then no less than every six months thereafter. 11. Survey results, quality record reviews, supervisory visits and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body.	

(outside) foot started bleeding and dripping on the floor while RN J pulled the dressing off. RN J then took a used dinner napkin from under an empty, dirty food (plastic) container on the couch, and placed it directly under the patient s right foot, on the floor. RN J then moistened additional stuck pieces of dressing with normal saline after the patient began bleeding and pulled them off with moistened gauze.

On 3/1/2022 at 11:20 AM, the right lower leg was observed. Skin from the knee down to the ankle was scaly, flaking, red, shiny in some areas, and swollen; the right foot and ankle were red, thickened, flaky, and swollen; the top of the right foot and toes evidenced copious amounts of macerated (wet, soggy, pale in color, due to excessive moisture) tissue and purulent greenish, yellow, foul-smelling drainage. RN J wiped this drainage off with saline moistened gauze and re-moistened the dirty gauze by placing it on top of the sterile saline bottle opening, tipping saline onto the dirty gauze, and then continued to cleanse the patient s foot.

Wounds observed during this visit to the right lower extremity included, but were not limited to, the following:

right 3rd toe with darkened area approximately 1x2 cm (centimeters), surrounding skin thickened, yellow, flaky, macerated, drainage was yellow/green, and purulent, and all toes were stuck together from old/current drainage;

right external lateral foot was brown/yellow in color, active bleeding, an open area approximately 2 x 10 cm, surrounding skin was thickened, yellow, flaky, and macerated;

top of right foot over the center evidenced an open area, was bright red, moist, macerated, with greenish yellow drainage, measured approximately 4 x 4 inches in, surrounding skin was macerated, flaky, yellow, and red;

bottom of the right heel evidenced a dark area next to a gray/light pink open area with full thickness (damage past all layers of skin), approximately 1 x 1 cm, surrounding skin was thickened, flaky, dry, cracking, yellow;

right interior lateral calf was dark red/purple in color, an open area approximately 2x2 cm, and surrounding skin was red, flaky, swollen.

and, posterior (backside) right calf evidenced 2 or more scabbed areas approximately 1x1 cm each, surrounded by red, swollen, flaky skin. The plan of care evidenced a wound to the right

heel, and failed to evidence additional wounds observed.

On 3/1/2022 at 11:40 AM, RN J wrapped right leg and foot with a dry gauze roll, no individual dressings (collagen) were applied to protect the open wounds, and the gauze roll had multiple wrinkles. RN J then applied an ace bandage to foot and ankle, secured it with a metal clip, over the patient s shin bone. RN J applied an additional ace wrap to ankle and calf, the wrap was unevenly applied, wrinkled, and she twisted the ace in front of the shin because Velcro was on the wrong side. The wrap extended to approximately 4 inches below the knee and did not cover the area of swelling between the knee and the top of the wrap. RN J then placed a blue paper shoe cover on patient s right foot, no footwear was applied, and wounds on the toes were left open to air. RN J failed to provide wound care as ordered by wound clinic M or instruct the patient to float his heels as instructed by the wound clinic physician (physician H).

On 3/1/2022 at 11:45 AM, RN J removed a black nylon stocking from the left leg, which was placed by wound clinic on 1/31/2022, per both the patient and RN J s testimony. The black nylon had a large amount of thick, brown exudate (drainage) on it. The patient s toes were visible, and all had skin sloughing (falling) off, were moist, yellow, and macerated. The left great toe had a nickel sized area of black necrosis (dead tissue) to the tip. RN J removed the second layer of wrap from the left leg and foot, which was saturated with foul smelling drainage on the left lateral foot and left heel. The dressing stuck to the outside of the foot. RN J did not use saline to remove the dressing. During this time, RN J stated, ... it s not as bad as I expected .... (when she observed the left leg and foot). The leg was red, swollen, had large dent in back from the wrap, and had flaky, scaly skin from knee to toes. RN J used moistened gauze to remove the dry dressing stuck to the left lateral foot, wiped macerated skin from the top of the left foot, which made it bleed. RN J stated ... that s why it s bleeding .... . The patient yelled in pain more than once and indicated he/she could feel when she pulled his/her skin off. When she moved to address the left foot, the patient indicated he/she couldn t feel it. RN J stated, ... there s no open area ... (in regard to left lateral foot), and surveyor pointed out open wound to RN J. RN J continued to debride (remove skin/tissue) from the leg and foot with gauze. The plan of care

removal/debridement of skin from the patient s leg/foot, the presence of any wounds to the left leg/foot, or orders for wound care/treatment to the left leg/foot.

Wounds observed during this visit to the left lower extremity included, but were not limited to, the following:

Top of left foot had no intact skin, presence of slough, maceration, was moist, red, bleeding, had a yellow area, approximately 4x4 inches, surrounding skin was macerated, yellow, and thickened; another small area was noted approximately 1x1cm to the center of this wound that was red, bleeding, and deeper into the tissue;

left toes were mostly without skin, macerated, had greenish/yellow drainage, pink wound beds, and were stuck together due to current/old drainage;

left great toe tip was black, necrotic, about the size of a nickel;

left external lateral foot evidenced an open area approximately 1x10 cm with brown, yellow, purulent, foul-smelling drainage, and surrounding skin was thickened, brown, and yellow;

left heel evidenced an open area approximately 3x3cm, dark red, shiny, moist, open wound;

plantar interior left ball of foot: darkened area, thickened, hard scabbed skin, approximately 1x1 cm;

left anterior (front) shin evidenced an approximately 1x1cm brown scabbed area;

and, posterior calf evidenced multiple open, draining areas. The plan of care failed to evidence any wounds or wound care/treatment to the left leg/foot.

Om 3/1/2022 at 12:00 PM, when queried about a wound caused by a pistachio shell (as noted in wound clinic M s document dated 1/31/2022), RN J stated ... I don t know anything about any pistachio shell ....

On 3/1/2022 at 12:05 PM, RN J remoistened dirty gauze again with the open bottle of saline to cleanse the patient s leg. RN J then wrapped the left foot and left leg with a dry gauze roll, no individual dressings (collagen) were applied to

multiple wrinkles. RN J then wrapped the foot and ankle with 2 ace wraps, which had multiple wrinkles. The wraps extended from foot to approximately 4 inches below the knee. Also, observed patient s bilateral fronts of thighs just above knees, which were red, the patient indicated this was new, and they were sore. During this time, RN J did not indicate she would report this to a physician, and failed to assess the areas, or the skin under his/her clothing/shorts.

On 3/1/2022 at 12:20 PM, RN J assessed the patient s pain after wound care was completed. The patient indicated it was a 9 in his/her right leg last night, and indicated he/she was crying last night because pain was so bad. The clinical record failed to indicate RN J coordinated with a physician to mitigate pain.

On 3/1/2022 at 12:25 PM, RN J failed to assess the patient s buttocks, posterior legs, and plantar surfaces of both feet. Upon prompting by surveyors, RN J assessed patient s buttocks, which appeared red/purple, but blanchable, and patient had stool residue in his/her underwear. RN J failed to offer the patient assistance for personal care, or change his/her undergarments. During this time, the patient indicated he/she hadn t showered in a couple weeks, he/she went to the sink to wash himself/herself up, and he/she had a shower chair. When queried if the agency ever offered a home health aide to assist with bathing, the patient indicated he/she was not. The plan of care evidenced the patient was a high risk for infection due to the open wound on the right heel, inadequate environmental cleaning (not further specified/described on the plan of care), and lack of a caregiver; and failed to evidence interventions to ensure the patient s personal care/hygiene needs were met, or psychosocial needs were met (such as transportation, home environment).

The home visit was completed on 3/1/2022 at 12:37 PM. During this visit, RN J failed to provide teaching regarding diabetic footcare or precautions, to float heels, signs or symptoms of infection; did not assess what the patient s blood sugar level was, or if he/she checked it; and did not reconcile the patient s medications. During this time, the patient queried RN J as to what she thought of the visit, to which RN J stated, ... I don t think you need any antibiotics or anything ... but you need to go to wound clinic . The patient then indicated to the surveyors that RN J

would inform him/her if he/she needed to call the doctor, and he/she would make a call if there were any issues. RN J failed to indicate to the patient if she was going to notify physician I or physician H (wound clinic M) about the elevated blood pressure, new/worsening wounds, or possible infection observed during this home visit.

A document dated and signed by RN J on 2/1/2022, titled ... Recertification [comprehensive reassessment] , which indicated the patient had a diabetic ulcer, non-pitting edema (swelling that does not leave pits in the skin after pressure is applied) to both lower legs, needed help with showering, but had no willing/able caregiver, and failed to evidence RN J treated or measured the wound identified by wound clinic M on 1/31/2022, on the patient s left plantar foot, and the right heel was cleansed with saline, non-adherent dressing and gauze 4x4 pads were applied, and then wrapped/secured with gauze wrap, and stated "... [patient] reports going to Wound Clinic yesterday ... This nurse looked at paper sent home with [patient] ... [physician H at wound clinic M] is requesting that [agency] visit [patient] MWF [Monday, Wednesday, Friday] to change dressings ... This nurse explained to [patient] that it isn't possible to see [him/her] 3x/wk [3 times per week] due to case load ... This nurse will follow up with Wound Clinic ...." The record failed to evidence RN J contacted the wound clinic, performed care to the left foot/leg, or provided wound care/treatment as ordered by wound clinic M.

Documents were received on 2/15/2022, dated and signed by RN J on 2/8/2022, 2/11/2022, and 2/15/2022 titled Skilled Nurse Visit . These documents all indicated the patient had 1 wound to the right heel, and failed to indicate RN J identified, treated, or measured the wound identified by wound clinic M on 1/31/2022, on the patient s left plantar foot. The documents also failed to evidence the presence of any other wounds on the patient s legs, feet, or toes.

During an interview on 3/2/2022 at 2:44 PM, the surveyors findings from the home visit observed on 3/1/2022 (10:30 AM) with the patient (#10) and RN J was discussed. During this time, person P (chief operations officer, owner) instructed administrator/clinical manager A to immediately send RN C to the patient s home and perform a comprehensive assessment.

A document received on 3/3/2022, dated 3/2/2022, but not yet signed by RN C, titled Skilled Nurse Visit , indicated the patient s blood pressure was 176/110 (blood pressure numbers of less than 120/80 are considered within the normal range), both legs had pitting edema, multiple new wounds were assessed, RN C suspected the presence of infection to wounds, physician I was notified, who instructed the patient to go to the emergency department (ED) for evaluation, and the patient indicated he/she didn t want to go and wait 5-6 hours. RN C also assessed the patient was unable to open his/her medication bottles with childproof lids due to neuropathy and provided/filled a 7-day pill planner.

During an interview on 3/3/2022 at 2:13 PM, RN C was queried to describe the home nursing visit with patient #10 on 3/2/2022. RN C indicated she was still working on completing the visit note, as it was overwhelming, the patient was in very poor condition, and he/she was unaware of the severity of his/her wounds.

During an interview on 3/3/2022 at 1:29 PM, while discussion of the IJ occurred, person P (chief operations officer, owner) indicated the findings during the surveyors home visit with patient #10 warranted the calling of an IJ.

The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR §484.60: Care planning, coordination of services, and quality of care.

17-13-1(a)

17-13-1(a)(1)(B)

17-13-1(a)(1)(C)

17-13-1(a)(1)(D)(ii, vi, vii, viii, ix, x, xii, xiii)

17-14-1(a)(1)(G)

17-13-1(a)(2)

G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review, and interview, the agency failed to ensure the patient received all services indicated on the plan of care, the patient s plan of care was individualized, and/or included patient-specific measurable outcomes and goals, for 13 of 14 records reviewed (#1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14). Findings include: 13. Record review for patient #1 was completed on 3/3/2022, start of care date 8/24/2021, for certification period 12/22/2021 2/19/2022. Record review evidenced a document dated and signed by registered nurse (RN) I on 12/20/2021 titled ... Recertification [comprehensive reassessment] , which indicated the patient was paraplegic (paralyzed from the waist down), had decreased adherence to treatment plan, home safety risks (not further elaborated), inadequate support network, lived alone, had three stage 3 pressure injuries (open wound extending through all layers of skin, but no muscle involvement) on the sacrum (lower back), right and left hips, required urinary catheterization (tube inserted into the bladder to drain urine), incontinent of bowel, needed help to dress, dependent with toileting needs, and unable to transfer self. A hospital AA document dated 8/18/2021 titled History and Physical indicated the patient s diagnoses included anxiety and PTSD (post-traumatic stress disorder) secondary to awakening from surgery as a paraplegic, and was positive for COVID-19 (8/18/2021).	G0572	1.The Administrator/Director of Health Care Services or Chief Clinical Officer will audit Comprehensive assessments and plan of care to ensure clinician has documented current patient status thoroughly. 2. The Administrator/Director of Health Care Services and/or RN Case Manager will ensure the current plans of care are provided in the home of patients. Completed 3/15/2022. 3. Clinicians will be reeducated on contents required on plan of care including: a. All pertinent diagnoses b. Patient’s mental, psychosocial, and cognitive status c. The types of services, supplies and equipment required d. The frequency and duration of visits to be made e. Prognosis f. Rehabilitation potential g. Functional limitations h. Activities permitted i. Nutritional requirements j. All medications and treatments k. Safety measures to protect against injury l. 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 m. Patient and caregiver education and training to facilitate timely discharge n. Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient o. Information related to any advanced directives p. Any additional items the HHA or physician may choose to include 4. Monitoring: 100% of comprehensive assessments and plans of care will be reviewed for 30 days. If 100% clinical compliance is not confirmed, 100% comprehensive assessments and plans of care will be reviewed for an additional 30 days until 100% compliant for a 30-day timeframe. 5. Once 100% compliance with thorough assessment and plan of care is achieved, 25%	2022-04-15

	A hospital AA document dated 8/19/2021 titled [doctor] Progress Notes indicated the patient self-catheterized every 4-6 hours at home (to drain urine from the bladder due urine retention), and the patient took norco (a narcotic/opioid pain medication) for pain control. A home visit was observed on 2/16/2022 at 11:55 AM, with the patient and RN C. The patient presented lying in his bed, wearing a t-shirt and athletic shorts. Both legs were atrophic (absence of muscle mass). Observed presence of straight catheters (to insert directly into bladder to drain urine), cigarettes, and a vape (battery-operated device to inhale vapor through the mouth). When queried about his lifestyle and health status, the indicated he did smoke and vape, his spinal cord was injured at the T 10 and 11 (thoracic vertebras lower mid-back) level, he took norco 3 times daily for his pain, he hasn t had issues with constipation for a while, but would like to learn how to do a bowel program (mechanical/medicinal method to elicit a bowel movement). During this time, RN C encouraged the patient to drink protein shakes to aide in wound healing. A document dated and signed by RN I on 12/20/2021, titled Home Health Certification and Plan of Care indicated the patient has been very compliant with his diet, has increased protein intake, his personal goal was for his wounds to heal, and nursing goals stated ... patient will be free of falls/injury ... remain free of infection ... achieve optimal wound healing ... will have no acute care hospitalizations, ER [emergency room] visits .... The document failed to include individualized, measurable outcomes/goals related to pain, amount of wound healing projected or accomplished since last certification period, compliance with treatment plan, home safety risks, personal care/homemaking needs, nutrition, smoking cessation, constipation, or bowel program needs identified by the patient. During an interview on 2/28/2022 at 2:27 PM, when queried if there were a lot of generic/non-specific plug and play entries (pre-populated, generalized interventions/goals in the EMR, from which the clinicians chose to include, that would populate on the plans of care) on the plans of care, administrator/clinical manager A indicated there were.		of assessments and plans of care will be reviewed quarterly. If at any time the agency falls out of compliance reeducation will be provided to clinicians and number 4 and 5 above will be repeated. 6. Survey results, quality record reviews, supervisory visits and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body 7. Completion date: 4/15/2022 and ongoing	

During an interview on 03/02/2022 at 1:05 PM, when queried what her expectations were for pain management and the plan of care, administrator/clinical manager A indicated she would expect education on pain management and interventions/goals for pain.

14. Record review for patient #3 was completed on 3/3/2022, start of care date 11/13/2021, transfer date 11/16/2021, for certification period 11/13/2021 1/11/2022. Record review evidenced a document dated and signed by RN J on 11/13/2021 titled ... Start of Care [comprehensive assessment] , which indicated the patient received enteral nutrition (artificial introduction of nutrition/fluid/medication into the stomach) via g-tube (tube inserted into opening in abdomen directly into stomach), absence of a capable caregiver, poor nutrition, overall poor status, 24-hour supervision required, presence of daily pain, a closed surgical incision covered with steri-strips (thin adhesive strips to hold tissue together), shortness of breath with minimal exertion, nausea, bowel and bladder incontinence, dependent on another for bathing, unable to take in nutrients orally, weight loss, patient wasn t tolerating g-tube feedings, and training was required.

A hospital FF document dated 11/12/2021, titled Referrals: Home Health Care , indicated diagnoses included tachycardia (fast heart rate, over 100 beats per minute), hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), and slow transit constipation; and orders for home nurse included 90 ounces of water via peg tube (g-tube) (a tube inserted through the wall of the abdomen directly into the stomach, allows air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid food, to the patient) daily, increase miralax (laxative) to twice daily via peg tube, may administer fleets enema once (to relieve constipation), and administer albuterol nebulizer (inhaled medication to open bronchial tubes and relieve shortness of breath) every four hours as needed for shortness of breath and wheezing.

A document dated and signed by RN J on 11/13/2021 titled Home Health Certification and Plan of Care personal goal was get back to my old self , and nursing goals stated ... will have no acute care hospitalizations, ER [emergency room] visits ... remain free of infection ... patient

	will be free of falls/injury .... The document failed to include individualized, measurable goals related to energy conservation, shortness of breath which required as needed medication intervention, competency of caregiver ability to correctly administer g-tube feedings, patient tolerance to feedings, weight loss, constipation, personal care/hygiene needs, or surgical incision status. During an interview on 2/23/2022 at 2:51 PM, when queried on the purpose of the plan of care, administrator/clinical manager A indicated it was a set of orders for home care interventions and goals. 15. Record review for patient #10 was completed on 3/3/2022, start of care date 12/7/2021, for certification period 2/5/2022 4/5/2022. Record review evidenced document signed and dated by RN J on 2/1/2022, and physician I (certifying, primary care physician) on 2/7/2022, titled "Home Health Certification and Plan of Care", for certification period 2/5/2022 - 4/5/2022. This document indicated diagnoses included diabetes with a foot ulcer (wound), hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time), moderate protein calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function); orders for skilled nursing was twice weekly, but stated, "... [patient] reports going to wound clinic yesterday (1/31/2022). This nurse looked at paper sent home with [patient] ... [person H, wound clinic M s physician] is requesting that Interim visit client MWF [Monday, Wednesday, Friday] to change dressings. This nurse explained to [patient] that it isn t possible to see [him/her] 3x/wk [3 times per week] due to case load ... will follow up with wound clinic .... ; indicated the patient s personal goal was to get all of this behind me ; and nursing goals stated ... patient will remain free of infection ...demonstrate competence with self-management of ... diabetes ... achieve optimal wound healing ... be free of falls/injury ... will have no acute care hospitalizations, ER [emergency room] visits .... The record failed to evidence skilled nursing visits were provided 3 times per week as ordered, and the plan of care failed to include individualized, measurable outcomes/goals related to progression of wound healing since last certification period, hypertensive heart disease, or moderate protein calorie malnutrition.			

Faxed documents in the patient s clinical record from wound clinic M, included a fax cover sheet, dated 1/31/2022 at 12:27 PM. This document stated, ... Wound assessments and orders for today, 1/31/2022 ... change dressings/wraps ... on Monday 2/7/22 ... due to [wound clinic physician H] being out of the office that day, and the normal Wednesday and Friday. Patient to RTC [return to clinic] on 2/14 [2022] .... An additional document was included, dated 1/31/2022, titled Office Visit (for wound clinic M), which stated ... here for new wound left foot and chronic wound right heel. Patient has visiting nurses applying collagen and ace wraps for swelling ... Wound care nurse noted on his initial evaluation today that there was a shell of a pistachio nut embedded into the plantar [bottom of] left foot. Therefore he has a new wound today on his left foot ... Full thickness ulceration right heel ... new ulceration from foreign body left foot but [sic] signs of infection ... Chronic lymphedema [condition in which extra lymph fluid builds up in tissues and causes swelling] ... Advised the patient never to go barefoot ... Physician orders ... Apply collagen [dressings derived from usually cow or pig collagen, a crucial role in the wound healing process], foam ... apply 3M 2 layer lite [a 2 layer compression system wrap, not the same as ace wrap] ... Home care to change dressing and wrap on Monday, Wednesday and Friday ... float heels to reduce pressure .... The clinical record failed to evidence a nursing visit was made on 2/7/2022 as ordered by wound clinic M, or 3 visits were made weekly for wound care. The record indicated during the first week of the certification period (week of 2/5/2022), visits were made on Tuesday, 2/8/2022 and Friday, 2/11/2022. The second week of the certification period (week of 2/12/2022), visits were made on Tuesday, 2/15/2022 and Friday, 2/18/2022.

A home visit was observed on 3/1/2022 at 10:30 AM with patient #10 and registered nurse (RN) J. RN J was not present upon surveyors arrival. Observed patient #10 seated in a wheelchair in his/her bedroom, with both lower extremities wrapped with compression wraps, approximately 3-4 inches below the knees, distal to toes. Toes on both feet were exposed. Both legs were swollen above the wraps, and his/her toes were swollen. The patient was alert and oriented, and able to answer questions appropriately.

On 3/1/2022 at 10:37 AM, the patient indicated he/she had a medical history of diabetes with

	numbness, tingling, and pain), and wounds; he/she took his/her blood glucose 1 time per day, since he/she only ate once per day, usually when someone could make him/her some food, and it was generally after 7:00 PM; he/she drank coffee and had oatmeal for breakfast sometimes; his/her blood sugars ran about 160 , and his/her doctor didn t care as long as they were below 200 . The plan of care failed to include an individualized measurable goal for blood sugar results to remain below 200. On 3/1/2022 at 10:40 AM, the patient indicated he/she hasn t been to wound clinic M for several weeks, since he/she didn t have transportation; his/her left leg and foot bandage hasn t been changed for 3 weeks, the right leg and foot hasn t been changed for 2 3 weeks, and this was because RN J wanted them left in place to heal ; the home health nurse was supposed to be out to see him/her 2 times per week, but sometimes she only came once because of staffing, and the last time the nurse came was last Tuesday (2/22/2022). On 3/1/2022 at 10:53 AM, surveyors observed medications in a patient belongings bag, and they were reviewed/reconciled with the patient. The patient confirmed that he/she only took the following medications: Levemir 18 U (units) daily, Atenolol 25 mg (milligrams) daily, Atorvastatin 40 mg daily, Ropinirole 0.5 mg daily, and Furosemide 40mg daily. When queried about other medications listed on the agency's current plan of care, he/she indicated he/she has not taken potassium chloride, aspirin, zinc, toujeo, multivitamins, florastor, or metronidazole since his discharge from skilled nursing facility (SNF) N in December of 2021. The plan of care failed to include an individualized measurable goal for medication management/compliance. On 3/1/2022 at 10:56 AM, the patient indicated his/her pain was currently about 4-5 (out of 10, with 0 = no pain, and 10 = worst pain ever), last night it was 10 , and when queried if he/she took any pain medications, he/she stated, ... My doctor [physician I] doesn t believe in that .... , and indicated physician I wanted him/her to go to the pain management place , but he/she didn t want to. The plan of care failed to include individualized measurable goals for pain. On 3/1/2022 at 12:00 PM, when queried about a			

wound caused by a pistachio shell (as noted in wound clinic M s document dated 1/31/2022), RN J stated ... I don t know anything about any pistachio shell .... The plan of care failed to include individualized measurable goals for the wound on the patient's left foot, identified by wound clinic M on 1/31/2022.

On 3/1/2022 at 12:25 PM, RN J failed to assess the patient s buttocks, posterior legs, and plantar surfaces of both feet. Upon prompting by surveyors, RN J assessed patient s buttocks, which appeared red/purple, but blanchable, and patient had stool residue in his/her underwear. The plan of care evidenced the patient had inadequate environmental cleaning (not further specified/described on the plan of care), and lack of a caregiver; and failed to include individualized measurable goals for the patient s personal care/hygiene, or psychosocial needs (such as transportation, home environment).

16. Record review for patient #11 was completed on 3/3/2022, start of care date 01/27/2022, discharge date 2/18/2022, for certification period 01/27/2022 03/27/2022. Record review evidenced a document dated and signed by RN I on 1/27/2022 titled ... Start of Care , which indicated the patient needed assist for personal care/hygiene and meals, cardiac assessment identified activity intolerance and fatigue/weakness, was incontinent of bowels, had parkinson s disease, was at a moderate nutritional risk (score of 30, and moderate risk was scored as between 26-55), diet was no added salt, unable to self-administer medications, had a donut cushion (for pressure relief while sitting), and the nurse instructed to increase protein intake.

A document dated and signed by RN I on 1/27/22, titled Home Health Certification and Plan of Care , for certification period 01/27/2022 03/27/2022, indicated a primary diagnosis of stage 2 pressure injury (wound caused by prolonged, unrelieved pressure, extending into, but not past the layers of the skin, and includes open or ruptured blisters) to left buttock; other diagnoses included dementia with Lewy bodies (a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain, which can lead to problems with thinking, movement, behavior, and mood), congestive heart failure (the heart s inability to effectively pump blood throughout the body), diabetes, depression, anxiety, atrial fibrillation (irregular heart beat/rhythm), BPH (benign prostatic

	hyperplasia, which causes blockage of urine flow), gastro-esophageal reflux disease (GERD) (indigestion/heartburn), and diverticulosis (a condition in which small, bulging pouches develop in the digestive tract); psychosocial status indicated the patient lived with his spouse; skilled nursing was ordered twice weekly for 9 weeks; the patient s personal goal was Wound to heal ; and nursing goals stated ... patient will be free of falls/injury ... will have no acute care hospitalizations, ER [emergency room] visits ... have promotion of healing and restoration of skin integrity without complications ... achieve optimal wound healing ... remain free of wound infection .... The plan of care failed to include individualized, measurable goals related to progression of wound healing, personal care/hygiene and meals, activity intolerance, fatigue/weakness, incontinent of bowels, parkinson s disease, nutritional risk/diet with increased protein intake, medication management, development of new or worsening wounds; or for diagnoses of BPH, diverticulosis, dementia with Lewy bodies, diabetes, depression, anxiety, atrial fibrillation, or GERD. The record also failed to evidence skilled nursing visits were provided 2 times per week as ordered. During the first week of the certification period (week of 1/27/2022), only 1 visit was made. A document dated and signed by RN I on 2/3/2022 (Thursday) titled Missed Visit stated ... Cancellation of Care ... Bad weather condition .... The record failed to indicate an attempt was made to re-schedule for another day during the week. Only 1 nursing visit was provided during the second week (week of 1/29/2022). 17. Record review for patient #12 was completed on 3/3/2022, start of care date 1/12/2022, for certification period 1/12/2022 3/12/2022. Record review evidenced a document dated and signed by RN I on 1/12/22, titled Home Health Certification and Plan of Care , indicated nursing visits were ordered once weekly for the first week, then 2 times per week for 2 weeks, then weekly for 6 weeks; a primary diagnosis of orthostatic hypotension, and other pertinent diagnoses included chronic obstructive pulmonary (lung) disease (COPD), chronic kidney disease, depression, and GERD; was prone to skin breakdown; the patient s personal goal was Be more stronger , and nursing goals stated ... patient will remain free of infection ... demonstrate return to stable cardiovascular status ... competence of self-management of diabetes .... The record evidenced only 1 nursing visit was made during week 3 (week of			

	1/22/2022), but 2 visits were ordered; and the plan of care failed to include individualized, measurable goals related to orthostatic hypotension, COPD, chronic kidney disease, depression, GERD, or skin integrity. A document from skilled nursing facility (SNF) W dated 12/13/2021, titled History and Physical stated ... [patient] presents with syncopal [fainting] episode reported by [family] ... She did not hit her head ... She was found to have orthostatic hypotension which is very significant ... States that she does get short of breath when exerting .... 18. Record review for patient #13 was completed on 3/3/2022, start of care date 12/16/2021, for certification period 12/16/2021 2/13/2022. Record review evidenced a document dated and signed by RN N on 12/16/2021 titled ... Start of Care indicated the patient was immunocompromised, had a recent lung transplant, was a high infection risk, had ringing in ears, pain, bruising, used a nebulizer, was short of breath with moderate exertion, used a bilevel PAP (Bilevel Positive Airway Pressure] device [a type of ventilator used to treat chronic conditions that affect your breathing , and delivers two levels of air pressure), the patient had hemorrhoids, nausea, diarrhea, and heartburn/reflux [regurgitation]; nutritional requirements included a 2 gram sodium restricted diet, and the patient had a right chest CVL (central venous line- a special intravenous (IV) line, a long, soft, thin, flexible tube that is inserted into a large vein). A document dated and signed by RN N on 12/16/2021, titled Home Health Certification and Plan of Care , indicated a primary diagnosis of cytomegaloviral disease (a virus), other diagnoses included primary pulmonary hypertension (a type of high blood pressure that affects the arteries in the lungs and the right side of the heart), chronic heart failure (CHF- the heart s inability to pump blood/oxygen effectively throughout the body); nutritional requirements included a 2 gram sodium restricted diet; medications included levothyrox (a thyroid hormone replacement), and atorvastatin (to lower cholesterol); interventions included to instruct patient/caregiver on management of depression, The plan of care indicated the patient s personal			

goal was I learn how to do this IV , and a goal which stated ... will demonstrate competence with self-management of pleural effusion [the build-up of excess fluid between the layers of the pleura outside the lungs. The pleura are thin membranes that line the lungs and the inside of the chest cavity and act to lubricate and facilitate breathing] .... The patient did not have a diagnosis of pleural effusion listed on the plan of care. The plan of care failed to include individualized, measurable goals for the diagnoses of pulmonary hypertension, CHF, depression, hypothyroidism, or high cholesterol; for resolution of hemorrhoids, nausea, diarrhea, heartburn/reflux, or achievement of a 2 gram sodium restricted diet.

17-13-1(a)

1. Review of an agency policy obtained 2/14/2022, revised 4/2/2021, titled Developing a Plan to Meet Patient/Client Needs , stated, Policy & An individualized Plan of Care/Service Plan is developed for each patient receiving care/service to specify the care and services necessary to meet the patient s specific needs and goals as identified in the comprehensive assessment &.

2. Review of an agency policy obtained 2/14/2022, revised 4/2/2021, titled Implementing the Plan of Care/Service Plan , stated, Policy & Interim Healthcare provides care/service in accordance with the Plan of Care/Service Plan and standards of practice & The DHCS (director health care services) ensures resources are available and processes are in place to implement the Plan of Care/Service Plan as documented & The DHCS or designee provides employees with the current plan of care/service plan for those patients/clients they are assigned to provide care/service & The DHCS, registered nurse or other appropriate skilled professional assigns a home health aide(s) to a specific patient that has written patient care instructions for the services of a home health aide & the patient care instructions for a home health aide are prepared by that registered nurse or other appropriate skilled professional (i.e., physical therapist, speech-language pathologist, or occupational therapist) &.

3. Review of an agency policy obtained 2/14/2022, revised 4/2/2021, titled Admission to Home Care , stated, Policy & An individual is admitted to home care only if: & The needed care/service can be provided by appropriately qualified employees in a timely manner and at

	the level of intensity indicated by the individual s identified needs &. 4. Review of an agency document obtained 2/14/2022, revised 2018, titled Statement of Patient s/Client s Rights stated, As a Patient/Client, you have the right to: & Receive all services outlined in your care plan &. 5. Clinical record review for patient #2 was completed on 3/3/2022, start of care 4/27/2020, for certification period reviewed 12/8/2021 2/15/2022. Review evidenced an agency document electronically signed by registered nurse N on 12/16/2021, titled Home Health Certification and Plan of Care which listed a primary diagnosis of hereditary hypogammaglobulinemia (an immune system disease in which the body does not produce enough antibodies). This document stated, &Orders for Discipline and Treatment & SN [skilled nurse] 1M2 [once a month for 2 months] & SN for assessment & SN to place peripheral IV [intravenous catheter] and administer IVIG [intravenous immunoglobulin]. TPR [temperature, pulse, respirations] and BP [blood pressure] before each rate change, then every 30 minutes for 2 hours when infusion is at the maximum rate and then every 2 hours until infusion is complete &. Review evidenced agency documents electronically signed by registered nurse N on 12/20/2021 and 1/12/2022, titled Skilled Nursing Infusion which failed to evidence blood pressure was taken during infusion visit as ordered on plan of care. Observation of a home visit was conducted on 2/16/2022 at 1:30 PM to observe a routine skilled nurse infusion. During the visit, registered nurse N stated, & we don t check blood pressures on kids &. She indicated blood pressure was an inaccurate indicator of pediatric status. During an interview on 2/28/2022 at 11:57 AM, administrator/clinical manager A indicated, when queried about what orders staff were responsible for completing, the nurses were expected to complete all tasks listed, under skilled nurse, in patient s individualized plan of care.			

6. Clinical record review for patient #4 was completed on 3/3/2022, start of care 5/19/2021, certification period 5/19/2021 6/15/2021. Review of an agency document electronically signed by registered nurse N on 5/19/2021 titled Home Health Certification and Plan of Care , listed a primary diagnosis of unilateral primary osteoarthritis of first carpometacarpal joint right hand [arthritis of the right thumb]. This document stated, & Orders for Discipline and Treatments: HHA [home health aide] Frequency: 3 hours a day x 14 days & HHA to assist with ADL s (activities of daily living) & IADL s [instrumental activities of daily living] per HHA care plan &.

Review evidenced unsigned agency documents dated 5/28/2021, 6/11/2021, and 6/14/2021, titled New Home Care HHA [home health aide, visit note] which were not completed, failed to evidence any interventions or treatments were completed on these days, and failed to evidence HHA visits were completed these days.

Record review evidenced agency documents titled Missed Visit for home health aides for the following dates: 5/29/2021, 5/30/2021, 5/31/2021, 6/12/2021, and 6/13/2021.

Record review failed to evidence any HHA visits from 6/2/2021 6/9/2021. No clinical documentation for these dates was evidenced. Agency failed to ensure patient #4 received HHA visits 3 hours per day for 14 days as ordered on plan of care.

Review of an agency document regarding a home health aide visit, dated 5/29/2021, electronically signed by person E (former scheduler, titled Missed Visit stated, & Reason & Cancellation of care & Client refused this caregiver &."

Review of an agency document regarding a home health aide visit, dated 5/30/2021, electronically signed by person E (former scheduler), titled Missed Visit stated, & Reason & Cancellation of care & client refused this caregiver &.

Review of an agency document, regarding a

electronically signed by person E (former scheduler), titled Missed Visit stated, & Reason & Cancellation of care & Client cancelled. Family provided care &.

A phone interview was conducted with patient #4 on 2/14/2022 at 5:45 PM. Patient #4 indicated on 5/20/2021 and 5/21/2021, person Q (former HHA), was at her house, and refused to help with shower or dressing, claiming & it wasn t part of their job description &. . Patient indicated person Q was sleeping on the couch during her shifts. Patient #4 indicated she fell in the bathtub on 5/21/2022 after asking for help in the shower. She indicated person Q refused to help her get up when she fell. Patient #4 stated she & complained to the agency about & [person Q] &, and the agency continued to send person Q to her house for visits because they were the only aide they had &. Patient #4 indicated she refused person Q to be her caregiver, and for one week, did not receive any home health aide services from the agency, and at the end of May, the agency sent a different caregiver. Patient #4 indicated she called her insurance company and they helped her find another home health agency to provide care.

The agency failed provide a caregiver per the patient s request, failed to coordinate care to provide all ordered services including frequency of visits, failed to coordinate care to meet patient s needs as evidenced by patient fall, and failed to coordinate care to assist patient in finding another provider.

During an interview on 2/21/22 at 2:20 PM, administrator/clinical manager A stated, when queried how the agency responds if the patient requests a different aide, & if they ask for different one, we try to find out why and attempt to get different aide & it might be a personality conflict & if it s a smaller issue, the clinical manager will try to intervene to talk to the HHA or patient &. When asked what 3 hours a day for 14 days means to the agency, administrator/clinical manager A stated, & 3 hours a day for 14 days in a row is how I would interpret this & I d have to see if they reauthorized the visits &. She did not know why patient did not receive visits after 5/27/2021.

Agency failed to ensure patients received frequency of services as written in a plan of care.

7. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Home Health Certification and Plan of Care . This document listed a primary diagnosis of myelodysplastic syndrome (group of diseases marked by disruption of production of blood cells). This document stated, & Prognosis & Good & Orders for Discipline and Treatments & SN [skilled nurse] frequency: 2 visits /week x 9 weeks & HHA [home health aide] Frequency: 2-4 hrs [hours] 1-2x/day 6 days/week x 9 weeks & Physical Therapy 2 v/week (visits per week) x9 weeks (for 9 weeks) & Skilled nurse overall assessment. TPR [temperature, pulse, respirations] B/P [blood pressure] Orthostatic B/P & SN to assess wound, ulcer for healing and infection & SN to measure wound, ulcer weekly recording results & Assess drainage for color, amount, odor, and consistency & Report any abnormal findings to MD [doctor] & Using aseptic technique, SN to clean wound, ulcer with wipes pat dry, apply Foam border dressing & change twice a week & prn [as needed] & SN to assess pain every visit & Instruct on pharmacological and non-pharmacological pain management & report pain level > 5 to MD & Instruct on energy conservation, incontinence care, and home safety measures & SN to notify MD of: Systolic BP [blood pressure] & less than 90 & SN to instruct on establishing bowel regimen & SN to instruct client to use prescribed assistive device when ambulating & HHA to assist with ADL s [activities of daily living] & IADL s [instrumental activities of daily living] per HHA care plan &. This document failed to evidence physical therapy interventions or orders.

Review evidenced an agency document electronically signed by alternate clinical manager C on 4/8/2021, titled Skilled Nurse Visit which stated, & Blood Pressure: & 100/58 & Integumentary & No Problems Identified & Visit Narrative & foam border dressings applied left right and coccyx &. This document failed to evidence wound measurement, orthostatic blood pressure, and education on pain management, energy conservation, incontinent care, home safety measures, or bowel regimen as ordered on plan of care.

Review evidenced an agency document electronically signed by licensed practical nurse T on 4/12/2021, titled Skilled Nurse Visit which

dressing applied to coccyx for protection & BP [blood pressure] sitting is 92/54 standing 88/50 &. This document failed to evidence wound measurement, notification of doctor for systolic BP less than 90, and education on pain management, energy conservation, incontinent care, home safety measures, or bowel regimen as ordered on plan of care.

Review evidenced an agency document electronically signed by alternate clinical manager C on 4/15/2021, titled Skilled Nurse Visit which stated, & Blood Pressure & 90/52 & Visit Narrative & Stood 2 more times with max assist for foam dressings to be applied left/right &. This document failed to evidence wound measurement or assessment, orthostatic blood pressure, pain assessment, and education on pain management, energy conservation, incontinent care, home safety measures, or bowel regimen as ordered on plan of care.

Review evidenced an agency document electronically signed by alternate clinical manager C on 4/19/2021, titled Skilled Nurse Visit which stated, & Blood Pressure & 112/68 & Integumentary & No Problems Identified & Visit Narrative & Reddened gluteal areas & Foam patches to left right gluteal areas &. This document failed to evidence wound measurement, orthostatic blood pressure, and education on pain management, energy conservation, incontinent care, home safety measures, or bowel regimen as ordered on plan of care.

Review evidenced an agency document electronically signed by alternate clinical manager C on 4/22/2021, titled Skilled Nurse Visit which stated, & Integumentary & No Problems Identified & Skin gluteal area red & 3 roam [sic] [foam] dressings to protect skin applied &. This document failed to evidence wound measurement, any vital signs, orthostatic blood pressure, and education on pain management, energy conservation, incontinent care, home safety measures, or bowel regimen as ordered on plan of care.

Record review failed to evidence 2 skilled nurse visits as ordered on plan of care for the week beginning 4/17/2021.

Review evidenced an agency document

	T on 4/26/2021, titled Skilled Nurse Visit which stated, & Integumentary & 0.25 x 0.25 cm coccyx & Visit Narrative & BP [blood pressure] sitting is 90/52, standing 72/44 & Small open area noted to coccyx measuring 0.25cm x 0.25 cm & area cleansed and a foam dressing applied &. This document failed to evidence wound assessment, doctor notification for blood pressure less than 90, and education on pain management, energy conservation, incontinent care, home safety measures, or bowel regimen as ordered on plan of care. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/29/2021, titled Skilled Nurse Visit which stated, & Visit Narrative & Sitting B/P [blood pressure] 86/54 & After standing & B/P 72/45 & upper gluteal crease stage 2 & 2cm slit .25 depth serous scant drainage & Left gluteal 1cm stage 2 5cm w 6cm of ark & pink to purple skin & Left upper thigh 2 stage 2 1cm diameters open skin & Foam dressings and Calvin [sic] in use, gel foam cushion & he is in a recliner all day all night & no way to position off back & right thigh upper has 1 2cm x 2cm .2cm depth area skin serous drainage & Right gluteal has 2cm area and 1cm area skin loss & also dark pink to purple from pressure &. This document failed to evidence wound dressing change, doctor notification for blood pressure less than 90, new wounds, and worsening condition, and education on pain management, energy conservation, incontinent care, home safety measures, or bowel regimen as ordered on plan of care. Review evidenced an agency document electronically signed by licensed practical nurse T on 5/3/2021, titled Skilled Nurse Visit which stated, & BP [blood pressure] while in a lying position is 86/46 & Coccyx is reddened & The small open area is healed & A bordered foam dressing placed over coccyx to protect skin &. This document failed to evidence wound measurement, orthostatic blood pressure, doctor notification for blood pressure less than 90, and education on pain management, energy conservation, incontinent care, home safety measures, or bowel regimen as ordered on plan of care. Review evidenced an agency document signed by home health aide H on 5/3/2021, 5/4/4/2021, 5/5/2021, and 5/6/2021, titled Home Care Aide Visit/Charting Sheet which indicated patient had increased or new severe pain to his leg on dates 5/3/2021, 5/4/2021, 5/5/2021, and 5/6/2021.			

Record review failed to evidence the nurses notified physician about severe pain, as indicated on the plan of care.

Review evidenced an agency document electronically signed by alternate clinical manager C on 5/6/2021, titled Skilled Nurse Visit which stated, & Blood Pressure & 78/40 & Integumentary & Cavilon spray to gluteal areas & Pain Profile & Primary Site: Right shoulder left knee & Current Pain Intensity: 9 [out of 10, with 10 being the worst pain possible] & Description & Dull & Tender & Pain is Relieved by/Mitigated by & Distraction & Medication & Reposition & Rest & Sleep & Response to Care /Progress Toward Goals & Stable skin at gluteal sacral area improved pink blanches easily, near anus one 2cm 1cm area loss of surface skin &. This document failed to evidence ordered wound dressing, orthostatic blood pressure, doctor notification for blood pressure less than 90, doctor notification for pain greater than 5, and education on pain management, energy conservation, incontinent care, home safety measures, or bowel regimen as ordered on plan of care.

Review evidenced an agency document electronically signed by licensed practical nurse T on 5/10/2021, titled Skilled Nurse Visit which stated, & Visit Narrative & Client c/o pain to his left knee and right shoulder which is worse when he is repositioned & wife has been giving client Acetaminophen as needed & Skin color is jaundiced & There is some redness to inner groin both sides & A medicated powder applied that was in the home & Client s buttocks are red and there are 3 small superficial areas present & A barrier cream applied then covered with a bordered foam dressing & O2 [oxygen saturation] sat at 90% on RA [room air] BP [blood pressure] low at 82/42 &. This document failed to evidence wound measurement, ordered wound care, doctor notification for blood pressure less than 90, doctor notification for O2 sat less than 92, and education on pain management, energy conservation, incontinent care, home safety measures, or bowel regimen as ordered on plan of care.

During an interview on 2/28/2022 at 10:12 AM, administrator/clinical manager A stated, when queried about process for rescheduling missed visits, & the process is scheduling is notified of the missed visit and reason, and they attempt to fill the schedule with skilled matched staff & if they are unable to they notify the patient & we

	had time to get it covered & we let the family know if we don t have coverage & rescheduling depends on the patient and what type of visit it is & if it s possible we reschedule a different day &. Administrator A indicated patients should receive all the visits they have ordered on plan of care. During an interview on 2/28/2022 at 10:35 AM, administrator/clinical manager A stated, when queried about wound documentation and measurement, & documentation of wounds should include & appearance, drainage, shape, size, redness, description, measurements, and whatever wound care is provided & some nurses will put wound care under integumentary and some under narrative section of visit note &. When queried whether patient #5 had 1 or 2 wounds, administrator A stated, & good question & I don t know & the nurses don t use the wounds manager on this side &. Administrator/clinical manager A indicated they didn t have a consistent method for documenting wound measurements and assessments. During an interview on 2/28/2022 at 10:45 AM, administrator/clinical manger A stated, when queried about where patient education is documented, & education should be documented under the narrative section on the nurses visit notes &. Administrator/clinical manager A indicated no education was charted on patient #5. During an interview on 2/28/2022 at 10:59AM, administrator/clinical manager A stated, when queried why nurses did not complete orthostatic blood pressure per plan of care, & it should go under vitals or narrative section &. Administrator/clinical manager A indicated nurses did not document orthostatic blood pressure on several visits. Administrator/clinical manager A stated, when queried about purpose of nurses checking vitals, & to monitor their oxygen level and see if it drops while doing exercises & we want to check blood pressure before activities & we don t want to do extensive therapy if the patient is hypotensive &. Administrator/clinical manager A indicated that nurses should have notified physician about pitting edema, patient decline, and low blood pressures below parameters. During an interview on 2/28/2022 at 11:10 AM, administrator/clinical manager A stated, when			

	completing all tasks on plan of care, & aides should be putting why they didn t do it & what reason was they didn t do it & and update the case manager & or at least let them know to read the note & Administrator/clinical manager A indicated case managers oversee patient s care, home health aides, and aides should be reporting any changes they notice to the case manager including new leg pain. Administrator/clinical manager A indicated teaching should be documented about pain medications. 8. Record review was completed on 3/3/2022 for patient #7, start of care 1/14/2003, for certification period 6/8/2021 8/6/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 6/15/2021, titled Home Health Certification and Plan of Care. This document listed a primary diagnosis of hemiplegia following unspecified cerebrovascular disease affecting left non-dominant side (paralysis affecting left side of body). This document stated, & Orders for Discipline and Treatments & SN [skilled nurse] Frequency: 1x Month & 1 prn [as needed] x 2 months for catheter complications & HHA [home health aide] Frequency: 2 V [visits] daily x 7 DW [days per week] x 9 W [weeks] (2 hr [hours] in am [morning] 1 hr in pm [evening] & Skilled Nurse for total assessment &. Assess vital signs and blood sugars with each visit and report to PCP [primary care provider] anything that is out of normal limits & Assess skin for any breakdown & Using sterile technique SN to change 14F [french] 3cc [cubic centimeters] Supra-pubic catheter 1x month and prn for any complications & Report to PCP any changes in condition &Home Health Aide to meet all client s ADL s [activities of daily living]/IADL s [instrumental activities of daily living] as on the HHA plan of care & SN to notify MD [doctor] of: & Systolic BP [blood pressure] greater than 180 or less than 100 & Diastolic BP greater than 90 or less than 58 & Random blood sugar greater than 200 or less than 100 &. Review evidenced an agency document electronically signed by alternate clinical manager C on 6/3/2021, titled Oaisis [outcome and assessment information set] D-1 Recert [recertification, comprehensive re-assessment] which stated, & Suprapubic catheter Last Changed 3/23/2021 &. Review evidenced an agency document electronically signed by alternate clinical manager C on 7/2/2021, titled Skilled Nurse Visit			

which stated, & Visit Narrative & Sterile 14 fr [French] catheter change &. This document failed to evidence catheter had been changed every month and failed to evidence blood glucose was checked as ordered on plan of care.

Review evidenced an agency document electronically signed by registered nurse N on 7/31/2021, titled Skilled Nurse Visit which failed to evidence the nurse checked a blood glucose as ordered on the plan of care.

Record review evidenced unsigned agency documents titled HHA Visit , which were not completed, and failed to evidence a HHA visit was completed, or any care was provided on the following days: 6/8/2021 (evening visit), 6/10/2021 (evening visit), 6/12/2021 (evening visit), 6/13/2021 (evening visit), 7/7/2021 (evening visit), 7/8/2021 (evening visit), and 7/25/2021 (evening visit).

Record review evidenced unsigned agency documents titled New Home Care HHA which were not completed, failed to evidence a HHA visit was completed, or any care was provided on the following days: 6/13/2021 (morning visit), and 7/7/2021 (evening visit).

Record review evidenced an agency document signed by HHA P on 6/11/2021, titled HHA Visit , which was not completed, failed to evidence an evening HHA visit was completed, and failed to evidence any tasks from the plan of care were completed.

Record review evidenced agency documents signed by HHA P on 6/12/2021 and 6/14/2021, titled New Home Care HHA , which were not completed, failed to evidence a morning HHA visit was completed, and failed to evidence any tasks from plan of care were completed.

Record review evidenced agency documents titled Missed Visit , which evidenced missed evening HHA visits on the following dates: 6/19/2021, 6/29/2021, 7/3/2021, 7/15/2021, and 7/24/2021.

During an interview 2/23/2022 at 1:34 PM,

	administrator/clinical manager A stated, when queried about aides notifying someone about changes in patient status, & the aides should notify the clinical manager if they notice something new & the nurses should notify the doctor if the vitals are outside of parameters &. When queried about missed visits, administrator/clinical manager A stated, & we notify the patient if we will miss a visit & he does probably have the right to not ask his visitor for help &. Administrator/clinical manager A indicated the aides and nurses should be performing all tasks on plan of care.			

	9. Clinical record review was completed on 3/3//2022, for patient #8, start of care 6/23/2008, certification period reviewed 12/13/21 2/10/2022, primary diagnosis of quadriplegia, C5-C7, incomplete (weakness or paralysis of all four limbs), evidenced an agency document electronically signed by alternate clinical manager C on 12/10/2021, titled Home Health Certification and Plan of Care . This document stated, & Orders for Discipline and Treatments & Home Health Aide 18-24 hours/day 7 days/week x 9 weeks & Skilled Nurse 1 visit 7 days/week x 9 weeks & HHA [home health aide] to assist with personal care, incontinent care and ADL s [activities of daily living] per POC [plan of care] & Skilled nurse for overall assessment focus on neurological, mood anxiety, pain management, appetite, hydration & medication setup &bowel care daily digital stimulation & manual removal, Suprapubic catheter 10ml [milliliter] water to balloon sterile catheter change weekly Friday and prn [as needed] emergent need & May apply mepilex sacral dressing 3x week and prn to protect fragile skin at coccyx & SN [skilled nurse] to notify MD [doctor] of: & Systolic BP [blood pressure] greater than 160 or less than 90 & Diastolic BP [blood pressure] greater than 100 or less than 50 & SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit & SN to report to physician if client experiences pain level greater than 9, pain medications not effective & SN to assess skin for breakdown every visit & May discontinue wound care when wound(s) have healed & SN to assess wound for S&S [signs and symptoms] of infection, healing status, wound deterioration, and complications & SN to assess/instruct on diabetic management to include: nail, skin & foot care, medication administration and proper diet & SN to instruct on establishing bowel regimen & SN to assess client for diet noncompliance & SN will assess foods being eaten as snacks and continue to teach patient how to read labels including Carbohydrate VS sugar amount in foods &. Review evidenced an agency document electronically signed by alternate clinical manager C on 12/16/2021, titled Skilled Nurse Visit which failed to evidence neurological, respiratory, cardiovascular, genitourinary, or endocrine assessment as ordered on plan of care. Review evidenced several agency documents titled Skilled Nurse Visit , for visits every day between 12/13/2021 2/10/2022, which all failed			

	diabetic management or diet as ordered on plan of care. These documents failed to evidence vitals were performed on all dates, daily between 12/13/2021 2/10/2022 except for the following dates: 12/13/2021, 12/30/2021, 12/31/2021, 1/7/2022, 1/12/2022, 1/13/2022, 1/24/2022, 2/8/2022, 2/9/2022, and 2/10/2022. These documents failed to evidence pain was assessed on the following dates: 12/13/2021, 12/14/2021, 12/15/2021, 12/23/2021, 12/24/2021, 12/28/2021, 12/29/2021, 12/31/2021, 1/1/2022, 1/4/2022, 1/7/2022, 1/8/2022, 1/9/2022, 1/11/2022, 1/12/2022, 1/13/2022, 1/19/2022, 1/21/2022, 1/26/2022, 1/27/2022, 1/31/2022, 2/3/2022. Review of an unsigned agency document dated 12/28/2021, from 1:00PM 10:00PM, titled New Home Care HHA , failed to evidence patient #8 received a visit or any HHA interventions this day. Review evidenced patient did not receive any HHA care visits as ordered on the plan of care from 1/1/2022 at 8:00 PM until 1/2/2022 at 7:00 PM (23 hours). Review of HHA visit notes failed to evidence patient #8 received a bath or shower on the following dates: 12/26/2021, 1/1/2022, 1/2/2022, 1/9/2022, 1/15/2022, 1/16/2022, 1/23/2022, 1/27/2022, 1/30/2022, 2/6/2022, 2/10/2022, and 2/11/2022 (20% of the certification period days). Record review evidenced several agency documents titled, Missed Visit , which indicated missed home health aide visits for patient #8 on dates: 12/15/2021, 12/17/2021, 12/20/2021, 12/21/2021, 12/22/2021, 12/23/2021, 12/24/2021, 12/26/2021, 12/27/2021, 12/29/2021, 12/30/2021, 12/31/2021, 1/1/2022, 1/2/2022, 1/3/2022, 1/5/2022, 1/9/2022, 1/10/2022, 1/11/2022, 1/12/2022, 1/15/2022, 1/16/2022, 1/21/2022, 1/23/2022, 1/26/2022, 1/28/2022, 1/30/2022, 1/31/2022, 2/6/2022, 2/8/2022, 2/8/2022, 2/9/2022, and 2/10/2022. Review failed to evidence patient received all services as ordered on the plan of care. During an interview 2/21/2022 at 3:15 PM, administrator/clinical manager A indicated that the patient did have several missed visits, and the nurses did not perform vitals, glucose checks, or pain assessments on several visit.			

isn t documented, it wasn t done. Administrator/clinical manager A indicated the aides and nurses should be providing care based on the plan of care.

10. Record review was completed on 3/3/2022 for patient #9, start of care 1/31/2022, certification period 1/31/2022 3/31/2022. Review evidenced an agency document electronically signed by registered nurse J on 1/31/2022, titled Home Health Certification and Plan of Care for certification period 1/31/2022 3/31/2022, which listed a primary diagnosis of hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease/ESRD (end stage renal disease) (heart disease caused by high blood pressure, and kidney failure, requiring dialysis). This document stated, & Orders for Discipline and Treatment & SN [skilled nurse] frequency: 2w2 [2 times per week for 2 weeks], 1w1 [1 time per week for 1 week] & SN to perform complete physical assessment each visit with emphasis on chronic disease management & SN to provide skilled assessment, teaching/training and reinforcement of teaching to properly assess, manage and mitigate pain & SN to instruct patient/caregiver regarding strategies to mitigate pain & SN to instruct patient on disease process, including who to contact if signs and symptoms persist or worsen as well as dietary measures, medication management, activities permitted &. SN to instruct patient/caregiver regarding self-management of oxygen therapy &.

Review evidenced an agency document electronically signed by registered nurse J on 2/10/2022, titled Skilled Nurse Visit which failed to evidence nurse provided any instruction to patient or caregiver on pain management, disease process, who to contact if symptoms worsen, dietary measures, medication management, activities permitted, or management of oxygen therapy as ordered on plan of care.

Review evidenced missed skilled nurse visits on 2/3/2022 and 2/8/2022, which resulted in patient only receiving 1 skilled nurse visit per week for week beginning 1/31/2022 and week beginning 2/5/2022. Agency failed to provide 2 skilled nurse visits per week as ordered on the plan of care.

During an interview on 3/2/2022 at 1:05 PM,

	queried about pain management, & we educate them on the use of medications and other ways to treat pain and manage pain & if we are addressing pain, yes we should have interventions and pain goals listed and instructions to mitigate pain &. Administrator/clinical A indicated that education should have been documented on the visit notes. 11. Record review was completed on 3/3/2022, for patient #14, start of care 4/22/2020, certification period 12/19/2021 2/16/2022. Record review evidenced an agency document electronically signed by administrator A on 2/17/2022, titled, Home Health Certification and Plan of Care which stated, & Orders for Discipline and Treatment & SN [skilled nurse] 1x/week x9 wks [weeks] & HHA [home health aide] Frequency: 4hrs [hours] 5 x/week & Skilled Nurse TPR [temperature, pulse, respirations] B/P [blood pressure] & Assessment & 7 day Medication box set up & Check blood sugar & Sterile Foley catheter 16 FR [french] 10 ml [milliliter] balloon monthly and PRN [as needed] & HHA to assist with personal care, incontinent care, and ADL s [activities of daily living] per POC [plan of care] under supervision of an RN & SN to notify MD of: & Random blood sugar greater than 300 & SN to assess wound for S&S [signs and symptoms] of infection, healing status, wound deterioration, and complications & SN to assess/instruct on diabetic management to include: nail, skin & foot care, medication administration and proper diet & SN to instruct on foley care, skin and perineal care, proper handling and storage of supplies & SN to instruct on adequate hydration, proper handling and maintenance of drainage bag &. Record review evidenced several agency documents titled, Missed Visit , which indicated missed visits on the following dates: 12/21/2021, 12/24/2021, 12/28/2021, 1/4/2022, 1/7/2022, 1/11/2022, 1/14/2022, 1/18/2022, 1/21/2022, 1/25/2022, 2/3/2022, 2/15/2022, and 2/18/2022. Agency failed to complete 5 HHA visits per week as per plan of care. Record review evidenced an agency document electronically signed by alternate clinical manager C on 1/12/2022, titled Skilled Nurse Visit which stated, & Blood Glucose: 301 & Agency failed to notify physician of blood glucose greater than 300 as per plan of care.			

	Record review evidenced an agency document electronically signed by alternate clinical manager C on 1/26/2022, titled Skilled Nurse Visit which stated, & Blood sugar 396 after meal & Agency failed to notify physician of blood glucose greater than 300 as per plan of care. Record review evidenced an agency document electronically signed by alternate clinical manager C on 2/10/2022, titled Skilled Nurse Visit which stated, & Blood sugar 345 & Agency failed to notify physician of blood glucose greater than 300 as per plan of care. Review of agency documents signed by alternate clinical manager C on 12/23/2021, 12/29/2021, 1/5/2022, 1/12/2022, 1/19/2022, 1/26/2022, 2/2/2022, and 2/10/2022, titled Skilled Nurse Visit failed to evidence any wound assessment, instruction on diabetic management, foley care education, medication education, or skin care education were provided to patient as ordered per plan of care. During an interview 2/28/2022 at 10:12 AM, administrator/clinical manager A stated, & Education should be documented under narrative on the nurses visit notes &. During an interview on 3/2/2022 at 1:26 PM, administrator/clinical manager A stated diabetic teaching would include, & signs and symptoms of high and low blood sugar, diet, wound prevention, compliance with orders, watching skin for wounds, diabetic foot care & Administrator/clinical manager A stated expectations for diabetic patient care would include, & that nurse would check feet and skin while she s there & report any changes & teach patient to let them know if he feels anything & teach patient to wear the appropriate footwear &. Administrator/clinical manager A indicated the nurse should have notified the physician about elevated blood sugar readings during visits.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following:	G0574	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will audit comprehensive assessments and plans of care to ensure clinician has documented current patient status thoroughly. 2. Clinicians will be reeducated on contents	2022-04-22

	(i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the agency failed to ensure the patient s plan of care included one or more of the following: all pertinent diagnoses, mental, psychosocial, and/or cognitive status, types of services, supplies, and equipment required, frequency and duration of visits to be made, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety measures to protect against injury, a description of the patient s risk for emergency department visits and hospital re-admission, all necessary interventions to address the underlying risk factors, patient-specific interventions and education, or information related to any advance directives, for 13 of 14 records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14). Findings include:		required on plan of care including: a. All pertinent diagnoses b. Patient’s mental, psychosocial, and cognitive status c. The types of services, supplies and equipment required d. The frequency and duration of visits to be made e. Prognosis f. Rehabilitation potential g. Functional limitations h. Activities permitted i. Nutritional requirements j. All medications and treatments k. Safety measures to protect against injury l. 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 m. Patient and caregiver education and training to facilitate timely discharge n. Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient o. Information related to any advanced directives p. Any additional items the HHA or physician may choose to include 3. Monitoring: 100% of comprehensive assessments and plans of care will be reviewed for 30 days. If 100% clinical compliance is not confirmed, 100% comprehensive assessments and plans of care will be reviewed for an additional 30 days until 100% compliant for a 30-day timeframe. 4. Once 100% compliance with thorough assessment and plan of care is achieved, 25% of assessments and plans of care will be reviewed quarterly. If at any time the agency falls out of compliance reeducation will be provided to clinicians and number 3 and 4 above will be repeated.	

	9. Record review for patient #1 was completed on 3/3/2022, start of care date 8/24/2021, for certification period 12/22/2021 2/19/2022. Record review evidenced a document dated and signed by registered nurse (RN) I on 12/20/2021 titled ... Recertification [comprehensive reassessment] , which indicated the patient was paraplegic (paralyzed from the waist down), had decreased adherence to treatment plan, home safety risks (not further elaborated), inadequate support network, lived alone, had three stage 3 pressure injuries (open wound extending through all layers of skin, but no muscle involvement) on the sacrum (lower back), right and left hips, required urinary catheterization (tube inserted into the bladder to drain urine), incontinent of bowel, needed help to dress, dependent with toileting needs, and unable to transfer self. A hospital AA document dated 8/18/2021 titled History and Physical indicated the patient s diagnoses included anxiety and PTSD (post-traumatic stress disorder) secondary to awakening from surgery as a paraplegic, and was positive for COVID-19 (8/18/2021). A hospital AA document dated 8/19/2021 titled [doctor] Progress Notes indicated the patient self-catheterized every 4-6 hours at home (to drain urine from the bladder due urine retention), and the patient took norco (a narcotic/opioid pain medication) for pain control. A home visit was observed on 2/16/2022 at 11:55 AM, with the patient and RN C. The patient presented lying in his bed, wearing a t-shirt and athletic shorts. Both legs were atrophic (absence of muscle mass). Observed presence of straight catheters (to insert directly into bladder to drain urine), adult briefs (which the patient used), a roho cushion (a pressure relief cushion that is made of soft, flexible air cells connected by small channels) on the seat of the wheelchair, cigarettes, and a vape (battery-operated device to inhale vapor through the mouth). When queried about his lifestyle and health status, the indicated he did smoke and vape, his spinal cord was injured at the T 10 and 11 (thoracic vertebras lower mid-back) level, he took norco 3 times daily for his pain, he hasn t had issues with constipation for a while, but would like to learn how to do a bowel program		5. Survey results, quality record reviews, supervisory visits and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body 6. Completion date: 4/22/2022 and ongoing	

	(mechanical/medicinal method to elicit a bowel movement). During this time, RN C encouraged the patient to drink protein shakes to aide in wound healing. The patient also indicated he went to wound clinic HH weekly for wound management. A document dated and signed by RN I on 12/20/2021, titled Home Health Certification and Plan of Care evidenced the patient took norco (for pain) 3 times daily, and mirtazapine (to treat PTSD/major depression); and failed to indicate diagnoses of PTSD, anxiety, pain, History of COVID-19, or current use of cigarettes and vape device; psychosocial needs for how the patient was transported to the wound clinic, or how his personal and homemaking/household needs were met; supplies included a roho cushion, adult briefs, and straight catheters (and other associated supplies to perform task); functional limitations included atrophy, the patient was chairbound, and unable to transfer self; nutritional requirements included supplemental protein shakes for wound healing; wound treatment orders for sacrum or right trochanter (hip bone area), the patient went to wound clinic HH weekly for wound management, or name and contact information for the wound clinic/wound clinic physician; safety measures to address home safety, inadequate support network, and lived alone; all necessary interventions to address the underlying risk factors for emergency department visits and hospital re-admission, such as pain mitigation, smoking cessation, and adherence to treatment plan; patient-specific interventions and education related to non-medicinal methods of pain relief, coping with PTSD, methods to prevent new or worsening skin breakdown, self-catheterization and infection control, re-use/cleaning of catheter supplies, bowel management/program, and interventions to meet the patient s personal care and transportation needs. During an interview on 02/28/2022 at 1:58 PM, when queried if there were orders for all 3 pressure injuries on the plan of care, administrator/clinical manager A stated ... No, I just see wound care orders for the one wound ... I would expect 3 orders .... When queried if she would expect to find the wound clinic physician on the plan of care, administrator/clinical manager A stated ... If it s not the certifying physician ... then, yes, it should be on the plan of care .... When queried what her expected interventions were for a patient who smoked, administrator/clinical manager A indicated to			

want to see it on the plan of care. When queried about the patient self-catheterization, administrator/clinical manager A indicated it should be on the plan of care.

During an interview on 03/02/2022 at 1:05 PM, when queried the agency's expectations for patient reported/observed severe pain, administrator/clinical manager A indicated she would expect education on medication management, or other ways to manage pain, and stated "... Yes, I would expect to see interventions ... goals for pain ...."

10. Record review for patient #3 was completed on 3/3/2022, start of care date 11/13/2021, transfer date 11/16/2021, for certification period 11/13/2021 1/11/2022. Record review evidenced a document dated and signed by RN J on 11/13/2021 titled ... Start of Care [comprehensive assessment] , which indicated the patient received enteral nutrition (artificial introduction of nutrition/fluid/medication into the stomach) via g-tube (tube inserted into opening in abdomen directly into stomach), absence of a capable caregiver, poor nutrition, overall poor status, 24-hour supervision required, presence of daily pain, a closed surgical incision covered with steri-strips (thin adhesive strips to hold tissue together), continuous oxygen use- 2 LPM (liters per minute) via NC (nasal canula), no smoking signs were not present in the home, shortness of breath with minimal exertion, nausea, bowel and bladder incontinence, high risk for falls, dependent on another for bathing, unable to take in nutrients orally, weight loss, patient wasn t tolerating g-tube feedings, training was required, feeding amount was 24 ounces, frequency was bolus feedings (a set amount administered by gravity, not pump), had a serious drug interaction, non-adherence to drug therapy, and unable to take medications unless administered by another person.

A hospital FF document dated 10/12/2021, titled Virtual Visit , indicated the patient was unable to eat by mouth due to severe disease of esophagus.

A hospital FF document dated 11/12/2021, titled Referrals: Home Health Care , indicated diagnoses included tachycardia (fast heart rate, over 100 beats per minute), hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), and slow transit constipation; and

	orders for home nurse included 90 ounces of water via peg tube (g-tube) (a tube inserted through the wall of the abdomen directly into the stomach, allows air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid food, to the patient) daily, increase miralax (laxative) to twice daily via peg tube, may administer fleets enema once (to relieve constipation), and administer albuterol nebulizer (inhaled medication to open bronchial tubes and relieve shortness of breath) every four hours as needed for shortness of breath and wheezing. A document dated and signed by RN J on 11/13/2021 titled Home Health Certification and Plan of Care failed to include diagnoses of tachycardia, hypoxia, or slow transit constipation, supplies/equipment included a nebulizer (machine to administer aerosol/inhaled medications) and associates equipment, or g-tube feeding equipment/tubing; nutritional requirements included NPO (latin term, nil per os , means no food or fluids are to be consumed orally) status; the type, amount, delivery method, or frequency of g-tube feedings; 90 ounces of water to be administered via peg tube (g-tube) daily; medications included miralax twice daily via peg tube, fleets enema once, or albuterol nebulizer every four hours as needed for shortness of breath and wheezing; use of cold or warm compresses included frequency or duration of use; all necessary interventions to address the underlying risk factors for emergency department visits and hospital re-admission, such as adherence to treatment plan; patient-specific interventions and education for constipation, tachycardia, hypoxia, oxygen safety, procedure for g-tube nutrition, fluid, and medication administration, checking tube placement, or monitoring for tolerance, complications, or precautions; or energy conservation, incontinence management/prevention of skin breakdown due to incontinence, or interventions to ensure the patient s personal care/hygiene needs were met. During an interview on 2/23/2022 at 2:51 PM, when queried what was expected on the plan of care, under nutritional requirements, administrator/clinical manager A indicated she would expect to see the patient s special diet or needs. When queried what was the purpose of the plan of care, administrator/clinical manager A indicated it was a set of orders for home care interventions and goals. When queried what enteral feedings was ordered for this patient, administrator/clinical manager A indicated she was looking at the medical record, but could not			

	find it. When queried if albuterol was on the plan of care or medication profile, administrator/clinical manager A stated No, I don t see it. When queried if a home health aide was offered (to assist with personal care/hygiene), administrator/clinical manager A indicated the patient might have already had one, she was on our private pay, Medicaid side , under home health aide services.			

	11. Record review for patient #10 was completed on 3/3/2022, start of care date 12/7/2021, for certification period 2/5/2022 4/5/2022. Record review evidenced an agency document signed and dated by RN J on 2/1/2022, and physician I (certifying, primary care physician) on 2/7/2022, titled "Home Health Certification and Plan of Care", for certification period 2/5/2022 - 4/5/2022. This document indicated skilled nursing was ordered twice weekly for 8 weeks, the patient s medications included metronidazole (an antibiotic), atenolol (to treat high blood pressure), lasix (a diuretic to treat fluid retention), potassium chloride (supplement), ropinirole (to treat restless leg syndrome), toujeo max solostar (insulin to treat diabetes), zinc sulfate (supplement), aspirin, furosemide (generic for Lasix- duplicate entry), a multivitamin, and florastor (probiotic for gut health); and stated ... Orders ... Skilled nurse [SN] ... to perform complete physical assessment with each visit with emphasis on wound care ... assess other co-morbidities including diabetes and other conditions ... notify physician immediately of any potential problems ... Nursing ... All necessary interventions ... as follows ... Instruct dietary, hydration measures and medication management ... wound care management based on physician orders ... SN to administer insulin sliding scale per physician orders as follows: [enter sliding scale order - blank] ... Instruct ... on Diabetic Footcare precautions ... at risk for falls ... PT [physical therapy] ... to assess ... to instruct ... Wound care orders ... to Right heel ... Cleanse/irrigate wound with sterile saline, apply non-adherent dressing, 4x4s [4 inch by 4-inch gauze pads]. Cover and secure with gauze wrap ... Other Physicians On The Case ... [physician H, at wound clinic M] .... This document failed to evidence the wound or orders for the left foot identified by wound clinic M on 1/31/2022, the order to see the patient on 2/7/2022, ordered nursing frequency of 3 times per week, or the current wound care treatment orders (per physician H on 1/31/2022), the correct list of all medications the patient used, interventions for a high nutritional risk due to tooth decay/missing teeth, and only eating 1 meal daily, or the physician's order for frequency of blood glucose monitoring. Faxed documents in the patient s clinical record from wound clinic M evidenced a fax cover sheet, dated 1/31/2022 at 12:27 PM, which stated ... Wound assessments and orders for today, 1/31/2022 ... change dressings/wraps ... on Monday 2/7/22 ... due to [wound clinic physician H] being out of the office that day, and the normal Wednesday and Friday. Patient to			

	additional document was included, dated 1/31/2022, titled Office Visit (for wound clinic M), which stated ... here for new wound left foot and chronic wound right heel. Patient has visiting nurses applying collagen and ace wraps for swelling ... Wound care nurse noted on his initial evaluation today that there was a shell of a pistachio nut embedded into the plantar [bottom of] left foot. Therefore he has a new wound today on his left foot ... Full thickness ulceration right heel ... new ulceration from foreign body left foot but [sic] signs of infection ... Chronic lymphedema [condition in which extra lymph fluid builds up in tissues and causes swelling] ... Advised the patient never to go barefoot ... Physician orders ... Apply collagen [dressings derived from usually cow or pig collagen, a crucial role in the wound healing process], foam ... apply 3M 2 layer lite [a 2 layer compression system wrap, not the same as ace wrap] ... Home care to change dressing and wrap on Monday, Wednesday and Friday ... float heels to reduce pressure .... A home visit was observed on 3/1/2022 at 10:30 AM with patient #10 and registered nurse (RN) J. RN J was not present upon surveyors arrival. Observed patient #10 seated in a wheelchair in his/her bedroom, with both lower extremities wrapped with compression wraps, approximately 3-4 inches below the knees, distal to toes. Toes on both feet were exposed. Both legs were swollen above the wraps, and his/her toes were swollen. The patient had tooth decay/missing teeth. The patient was alert and oriented, and able to answer questions appropriately. On 3/1/2022 at 10:37 AM, the patient indicated he/she had a medical history of diabetes with neuropathy (nerve damage which causes numbness, tingling, and pain), and wounds; he/she took his/her blood glucose 1 time per day, since he/she only ate once per day, usually when someone could make him/her some food, and it was generally after 7:00 PM; he/she drank coffee and had oatmeal for breakfast sometimes; his/her blood sugars ran about 160 , and his/her doctor didn t care as long as they were below 200 ; he/she took 18 units of Levemir daily. On 3/1/2022 at 10:40 AM, the patient indicated he/she hasn t been to wound clinic M for several weeks, since he/she didn t have transportation; his/her left leg and foot bandage hasn t been changed for 3 weeks, the right leg and foot hasn t been changed for 2 3 weeks, and this was			

	because RN J wanted them left in place to heal ; the home health nurse was supposed to be out to see him/her 2 times per week, but sometimes she only came once because of staffing, and the last time the nurse came was last Tuesday (2/22/2022); he/she was in the hospital/nursing home (skilled nursing facility (SNF) N) in November (2021) for wound infection and swollen legs, he/she left SNF N on 12/1/2021, and home health care services started the next week (12/7/2021). The plan of care signed by RN J on 2/1/2022, evidenced orders for skilled nursing twice weekly, but stated, "... [patient] reports going to wound clinic yesterday. This nurse looked at paper sent home with [patient] ... [person H, wound clinic physician] is requesting that Interim visit client MWF [Monday, Wednesday, Friday] to change dressings. This nurse explained to [patient] that it isn t possible to see [him/her] 3x/wk [3 times per week] due to case load ... will follow up with wound clinic .... The plan of care failed to evidence orders to leave the patient s dressings on for 3 weeks to let them heal, and the patient s record failed to evidence RN J coordinated with wound clinic M for clarification of visit frequency. On 3/1/2022 at 10:53 AM, the patient indicated he/she used a wheelchair, and sometimes used a cane to walk. He/she indicated he/she tried to elevate his/her legs at night while sleeping. During this time, the surveyors observed medications in a patient belongings bag, and they were reviewed/reconciled with the patient. The patient confirmed that he/she only took the following medications: Levemir 18 U (units) daily, Atenolol 25 mg (milligrams) daily, Atorvastatin 40 mg daily, Ropinirole 0.5 mg daily, and Furosemide 40mg daily. When queried about other medications listed on the agency's current plan of care, he/she indicated he/she has not taken potassium chloride, aspirin, zinc, toujeo, multivitamins, florastor, or metronidazole since his discharge from skilled nursing facility (SNF) N in December of 2021. On 3/1/2022 at 10:56 AM, the patient indicated his/her pain was currently about 4-5 (out of 10, with 0 = no pain, and 10 = worst pain ever), last night it was 10 , and when queried if he/she took any pain medications, he/she stated, ... My doctor [physician I] doesn t believe in that .... , and indicated physician I wanted him/her to go to the pain management place , but he/she didn t want to. The plan of care failed to evidence interventions to mitigate pain.			

	On 3/1/2022 at 11:06 AM, when queried how many wounds patient had, RN J stated, I don t know ... there s not a number ... it s hard to tell how many wounds because they all blend together ... one kind of goes into the other ... mainly [his/her] right leg ... we wrapped the left leg mainly for swelling ... no open wound on left leg .... When queried when the last time wound care was performed, RN J indicated she performed wound care on Friday (2/25/2022), and the patient indicated her last home visit was Tuesday (2/22/2022). When queried how often she measured wounds, RN J indicated the agency measured wounds weekly. When queried what the current wound care orders for this patient were, RN J indicated the wound orders were to wash with normal saline and rewrap. RN J failed to indicate or perform wound treatment based on wound clinic M s order dated 1/31/2022. On 3/1/2022 at 11:20 AM, the right lower leg was observed. Skin from the knee down to the ankle was scaly, flaking, red, shiny in some areas, and swollen; the right foot and ankle were red, thickened, flaky, and swollen; the top of the right foot and toes evidenced copious amounts of macerated (wet, soggy, pale in color, due to excessive moisture) tissue and purulent greenish, yellow, foul-smelling drainage. Wounds observed during this visit to the right lower extremity included, but were not limited to, the following: right 3rd toe with darkened area approximately 1x2 cm (centimeters), surrounding skin thickened, yellow, flaky, macerated, drainage was yellow/green, and purulent, and all toes were stuck together from old/current drainage; right external lateral foot was brown/yellow in color, active bleeding, an open area approximately 2 x 10 cm, surrounding skin was thickened, yellow, flaky, and macerated; top of right foot over the center evidenced an open area, was bright red, moist, macerated, with greenish yellow drainage, measured approximately 4 x 4 inches in, surrounding skin was macerated, flaky, yellow, and red; bottom of the right heel evidenced a dark area next to a gray/light pink open area with full thickness (damage past all layers of skin), approximately 1 x 1 cm, surrounding skin was thickened, flaky, dry, cracking, yellow; right interior lateral calf was dark red/purple in color, an open area approximately 2x2 cm, and surrounding skin was red, flaky, swollen.			

	and, posterior (backside) right calf evidenced 2 or more scabbed areas approximately 1x1 cm each, surrounded by red, swollen, flaky skin. The plan of care evidenced a wound to the right heel, and failed to evidence additional wounds observed. On 3/1/2022 at 11:45 AM, RN J removed a black nylon stocking from the left leg, which was placed by wound clinic on 1/31/2022, per both the patient and RN J s testimony. The black nylon had a large amount of thick, brown exudate (drainage) on it. The patient s toes were visible, and all had skin sloughing (falling) off, were moist, yellow, and macerated. The left great toe had a nickel sized area of black necrosis (dead tissue) to the tip. RN J removed the second layer of wrap from the left leg and foot, which was saturated with foul smelling drainage on the left lateral foot and left heel. The dressing stuck to the outside of the foot. RN J did not use saline to remove the dressing. During this time, RN J stated, ... it s not as bad as I expected .... (when she observed the left leg and foot). The leg was red, swollen, had large dent in back from the wrap, and had flaky, scaly skin from knee to toes. RN J used moistened gauze to remove the dry dressing stuck to the left lateral foot, wiped macerated skin from the top of the left foot, which made it bleed. RN J stated ... that s why it s bleeding .... . The patient yelled in pain more than once and indicated he/she could feel when she pulled his/her skin off. When she moved to address the left foot, the patient indicated he/she couldn t feel it. RN J stated, ... there s no open area ... (in regard to left lateral foot), and surveyor pointed out open wound to RN J. RN J continued to debride (remove skin/tissue) from the leg and foot with gauze. The plan of care failed to evidence orders for the removal/debridement of skin from the patient s leg/foot, the presence of any wounds to the left leg/foot, or orders for wound care/treatment to the left leg/foot. Wounds observed during this visit to the left lower extremity included, but were not limited to, the following: Top of left foot had no intact skin, presence of slough, maceration, was moist, red, bleeding, had a yellow area, approximately 4x4 inches, surrounding skin was macerated, yellow, and thickened; another small area was noted approximately 1x1cm to the center of this wound that was red, bleeding, and deeper into the tissue;			

	left toes were mostly without skin, macerated, had greenish/yellow drainage, pink wound beds, and were stuck together due to current/old drainage; left great toe tip was black, necrotic, about the size of a nickel; left external lateral foot evidenced an open area approximately 1x10 cm with brown, yellow, purulent, foul-smelling drainage, and surrounding skin was thickened, brown, and yellow; left heel evidenced an open area approximately 3x3cm, dark red, shiny, moist, open wound; plantar interior left ball of foot: darkened area, thickened, hard scabbed skin, approximately 1x1 cm; left anterior (front) shin evidenced an approximately 1x1cm brown scabbed area; and, posterior calf evidenced multiple open, draining areas. The plan of care failed to evidence any wounds or wound care/treatment to the left leg/foot. On 3/1/2022 at 12:00 PM, when queried about a wound caused by a pistachio shell (as noted in wound clinic M s document dated 1/31/2022), RN J stated ... I don t know anything about any pistachio shell .... On 3/1/2022 at 12:20 PM, RN J assessed the patient s pain after wound care was completed. The patient indicated it was a 9 in his/her right leg last night, and indicated he/she was crying last night because pain was so bad. The plan of care failed to include interventions to mitigate pain. 12. Record review for patient #11 was completed on 3/3/2022, start of care date 01/27/2022, discharge date 2/18/2022, for certification period 01/27/2022 03/27/2022. Record review evidenced a document dated and signed by RN I on 1/27/2022 titled ... Start of Care , which indicated the patient needed assist for personal care/hygiene and meals, cardiac assessment identified activity intolerance and fatigue/weakness, was incontinent of bowels, had parkinson s disease, was at a moderate nutritional risk (score of 30, and moderate risk was scored as between 26-55), diet was no added salt, unable to self-administer			

relief while sitting), and the nurse instructed to increase protein intake.

A document dated and signed by RN I on 1/27/22, titled Home Health Certification and Plan of Care , indicated a primary diagnosis of stage 2 pressure injury (wound caused by prolonged, unrelieved pressure, extending into, but not past the layers of the skin, and includes open or ruptured blisters) to left buttock; other diagnoses included dementia with Lewy bodies (a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain, which can lead to problems with thinking, movement, behavior, and mood), congestive heart failure (the heart s inability to effectively pump blood throughout the body), diabetes, depression, anxiety, atrial fibrillation (irregular heart beat/rhythm), BPH (benign prostatic hyperplasia, which causes blockage of urine flow), gastro-esophageal reflux disease (GERD) (indigestion/heartburn), and diverticulosis (a condition in which small, bulging pouches develop in the digestive tract); and psychosocial status indicated the patient lived with his spouse. The plan of care failed to indicate diagnosis of parkinson s disease, psychosocial status included transportation needs or spouse s ability to provide all needed care, equipment included a donut cushion, nutritional requirements included increased protein in diet, all necessary interventions to address the underlying risk factors for emergency department visits and hospital re-admission, such as the moderate nutritional risk, risk for urinary complications due to BPH, risk of gastrointestinal complications due to diverticulosis; or interventions to address diagnoses of dementia with Lewy bodies, diabetes, depression, anxiety, atrial fibrillation, or GERD, or interventions to ensure the patient s personal care needs were met.

13. Record review for patient #12 was completed on 3/3/2022, start of care date 1/12/2022, for certification period 1/12/2022 3/12/2022. Record review evidenced a document dated and signed by RN I on 1/12/2022 titled ... Start of Care , which indicated the patient was at high risk for infection, diabetes was uncontrolled, reported exhaustion, lived with a family member, required 24 hour supervision, had pain that interfered with activity, respiratory assessment indicated difficulty breathing, cardiac assessment indicated dizziness/lightheadedness, and orthostatic hypotension (a drop in blood pressure when changing positions from lying to sitting or

person for personal care/hygiene, unable to self-administer medications, serious drug to drug interaction identified, and RN I instructed to increase protein in diet.

A document from skilled nursing facility (SNF) W dated 12/13/2021, titled History and Physical stated ... [patient] presents with syncopal [fainting] episode reported by [family] ... She did not hit her head ... She was found to have orthostatic hypotension which is very significant ... States that she does get short of breath when exerting ....

A document dated and signed by RN I on 1/12/22, titled Home Health Certification and Plan of Care , indicated a primary diagnosis of orthostatic hypotension, and other pertinent diagnoses included chronic obstructive pulmonary (lung) disease (COPD), chronic kidney disease, depression, and GERD; and a low sugar diet, was oriented to self and place, forgetful, short term memory issues, prone to skin breakdown; medications included sertraline (to treat depression), and tylenol 650 mg (milligrams): 2 capsules every 4 hours as needed orally for pain. The plan of care failed to include cognitive status of the patient s ability to comprehend and retain teaching, family availability to provide all needed care, nutritional requirements included increased protein in diet, all necessary interventions to address the underlying risk factors for emergency department visits and hospital re-admission, such as assessment and monitoring for orthostatic hypotension, or respiratory precautions due to shortness of breath/difficulty breathing; or precautions for use of tylenol, such as maximum daily dose (specific to a patient with kidney disease), interventions to address diagnoses of COPD, chronic kidney disease, depression, and GERD; or interventions to ensure the patient s personal care needs were met.

14. Record review for patient #13 was completed on 3/3/2022, start of care date 12/16/2021, for certification period 12/16/2021 2/13/2022. Record review evidenced a document dated and signed by RN N on 12/16/2021 titled ... Start of Care indicated the patient immunocompromised, had a recent lung transplant, was a high infection risk, had ringing in ears, pain, bruising, used a nebulizer, short of breath with moderate exertion, and stated ... Auto titrations bilevel PAP [Bilevel Positive

used to treat chronic conditions that affect your breathing , and delivers two levels of air pressure] with max IPAP [inspiratory positive airway pressure] 18, min [minimum] EPAP [expiratory positive airway pressure] 9, PS [pressure support- the difference between expiratory positive airways pressure and inspiratory positive airways pressures] ... 4-8 cm [centimeters] water and heated humidification Medium [size] Fisher and Paykel Simple s [brand name] full face mask without chin strap .... The document also indicated the patient had hemorrhoids, nausea, diarrhea, and heartburn/reflux [regurgitation]; nutritional requirements included a 2 gram sodium restricted diet, and the patient had a right chest CVL (central venous line- a special intravenous (IV) line, a long, soft, thin, flexible tube that is inserted into a large vein).

A hospital II document dated 12/15/2021 titled Discharge Summary stated ... Lab monitoring plan/orders ... CBC/DIFF [complete blood count with differential] every Monday ... Creatinine [level] every Monday ... CMV DNA level every Monday .... , and indicated labs were to be repeated while the patient received ganciclovir (antibiotic). The document also stated ... Catheter [CVL] care ... Must use medicated disc (biopatch) or tegaderm CHG (chorhexedine gluconate) gel pad over insertion site and cover with transparent dressing ... When the patient is on an intermittent IV antibiotic dosing schedule ... SASH [flush with saline, administer antibiotic, flush with saline, then flush with heparin] method ... Administer normal saline 5ml [milliliters] to port [CVC] ... Routine lab draws may be done on Tuesday if Monday is a holiday ....

A hospital II document dated 12/6/2021 12/15/2021 titled After Visit Summary indicated physician LL (infectious disease) and physician MM (hematology/Oncology) were involved with this patient s plan of treatment and wrote orders.

A document dated 12/28/2021 titled Medical Authorization/Verbal Order indicated physician LL managed and wrote orders for antibiotics and lab draws.

A document dated and signed by RN N on 12/16/2021, titled Home Health Certification and Plan of Care , indicated a primary diagnosis of cytomegaloviral disease (a virus), nutritional

	restricted diet, psychosocial status included the patient lived with spouse, caregiver status included spouse (was) home when not working, medications included levothyrox (a thyroid hormone replacement), atorvastatin (to lower cholesterol); interventions included to instruct patient/caregiver on management of depression, and stated ... timely dressing changes .... The plan of care failed to include diagnoses of depression, hypothyroidism, or high cholesterol; psychosocial status included the caregiver s ability and availability to provide assistance with care; equipment/supplies included the BIPAP and associated equipment, medicated disc (biopatch) or tegaderm CHG (chorhexedine gluconate) gel pad for CVL dressing changes; included names and contact information for physicians LL and MM; presence of, type, or location of IV access used for infusions; included frequency of, and details for CVL dressing changes; included settings for BIPAP machine or when the patient used it; included specific labs ordered, or frequency; or included interventions to address hemorrhoids, nausea, diarrhea, heartburn/reflux, or how to ensure the patient maintained/achieved a 2 gram sodium restricted diet. During an interview on 2/28/2021 at 3:43PM, when queried, administrator/clinical manager A indicated the patient s immunosuppression should have been on the plan of care, the labs should have been, as well as other physicians who were involved with the plan of care. 17-13-1(a)(1)(B) 17-13-1(a)(1)(C) 17-13-1(a)(1)(D)(ii, vi, vii, viii, ix, x, xii, xiii) 1. Review of an agency policy obtained 2/14/2022, revised 4/2/2021, titled Developing a Plan to Meet Patient/Client Needs , stated, Policy & An individualized Plan of Care/Service Plan is developed for each patient receiving care/service to specify the care and services necessary to meet the patient s specific needs and goals as identified in the comprehensive assessment & A Patient s/client s individualized plan of care/service plan at a minimum includes, but is not limited to the following elements: & All pertinent diagnoses & A statement of agreed upon goals and outcomes & Potential for the patient/client to achieve established goals and outcomes & The patient s mental, psychosocial, and cognitive status & Types of services, including the mode of care-delivery, & supplies,			

	and equipment required & All medications and treatments & Patient/Client safety precautions, if any & Patient and caregiver education and training & Allergies & Functional limitations & Description of the patient s risk for emergency department visits and hospital readmission & interventions or services to address specifically identified problems & When required by law, regulation or contract, orders (i.e., discipline, frequency and duration) from the physician or allowed practitioner & including patient/client specific and disease specific parameters defining when to notify the physician or allowed practitioner & of significant changes & Information related to advance directives &. 2. Clinical record review for patient #2 was completed on 3/3/2022, start of care 4/27/2020, for certification period reviewed 12/8/2021 2/15/2022. Review evidenced an agency document electronically signed by registered nurse N on 12/16/2021, titled Home Health Certification and Plan of Care which listed a primary and only diagnosis of hereditary hypogammaglobulinemia (an immune system disease in which the body does not produce enough antibodies). This document stated, & Medications: & There is no data for this section &. Review evidenced an unsigned agency document titled Medication Profile which stated, & PRIVIGEN [antibodies] 10% IV [intravenous] solution & q [every] 4 weeks & HYDROCORTISONE [steroid for inflammation] 100 MG [milligrams] vial & PRN [as needed] & EPINEPHRINE [medication for allergic reactions] 0.1 MG/ML [milligram per milliliter] INJECTABLE SOLUTION & PRN respiratory distress or anaphylaxis [a life threatening allergic reaction] intramuscular & DIPHENHYDRAMINE [medication for allergic reaction] 50 MG/ML & by slow IV push PRN IVIG [intravenous immunoglobulin] reaction & ALBUTEROL 90 MCG [micrograms] & BID [2 times per day] inhaled & AZITRHOMYCIN [antibiotic] 250 MG & 3 x a week on M-W-F by mouth & NORMAL SALINE [water solution] 3ML BID hand held nebulizer &. Plan of care failed to include all medications. Review evidenced an agency document electronically signed by registered nurse N on 4/27/2020, titled Pediatric SOC [start of care, comprehensive assessment] which stated, & He also has a diagnosis of Bronchiectasis [a condition in which lungs become damaged] and			

	percussion therapy] vest &. Plan of care failed to evidence diagnosis of Bronchiectasis. During an interview on 2/21/2022 at 2:48 PM, administrator/clinical manager A stated, when queried why plan of care did not list bronchiectasis as a diagnosis and did not include patient s medications, & the care plan diagnosis are based off of the referral information & the nurse probably didn t add it & I can t answer why those didn t pull over the medications on the list & the nurse probably forgot to click to pull the medication from the profile &. 3. Clinical record review for patient #4 was completed on 3/3/2022, start of care 5/19/2021, certification period 5/19/2021 6/15/2021. Review of an agency document electronically signed by registered nurse N on 5/19/2021 titled Home Health Certification and Plan of Care , listed a primary diagnosis of unilateral primary osteoarthritis of first carpometacarpal joint right hand (arthritis of the right thumb). This document stated, & Orders for Discipline and Treatments: HHA [home health aide] Frequency: 3 hours a day x 14 days & HHA to assist with ADL s [activities of daily living] & IADL s [instrumental activities of daily living] per HHA care plan &. This document failed to include surgical procedures or nutritional requirements. Review evidenced an agency document electronically signed by registered nurse N on 5/19/2021, titled Non Oasis [outcome and assessment information set] SOC [start of care, comprehensive assessment] which stated, & Narrative & Requires HHA [home health aide] assistance & after carpal tunnel surgery on right wrist & Had surgery on left wrist in February and has not fully recovered &. Review evidenced an agency document electronically signed by physician CC on 4/29/2021, titled Referral Order which stated, & reason for Referral: Home health aide x 2 weeks po [post-op] surgery on 5/18/2021 &. During an interview on 1/21/2022 at 2:02 PM, administrator/clinical manager A stated, when queried what information should be included in patient #4 s plan of care, & yes, I would expect it to have all patient diagnosis, and surgeries & the comprehensive assessment is more			

	Medicaid side & we go off of the referral diagnosis listed on the referral information sent over & I would expect to see the recent surgery listed for this patient on the plan of care &. Administrator/clinical manager A indicated the plan of care should include nutritional requirements. 4. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Home Health Certification and Plan of Care . This document listed a primary diagnosis of myelodysplastic syndrome (group of diseases marked by disruption of production of blood cells). This document stated, & Nutritional Requirements & Regular & Prognosis & Good & Orders for Discipline and Treatments & SN [skilled nurse] frequency: 2 visits /week x 9 weeks & HHA [home health aide] Frequency: 2-4 hrs [hours] 1-2x/day 6 days/week x 9 weeks & Physical Therapy 2 v/week [visits per week] x9 weeks [for 9 weeks] & Skilled nurse overall assessment. TPR [temperature, pulse, respirations] B/P [blood pressure] Orthostatic B/P & Assess skin & apply Foam border dressing to sacral area twice a week and as needed & HHA to assist with personal care, incontinent care, and ADL s [activities of daily living] per plan of care &. This document failed to include any durable medical equipment or supplies, protein shakes requirements, or atrial fibrillation or traumatic brain injury as diagnoses. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Non Oasis [outcome and assessment information set] Recertification [comprehensive re-assessment] which stated, & uses commode & will drink protein shakes daily & atrial fibrillation managed 2 ablation surgeries & history of TBI [traumatic brain injury] & walker & wheelchair for distance &. Plan of care failed to include diagnosis of atrial fibrillation and traumatic brain injury. Plan of care failed to include walker, wheelchair, dressing supplies, and commode in durable medical equipment/supplies section. Plan of care failed to include protein shakes in nutritional requirements section. During an interview on 2/28/2022 at 10:20 AM, administrator/clinical manager A stated, when queried what should be included on plan of care for durable medical equipment, & whatever supplies are in the home being used & such as			

& grab bars, raised toilet seat, wound supplies, hospital bed, commode, walker, wheelchair & any type of medical supplies being used in the home &.

During an interview on 2/28/2022 at 11:16 AM, administrator/clinical manager A stated, when asked what should be included on plan of care, & yes, protein shakes/supplements should be listed & I have to check and see where they put it & sometimes they don t get pulled over to the care plan from the comprehensive assessment & I would expect to see atrial fibrillation on the plan of care, but the admitting nurse uses the information from the paperwork that is sent over to fill out the care plan &. Administrator/clinical manager A indicated that plan of care should include all pertinent diagnoses.

5. Clinical record review was completed on 3/3/2022 for patient #6, start of care date 3/15/2021, certification period 5/13/2021 7/11/2021, evidenced an agency document electronically signed by alternate clinical manager C on 5/10/2021, titled Home Health Certification and Plan of Care which stated, & start of care & 3/15/2021 &. This document evidenced a primary diagnosis of heart failure. This document stated, & Orders for Discipline and Treatments & HHA [home health aide] frequency: & HHA 1-2 hours 2 x a week for bathing x 9 weeks & HHA to assist with personal care, incontinent care, and ADL s [activities of daily living] per POC [plan of care] under supervision of an RN [registered nurse] &.

Record review evidenced an agency document electronically signed by registered nurse N on 3/15/2021, titled Non Oasis [outcome and assessment information set] SOC [start of care, comprehensive assessment] which stated, & Arthritis pain in knees with ambulation &.

Review failed to evidence diagnosis of arthritis was included on plan of care.

6. Clinical record review was completed on 3/3/2022 for patient #7, start of care 1/14/2003, for certification period 6/8/2021 8/6/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 6/3/2021, titled Home Health Certification and Plan of Care. This document listed a primary diagnosis of hemiplegia

affecting left non-dominant side (paralysis affecting left side of body). This document stated, & Orders for Discipline and Treatments & SN [skilled nurse] Frequency: 1x Month & 1 prn [as needed] x 2 months for catheter complications & HHA [home health aide] Frequency: 2 V [visits] daily x 7 DW [days per week] x 9 W [weeks] (2 hr [hours] in am [morning] 1 hr in pm [evening] &. This document failed to evidence any teaching, education, or training was ordered for patient #7

During an interview on 2/28/2022 at 10:30 AM, administrator/clinical manager A indicated teaching should be ordered on the plan of care for all patient s relating to their goals.

7. Clinical record review was completed on 3/3//2022, for patient #8, start of care 6/23/2008, certification period reviewed 12/13/21 2/10/2022, primary diagnosis of quadriplegia, C5-C7, incomplete (weakness or paralysis of all four limbs), evidenced an agency document electronically signed by alternate clinical manager C on 12/10/2021, titled Home Health Certification and Plan of Care . This document stated, & DME [durable medical equipment] and Supplies & Alcohol Pads, Chux/Underpads, Drainage Bag, Exam Gloves, Foley Catheter, Gauze Pads, Insertion Kit, Tape & Nutritional Requirements & No Concentrated Sweets & Activities Permitted & overhead hoyer & Orders for Discipline and Treatments & Home Health Aide 18-24 hours/day 7 days/week x 9 weeks & Skilled Nurse 1 visit 7 days/week x 9 weeks &.

Review evidenced an agency document electronically signed by alternate clinical manager C on 12/10/2021, titled Non Oasis [outcome and assessment information set] Recertification [comprehensive re-assessment] which stated, & History of blood clots year of SCI [spinal cord injury] with GreenField filter placement required & No further clotting issues since starting Daily ASA [aspirin] dose & Nutritional Health Screen & Protein shakes daily & Supplies/DME [durable medical equipment] & Chux/Underpads & Foley catheter & Gauze pads & Tape & Drainage Bag & Insertion Kit & Additional Orders & apply mepilex sacral dressing 3x/week & Wheelchair & ROHO [wheelchair pressure relief cushion] & used low air loss mattress &.

Plan of care failed to evidence diagnosis of blood clots or greenfield filter placement; failed

to include dressing supplies, wheelchair cushion, low air loss mattress, wheelchair, and Hoyer lift in DME and Supplies section; and failed to include protein shakes in nutritional requirements.

During an interview on 2/21/2022 at 3:51 PM, administrator/clinical manager A indicated plans of care should include all relevant diagnosis and surgeries, all DME including: Hoyer lifts, wheelchairs, wheelchair cushions, and dressing supplies; and protein shakes should be listed on plan of care under nutritional requirements.

During an interview 2/28/2022 at 10:15 AM, administrator/clinical manager A indicated the plan of care was generated from the comprehensive assessment, but it utilized a lot of copy and pasting from the assessment, and she was not sure how exactly the plan of care pulled the information over. She stated she would, & look into it &.

8. Clinical record review was completed on 3/3/2022, for patient #14, start of care 4/22/2020, certification period 2/17/2022 4/17/2022. Record review evidenced an agency document electronically signed by administrator A on 2/17/2022, titled, Home Health Certification and Plan of Care which stated, & Orders for Discipline and Treatment & SN [skilled nurse] 1x/week x9 wks [weeks] & HHA [home health aide] Frequency: 4hrs [hours] 5 x/week & Skilled Nurse TPR [temperature, pulse, respirations] B/P [blood pressure] & Assessment & 7 day Medication box set up & Check blood sugar & Sterile Foley catheter 16 FR [french] 10 ml [millileter] balloon monthly and PRN [as needed] & HHA to assist with personal care, incontinent care, and ADL s [activities of daily living] per POC [plan of care] under supervision of an RN . &

Observation of a home visit for patient #14 was conducted on 2/21/2022 at 10:30 AM to observe a routine home health aide visit. During the visit a prescription filled 1/21/2022, by physician EE, for amlodipine (blood pressure medication) 10 milligrams daily was observed. Plan of care for patient #14 failed to include amlodipine on medication list.

During an interview on 3/2/2022 at 1:26 PM, administrator/clinical manager A indicated the

	during their visits to include amlodipine.			
G0576	All orders recorded in plan of care 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. Based on observation, record review and interview, the home health agency failed to ensure all patient care orders were recorded in the plan of care for 1 out of 6 home visits completed (#9). Findings include: Review of an agency policy obtained 2/22/2022, revised 4/2/2021, titled Coordination of Care/Services stated, & The designated Clinical Manager: & Monitors and timely implementation of physician or allowed practitioner orders & Documents changes in the plan of care/service plan & Communicates significant information promptly to all health care team members & Conferences are conducted and documented to evaluate the patient s/client s progress and to consider revisions to the patient s/client s care/service to meet changing needs &. Clinical record review was completed on 3/3/2022 for patient #9, start of care 1/31/2022, certification period 1/31/2022 3/31/2022. Review evidenced an agency document electronically signed by registered nurse J on 1/31/2022, titled Home Health Certification and Plan of Care , which listed a primary diagnosis of hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease/ESRD (end stage renal disease) (heart disease caused by high blood pressure, and kidney failure, requiring dialysis). This document stated, & Caregiver Status & Lives with spouse; he provides any/all assistance at this time, but cannot shower her & Orders for Discipline and Treatment & SN [skilled nurse] frequency: 2w2 [2 times per week for 2 weeks], 1w1 [1 time per week for 1 week] & SN to perform complete physical assessment each visit with emphasis on chronic disease management & SN to provide skilled assessment, teaching/training and reinforcement of teaching to properly assess, manage and mitigate pain & SN to instruct patient/caregiver regarding strategies to mitigate pain & SN to instruct patient on disease process, including who to contact if signs and symptoms persist or	G0576	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will audit all active patient charts to ensure all physician orders are documented on the patient plan of care. 2. Any record not in compliance will be brought into compliance by updating the plan of care and obtaining any applicable orders from the patient's physician. 3. Any identified patient needs will be reported to MD and order to start those services will occur. 4. The physician will be updated for any refusal of discipline on the referral as well as services that are not appropriate at time of assessment and an order to cancel order services will be written. 5. The Administrator/Director of Health Care Services will provide reeducation to clinicians regarding documenting all physician orders on the plan of care. 6. Monitoring: 100% of plans of care for 30 days for compliance with all orders written on the plan of care as well as refusals of disciplines or inappropriate disciplines ordered. If 100% clinical compliance is not confirmed, 100% plans of care will be reviewed for an additional 30 days until 100% compliant for a 30-days. 7. Once 100% compliance with including all orders and or refusals on plan of care is achieved, 25% of plans of care will be reviewed quarterly. If at any time the agency falls out of compliance reeducation will be provided to clinicians and number 6 and 7 above will be repeated. 8. Survey results, quality record reviews, supervisory visits and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body 9. Completion date: 4/15/2022 and ongoing.	2022-04-15

	worsen as well as dietary measures, medication management, activities permitted &. SN to instruct patient/caregiver regarding self-management of oxygen therapy & Physical Therapy to assess functional status & Occupational Therapy to assess &. Review evidenced a referral order electronically signed by physician Z on 1/24/2022, titled Face-to-Face Patient Encounter Visit for Home Care Needs and Services which stated, &The following services are medically necessary home health care services: PT [physical therapy] & OT [occupational therapy] & Nursing & Shower aid &. Plan of care failed to evidence a shower aid was ordered on plan of care per physician order. Observation of a home visit for patient #9 was conducted 2/22/2022 at 3:30 PM, to observe a routine physical therapy visit. During the visit, person GG stated, when queried if the agency offered them a home shower aide, & No, but it would help &. During an interview on 3/2/2022 at 1:05PM, administrator/clinical manager A stated, when queried if a shower aide was offered to patient #9, & If it s not documented specifically, I can t say we did &.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on observation, record review and interview, the agency failed to ensure all drugs, services, and/or treatments were administered only as ordered by a physician for 4 of 14 records reviewed (#1, 2, 5, 8). Findings include: 9. Record review for patient #1 was completed on 3/3/2022, start of care date 8/24/2021, for certification period 12/22/2021 2/19/2022.	G0580	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will review 100% of medication profiles and plans of care to assess that all medication patient taking, or staff/caregiver administering are on the plan of care. Any record not in compliance will be brought into compliance by updating the plan of care and obtaining any applicable orders from the patient's physician. 2. The Administrator/Director of Health Care Services or Chief Clinical Officer will provide reeducation for clinician staff to include: a. Refusal of disciplines ordered on referral order or any disciplines that are inappropriate based on comprehensive assessment, the physician will be consulted, and orders will be documented on the plan of care. b. All medication and treatments must be on the patient's plan of care. c. Medications or treatments not on a plan of care may not be administered by clinician.	2022-04-15

	signed by registered nurse (RN) I on 12/20/2021 titled ... Recertification [comprehensive reassessment] , which indicated the patient was paraplegic (paralyzed from the waist down), and had three stage 3 pressure injuries (open wound extending through all layers of skin, fat may be visible, but no muscle involvement) on the sacrum (lower back), right and left hips. A home visit was observed on 2/16/2022 at 11:55 AM, with the patient and RN C. The patient presented lying in his bed, wearing a t-shirt and athletic shorts. Both legs were atrophic (absence of muscle mass). Observed RN C perform wound care to the patient s sacrum, left, and right hip. All wounds were cleansed with normal saline, hydrofera blue foam (a powerful antibacterial wound dressing) was applied to the wound beds, then covered with a foam dressing, and secured with tape. The patient also indicated he went to wound clinic HH weekly for wound management. A document dated and signed by RN I on 12/20/2021, titled Home Health Certification and Plan of Care included wound orders for the left hip, but failed to include wound treatment orders for the sacrum or right hip. During an interview on 02/28/2022 at 1:58 PM, when queried if there were orders for all 3 pressure injuries on the plan of care, administrator/clinical manager A stated ... No, I just see wound care orders for the one wound ... I would expect 3 orders .... When queried if she would expect to find the wound clinic physician on the plan of care, administrator/clinical manager A stated ... If it s not the certifying physician ... then, yes, it should be on the plan of care .... 17-13-1(a) 1. Review of an agency policy obtained 2/14/2022, revised 4/2/2021, titled Developing a Plan to Meet Patient/Client Needs , stated, Policy & An individualized Plan of Care/Service Plan is developed for each patient receiving care/service to specify the care and services necessary to meet the patient s specific needs and goals as identified in the comprehensive assessment & The Plan of care/Service Plan directs the delivery of care/service & care/Services are furnished in accordance with accepted standards of practice, law and		d. Updating plan of care as needed for any noted discrepancies to ensure treatments and medications are accurately listed on plan of care. e. Therapy orders must be on a plan of care and therapy assessment must include interventions and measurable goals before providing treatments. f. Documentation of all wounds including description of wound, complete wound care orders, healed wounds, and or new wounds must be documented. 3. Monitoring: 100% of plans of care for 30 days to assess for compliance with all orders written on the plan of care as well as refusals of disciplines or inappropriate disciplines ordered are documented on plan of care, and medication profile is accurate. If 100% clinical compliance is not confirmed, 100% of plans of care and medication profiles will be reviewed for an additional 30 days until 100% compliant for a 30-days. 4. Once 100% compliance with including all orders and medications and or refusals on plan of care is achieved, 25% of plans of care and medication profiles will be reviewed quarterly. If at any time the agency falls out of compliance reeducation will be provided to clinicians and number 3 and 4 above will be repeated. 5. Survey results, quality record reviews, supervisory visits and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body. 6. Completion date: 4/15/2022 and ongoing.	

	ensures that processes are in place to deliver only care/service that correlates to the plan of care/service plan & The DHCS/Clinical Manager ensures that processes are in place to that the designated employee(s) has access to and is aware of current orders for the care/service provided to a patient/client and any subsequent revisions or additions to the plan of care/service plan &. 2. Review of an agency policy obtained 2/14/2022, revised 4/2/2021, titled Developing a Plan to Meet Patient/Client Needs continued stated, When Orders for Care/Service Are Required & The DHCS or designee documents any orders added or changed at the time the orders are received & Orders for skilled services added or changed are documented in a format defined by law, regulation, or payor (e.g., Plan of care/Physician or Allowed Practitioner Orders Revision) &. 3. Review of an agency policy obtained 2/22/2022, revised 4/2/2021, titled Coordination of Care/Services stated, & The designated Clinical Manager: & Monitors and timely implementation of physician or allowed practitioner orders & Documents changes in the plan of care/service plan & Communicates significant information promptly to all health care team members & Conferences are conducted and documented to evaluate the patient s/client s progress and to consider revisions to the patient s/client s care/service to meet changing needs &. 4. Clinical record review for patient #2 was completed on 3/3/2022, start of care 4/27/2020, for certification period reviewed 12/8/2021 2/15/2022. Review evidenced an agency document electronically signed by registered nurse N on 2/10/2022, titled Home Health Certification and Plan of Care which listed a primary diagnosis of hereditary hypogammaglobulinemia (an immune system disease in which the body does not produce enough antibodies). This document stated, & Medications: & There is no data for this section & Orders for Discipline and Treatment & Mother will apply Lidocaine cream to each AC [antecubital] & SN to place peripheral IV [intravenous catheter] and administer IVIG [intravenous immunoglobulin] &. No orders were evidenced for lidocaine or IVIG. The agency failed to ensure medications were administered only with a physician order.			

5. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Home Health Certification and Plan of Care . This document listed a primary diagnosis of myelodysplastic syndrome (group of diseases marked by disruption of production of blood cells). This document indicated patient was receiving skilled nurse visits twice a week and home health aide visits twice a day, 6 days a week and physical therapy twice per week. The plan of care indicated nurses were to apply a foam dressing to sacral area twice per week and as needed. This document failed to evidence physical therapy interventions or orders.

Review of an agency document electronically signed by licensed practical nurse T on 4/5/2021, titled Skilled Nurse Visit stated, & barrier cream applied to coccyx as preventative &. No orders were evidence for application of barrier cream.

Review evidenced an agency document electronically signed by certified nursing assistant U on 4/25/2021, titled New Home Care HHA [home health aide] which stated, &Bike 40 min [minutes] &. Review failed to evidence any orders for patient to bike during home visits.

Review evidenced an agency document electronically signed by alternate clinical manager C on 5/6/2021, titled Skilled Nurse Visit which stated, & Cavilon spray to gluteal areas & Pain Profile & Current Pain Intensity: 9 & Pain is Relieved/Mitigated By & Medication & Complaint of shoulder ache & Complaint of knees hurting when moved & wife will reassess in the morning & she is giving analgesic &. Review of plan of care failed to evidence orders for Cavilon wound spray, or analgesic pain medication which were being administered.

During an interview on 02/22/2022 at 1:39 PM, administrator/clinical manager A stated, when queried about the physical therapy plan of care for patient #5, & it doesn t auto generate the plan of care, so when I look in here it doesn t even give me a PT [physical therapy] care plan & It doesn t generate a plan of care, just an evaluation & I m going to inquire about this &.

	During an interview on 2/28/2022 at 10:12 AM, administrator'/clinical manager A stated, when queried what interventions employees should be performing during visits, & any treatment we are providing to patient should be in clinical record &. Administrator A stated, when queried why Cavilon and barrier cream were applied but not ordered, & barrier cream and Cavilon should be on plan of care under medications and on the HHA care plan if they re applying it &. When queried why patient #5 was receiving an analgesic from his wife for pain, but there was no analgesic ordered, administrator A stated, & the nurse should get a PRN [as needed] order or notify the doctor & teaching should be documented about pain meds, and the order for pain medication should have been added to medication list on plan of care &. 6. Clinical record review was completed on 3/3//2022, for patient #8, start of care 6/23/2008, certification period reviewed 12/13/21 2/10/2022, primary diagnosis of quadriplegia, C5-C7, incomplete (weakness or paralysis of all four limbs), evidenced an agency document electronically signed by alternate clinical manager C on 12/10/2021, titled Home Health Certification and Plan of Care . This document stated, & Orders for Discipline and Treatments & Home Health Aide 18-24 hours/day 7 days/week x 9 weeks & Skilled Nurse 1 visit 7 days/week x 9 weeks & Skilled nurse for overall assessment focus on neurological, mood anxiety, pain management, appetite, hydration & medication setup &bowel care daily digital stimulation & manual removal, Suprapubic catheter 10ml [milliliter] water to balloon sterile catheter change weekly Friday and prn [as needed] emergent need & May apply mepilex sacral dressing 3x week and prn to protect fragile skin at coccyx & SN [skilled nurse] to notify MD [doctor] of: & Systolic BP [blood pressure] greater than 160 or less than 90 & Diastolic BP [blood pressure] greater than 100 or less than 50 & SN to assess pain level and effectiveness of pain medications and current pain management therapy every visit & SN to report to physician if client experiences pain level greater than 9, pain medications not effective & SN to assess skin for breakdown every visit & May discontinue wound care when wound(s) have healed & SN to assess wound for S&S [signs and symptoms] of infection, healing status, wound deterioration, and complications & SN to assess/instruct on diabetic management to include: nail, skin & foot care, medication administration and proper diet & SN to instruct on establishing bowel regimen & SN to assess client for diet noncompliance & SN will assess foods being eaten as snacks and continue to teach patient how to read labels			

	including Carbohydrate VS sugar amount in foods &. Review evidenced an agency document electronically signed by alternate clinical manager C on 1/31/2022, titled Skilled Nurse Visit which stated, & Wound deteriorated & physician FF informed calcium alginate 4x4 half ABD [abdominal pad] medipire [sic] tape to secure &. Plan of care failed to evidence physician orders for calcium alginate wound care orders. During an interview on 2/21/2022 at 3:27 PM, administrator/clinical manager A stated, when queried what was expected when changing patient s dressing orders or medications, & they should be putting in orders to send to doctor for signature if they are changing dressing orders & should be updating medication list with PRN s [as needed] and new medications every visit &.			
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Based on record review and interview, the agency failed to ensure the patient s plan of care was reviewed no less frequently than once every 60 days, for 4 of 9 records reviewed where a recertification/comprehensive reassessment occurred (#1, 6, 7, 8). Findings include: 6. Record review for patient #1 was completed on 3/3/2022, start of care date 8/24/2021, for certification period 12/22/2021 2/19/2022. Record review evidenced a document was dated and signed by RN I on 12/20/2021 titled ... Recertification [comprehensive reassessment] . The agency s EMR (electronic medical record) was reviewed on 2/25/2022 at 12:15 PM, which	G0588	1. The Administrator/Director of Health Care Services or Chief Clinical Officer review 100% of the revised plans of care, comprehensive assessments, and plans of care for timely submission and accuracy. 2. The Administrator/Director of Health Care Services or Chief Clinical Officer will lead documentation education sessions and conduct reviews of comprehensive assessment, plans of care, and revised plans of care. Re-education with clinicians on timely submission of comprehensive assessment, plans of care, and revised plans of care to ensure plan of care generates and is sent to physician for review. 3. The Administrator/Director of Health Care will run the Visits by Status Report daily on business days and follow up with clinicians to complete open documentation. 4. Assessments must be completed within 5 days after start of care or, resumption of care, or recertification comprehensive assessment. 5. Monitoring: 100% of plans of care, revised plans of care, and comprehensive assessments for 30 days to assess for compliance with timely completion of comprehensive assessments and generated plans of care/revised are sent to physician timely. If 100% clinical compliance is not confirmed, 100% of plans of care, revisions of plan of care, and comprehensive assessments will be reviewed for an additional	2022-04-15

	(this tab reflected when a document was created, quality assurance reviewed, modified, and subsequently completed). The EMR indicated the comprehensive reassessment was completed on 12/29/2021 (on the 68th day), not 12/20/2021 (59th day), and the plan of care was created on 12/29/2021 (also on the 68th day). During an interview on 2/14/2022 at 2:45 PM, when queried why the plan of care was not signed by the certifying physician (physician QQ), administrator/clinical manager A indicated the agency had trouble getting this physician to sign documents. During an interview on 02/23/2022 at 2:51 PM, when queried how the plan of care was developed, administrator/clinical manager A indicated it was generated (in the EMR) from the comprehensive assessment, and it couldn t be generated until after the comprehensive assessment was completed. 17-13-1(a)(2) 1. Review evidenced an agency policy obtained 2/22/2022, revised 4/2/2021, titled Follow-Up Comprehensive Assessment which stated, & The patient/client is reassessed: & No less frequently than every 60 days beginning with the start of care date & The plan of care/service plan in developed to represent the patient s/client s identified continuing care needs & The employee reviews and updates the plan of care and/or service plan, as appropriate, in coordination with the physician(s) or allowed practitioner(s) &. 2. Clinical record review was completed on 3/3/2022 for patient #6, start of care date 3/15/2021, evidenced an agency document electronically signed by physician EE on 3/24/2021, titled Home Health Certification and Plan of Care which evidenced a primary diagnosis of heart failure. Review evidenced an agency document for certification period 5/13/2021 7/11/2021, electronically signed by alternate clinical manager C on 5/10/2021, titled Home Health Certification and Plan of Care . This document was signed by physician EE on 6/23/2021, 91 days after previous plan of care was reviewed. Agency failed to ensure the physician reviewed		30 days until 100% compliant for a 30-days. 6. Once 100% compliance with timely completion of comprehensive assessment, plan of care, and revised plans of care is achieved, 25% of plans of care, revised plans of care, and comprehensive assessments will be reviewed quarterly. If at any time the agency falls out of compliance reeducation will be provided to clinicians and number 3 and 4 above will be repeated. 7. Survey results, quality record reviews, supervisory visits and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body. 8. Completion date: 4/15/2022 and ongoing.	

	the plan of care every 60 days. 3. Clinical record review was completed on 3/3/2022 for patient #7, start of care 1/14/2003, for certification period 12/5/2021 2/2/2022. The agency s EMR (electronic medical record) for patient #7 was reviewed on 2/28/2022, which evidenced a tab titled Schedule Task Logs . This tab evidenced an Oaisis [sic] D-1 Recert [comprehensive re-assessment] completed by alternate clinical manager C on 2/12/2022 at 9:37 PM for certification period 12/5/2021 2/2/2022. Agency failed to update the comprehensive assessment within the last 5 days of the certification period, and thus failed to ensure the plan of care was updated and revised by the physician within 60 days. 4. Clinical record review was completed on 3/3/2022, for patient #8, start of care 6/23/2008, certification period reviewed 12/13/21 2/10/2022. Review evidenced an agency document electronically signed by alternate clinical manager C on 12/10/2021, titled Home Health Certification and Plan of Care . The agency s EMR (electronic medical record) for patient #8 was reviewed on 2/28/2022, which evidenced a tab titled Schedule Task Logs . This tab evidenced a Non Oasis [outcome and assessment information set] Recertification [comprehensive re-assessment] completed by alternate clinical manager C on 2/13/2022 at 3:11 PM for certification period 12/13/21 2/10/2022. Agency failed to update the comprehensive assessment within the last 5 days of the certification period, and thus failed to ensure the plan of care was updated and revised by the physician within 60 days. 5. During an interview on 2/14/2022 at 3:04 PM, administrator/clinical manager A stated, when queried why plans of care were signed by physicians so late, & A few doctors are bad about signing the plan of care & We send it out automatically every 7 days, for 3 to 5 times for the physician to sign the orders &. At 3:19 PM, receptionist E indicated she calls to follow-up on unsigned plans of care but doesn t keep a log of how often or when she contacts the physician. During an interview on 02/23/2022 at 3:02 PM,			

	administrator/clinical manager A indicated the plan of care was generated from the start of care, or comprehensive assessments. Administrator A stated, when queried what the purpose of the plan of care was, & the Plan of care is our documentation that gets sent to the physician signed and sent back that includes all our orders, interventions, goals &. During an interview on 2/28/2022 at 3:30 PM, when queried why comprehensive assessments/reassessments were authenticated/electronically signed by the nurses on the same day the visit occurred, instead of being dated/signed as completed after any quality review/modifications to the documents were made (as evidenced in the electronic medical record task/event logs), administrator/clinical manager A indicated she didn t know why the documents were signed earlier than they were completed, she couldn t answer that, and she d have to investigate it more.			
G0590	Promptly alert relevant physician of changes 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. Based on record review and interview, the home health agency failed to ensure the physician was promptly notified of any changes in the patient's condition or needs that suggest outcomes were not being achieved or plan of care needed to be altered for 5 of 14 clinical records reviewed (#1, 5, 8, 12, 14). Findings include: 5. Record review for patient #1 was completed on 3/3/2022, start of care date 8/24/2021, for certification period 12/22/2021 2/19/2022. Record review evidenced a document dated and signed by RN I on 12/20/2021 titled ... Recertification [comprehensive reassessment] , which indicated the patient was paraplegic (paralyzed from the waist down), and had three stage 3 pressure injuries (open wound extending through all layers of skin, fat may be visible, but no muscle involvement) on the sacrum (lower back), and right and left hips; and described the 3 wound bed tissues as epithelial (epithelialization occurs when the skin	G0590	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will audit 100% of clinical notes created by clinicians for evidence of notification to physician promptly of any relevant changes. 2. The Administrator/Director of Health Care Services or Chief Clinical Officer will provide training to all clinicians regarding prompt notification to physician(s) regarding any relevant change in condition. Education will include: a. Notification of physician of change in condition. b. Collaboration with disciplines on patient change in condition. c. Notification to MD for any vital signs including pain status and blood sugar readings out of physician ordered parameters. d. Refusal of visits, ER visits, and any change from patient baseline. e. Any new reported symptoms by patient or caregiver. f. Thorough documentation to include collaboration with disciplines and MD notification including follow up orders from MD if any. g. Conversing change of condition with DHCS to ensure follow up was completed and to assess for changes necessary to patient plan of care.	2022-04-15

	regenerates over a wound surface, and the wound is considered closed). A document dated and signed by RN I on 12/30/2021, titled Skilled Nursing Visit , indicated the sacral and left hip pressure wound beds were described as slough (dead tissue, usually cream or yellow in color, requiring medical intervention to promote wound healing), and stated ... New wounds [hip] tubercle [sic-tuberosity] left 2cm [centimeters] x 1 cm ... states he was on it a lot ... Peri care [cleaning of the private areas] poor .... The document failed to indicate RN I notified neither the certifying physician, nor the wound clinic physician, of the deteriorated wound statuses, the new wound, or the poor peri-care (which could negatively affect wound healing). A document dated and signed by RN I on 2/14/2022, titled Skilled Nursing Visit , indicated the three stage 3 pressure injuries on the sacrum, right and left hips described the (3) wound bed tissues as epithelial . A home visit was observed on 2/16/2022 at 11:55 AM, with the patient and RN C. The patient presented lying in his bed, wearing a t-shirt and athletic shorts. Observed drainage from the wounds had soaked through the dressings, and his athletic shorts were soaked with drainage. RN C performed wound care to the patient s sacrum, left, and right hip. The right hip wound bed extended deeper than all layers of skin, was black, had 2 small white areas with potential bone or tendon exposed, and the surrounding skin was red/inflamed. The left hip wound bed was considerably hypergranulated (overgrowth of granulation tissue (healing wound bed tissue, beefy red) above the height or border of the skin edge, and wounds cannot heal with hypergranulation). The sacrum wound bed was red, with visible adipose tissue (fatty tissue under the skin). During this time, the patient indicated the wound drainage could soak through the dressings and his clothes almost immediately after wound care was performed, and indicated he went to wound clinic HH for wound management. A document dated and signed by RN C on 2/16/2022, titled Skilled Nursing Visit , indicated the sacrum wound bed was other , with no further description indicated, the right hip wound		3. Monitoring: 100% of clinical notes to ensure relevant changes are promptly reported to the physician. 100% of the clinical documentation will be reviewed for an additional 30 days until 100% clinical compliance is achieved for 30 days. 4. Once 100% compliance with prompt notification to physician and documentation of notification in clinical record, 25% of clinical notes will be reviewed quarterly. If at any time the agency falls out of compliance, reeducation will be provided to clinicians regarding prompt notification to physician for relevant change and number 2 and 3 above will be repeated. 5. Survey results, quality record reviews, supervisory visits and any issues regarding quality improvement will be addressed through QAPI (Quality Assurance Performance Improvement) and communicated with the Governing Body. 6. Completion date: 4/15/2022 and ongoing.	

actually hypergranulated), and left hip wound bed was other , not further described. .... The document failed to indicate RN C notified neither the certifying physician, nor the wound clinic physician, of the deteriorated wound statuses as compared to the skilled nursing visit performed on 2/14/2022.

During an interview on 02/28/2022 at 1:58 PM, when queried if there were orders for all 3 pressure injuries on the plan of care, administrator/clinical manager A stated ... No, I just see wound care orders for the one wound ... I would expect 3 orders .... When queried if she would expect to find the wound clinic physician on the plan of care, administrator/clinical manager A stated ... If it s not the certifying physician ... then, yes, it should be on the plan of care ....

6. Record review for patient #12 was completed on 3/3/2022, start of care date 1/12/2022, for certification period 1/12/2022 3/12/2022. Record review evidenced a document dated and signed by RN I on 1/12/22, titled Home Health Certification and Plan of Care , indicated a primary diagnosis of orthostatic hypotension, and other pertinent diagnoses included chronic obstructive pulmonary (lung) disease (COPD), chronic kidney disease, diabetes, depression, and gastroesophageal reflux disorder (GERD) (acid-reflux/heartburn).

A document dated and signed by RN I on 1/12/2022 titled ... Start of Care indicated the patient had a fair appetite, and RN I instructed family to obtain nutritional supplement drinks with added protein to assist with protein/nutrition intake.

A document dated and signed by physical therapist (PT) K on Tuesday, 2/8/2022 at 6:21 PM, titled Communication Note stated ... [family] reports patient eating and drinking basically nothing since Friday [2/4/2022] .... , which was the patient s 4th day without food/fluid intake. The document failed to indicate PT K notified the physician.

17-13-1(a)(2)

1. Review of an agency policy obtained 2/22/2022, revised 4/2/2021, titled Coordination of Care/Services stated, & The designated

	Clinical Manager regularly confers with the patient/client/caregiver, the patient s/client s physician or allowed practitioner as appropriate, and with other health care team members providing care/service to the patient/client & The designated employee contacts the physician or allowed practitioner when any of the following events occurs: & The patient s/client s condition changes & The patient s/client s response to care/treatments or medications is not as expected & Changes occur in caregiver support or the patient s/client s environment that impacts the plan of care/service plan & laboratory test results are available & designated Clinical Manager: & Documents changes in the plan of care/service plan & Conferences are conducted and documented to evaluate the patient s/client s progress and to consider revisions to the patient s/client s care/service to meet changing needs &. 2. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Home Health Certification and Plan of Care . This document listed a primary diagnosis of myelodysplastic syndrome (group of diseases marked by disruption of production of blood cells). This document stated, & Prognosis & Good & Orders for Discipline and Treatments & SN [skilled nurse] frequency: 2 visits /week x 9 weeks & HHA [home health aide] Frequency: 2-4 hrs [hours] 1-2x/day 6 days/week x 9 weeks & Physical Therapy 2 v/week [visits per week] x9 weeks [for 9 weeks] & Skilled nurse overall assessment. TPR [temperature, pulse, respirations] B/P [blood pressure] Orthostatic B/P & Assess skin & apply Foam border dressing to sacral area twice a week and as needed & HHA to assist with personal care, incontinent care, and ADL s [activities of daily living] per plan of care &. Record review evidenced an agency document electronically signed by licensed practical nurse T, on 4/5/2021 which stated, & BP [blood pressure] sitting 72/48 & Patient has become more weak and needs an assist of 1 or 2 for transfers & Patient becomes SOB [short of breath] with any activity including standing up &. This document stated, & Care Coordination with Clinical Manager & Regarding & visit details &. Record review failed to evidence the physician was notified with the change in status, including low blood pressure, shortness of breath, and progressive weakness.			

Review evidenced an agency document electronically signed by licensed practical nurse T on 4/26/2021, titled Skilled Nurse Visit which stated, & He has become more forgetful recently & has difficulty standing up and needs an assist of 2 & Client has 2+ pitting edema to RLE [right lower extremity] and 3+ pitting edema to LLE [left lower extremity] & BP [blood pressure] sitting is 90/52, standing 72/44 & Skin assess and a small open area noted to coccyx measuring 0.25cm x 0.25cm &. Review failed to evidence a physician was notified of change in patient condition including weakness, change in mobility, increased edema, low blood pressure, and new open wound.

Review evidenced an agency document electronically signed by physical therapist K on 4/28/2021, titled PT [physical therapy] which stated, & recommended getting hospital bed because patient no longer able to use commode & may not be able to stand each time for future PT sessions &. Review failed to evidence physician was notified of decline in mobility.

Review evidenced an agency document electronically signed by alternate clinical manager C on 4/29/2021, titled Skilled Nurse Visit which stated, & sitting B/P [blood pressure] 86/54 & after standing 30 seconds & 72/45 & A month ago he started physical decline & this decline has continued each week & [physician HH] notified of situation and patient and wife s agreement to hospital bed & upper gluteal crease stage 2 2cm [centimeter] slit 0.25 depth serous scant drainage & left gluteal 1cm stage 2 5cm w 6cm of dark pink to purple skin & left upper thigh 2 stage 2 1cm diameters open skin & right thigh upper has 1 2cm x 2cm 0.2cm depth area skin serous drainage & right gluteal has 2cm area and 1cm area skin loss & also dark pink to purple from pressure &. Review failed to evidence physician notification of new wounds, and patient decline.

Review evidenced an agency document electronically signed by alternate clinical manager C on 5/6/2021, titled Skilled Nurse Visit which stated, & Pain Profile & Right shoulder left knee & Current Pain Intensity: & 9 &. Review failed to evidence the physician was notified of patient s new onset pain.

During an interview on 2/23/2022 at 1:17 PM, administrator/clinical manager A stated, when queried about some indications for physician notification, & aides should notify the clinical manager if they notice something has changed & RN s [registered nurses] should notify the physician if vitals are outside of parameters, there is any change in condition or medication, anything they would need an order for, and a change to any routine &. Administrator/clinical manager A stated, when asked where documentation of physician or nurse notification would be located, & A verbal order gets put in as an electronic order & if no orders are received, it would be in a communication note or in the narrative on the visit note & If they didn t get ahold of the doctor, they would put it in the narrative section that they left a message but should follow-up with a communication note &. Administrator/clinical manager A indicated licensed practical nurses should also be calling the doctors to update.

During an interview on 2/28/21 at10:12am, administrator/clinical manager A stated, when queried about process if patient is not getting better, & if we do a recertification, we assess if the patient is not meeting their goals & if they do a recertification, it would update the plan of care & or a discharge would generate &. Administrator/clinical manager A indicated home health aides would notify the clinical manager if they noticed any changes to skin, edema, mentation. She indicated this would be entered on the HHA [home health aide] visit note under comments, and then the nurse would call the patient s doctor and document under narrative. Administrator/clinical manager A stated, when reviewing skilled nurse visit notes, & the narrative section, and care coordination sections do not specify what was talked about with the physician or clinical manager, and it should &. She indicated it should also include the time of notification, date, and response. Administrator/clinical manager A stated, regarding documentation of physician or nurse notification, & if it s not documented, I would say no, it wasn t done &. Administrator A indicated the physician should have been notified for new wound orders, low blood pressures, new wounds, and bloody nose patient had.

During an interview on 2/28/2021 at 11:45 AM, administrator/clinical manager A indicated the plan of care should have been updated if there was a change in patient condition, the physician should have been notified, and the patient

She did not know when patient had been referred to hospice, or when he started receiving hospice care.

3. Clinical record review was completed on 3/3//2022, for patient #8, start of care 6/23/2008, certification period reviewed 12/13/21 2/10/2022, primary diagnosis of quadriplegia, C5-C7, incomplete (weakness or paralysis of all four limbs), evidenced an agency document electronically signed by alternate clinical manager C on 12/10/2021, titled Home Health Certification and Plan of Care . This document stated, & Orders for Discipline and Treatments & Home Health Aide 18-24 hours/day 7 days/week x 9 weeks & Skilled Nurse 1 visit 7 days/week x 9 weeks &.

Record review evidenced an agency document electronically signed by alternate clinical manager C on 12/10/2021, titled Non Oasis [outcome and assessment information set] Recertification [comprehensive re-assessment] which stated, & Integumentary status & 6cm [centimeter] x 5 cm areas with stage 2 pressure ulcers 2cm x 1cm at gluteal area &.

Record review evidenced an agency document electronically signed by alternate clinical manager C on 2/7/2022, titled Non Oasis Recertification which stated, & Integumentary status & 6cm x 5cm areas irregular with loss of surface skin with stage 2 pressure ulcer with 6cm x 8cm area of stage 1 pressure sacral area &. Record review failed to evidence the physician was notified of increase in wound size and status.

Record review evidenced an agency document electronically signed by registered nurse J on 12/25/2021, titled Skilled Nurse Visit which stated, & client reports diarrhea all night; caregiver explained that client had diarrhea all night long & at one point, spouse called 911 and made client go to hospital to make sure everything was okay & Naturally, client was sent back home with no new orders &. Review failed to evidence the home health physician was notified of excessive diarrhea.

During an interview on 2/21/2022 at 3:27PM, administrator/clinical manager A stated, when queried about when the physician should be notified, & the nurses should be putting in

orders to send to doctor for signature if they are changing dressing orders &. She indicated the physicians should be updated on any changes to patient s status such as increasing wound size or diarrhea if not resolved.

4. Clinical record review was completed on 3/3/2022, for patient #14, start of care 4/22/2020, certification period 2/17/2022 4/17/2022. Record review evidenced an agency document electronically signed by administrator A on 2/17/2022, titled, Home Health Certification and Plan of Care which stated, & Orders for Discipline and Treatment & SN [skilled nurse] 1x/week x9 wks [weeks] & HHA [home health aide] Frequency: 4hrs [hours] 5 x/week & Skilled Nurse TPR [temperature, pulse, respirations] B/P [blood pressure] & Assessment & SN to notify MD of: & Random blood sugar greater than 300 &. This document listed a primary diagnosis of bilateral retinal hemorrhage (bleeding into the retinas of both eyes).

Review evidenced an agency document electronically signed by alternate clinical manager C on 1/12/2022, titled Skilled Nurse Visit which stated, & Blood Glucose & 301 &. Review failed to evidence physician was notified of hyperglycemia.

Review evidenced an agency document electronically signed by alternate clinical manager C on 1/26/2021, titled Skilled Nurse Visit which stated, & Blood sugar 396 &. Review failed to evidence physician was notified of elevated blood sugar.

Review evidenced an agency document electronically signed by alternate clinical manager C on 2/10/2022, titled Skilled Nurse Visit which stated, & Blood sugar 345 &. Review failed to evidence a physician was notified for elevated blood sugar.

Observation of a home visit for patient #14 was conducted on 2/21/2022 at 10:30 AM to observe a routine home health aide visit. During this visit, alternate clinical manager C indicated the patient s insurance company had changed his insulin to a generic, and because of this, his blood sugars have been elevated. She indicated that the doctor had since been made aware and they were going to switch back to his previous insulin. During this visit, a calendar was noted

	on patient s wall, listing his blood sugar readings for the month of February. The following blood sugar readings were evidenced: 1/28/2022 471 & 352, 2/1/2022 351, 2/10/2022 345 & 391, 2/21/2022 351. No documentation of physician notification was evidenced. The agency failed to coordinate blood glucose management with physician and patient to meet patient s goals of being free from hyperglycemia. During an interview on 3/2/2022 at 1:26 PM, administrator/clinical manager A indicated, when asked about protocol when patient s blood glucose is consistently outside of parameters, the nurses should notify the managers, who then notify the physician, the home health aides should be notifying the nurses. She indicated she couldn t say if the physician was notified unless it was documented.			
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Based on observation, record review and interview, the home health agency failed to ensure a revised plan of care reflected current information from an updated comprehensive assessment and contained information concerning the patient's progress toward the measurable outcomes and goals in the plan of care in 2 of 14 records reviewed (#5, 14). Findings include: 1. Review of an agency policy obtained 2/14/2022, revised 4/2/2021, titled Developing a Plan to Meet Patient/Client Needs continued , stated When Orders for Care/Service Are Required & Procedure & A qualified designated employee obtains orders for care/service prior to the delivery of such, and & The orders are incorporated into the plan of care/service plan in a format defined by law, regulation or payor & The designated employee identifies the	G0592	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will provide training to all clinicians regarding updating patient plan of care with reassessment or change in status. Education will include: a. Updating of the plan of care to document accurate current patient status and care needs. b. Review of plan of care plan each clinical visit and updating plan of care as necessary to reflect current patient status. c. Notification to MD of any discrepancies or changes being made to the current plan of care. d. Collaboration with other clinical team members of updates to plan of care. e. Progress towards goals. f. Updating goals/interventions on patient plan of care to meet patient care needs. 2. Monitoring: 100% of reassessment and change in condition assessments for 30 days. If 100% clinical compliance is not confirmed, 100% of reassessment and change in condition assessments will be reviewed for an additional 30 days until 100% compliance is maintained for 30 consecutive days. 3. Once 100% compliance with updated the plan of care with reassessments or change in status is achieved, 25% of reassessment and change in condition assessments will be reviewed	2022-04-15

	following: & Patient s/client s specific needs and clinical problems & Realistic patient-specific goals and the anticipated outcomes of care/service that are measurable, time specific and relate to identified patient/client needs & Patient/client barriers & that inhibit the patient s/client s ability &. 2. Review of an agency policy obtained 3/2/2022, revised 1/13/2018, titled Administrative Responsibilities for the Management of Patient Care and Client Services , stated Procedure & The DHCS [director health care services] or designee ensures processes are in place to result in the effective management of patient care and client service including: & Conducting comprehensive assessments as indicated & Analysis of the assessment findings to determine patient/client needs & Development of a plan to meet patient/client needs &. Implementation of the written plan of care/service plan according to acceptable standards & Ongoing Interdisciplinary assessment and evaluation of the effectiveness of the plan of care or service plan in meeting patient/client needs &. 3. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Home Health Certification and Plan of Care which stated, & Improved over all strength past 60 days & 2 falls in kitchen & &. This document listed a primary diagnosis of myelodysplastic syndrome (group of diseases marked by disruption of production of blood cells). This document stated, & Client will maintain optimal joint function, increased mobility and independence in ADL s [activities of daily living] by the end of the care period & The client will be free from falls during the care period &." Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Non Oasis [outcome and assessment information set] which stated, & loss of control fear of falling and extreme weakness reducing his independence are problematic at this time &. Agency failed to revise plan of care to reflect current mobility status, fall risk status, and progress or lack of progress toward mobility goals.		quarterly. If at any time the agency falls out of compliance, reeducation will be provided to clinicians regarding updated the plan of care with follow up assessment and or change in condition comprehensive assessment and number 2 and 3 above will be repeated. 4. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI quarterly and communicated with the Governing Body 5. Completion date: 4/15/2022 and ongoing.	

	4. Clinical record review was completed on 3/3/2022, for patient #14, start of care 4/22/2020, certification period 2/17/2022 4/17/2022. Record review evidenced an agency document electronically signed by administrator A on 2/17/2022, titled, Home Health Certification and Plan of Care which stated, & Goals/Rehabilitation Potential/Discharge Plans & Wound(s) will heal without complication by the end of the care period &. This document listed a primary diagnosis of bilateral retinal hemorrhage (bleeding into the retinas of both eyes). Review of an agency document electronically signed by alternate clinical manager C on 2/16/2022, titled Oasis [outcome and assessment information set] D-1 Recertification [comprehensive re-assessment] stated, & Wound 1 & Onset Date 10/04/2021 & Right Knee & Wound Type & Trauma & Treatment Performed Patient dresses with 4x4 per doctor instructions &. Observation of a home visit for patient #14 was conducted on 2/21/2022 at 10:30 AM to observe a routine home health aide visit. During the visit, the patient indicated he did not have any wounds. Agency failed to update the plan of care to include patient s progress toward measurable goals and outcomes regarding wound healing. During an interview on 3/2/2022 at 1:35 PM administrator/clinical manager A stated, when queried why the care plan would list a goal of wound healing when patient stated he did not have a wound, & I would have to look back at previous charting & She indicated the plans of care are updated and revised every certification period (60 days) based on the comprehensive assessment.			
G0602	Communication with all physicians 484.60(d)(1) Assure communication with all physicians or allowed practitioners involved in the plan of care. Based on record review and interview, the home health agency failed to ensure communication with all physicians in the plan of care in 2 out of	G0602	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will provide reeducation to all clinicians regarding updating all physicians regarding patient status. Education will include: a. Ensuring clinician assess for all physicians involved in patient care. b. Notification of all identified agencies,	2022-04-15

	14 clinical records reviewed (#5, 8). Findings include: 1. Review of an agency policy obtained 2/22/2022, revised 4/2/2021, titled Coordination of Care/Services stated, & The designated Clinical Manager regularly confers with the patient/client/caregiver, the patient s/client s physician or allowed practitioner as appropriate, and with other health care team members providing care/service to the patient/client & The designated employee contacts the physician or allowed practitioner when any of the following events occurs & The patient s/client s condition changes & The patient s/client s response to care/treatments or medications is not as expected & Communicates significant information promptly to all health care team members &. 2. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Home Health Certification and Plan of Care . This document listed a primary diagnosis of myelodysplastic syndrome (group of diseases marked by disruption of production of blood cells). This document stated, & Physician or Allowed Practitioner & [Physician HH] & Prognosis & Good &. Review evidenced a faxed document received from hospice K on 2/23/2022, which included a communication note from physician HH s office, which stated, & 4/28/2021 & Call from & Interim Healthcare clinical manager & patient #5 having increase weakness so much that requiring minimum 2 person assist & She talked with wife about facility or staying at home & She is agreeable to get an electric bed with overlay to prevent sores &. Review evidenced a faxed document received from hospice K on 2/23/2022, titled Referral Intake which stated, & Date: 4/30/2021 & Referring/Attending Physician & Physician HH &. Review evidenced document received on 2/23/2022 from hospice K, titled Patient Information Report which stated, & Care Type		physicians, and disciplines currently providing patients with care, including Hospice. c. Services allowable under Medicare services cannot overlap. If the patient is getting skilled care from Hospice, the patient is unable to get home health. If a patient receiving home health must not be on Hospice care. 2. Monitoring: 100% of clinical notes for evidence of documentation of notification to physician regarding patient status as well as any other physician involved in patient care or other agencies. 100% of the clinical notes will be reviewed for 30 days. If 100% clinical compliance is not confirmed, 100% of clinical notes will be reviewed for an additional 30 days until 100% is maintained for 30 consecutive days. 3. Once 100% compliance with documentation of notification to physician regarding patient status as well as any other physician involved in patient care or other agencies, 25% of clinical notes will be reviewed quarterly. If at any time the agency falls out of compliance, reeducation will be provided to clinicians regarding notification to physician regarding patient status, as well as other physicians involved in patient care or other agencies and number 2 and 3 above will be repeated. 4. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI quarterly and communicated with the Governing Body 5. Completion date: 4/15/2022 and ongoing.	

Primary Physician & physician II & Date of death: 5/12/2021 &.

Review evidenced an agency document electronically signed by person E (former scheduler) on 5/13/2021, titled Missed Visit which stated, & Date of Visit: 5/12/2021 & Last minute cancellation & Family and hospice staff provided care &. Record review failed to evidence any communication between the home health agency and hospice and failed to evidence the home health agency communicated with hospice physician, who was involved in the plan of care.

During an interview with on 2/28/2022 at 11:50AM, administrator/clinical manager A indicated she did not know if the home health agency was aware of hospice care and could not find documentation of any communication with hospice physician, when asked where documentation of hospice referral, or communication with hospice physician would be. Administrator/clinical manager A indicated there should be communication between home health and hospice physician to update plan of care.

3. Clinical record review was completed on 3/3//2022, for patient #8, start of care 6/23/2008, certification period reviewed 12/13/21 2/10/2022, primary diagnosis of quadriplegia, C5-C7, incomplete (weakness or paralysis of all four limbs), evidenced an agency document electronically signed by alternate clinical manager C on 12/10/2021, titled Home Health Certification and Plan of Care . This document stated, & Orders for Discipline and Treatments & SN [skilled nurse] or HHA [home health aide] will assist with scheduling Podiatrist appointment q [every] 3 months &. Record review failed to evidence communication with podiatrist to make patient an appointment as ordered on plan of care.

Review evidenced an agency document electronically signed by alternate clinical manager C on 12/27/2021 which stated, & Psoriasis active red flaky areas face neck/ near eyes ... eyelids red, mild edema & instructed to leave fingers off eyes call [physician JJ] for follow up &. Review failed to evidence physician JJ was contacted.

During an interview on 2/21/2022 at 3:43PM,

	agency should be communicating with all patient s physicians directly and coordinating patient s care. She indicated all physicians should be listed on the plan of care. 17-14-1(a)(1)(G)			
G0610	Patients receive education and training 484.60(d)(5) Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge. Based on observation, record review, and interview, the home health agency failed to ensure each patient or caregiver received ongoing education and training provided by the home health agency regarding care and services identified in the plan of care to ensure a timely discharge in 8 out of 14 clinical records reviewed (#2, 4, 5, 6, 7, 8, 9, 14). Findings include: 1. Review of an agency policy obtained 2/14/2022, revised 4/2/2021, titled Developing a Plan to Meet Patient/Client Needs , stated, Policy & An individualized Plan of Care/Service Plan is developed for each patient receiving care/service to specify the care and services necessary to meet the patient s specific needs and goals as identified in the comprehensive assessment & The designated employee identifies the following: & Patient and caregiver education and training specific to the patient s care needs &. 2. Clinical record review for patient #2 was completed on 3/3/2022, start of care 4/27/2020, for certification period reviewed 12/8/2021 2/15/2022. Review evidenced an agency document electronically signed by registered nurse N on 12/16/2021, titled Home Health Certification and Plan of Care which listed a primary diagnosis of hereditary hypogammaglobulinemia (an immune system disease in which the body does not produce enough antibodies). Review failed to evidence any education or teaching orders on plan of care.	G0610	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will provide training for all clinicians regarding updating all physicians regarding patient care and patient status. Education will include: a. Documentation of patient/caregiver teaching must be documented on assessments, plan of care, and clinical notes including IV therapy, infection prevention, nutrition, disease management, and safety measures. b. Documentation of education provided to patients/caregiver regarding pain management, proper footwear with ambulation, change position slowly, energy conservation, incontinence care, use of assistive device, frequent rests, small frequent meals, avoid large meals/overeating, controlling stress, catheter care, weakness, diabetic management, wound prevention, wound care, and changing position slowly. c. Documentation regarding ongoing discharge planning. d. Documentation towards all interventions and goals on clinical note. e. Every assessment must include educational needs for disease management. f. Education on oxygen therapy, hydration, medications including indication for use, potential side effects, and dosage. 2. Monitoring: 100% of clinical notes for evidence of documentation of education and training to patients and caregivers, documentation of ongoing discharge planning, documentation towards interventions and goals, and documentation on treatments, medications, and disease management. If 100% clinical compliance is not confirmed, 100% of clinical notes will be reviewed for an additional 30 days until 100% is maintained for 30 consecutive days. 3. Once 100% compliance with documentation of education and training to patients and caregivers, documentation of ongoing discharge planning, documentation towards interventions and goals, and documentation on treatments, medications, and disease management, 25% of	2022-04-15

	Review evidenced an agency document electronically signed by registered nurse N on 12/20/2021, titled Skilled Nursing Infusion which stated, & Narrative and Teaching & Tolerated infusion well &. Document failed to evidence any teaching or education about infection prevention, nutrition, disease management or safety measures were provided to patient/caregiver. Review evidenced an agency document electronically signed by registered nurse N on 1/12/2021, titled Skilled Nursing Infusion which stated, & Narrative and Teaching & Tolerated infusion well &. Document failed to evidence any teaching or education about infection prevention, nutrition, disease management or safety measures were provided to patient/caregiver. 3. Record review for patient #4 was completed on 3/3/2022, start of care 5/19/2021, certification period 5/19/2021 6/15/2021. Review of an agency document electronically signed by registered nurse N on 5/19/2021 titled Home Health Certification and Plan of Care , listed a primary diagnosis of unilateral primary osteoarthritis of first carpometacarpal joint right hand (arthritis of the right thumb). This document stated, & Orders for Discipline and Treatments & SN [skilled nurse] to instruct client to take pain medication before pain becomes severe to achieve better pain control & SN to instruct client on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs & SN to instruct on pain management, proper body mechanics and safety measures & SN to instruct client to wear proper footwear when ambulating & SN to instruct client to change positions slowly &. An agency document electronically signed by registered nurse N on 5/19/2021, titled Non Oasis [outcome and assessment information set] SOC [start of care] stated, & Skilled Intervention/Teaching & No skilled intervention needed &. Document failed to evidence teaching was completed to facilitate discharge, educate on pain relief, proper footwear, or position changes per care plan. During an interview 2/21/2022 at 2:12 PM, administrator/clinical manager A indicated		clinical notes will be reviewed quarterly. If at any time the agency falls out of compliance, reeducation will be provided to clinicians regarding documentation of education and training to patients and caregivers, documentation of ongoing discharge planning, documentation towards interventions and goals, and documentation on treatments, medications, and disease management and number 2 and 3 above will be repeated. 4. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI quarterly and communicated with the Governing Body 5. Completion date: 4/15/2022 and ongoing.	

patient #4 only qualified for one skilled nurse visit, so no further skilled visits were completed. She indicated teaching should be documented on the visit notes in the narrative section.

4. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled Home Health Certification and Plan of Care which stated, & start of care & 12/7/2020 &. This document listed a primary diagnosis of myelodysplastic syndrome (group of diseases marked by disruption of production of blood cells). This document stated, & Orders for Discipline and Treatments & Instruct on Pharmacological and Non-pharmacological pain management & Instruct on energy conservation, incontinent care and home safety measures &SN [skilled nurse] to instruct on establishing bowel regimen & SN to instruct client to use prescribed assistive device when ambulating & SN to instruct client to change positions slowly &.

Record review evidenced multiple agency documents electronically signed, titled Skilled Nurse Visit for the following dates: 4/8/2021, 4/12/2021, 4/15/2021, 4/19/2021, 4/22/2021, 4/26/2021, 4/29/2021, 5/3/2021, 5/6/2021, and 5/10/2021. These documents failed to evidence instruction on pain management, bowel regimen, assistive devices, or changing positions slowly. These documents also failed to instruct client on disease management, fall prevention, safety measures, or hospice care.

During an interview on 2/28/2022 at 10:45 AM, administrator/clinical manager A indicated, when queried if education should be documented, and where, & yes & education should be documented under the narrative section on the nurses visit notes &. She indicated if teaching wasn t documented, she didn t know if the nurses completed education.

5. Clinical record review was completed on 3/3/2022 for patient #6, start of care date 3/15/2021, certification period 5/13/2021 7/11/2021, evidenced an agency document electronically signed by alternate clinical manager C on 5/10/2021, titled Home Health Certification and Plan of Care which stated, & start of care & 3/15/2021 &. This document

This document stated, & Orders for Discipline and Treatments & SN [skilled nurse] to instruct client on energy conserving measures including frequent rest periods, small frequent meals, avoiding large meals/overeating, controlling stress &.

Review evidenced an agency document electronically signed by alternate clinical manager C on 5/10/2021, titled Non Oasis [outcome and assessment information set] Recertification [comprehensive re-assessment] which stated, & Skilled Intervention/Teaching &. This document failed to evidence any teaching, including, energy conserving measures, frequent rest periods, small frequent meals, or controlling stress.

6. Clinical record review was completed on 3/3/2022 for patient #7, start of care 1/14/2003, for certification period 6/8/2021 8/6/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 6/3/2021, titled Home Health Certification and Plan of Care. This document listed a primary diagnosis of hemiplegia following unspecified cerebrovascular disease affecting left non-dominant side (paralysis affecting left side of body). Other diagnosis included but were not limited to: type 2 diabetes (a condition affecting the way the body uses sugar), hyperlipidemia (high cholesterol), and urinary device (catheter). This document failed to evidence any education orders or goals.

Review evidenced an agency document electronically signed by alternate clinical manager C on 6/3/2021, titled Oaisis [sic] D-1 Recert [comprehensive re-assessment] which stated, & Skilled Intervention/Teaching &. This section was incomplete. No teaching or instruction was documented on this visit.

Review evidenced an agency document electronically signed by alternate clinical manager C on 7/2/2021, titled Skilled Nurse Visit which failed to evidence any teaching or education on bowel regimen, safety measures, transfers, supra-pubic catheter care, or diabetes management.

Review evidenced an agency document electronically signed by registered nurse N on 7/31/2022 titled Skilled Nurse Visit which failed to evidence any teaching or education on bowel

regimen, safety measures, transfers, supra-pubic catheter care, or diabetes management.

7. Clinical record review was completed on 3/3//2022, for patient #8, start of care 6/23/2008, certification period reviewed 12/13/21 2/10/2022, primary diagnosis of quadriplegia, C5-C7, incomplete (weakness or paralysis of all four limbs), evidenced an agency document electronically signed by alternate clinical manager C on 12/10/2021, titled Home Health Certification and Plan of Care . Record review evidenced patient had a supra-pubic catheter, wound, and was bedbound. This document stated, & Orders for Discipline and Treatments & SN [skilled nurse] to assess/instruct on diabetic management to include: nail, skin & foot are, medication administration and proper diet & SN to instruct on establishing bowel regimen & SN to teach/remind patient #8 the reason he should consume complex carbohydrates vs simple sugar s with meals and snacks &. Plan of care failed to evidence individualized education orders regarding safety measures, catheter care, infection prevention, wound prevention, or medications.

Review evidenced several agency documents electronically signed, titled Skilled Nurse Visit for the following dates: 12/13/2021, 12/14/2021, 12/15/2021, 12/16/2021, 12/17/2021, 12/18/2021, 12/19/2021, 12/20/2021, 12/21/2021, 12/22/2021, 12/23/2021, 12/24/2021, 12/25/2021, 12/27/2021, 12/28/2021, 12/29/2021, 12/30/2021, 12/31/2021, 1/1/2022, 1/2/2022, 1/3/2022, 1/4/2022, 1/5/2022, 1/6/2022, 1/7/2022, 1/8/2022, 1/9/2022, 1/10/2022, 1/11/2022, 1/12/2022, 1/13/2022, 1/14/2022, 1/15/2022, 1/16/2022, 1/17/2022, 1/18/2022, 1/19/2022, 1/20/2022, 1/21/2022, 1/24/2022, 1/25/2022, 1/26/2022, 1/27/2022, 1/28/2022, 1/29/2022, 1/30/2022, 1/31/2022, 2/1/2022, 2/2/2022, 2/3/2022, 2/4/2022, 2/5/2022, 2/6/2022, 2/7/2022, 2/8/2022, 2/9/2022 and 2/10/2022. These documents all failed to evidence teaching was provided to patient including: safety measures, catheter care, infection prevention, wound care, pressure ulcer prevention, medication, diabetic management, bowel regimen, and diabetic diet.

8. Clinical record review was completed on 3/3/2022 for patient #9, start of care 1/31/2022, certification period 1/31/2022 3/31/2022. Review evidenced an agency document

	1/31/2022, titled Home Health Certification and Plan of Care , which listed a primary diagnosis of hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease/ESRD (end stage renal disease) (heart disease caused by high blood pressure, and kidney failure, requiring dialysis). This document stated, & Orders for Discipline and Treatment & SN [skilled nurse] to instruct patient/caregiver regarding strategies to mitigate pain & SN to instruct patient on disease process, including who to contact if signs and symptoms persist or worsen as well as dietary measures, medication management, activities permitted &. SN to instruct patient/caregiver regarding self-management of oxygen therapy & SN to instruct patient/caregiver regarding heart failure status and self-management program & SN to assess, instruct patient/caregiver on diabetic footcare precautions and reinforce proper care & SN to instruct patient on self-management program to include, disease process & dietary measures & medication management, foot care precautions, blood sugar monitoring, hypo/hyperglycemia management and long-term complications SN to instruct on all new and changed medications and reinforce teaching related to use of medications as part of disease process or demonstration of knowledge deficit & SN to & instruct patient/caregiver on measures to prevent infection &. Review evidenced an agency document electronically signed by registered nurse J on 2/10/2022 titled Skilled Nurse Visit which stated, & Visit Narrative & The nurse tried to encourage client that everything takes time; that she was extremely sick and needed to allow herself time like she would anyone else. Client verbalized understanding &. This document failed to evidence teaching was completed regarding who to contact with signs and symptoms, pain management, dietary instructions, medication management, activities permitted, oxygen therapy, heart failure, diabetes, foot care, and infection prevention. During an interview on 3/2/2022 at 1:18 PM, administrator/clinical manager A stated, when queried how nurses would educate patient s having pain, & they would educate them on use of medications and other ways to treat pain & the nurses should educate the patient on how to manage pain & it should be included on the visit note &. Administrator/clinical manager A indicated if education was not documented, she could not say whether it was done or not.			

	9. Clinical record review was completed on 3/3/2022, for patient #14, start of care 4/22/2020, certification period 2/17/2022 4/17/2022. Record review evidenced an agency document electronically signed by administrator A on 2/17/2022, titled, Home Health Certification and Plan of Care which stated, & Orders for Discipline and Treatment & SN [skilled nurse] to assess/instruct on diabetic management to include: nail, skin & foot care, medication administration and proper diet & SN to instruct on foley care, skin and perineal care, proper handling and storage of supplies & SN to instruct on adequate hydration, proper handling and maintenance of drainage bag & SN to instruct the client/caregiver on precautions for high risk medications, such as hypoglycemics, anticoagulants/antiplatelets, sedative hypnotics, narcotics, antiarrhythmics, antineoplastics, skeletal muscle relaxants &. This document listed a primary diagnosis of bilateral retinal hemorrhage (bleeding into the retinas of both eyes). Record review evidenced agency documents electronically signed and titled Skilled Nurse Visit which all failed to evidence any teaching regarding diabetes, foley catheter management, high risk medications, skin care, or disease management for the following dates: 12/23/2021, 12/29/2021, 1/5/2021, 1/12/2021, 1/19/2021, 1/26/2021, 2/2/2021, 2/10/2021. Observation of a home visit for patient #14 was conducted on 2/21/2022 at 10:30 AM to observe a routine home health aide visit. During the home visit patient #14 indicated the nurses don t do any diabetic education because & I was an aide &. Surveyors observed patient walk outside apartment building with only socks on prior to home visit. During an interview on 3/2/2022 at 1:26 PM, administrator/clinical manager A indicated, when queried what diabetic education would include, & signs and symptoms of high and low blood sugar, diet, wound prevention, compliance with orders, watching skin for wounds, and diabetic foot care & the nurse would check & teach the patient to wear the appropriate footwear &. Administrator/clinical manager A indicated education would be documented in the visit notes under narrative. She indicated if teaching wasn t documented, she couldn t say it was done.			

	17-14-1(a)(1)(G)			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on observation and record review, the home health agency failed to ensure patients received a written visit schedule including the frequency of home health agency visits and personnel in 5 out of 5 applicable home visits completed (#1, 2, 7, 9, 10) Findings include: 1. Record review evidenced an agency policy obtained 2/14/2022, revised 4/2/2021, titled Contents of the Patient/Client Record which stated, & The following standardized paper forms or their equivalent are found in the in-home presentation Picket Folder: & Written information to the patient that includes: & Visit schedule, including the frequency of care/service to be provided &. 2. A home visit was conducted for patient #1 on 2/16/2022 at 11:56 AM to observe a routine skilled nurse visit. During this visit a home folder was reviewed. Review failed to evidence a visit schedule for the home health agency 3. A home visit was conducted on 2/16/2022 at 1:30 PM for patient #2, to observe registered nurse N administering an intravenous infusion of immunoglobulin G (an antibody to treat low antibody levels). During the visit, person S (patient #2 s mother), indicated she did not know if they had a home folder anymore with the visit schedule. She indicated the nurse called or texted to schedule the visits the day before, and the day of. Agency failed to ensure patient had written visit schedule in home.	G0614	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will provide training for all clinicians and clinical record assistant regarding ensuring patients are provided with a current written schedule in each patient's home. a. Patients are to have a current written schedule at home with frequencies. b. Education regarding all patients and caregivers' rights to have a written schedule. c. Updating visit schedule in home with any changes. d. Clinicians will bring the schedule home e. Education with patients and caregivers to visit schedule. f. Checking the home folder on visits and verifying information is accurate and up to date. 2. Nursing staff hand delivered patient visit schedules. Completed 3/15/2022. 3. Monitoring: The Administrator/Director of Health Care Services will review 100% of the clinical documentation weekly for evidence of documentation regarding providing visit schedule in home. Documentation record review will continue until 100% compliance is maintained for 3 consecutive months. The Administrator/Director of Health Care Services or designee will make random home visits monthly for the remainder of 2022 to verify written information regarding patient schedule was provided to patients. Clinician staff will pick up revised plans of care weekly with case conference and deliver to patient home on next visit 4. Once 100% compliance with documentation of providing visit schedule in home, and 100% of home visits finding visit schedule in home, 25% of clinical notes will be reviewed quarterly. If at any time the agency falls out of compliance, reeducation will be provided to clinicians regarding documentation of providing written schedule in patient's home and steps 3 and 4 above will be repeated. 5. Survey results, quality record reviews, and any issues regarding quality improvement will be	2022-03-08

	4. A home visit observation was conducted on 2/21/2022 at 9:30 AM for patient #7, to observe home health aide (HHA) P completing a routine HHA visit. During the visit, patient #7 indicated he hadn t received a written visit schedule in 9 years, since he started receiving services from the home health agency. 5. Observation of a home visit for patient #9 was conducted on 2/22/2022 at 3:30 PM, to observe a routine physical therapy visit. During the visit, a home folder was reviewed by surveyor. The home folder failed to evidence a written visit schedule. 6. Observation of a home visit for patient #10 was conducted on 3/1/2022 at 10:30 AM to observe a routine skilled nurse visit. During the visit, no home folder was observed, and observation failed to evidence a visit schedule.		addressed through QAPI quarterly and communicated with the Governing Body	
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review, and interview the home health agency failed to ensure patients received medication schedule/instructions, including medication name, dosage and frequency in 5 out of 5 applicable home visits conducted (#1, 2, 7, 9, 10). Findings include: 1. Record review evidenced an agency policy obtained 2/14/2022, revised 4/2/2021, titled Contents of the Patient/Client Record which stated, & The following standardized paper forms or their equivalent are found in the in-home presentation Picket Folder: & Written information to the patient that includes: & patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by employees/contractors &.	G0616	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will provide training for all clinicians and regarding ensuring patients are provided with a current written medication list at home. Education will include: a. Patients are to have a current written medication list at home with instructions. For any changes, hand Write on written copy at home and bring a printed copy on my next visit. b. Education regarding all patients and caregivers' rights to have a written medication list provided to them. c. Updating medication list in home with any changes in EMR. d. Checking the home folder on visits and verifying information is accurate and up to date. 2. Nursing staff hand delivered patient medication schedule/instructions, including medication name, dosage, and frequency, as well as which medications will be administered by our employees or if by patient or caregiver Completed 3/15/2022. 3. Monitoring: The Administrator/Director of Health Care Services will review 100% of the clinical documentation weekly for evidence of documentation regarding providing medication list in home. Documentation record review will continue until 100% compliance is maintained for 3 consecutive months. The	2022-04-15

	2. A home visit was conducted for patient #1 on 2/16/2022 at 11:56 AM to observe a routine skilled nurse visit. During this visit a home folder was reviewed. Observation failed to evidence a medication schedule/instructions. 3. A home visit was conducted on 2/16/2022 at 1:30 PM for patient #2, to observe registered nurse N administering an intravenous infusion of immunoglobulin G (an antibody to treat low antibody levels). During the visit, person S (patient #2 s mother), indicated she did not know if they had a home folder anymore with the medication schedule. Agency failed to ensure patient had medication schedule/instructions in the home. 4. A home visit observation was conducted on 2/21/2022 at 9:30 AM for patient #7, to observe home health aide (HHA) P completing a routine HHA visit. During the visit, patient #7 indicated he hadn t received a home folder, including medication schedule in 9 years, since he started receiving services from the home health agency. 5. Observation of a home visit for patient #9 was conducted 2/22/2022 at 3:30 PM, to observe a routine physical therapy visit. During the visit, a home folder was reviewed by surveyor. The home folder failed to evidence a written medication schedule/instructions. 6. Observation of a home visit for patient #10 was conducted on 3/1/2022 at 10:30 AM to observe a routine skilled nurse visit. During the visit, no home folder was observed, and observation failed to evidence a medication list/instructions.		Administrator/Director of Health Care Services or designee will make random home visits monthly for the remainder of 2022 to verify written information regarding medications was provided to patients. Clinicians will bring updated plans of care to patient homes with any changes, and at minimum every 60 days. 4. Once 100% compliance with documentation of written medication list in home, and 100% of home visits finding accurate medication list in home, 25% of clinical notes will be reviewed quarterly. If at any time the agency falls out of compliance, reeducation will be provided to clinicians regarding documentation of providing written medication list in patient's home and steps 3 and 4 above will be repeated. 5. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI quarterly and communicated with the Governing Body 6. Completion date: 04/15/2022 and ongoing	

G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation, record review, and interview, the home health agency failed to ensure patients received written instruction on any treatments to be administered by home health agency personnel, including therapy services in 5 out of 5 applicable home visits (#1, 2, 7, 9, 10). Findings include: 1. Record review evidenced an agency policy obtained 2/14/2022, revised 4/2/2021, titled Contents of the Patient/Client Record which stated, & The following standardized paper forms or their equivalent are found in the in-home presentation Picket Folder: & Any treatments to be administered by agency personnel and personnel acting on behalf of the agency, including therapy services &. 2. A home visit was conducted for patient #1 on 2/16/2022 at 11:56 AM to observe a routine skilled nurse visit. During this visit a home folder was reviewed. Review failed to evidence a plan of care for the home health agency 3. A home visit was conducted on 2/16/2022 at 1:30 PM for patient #2, to observe registered nurse N administering an intravenous infusion of immunoglobulin G (an antibody to treat low antibody levels). During the visit, person S (patient #2 s mother), indicated she did not know if they had a home folder anymore with the current plan of care. Agency failed to ensure patient had written plan of care, or other written instructions containing treatments to be administered by agency personnel. 4. A home visit observation was conducted on 2/21/2022 at 9:30 AM for patient #7, to observe home health aide (HHA) P completing a routine HHA visit. During the visit, patient #7 indicated he hadn t received a home folder, including plan of care in 9 years, since he started receiving services from the home health agency. 5. Observation of a home visit for patient #9 was	G0618	1. The Administrator/Director of Health Care Services or Chief Clinical Officer will provide training for all clinicians and regarding ensuring patients are provided with a current written list of patient's treatments, including therapy patient is receiving in home. Education will include: a. Patients are to have a current written treatment plan in the home including instructions. For any changes, hand write on written copy at home and bring a printed copy on the next visit. b. Education regarding all patients and caregivers' rights to have a written list of treatments receiving in home. c. Updating treatments in the home with any changes in EMR. d. Checking the home folder on visits and verifying information is accurate and up to date. 2. Clinicians hand delivered patient treatments/instructions 3/15/2022. 3. Monitoring: The Administrator/Director of Health Care Services will review 100% of the clinical documentation weekly for evidence of documentation regarding providing treatment list in home. Documentation record review will continue until 100% compliance is maintained for 3 consecutive months. The Administrator/Director of Health Care Services or designee will make random home visits monthly for the remainder of 2022 to verify written information regarding treatments was provided to patients. Clinicians will bring updated treatment list homes with any changes, and at minimum every 60 days. 4. Once 100% compliance with documentation regarding providing written treatment list in home, and 100% of home visits finding accurate treatment list in home, 25% of clinical notes will be reviewed quarterly. If at any time the agency falls out of compliance, reeducation will be provided to clinicians regarding documentation of providing written treatment list in patient's home and steps 3 and 4 above will be repeated.	2022-04-15

	conducted 2/22/2022 at 3:30 PM, to observe a routine physical therapy visit. During the visit, a home folder was reviewed by surveyor. The home folder failed to evidence a plan of care including treatments to be administered by agency personnel. 6. Observation of a home visit for patient #10 was conducted on 3/1/2022 at 10:30 AM to observe a routine skilled nurse visit. During the visit, no home folder was observed, and observation failed to evidence a plan of care.		5. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI quarterly and communicated with the Governing Body 6. Completion date: 04/15/2022 and ongoing	
G0680	Infection prevention and control 484.70 Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. Based on observation, record review, and interview, the agency the agency was non-compliant with the 100% COVID-19 vaccination requirement; failed to ensure all employees practiced the use of standard precautions during patient care to prevent the transmission of infections and communicable diseases (See tag G682); failed to ensure all employees received, at a minimum, the first dose of a multi-dose COVID-19 vaccine, or a one-dose dose COVID-19 vaccine, or was granted (or had a pending request for) exemption, or was identified as having a temporary vaccination delay; failed to ensure employees who failed to meet the phase 1 deadline (2/14/2022) for vaccination (or exemption/temporary delay) were immediately removed from providing any care, treatment, or other services for the agency or its patients; and failed to ensure the agency s policy for COVID-19 vaccination mandate specified the deadline dates for compliance with Indiana s phase 1 and 2 requirements (2/14/2022 and 3/15/2022) (See tag G687). This practice had the potential to affect all agency patients.	G0680	The Human Resource manager will audit all current employee files for compliance with Covid Vaccination mandate. 1. Any staff member not in compliance with Covid vaccination mandate will be removed from patient care/position until they are able to provide proof of vaccination status or approved medical or religious exemption. Completed 3/15/2022. 2. A log will be created and maintained by Human Resource manager of all staff and vaccination status. 3. All new hires will not work with patients until proof of vaccination status is obtained or approved religious or medical exemption is received. 4. All employees will be reeducated on Covid vaccination policy. 5. The Administrator/Director of Health Care Services will audit 100% of new hire records for vaccination status or approved waiver to ensure proper documentation is received prior to employee being hired for patient care for 3 months. If 100 % compliance is not achieved, the Director of Health Care Services will review employee files for 3 more months, until 100% compliance is maintained for 3 consecutive months. 6. Once 100% compliance with Covid Vaccination mandate, 25% of employee files will be reviewed quarterly. If at any time the agency falls out of compliance, reeducation will be provided to Human Resource manager regarding Covid vaccination mandate policy and steps 5 and 6 above will be repeated. 7. Completion date 03/15/2022 and ongoing	2022-03-15

	The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR §484.70: Infection Prevention and Control. 17-12-1(m)			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure all employees practiced the correct use of standard precautions during patient care to prevent the transmission of infections and communicable diseases for 1 of 6 home visits observed (#10). Findings include:	G0682	1. RN Nurse J was immediately removed from all cases and after a full investigation RN (Registered Nurse) J: a.Terminated b. Reported misconduct/unsafe clinical practices to Indiana State Board of Nursing and Michigan State Board of Nursing c. Reported to Office of Inspector General for fraudulent medical record entries and fabricating documentation for visits not performed 2. Director of Health Care Services or Chief Clinical Officer will provide education to all clinicians including the following: a. Correct bag technique, cleaning of equipment, and hand hygiene including return demonstration by clinician. b. assessment for infection of wounds, IV lines, or other skin areas including proper removal of old dressings to prevent further worsening of wounds and or infection of wounds. c. notification immediately to physician of potential signs of infection. d. properly placed identification badge. e. washing in between patient toes and assessing for infection and or wounds. f. providing personal hygiene assistance to a patient when notably soiled. 3. All clinicians will be signed off by Administrator/Director of Health Care Services, Alternate Administrator/Alternate Nursing Supervisor, or Chief Clinical Officer on hand washing technique, wound assessment, and bag Technique. 4. The Human Resource manager will be educated in completion of hand hygiene and bag technique with orientation. 5. The Human Resource manager will audit	2022-04-22

	Record review for patient #10 was completed on 3/3/2022, start of care date 12/7/2021, for certification period 2/5/2022 4/5/2022. Record review evidenced an agency document signed and dated by RN J on 2/1/2022, and physician I (certifying, primary care physician) on 2/7/2022, titled "Home Health Certification and Plan of Care", for certification period 2/5/2022 - 4/5/2022. This document indicated skilled nursing was ordered twice weekly for 8 weeks, safety precautions included proper handling of biohazard waste (potentially infectious/contaminated items), and standard precautions/infection control; and stated ... Orders ... Skilled nurse [SN] ... to perform complete physical assessment with each visit with emphasis on wound care ... Wound care orders ... to Right heel ... Cleanse/irrigate wound with sterile saline .... A home visit was observed on 3/1/2022 at 10:30 AM with patient #10 and registered nurse (RN) J. At 11:07 AM, RN J hand sanitized, donned gloves, placed an automatic blood pressure cuff on the patient s right upper arm, and cycled it. Then, without removing her gloves and performing hand hygiene, RN J reached into her nursing bag (after touching the patient) to retrieve a pulse oximeter (a machine to test oxygenation of blood and assess heart rate) and a thermometer. On 3/1/2022 at 11:10 AM, RN J placed the blood pressure cuff, pulse oximeter, and thermometer on the patient s bed, next to, not on, the plastic drape. RN J then removed her gloves, performed hand hygiene, and donned new gloves. She then grabbed the patient s garbage can, placed it next to patient and began unwrapping the right leg ace bandage, while wearing gloves that touched the garbage can. On 3/1/2022 at 11:15 AM, after the first layer of the right leg was unwrapped by RN J, surveyors observed the second layer, which was saturated with brown, purulent drainage, with very foul odor. RN J pulled the dry gauze batting wrap off the leg and foot. The dressing was stuck to several areas, including the right heel, top of right foot, and lateral right foot. RN J pulled the dry dressing off without soaking it first, which would prevent/reduce risk of traumatic injury to underlying skin/tissue. The patient s right lateral (outside) foot started bleeding and dripping on the floor while RN J pulled the dressing off. RN J then took a used dinner napkin from under an empty, dirty food (plastic) container on the		100% of nursing and therapy's employee files for documentation of hand hygiene technique and bag technique in each file. Human Resource manager contact staff who do not have evidence of education to come into the office to complete hand hygiene techniques and bag technique. Wound care assessment for appropriate clinicians. The Director of Health Care Services will audit 100% of new nurses and therapy files for 3 months to ensure 6. Once 100% compliance documentation of hand hygiene and bag technique is achieved in employee files, 25% of employee files will be reviewed quarterly. If at any time the agency falls out of compliance, re-education will be provided to Human Resource manager steps 4 and 5 above will be repeated. 7. Completion date 04/22/2022 and ongoing	

couch, and placed it directly under the patient s right foot, on the floor. Still wearing the same gloves, RN J then moistened additional stuck pieces of dressing with normal saline after the patient began bleeding and pulled them off with moistened gauze.

On 3/1/2022 at 11:20 AM, the right lower leg was observed. Skin from the knee down to the ankle was scaly, flaking, red, shiny in some areas, and swollen; the right foot and ankle were red, thickened, flaky, and swollen; the top of the right foot and toes evidenced copious amounts of macerated (wet, soggy, pale in color, due to excessive moisture) tissue and purulent greenish, yellow, foul-smelling drainage. RN J wiped this drainage off with saline moistened gauze and re-moistened the dirty gauze by placing it on top of the sterile saline bottle opening, tipping saline onto the dirty gauze, and then continued to cleanse the patient s foot.

On 3/1/2022 at 11:35 AM, RN J s employee identification badge, which hung from a lanyard on her neck, contacted the patient s right leg as she performed wound care. She directed the patient to tuck it into her hood for her, had the patient open gauze packages, and hold them open for her. She wet gauze pads with saline and wiped down the leg. She failed to clean or assess between the patient s toes, which were stuck together due to open wounds with drainage.

On 3/1/2022 at 12:05 PM, RN J remoistened dirty gauze again with the open bottle of saline to cleanse the patient s left leg.

On 3/1/2022 at 12:25 PM, RN J failed to assess the patient s buttocks, posterior legs, and plantar surfaces of both feet. Upon prompting by surveyors, RN J assessed patient s buttocks, which appeared red/purple, but blanchable, and patient had stool residue in his/her underwear. RN J failed to offer the patient assistance for personal care, or change his/her undergarments. During this time, the patient indicated he/she hadn t showered in a couple weeks.

The home visit was completed on 3/1/2022 at 12:37 PM. During this visit, RN J failed to provide teaching regarding signs or symptoms of infection. During this time, the patient queried

	RN J as to what she thought of the visit, to which RN J stated, ... I don t think you need any antibiotics or anything ... but you need to go to wound clinic . The patient then indicated to the surveyors that RN J would inform him/her if he/she needed to call the doctor, and he/she would make a call if there were any issues. RN J failed to indicate to the patient if she was going to notify physician I or physician H (wound clinic M) about the elevated blood pressure, new/worsening wounds, or possible infection observed during this home visit. A document dated and signed by RN J on 2/1/2022, titled ... Recertification [comprehensive reassessment] , which indicated the patient was at a high risk for infection. A document received on 3/3/2022, dated 3/2/2022, but not yet signed by RN C, titled Skilled Nurse Visit , indicated multiple new wounds were assessed, RN C suspected the presence of infection to wounds, physician I was notified, who instructed the patient to go to the emergency department (ED) for evaluation, and the patient indicated he/she didn t want to go. During an interview on 3/3/2022 at 2:13 PM, RN C was queried to describe the home nursing visit with patient #10 on 3/2/2022. RN C indicated she was still working on completing the visit note, as it was overwhelming, the patient was in very poor condition, and he/she was unaware of the severity of his/her wounds. 17-12-1(m)			
G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control. (d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for	G0687	1. The Human Resource manager will audit all current employee files for compliance with Covid Vaccination mandate. 2. Any staff member not in compliance with Covid vaccination mandate will be removed from work until they are able to provide proof of vaccination status or approved medical or religious exemption. 3. Covid tracking process will include a covid log maintained by Human Resource manager of all staff and vaccination status. Any staff member not in compliance with the Covid policy, the Human Resource manager will report to the Administrator.	2022-03-15

	COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and (ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients;		4. All new hires will not work with patient care until proof of vaccination status is obtained or approved religious or medical exemption is received. 5. All employees will be reeducated on Covid vaccination policy. 6. The Human Resource manager will educate any employee with an approved religious or medical vaccination of Covid policy requiring them to monitor self for symptoms daily before providing any patient care, notification to Director of Health Care Services if has any symptoms of Covid, wearing masks for all patient care and indoor interaction unless eating or drinking, and Covid testing weekly. 7. The Administrator/Director of Health Care Services will audit 100% of new hire records for vaccination status or approved waiver to ensure proper documentation is received prior to employee being hired for patient care for the next 12 months. If noncompliance is identified, the Human Resources Manager will be reeducated, and #5 above repeated. 8. Completion date 03/15/2022 and ongoing	

	(ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (d)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains (A) All information specifying which of the			

contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and

(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;

(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and

(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Based on record review and interview, the agency was non-compliant with the 100% COVID-19 vaccination requirement; failed to ensure all employees received, at a minimum, the first dose of a multi-dose COVID-19 vaccine, or a one-dose dose COVID-19 vaccine, or was granted (or had a pending request for) exemption, or was identified as having a temporary vaccination delay; failed to ensure employees who failed to meet the phase 1 deadline (2/14/2022) for vaccination (or exemption/temporary delay) were immediately removed from providing any care, treatment, or other services for the agency or its patients; and failed to ensure the agency s policy for COVID-19 vaccination mandate specified the deadline dates for compliance with Indiana s phase 1 and 2 requirements (2/14/2022 and 3/15/2022).

Findings include:

An agency policy received on 2/28/2022, copyright 2022 Interim HealthCare, Inc., revised 01/2022, titled CMS [Centers for Medicare and Medicaid Services] COVID-19 Vaccination Mandate stated ... Agency staff ... are not assigned to provide any care, treatment, or other

	services for the agency and/or its patients, until the following requirements have been met ... PHASE 1 Deadline [evidenced no date] ... agency staff must demonstrate they have ... Received a first dose or only dose of the COVID-19 primary vaccination series, OR ... Proof of a full vaccination status for COVID-19, OR ... Submitted a request for a medical or religious exemption from COVID-19 vaccination, OR ... Received approval and have been granted a lawful medical or religious exemption from COVID-19 vaccination, OR ... Received approval for a delay in COVID-19 vaccination as recommended by the Centers for Disease Control and Prevention (CDC) ... The office [agency] maintains ... supporting documentation of the agency s staff s vaccination status, and of all exemption requests and supporting documentation ... For agency staff that do not submit proof of vaccination and do not request an exemption are considered as unvaccinated without an exemption ... After phase 1 deadline [no date entered] ... agency staff are not eligible to provide care, treatment, or other services for the agency or its patients until they demonstrate evidence of being fully vaccinated ... The Administrator/Manager or designee ensures the following information is filed appropriately ... including but not limited to ... vaccination status, exemption requests, and any supporting documentation .... An agency document received on 2/28/2022, titled Employee Roster evidenced a list of 79 agency employees, and had 7 columns, titled from left to right, which stated, Employee Last Name ... Employee First Name ... COVID-19, Single Dose ... COVID-19, First Dose ... COVID-19, Second Dose ... COVID-19, Booster ... COVID-19, Declined. This list evidenced 18 employees have not received any doses of COVID-19 vaccine and do not have a documented pending request for exemption, or have temporary delay, and 3 employees received only the first dose of a multi-dose COVID-19 vaccine, all administered in 2021 (4/3/2021, 12/1/2021, and 12/1/2021). The agency was 73% compliant with the Phase 1 vaccination requirement, effective 2/14/2022. During an interview on 02/28/2022 at 12:05 PM with human resource (HR) manager B and administrator/clinical manager A, the agency s COVID-19 vaccine policy and employee tracking log was reviewed. An agency document was submitted by HR manager B on 2/28/2022 at 12:05 PM, titled Employee Roster . When queried, HR Manager indicated the list included			

status. At 1:11 PM, when queried who was overseeing the COVID-19 vaccine mandate, HR manager B indicated she was. When queried if the employee list included employees at the branch office, HR manager B indicated branch employees were included on the list, and person P (Co-owner, COO, chief operating officer) and person KK (CFO, chief financial officer) were handling the branch HR files for now. When queried what was the phase 1 deadline date for compliance with COVID-19 vaccination compliance, administrator/clinical manager A and HR manager B both indicated the date was 2/14/2022.

On 2/28/2022 at 1:15 PM, surveyor queried administrator/clinical manager A and HR manager B on a sample of 10 employees listed as non-compliant on the employee list. The list did not include the employees job titles. Administrator/clinical manager A and HR manager B indicated the following:

Employee Y was a new employee, was a home health aide (HHA), had an appointment today (2/28/2022) at CVS for her first vaccination, and currently provided care to agency patients (the employee list failed to evidence employee Y had an appointment on 2/28/2022 for a COVID-19 vaccination).

Employee Z was an HHA, was going to be putting in for an exemption, and currently provided care to agency patients. When queried if the request for exemption was submitted, HR manager B stated No.

Employee Q was an HHA, was going to be putting in for a religious exemption, and currently provided care to agency patients. When queried if the request for religious exemption was submitted, HR manager B stated No.

Employee BB was an HHA, was unvaccinated, and currently provided care to agency patients.

Employee CC was an HHA, currently provided care to agency patients, and the agency had no documentation for COVID-19 vaccination status.

	Employee DD (unknown job title) currently provided care to agency patients, and the agency had no documentation for COVID-19 vaccination status. When queried if the agency maintained a separate file to demonstrate proof of employees vaccination status, HR manager B stated No .... , and indicated they were in each employee s file. Employee EE was an HHA, currently provided care to agency patients, and the agency had no documentation for COVID-19 vaccination status. Employee FF was an HHA, currently provided care to agency patients, and the agency had no documentation for COVID-19 vaccination status. Employee AA (unknown job title) was a new employee (hire date 2/8/2022), has not yet provided care to agency patients, and the agency had no documentation for COVID-19 vaccination status. When queried if the employee was scheduled to receive a COVID-19 vaccination, HR manager B stated, Not to my knowledge. Employee O was office staff, mostly worked remote, but did come into the office once in a while, it was very infrequent, and hasn t been here in the last month. On 2/28/2022 at 1:45 PM, when queried how many employees the agency had, HR manager B indicated she was pretty sure 79 between the 2 offices combined. When queried to describe the agency s COVID-19 vaccine mandate policy, administrator/clinical manager A indicated it followed CMS regulations, and it didn t include Indiana s phase 1 and 2 deadline because it was a corporate policy, and it affected multiple states. When queried if staff was in-serviced about this policy and COVID-19 vaccine requirements, HR manager B indicated she sent an email in November or December (2021) to all staff for which the agency had no proof of COVID-19 vaccination status to submit it. On 2/28/2022 at 1:55 PM, administrator/clinical manager A indicated there was no documentation which evidenced staff was educated on the agency s COVID-19			

	date the policy was implemented, administrator/clinical manager A indicated she would have to go back and look in her emails. When queried if there were governing body meeting minutes that addressed the COVID-19 vaccination mandate policy, administrator/clinical manager A indicated she didn t know, and didn t don t know if the governing body had a meeting since that policy came out. Upon survey exit, nothing further was submitted. When queried about the contingency plan for employees who were unvaccinated, or pending exemption, administrator/clinical manager A and HR manager B both indicated they were reaching out often . When queried if unvaccinated or non-exempt employees still provided care to agency patients, administrator/clinical manager A and HR manager B both indicated they were, and were unaware that they shouldn t. When queried if the agency tested unvaccinated employees for COVID-19, administrator/clinical manager A indicated they were tested if they develop any signs or symptoms of COVID-19.			
G0750	Home health aide services 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Based on record review and interview, the home health agency (HHA) failed to employ qualified home health aides; failed to adequately train home health aides; failed to make appropriate HHA patient assignments; failed to assign HHA's to a specific patient by a registered nurse with written care instructions for a home health aide (See G798); and failed to ensure HHA's provide care which is ordered by the physician, included in the plan of care, and consistent with home health aide training (See G800). 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 §484.80: Home health aide services. 17-13-2(a)	G0750	1. The Human Resource manager will audit all current employee files for qualifications to work as a home health aide including evidence of the home health aide written knowledge exam and good standing on state registry. The Human Resource manager will review all resumes for home health aides to ensure they have had 6 months of healthcare experience per the home health aide job description. a. Any staff member not in compliance will be removed from care in which they do not meet qualifications. b. No home health aide competency testing will be conducted by home health agency for 2 years. Agency will contract with an RN who is not employed by Interim Health Care for competency testing. c. Education with RN case managers and home health aides will be completed by the Chief Clinical Officer or Director of Health Care	2022-03-15

	17-14-1(m) A standard citation was also evidenced at this level as follows: Based on record review, and interview, the home health agency (HHA) failed to ensure home health aide services were provided by individuals who met personnel requirements including successfully completing a competency evaluation; failed to ensure HHA's performed only those tasks they were deemed satisfactory in; failed to provide/maintain documentation of subsequent evaluation; and failed to maintain/provide documentation demonstrating requirements of competency training program had been met. The findings include: 1. Review of an agency policy obtained 2/14/2022, revised 4/2/201, titled Implementing the Plan of Care/Service Plan stated, & Interim HealthCare employees provide only those care/services for which they have appropriate training and experience & The DHCS [director healthcare services], registered nurse or other appropriate skilled professional assigns a home health aide(s) to a specific patient that has written patient care instructions for the services of a home health aide & The employee contacts their supervisor if any part of the plan of care/service plan requires skills for which the employee is not qualified through their training and experience, or for additional training and supervision prior to accepting the assignment or implementing the plan of care/service plan &. 2. Review of an agency policy obtained 2/22/2022, revised 10/2017, titled Home Health Aide Home Care Job Description stated, & Minimum Education & Experience Requirements: six months of experience in healthcare or completion of the Office s preceptor program & Successfully completed: & A specific aide training and competency evaluation program as required by State and the federal regulations & or & An aide competency evaluation program as required by State and the federal regulations & or & A nurse aide training and competency evaluation program approved by State and meets the requirements of the federal regulations and is currently listed in good standing on the state nurse aide registry & Knowledge, Skills & Abilities Required: Two positive references & Evidence of passing a		Services. Education will include: d. No providing of tasks not assigned on home health aide care plan. e. Updating RN of need to update care plan, as necessary if patient is requesting tasks not on care plan or refusing tasks on care plan. f. RN must assess home health aide care plan for accuracy and update as needed minimally every 60 days even if no changes occur for home health aide only cases. g. Health aide must update supervisory RN of any tasks assigned that is not qualified to perform. h. If a caregiver refuses to assist with task on plan follow up with will occur and could include disciplinary action. . No use of personal phone during assignment. j. Reporting to supervisory RN of any falls, witnessed or reported. k. Patients right to refuse care giver and agency requirement to find alternative assistance or find other agency who can provide patients with their needs. 2. Reeducation with Human Resource manager regarding qualifications of home health aide and employee file for necessary proof of training, education, and testing, as well as two positive references. Will also reeducate Human Resources manager on orientation process and utilization of orientation slides to ensure proper training of all employees. 3. The Administrator/Director of Health Care Services will view all employees' self-evaluation and competency check list on hire to ensure home health aide receives training on tasks providing that employee marked self as needing more training. The Director of Health Care Services will delegate education required if identified. 4. All new employee files will be audited by the Administrator/Director of Health Care Services after the Human Resource manager's final audit to ensure compliance with all necessary training, knowledge, and on the state registry for 3 months and 100% compliance is met. 5. Once 100% compliance with Covid Vaccination mandate, 25% of employee files will be reviewed quarterly. If at any time the agency falls out of compliance, reeducation will be provided to Human Resource manager regarding Covid vaccination mandate policy and steps 5 and 6 above will be repeated.	

	home health aide written knowledge exam &. 3. Person Q's (former HHA) employee file was reviewed 2/25/2022. Review of an agency document obtained on 2/25/2022, titled Contingent Employment Offer Letter indicated person Q (former home health aide) was hired on 4/5/2021. Review of a webpage on 2/25/2022, titled https://mylicense.in.gov/everification/, indicated person Q received a home health aide license on 5/13/2021. Review of person Q s employee file on 2/22/2022, evidenced she completed a competency evaluation program on 4/8/2021 supervised by registered nurse N which was titled, Skills Evaluation & Competency Checklist . The employee file indicated person Q marked a 1 or had limited experience and required additional supervision/training in the following areas: able to verbally report clinical information to patients, representatives, and caregivers, able to verbally report clinical information to other agency staff, taking, reading and recording pulse, hair shampoo in sink, nail care, skin care, ambulation, transfer techniques, taking, reading and recording blood pressure, measuring and recording intake and output, weighing a patient, equipment/supply bag technique, and use of personal protective equipment. Person Q's employee file indicated person Q marked a 0 or had no experience in the following areas: bed bath, sponge bath, tub bath, hair shampoo in tub, and hair shampoo in bed. Person Q's employee file stated, & During my employment, I will perform only those tasks for which I have entered a 2 , unless I receive additional training/supervision and provide appropriate documentation to my DHCS [director healthcare services] or supervisor &. Person Q signed and dated this document on 4/8/2021. No further documentation was evidenced providing evidence person Q had been deemed competent in these areas.		6. Completion date 03/15/2022 and ongoing	

Person Q's employee file stated, & The DHCS [director healthcare services] or designee signature indicates that they have review this candidate/employee s skill levels and will assign only those skills that are scored a 2 and will ensure the employee has provided evidence of training/supervision for items scores 0 or 1 prior to being assigned those tasks &. Person B (previous administrator/clinical manager) signed this document on 4/8/2021.

Review of an agency document signed by person Q (former HHA), registered nurse N, and person B (former administrator/clinical manager) on 4/8/2021, stated, & Home Health Aide Applicant: I, [person Q] swear and affirm under the penalties of perjury that the foregoing is true and accurate, and that I have read and understood 42 CFR 484.36 and have completed a competency evaluation program as required by this regulation & I [registered nurse N] swear and affirm under the penalties of perjury that the foregoing is true and accurate, and that the home health aide applicant named in this application has satisfactorily completed a competency evaluation program as required by 42 CFR 484.36 &.

Review of person Q s resume evidenced they worked in a nursing home cafeteria as a dietary aide, and as a direct support professional with people with special needs at a day program. Resume failed to evidence person Q had 2 years of experience in healthcare as required in home health aide job description.

Review of agency documents dated, 4/5/2021, titled Reference Letter indicated the agency failed to get in contact with 1 previous employer, and the second reference had & not much info & Agency failed to ensure per job description applicant had two positive references.

4. During an interview on 2/14/2022 at 11:12 AM, front desk/receptionist E stated, & we offer HHA [home health aide] orientation training, when hired & we don t have a HHA training program & when queried if the agency provides any training programs.

5. During an interview on 2/21/2022 at 1:15 PM, HR (human resources) manager B indicated person Q s (former home health aide) start date

	was 4/5/2021 and first patient contact date was 4/6/2021. 6. Clinical record review for patient #4 was completed on 3/3/2022, start of care 5/19/2021, certification period 5/19/2021 6/15/2021. Records review, evidenced person Q was the patient s home health aide in May 2021. Record review evidenced an agency document for patient #4 titled, HHA [home health aide] Care Plan which stated, & Hair care & Skin care & Nail Care & Oral care//Denture & Assist with dressing & Shower with chair/bench & Sponge bath & Pericare &. Agency failed to assign person Q to an appropriate patient. Person Q was not competent to perform the following from patient #4's care plan: hair care, skin care, nail care, ambulation, and transfer techniques. 7. A phone interview was conducted with patient #4 on 2/14/2022 at 5:45 PM. Patient #4 alleged the following: Patient #4 indicated she received home health aide services to assist her after carpal tunnel surgery on both her hands. She indicated the agency was supposed to help her shower, dress, brush hair, clean up, help with meals, housework, and getting on the bus since she was unable to use her hands. Patient #4 stated that on 5/20/2021 and 5/21/2021, person Q (former HHA), was at her house, and refused to help with shower or dressing, claiming it wasn t part of her job description . Patient #4 indicated person Q was sleeping on the couch during her shifts. Patient indicated she fell in the bathtub on 5/21/2022 after asking for help. She indicated person Q refused to help her get up when she fell, and instead was sitting on the couch on her phone. Patient #4 stated she complained to the agency about person Q, and the agency continued to send person Q to her house for visits because they were the only aide they had. The patient refused this caregiver, and for one week, did not receive any home health aide services from this agency, and at the end of May, the agency sent a different caregiver. The patient indicated she called her insurance company and they helped her find another home health agency to provide care.			

G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review, and interview, the agency failed to ensure home health aides were assigned with written patient care instructions prepared by registered nurses in 1 out of 6 clinical records reviewed with home health aides (#6). Findings Include: Record review evidence an agency policy obtained 2/14/2022, revised 4/2/201, titled Implementing the Plan of Care/Service Plan which stated, & The DHCS [director healthcare services], registered nurse or other appropriate skilled professional assigns a home health aide(s) to a specific patient that has written patient care instructions for the services of a home health aide & The written patient care instructions for a home health aide are prepared by that registered nurse or other appropriate skilled professional &. Clinical record review was completed on 3/3/2022 for patient #6, start of care date 3/15/2021, certification period 5/13/2021 7/11/2021, evidenced an agency document electronically signed by alternate clinical manager C on 5/10/2021, titled Home Health Certification and Plan of Care which stated, & start of care & 3/15/2021 &. This document evidenced a primary diagnosis of heart failure. This document stated, & Orders for Discipline and Treatments & HHA [home health aide] frequency: & HHA 1-2 hours 2 x a week for bathing x 9 weeks & HHA to assist with personal care, incontinent care, and ADL s [activities of daily living] per POC [plan of care] under supervision of an RN [registered nurse] &. Review evidenced an agency document electronically signed by registered nurse N on 3/15/2021, titled HHA [home health aide] Care	G0798	1. The Administrator/Director of Health Care Services will audit 100% of patient charts who are receiving home health services for current home health aide care plan with tasks assigned on the care plan. 2. Any patient without a current home health aide care plan will be reported to the clinical manager and creation of home health aide care plan will be completed. 3. Education with RNs will be completed by the Chief Clinical Officer or Administrator/Director of Health Care Services education will include: a. Health aide care plan must be completed at the start of care or at other times as required such as change in condition and recertification, resumption of patient care, and or upon patient request. b. RN must update the care plan, as necessary if patient is requesting tasks not on care plan or refusing tasks on care plan. c. RN must assess home health aide care plan for accuracy and update as well as, minimally every 60 days even if no changes occur as well as ongoing education with home health aides to notify nurse of any refusals of care so physician can be updated. d. Documentation of communication with home health regarding any patient refusals as well as who will provide the care for refusal and or inability to cover visits and patient refuses another agency. e. Patients right to refuse care giver and agency requirement to find alternative assistance or f. Documentation of offering alternative agency to patient if unable to meet needs, and if they refuse that to document that. 4.Monitoring: The Administrator/Director of Health Care Services will review 100% of home health aide care plans to ensure current care plans include tasks assigned. 100% of the home health aide care plans will be reviewed for 30 days. If 100% clinical compliance is not confirmed, 100% of home health aide notes will be reviewed for an additional 30 days until 100% is maintained for 30 consecutive days. 5. Once 100% compliance with home health aide care plans including tasks assigned is achieved, 25% of home health aide care plans will be reviewed quarterly. If at any time the agency falls out of compliance, reeducation will be provided to clinicians regarding home health aide care plans including tasks assigned and 4 and 5 above will be repeated. 6. Survey results, quality record reviews, and	2022-04-15

	instructions for home health aide. Review evidenced agency documents signed by home health aides titled Home Care Aide Visit/Shift Charting Sheet which indicated home health aide visits were performed on the following dates with no care plan: 3/24/2021, 4/6/2021, 4/8/2021, 4/11/2021, 4/15/2021, 4/22/2021, 4/25/2021, 4/29/2021, 5/2/2021, 5/7/2021, 5/10/2021, and 5/13/2021. During an interview on 1/21/2022 at 2:32 PM, administrator/clinical manager A stated, when queried about why HHA care plan was not completed, and how the aides knew what interventions to complete, & she didn t do the HHA plan of care for initial visits & the aides were just bathing the patient &. 17-13-2(a) 17-14-1(m)		any issues regarding quality improvement will be addressed through QAPI quarterly and communicated with the Governing Body 7. Completion date: 4/15/2022 and ongoing.	
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on observation, record review, and interview, the agency failed to ensure home health aides provided only services as ordered and included on the plan of care, and performed by appropriately trained personnel in 5 of 6 patients receiving home health aide services (#5, 6, 7, 8, 14). The findings include: 1. Record review evidence an agency policy obtained 2/14/2022, revised 4/2/201, titled Implementing the Plan of Care/Service Plan	G0800	1. The Administrator/Director of Health Care Services will audit 100% of current patients' home health aide notes for completion of assigned tasks. 2. Education with RNs and home health aides will be completed by Chief Clinical Officer, alternate nursing supervisor, or The Administrator/Director of Health Care Services. Education will include: a. Health aide care plan must be followed, and all tasks must be documented. b. RN must update the care plan, as necessary if patient is requesting tasks not on care plan to be added or refusing tasks on care plan. c. health aide must notify RN of noted discrepancies or patient request for changes to plan of care d. health aide must notify RN of any refusals and document this. RN must document communication with home health aide on refusals or changes requested to care plan. e. The home health aide must notify RN of any missed visits. The physician will be updated by RN and it will be documented who is providing the care for patient. 3. Monitoring: The Administrator/Director of Health Care Services will review 100% of home	2022-04-15

	services], registered nurse or other appropriate skilled professional assigns a home health aide(s) to a specific patient that has written patient care instructions for the services of a home health aide & The written patient care instructions for a home health aide are prepared by that registered nurse or other appropriate skilled professional &. 2. Record review evidenced an agency document obtained 2/14/2022, revised 10/2017, titled Home Health Aide Home Care Job Description which stated, & Follows the assignment sheet/service plan performing only tasks that are assigned &. 3. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. Review evidenced an agency document electronically signed by alternate clinical manager C on 4/1/2021, titled HHA [home health aide] Care Plan which stated, & Hair care & skin Care & Assist with dressing & Sponge bath & Assist with ambulation & Walker & Pericare & Assist with bedside commode &. Record review evidenced an agency document electronically signed by person Q (former HHA) on 4/12/2021, titled New Home Care HHA which indicated person Q performed the following tasks they were not competent to perform: Hair care, skin care, Assist with ambulation, Assist with bedside commode. Record review evidenced an agency document electronically signed by person Q (former HHA) on 4/13/2021, titled New Home Care HHA which indicated person Q performed the following tasks they were not competent to perform: hair care, skin care, assist with ambulation, assist with bedside commode. This document stated, & Client also had a bloody nose about an hour into my visit &. Person Q required additional supervision and training in being able to verbally report clinical information to other agency staff.		health aide notes to ensure current care plans are filled out for all ordered tasks for 30 days. If 100% clinical compliance is not confirmed, 100% of home health aide notes will be reviewed for an additional 30 days until 100% is maintained for 30 consecutive days. 4. Once 100% compliance with documentation of all assigned tasks on home health care notes, 25% of home health aide notes will be reviewed quarterly. If at any time the agency falls out of compliance, reeducation will be provided to clinicians and home health aides regarding full completion of all tasks on home health aide visit note and number 3 and 4 above will be repeated. 5. Survey results, quality record reviews, and any issues regarding quality improvement will be addressed through QAPI quarterly and communicated with the Governing Body 6. Completion date: 4/15/2022 and ongoing.	

	Record review evidenced an agency document electronically signed by person Q (former HHA) on 4/17/2021, titled New Home Care HHA which indicated person Q performed the following tasks they were not competent to perform: hair care, skin care, assist with bedside commode. Record review evidenced an agency document electronically signed by person Q (former HHA) on 4/18/2021, titled New Home Care HHA which indicated person Q performed the following tasks they were not competent to perform: skin care, sponge bath, assist with bedside commode. Record review evidenced an agency document electronically signed by person Q (former HHA) on 4/22/2021, titled New Home Care HHA which indicated person Q performed the following tasks they were not competent to perform: hair care, skin care, assist with ambulation, assist with bedside commode. Record review evidenced an agency document electronically signed by person Q (former HHA) on 4/23/2021, titled New Home Care HHA which indicated person Q performed the following tasks they were not competent to perform: skin care, assist with ambulation, assist with bedside commode. Record review evidenced an agency document electronically signed by person Q (former HHA) on 4/26/2021, titled New Home Care HHA which indicated person Q performed the following tasks they were not competent to perform: hair care, skin care, sponge bath, assist with ambulation, assist with bedside commode. Record review evidenced an agency document electronically signed by person Q (former HHA) on 4/27/2021, titled New Home Care HHA which indicated person Q performed the following tasks they were not competent to perform: hair care, skin care, assist with ambulation, assist with bedside commode. Record review evidenced an agency document electronically signed by person Q (former HHA) on 5/1/2021, titled New Home Care HHA which			

tasks they were not competent to perform: hair care, skin care, sponge bath, assist with bedside commode.

Record review evidenced an agency document electronically signed by person Q (former HHA) on 5/2/2021, titled New Home Care HHA which indicated person Q performed the following tasks they were not competent to perform: hair care, skin care, sponge bath, assist with bedside commode.

4. Clinical record review was completed on 3/3/2022 for patient #6, start of care date 3/15/2021, certification period 3/15/2021 5/12/2021, evidenced an agency document electronically signed by registered nurse N on 3/15/2021, titled HHA [home health aide] Care Plan which failed to include any home health aide interventions, orders, or tasks to be performed during visits.

Record review evidenced an agency document electronically signed by person Q (former HHA) on 4/15/2021, titled HHA Visit which stated, & did a bedbath &. Person Q was not competent to perform a bed bath.

Record review evidenced an agency document electronically signed by person Q on 5/2/2021, titled HHA Visit which stated, & gave client a sponge bath &. Agency failed to provide evidence person Q was competent to perform a bed bath and failed to appropriately assign HHA.

Record review evidenced an agency document electronically signed by person Q on 5/10/2021, titled HHA Visit which stated, & gave client a sponge bath &. Agency failed to provide evidence person Q was competent to perform a bed bath and failed to appropriately assign HHA.

5. Clinical record review completed on 3/3/2022 for patient #7, start of care 1/14/2003, evidenced a document electronically signed by alternate clinical manager C on 6/15/2021, titled Home Health Certification and Plan of Care for certification period 6/8/2021 8/6/2021. This document listed a primary diagnosis of hemiplegia (paralysis of one side of the body). This document stated, & Orders for Discipline and Treatments & SN [skilled nurse] frequency:

for catheter complications. HHA [home health aide] frequency: & 2 V [visits] daily x 7 DW [days/week] x 9 W [weeks] - 2 hr [hours] am [morning] 1 hr pm [evening] &.

Clinical record review evidenced a document electronically signed by person B (former administrator) on 6/8/2021, titled HHA Care Plan . This document stated, & Plan Details & Per request Assist with blood sugar using hand-over-hand assistance & Apply lotion per request & Shampoo once a month am with shower & Skin care keep clean and dry & Nail care File only & Oral care per request assist & Observe for pressure areas report any reddened or open areas & Shower with chair/bench 2 3 times a week & Complete bed bath on days not showering & Assist with transfers & Wheelchair & Return to bed pm & Lift stander & Range of motion upper extremities & Range of motion lower extremities & Assist with toilet lift stander & Meal preparation per request & Make bed morning visit & Change linen per request & Light housekeeping per request clean around clients area and keep items in reach &.

Record review evidenced unsigned agency documents titled HHA Visit , which were not completed, and failed to evidence a HHA visit was completed, or any care was provided on the following days: 6/8/2021 (evening visit), 6/10/2021 (evening visit), 6/12/2021 (evening visit), 6/13/2021 (evening visit), 7/7/2021 (evening visit), 7/8/2021 (evening visit), and 7/25/2021 (evening visit).

Record review evidenced unsigned agency documents titled New Home Care HHA which were not completed, failed to evidence a HHA visit was completed, or any care was provided on the following days: 6/13/2021 (morning visit), and 7/7/2021 (evening visit).

Record review evidenced an agency document signed by HHA P on 6/11/2021, titled HHA Visit , which was not completed, failed to evidence an evening HHA visit was completed, and failed to evidence any tasks from the plan of care were completed.

Record review evidenced agency documents signed by HHA P on 6/12/2021 and 6/14/2021, titled New Home Care HHA , which were not completed, failed to evidence a morning HHA

tasks from plan of care were completed.

Record review evidenced agency documents titled Missed Visit , which evidenced missed evening HHA visits on the following dates: 6/19/2021, 6/29/2021, 7/3/2021, 7/15/2021, and 7/24/2021.

An interview was conducted with patient #7 on 2/17/2022 at 9:50 AM. The patient stated, & about 3 times per week, the home health agency doesn t come out in the evenings and weekend morning and nights to help me get to bed &. He indicated he tried to get a neighbor or friend to come help him get to bed when the agency couldn t. Patient #7 indicated, for 2 or 3 years, there had been staffing issues and missed visits. He stated, & nobody wants to work &.

During a home visit with patient #7 on 2/21/2022 at 9:30 AM, patient #7 indicated he was shot in the head in 2000, and his right side had limited movement. He is wheelchair bound and uses a standing lift to get back to bed. Patient #7 stated, & nobody came last night (2/20/2021) or Saturday night (2/19/2021) & to help him get back into bed. He indicated he called the on-call service 3 times on Saturday (2/19/2022) and spoke with scheduler O about getting someone from the agency to help him back to bed, and nobody called him back. He indicated he sat in his wheelchair from Saturday morning until Sunday at 1:00 AM, when his nephew helped him get back to bed. He stated, & at most, 2 3 days in the evening per week, I get help to bed &.

During an interview on 2/23/2022 at 1:48 PM, administrator/clinical manager A stated, when asked how the agency coordinates missed visits with patient, & we notify the patient if we will miss a visit & he does probably have the right to not ask his visitors for help & it should be documented if his family or friends will provide care & we reach out to all skilled staff to cover shift &.

6. Clinical record review was completed on 3/3//2022, for patient #8, start of care 6/23/2008, certification period reviewed 12/13/21 2/10/2022, primary diagnosis of quadriplegia, C5-C7, incomplete (weakness or paralysis of all four limbs), evidenced an agency document electronically signed by alternate clinical

	Certification and Plan of Care . This document stated, & Orders for Discipline and Treatments & Home Health Aide 18-24 hours/day 7 days/week x 9 weeks & Skilled Nurse 1 visit 7 days/week x 9 weeks &. Review of an agency document electronically signed by alternate clinical manager C on 12/7/2021, titled HHA [home health aide] Care Plan stated, & Plan Details & Shampoo with shower & Shower with chair/bench Monday Friday and as requested & Sponge bath If no shower face hands armpits and groin &. Record review evidenced several agency documents titled, Missed Visit , which indicated missed HHA visits for patient #8 on the following dates: 12/15/2021, 12/17/2021, 12/20/2021, 12/21/2021, 12/22/2021, 12/23/2021, 12/24/2021, 12/26/2021, 12/27/2021, 12/29/2021, 12/30/2021, 12/31/2021, 1/1/2022, 1/2/2022, 1/3/2022, 1/5/2022, 1/9/2022, 1/10/2022, 1/11/2022, 1/12/2022, 1/15/2022, 1/16/2022, 1/21/2022, 1/23/2022, 1/26/2022, 1/28/2022, 1/30/2022, 1/31/2022, 2/6/2022, 2/8/2022, 2/8/2022, 2/9/2022, and 2/10/2022. Review evidenced patient did not receive any HHA care visits from 1/1/2022 at 8:00 PM until 1/2/2022 at 7:00 PM (23 hours). Review of HHA visit notes failed to evidence patient #8 received a bath or shower on the following dates: 12/26/2021, 1/1/2022, 1/2/2022, 1/9/2022, 1/15/2022, 1/16/2022, 1/23/2022, 1/27/2022, 1/30/2022, 2/6/2022, 2/10/2022, and 2/11/2022 (20% of the certification period days). Review failed to evidence coordination with patient regarding frequent missed visits. Agency failed to coordinate care with the patient/caregiver to meet bathing needs and HHA visit needs.			

During an interview on 2/21/2022 at 3:31 PM, administrator/clinical manager A stated, regarding patient going 23 hours without a home health aide, & office notified family and son went to stay with patient & a lot of the missed visits are only a few hours &. Administrator/clinical manager A indicated the agency should be able to provide all visits required for the patients.

7. Clinical record review was completed on 3/3/2022, for patient #14, start of care 4/22/2020, certification period 2/17/2022 4/17/2022. Record review evidenced an agency document electronically signed by administrator A on 2/17/2022, titled, Home Health Certification and Plan of Care which stated, & Orders for Discipline and Treatment & SN [skilled nurse] 1x/week x9 wks [weeks] & HHA [home health aide] Frequency: 4hrs [hours] 5 x/week & HHA to assist with personal care, incontinent care, and ADL s [activities of daily living] per POC [plan of care] under supervision of an RN &) This document listed a primary diagnosis of bilateral retinal hemorrhage (bleeding into the retinas of both eyes).

Review evidenced an agency document electronically signed by alternate clinical manager C on 2/16/2022, titled HHA [home health aide] Care Plan which failed to evidence orders for home health aides to assist patient with checking his blood sugars.

Observation of a home visit for patient #14 was conducted on 2/21/2022 at 10:30 AM to observe a routine home health aide visit. At 10:40 AM, patient #14 stated, & the aide helps me check my blood sugar every day &. He indicated he checked his sugar once per day, and because he was blind, the aides helped him with his glucometer.

During an interview on 3/2/2022 at 1:26 PM, administrator/clinical manager A stated, when queried if home health aides can check blood sugars, & I don t believe so & I would need to ask specifically & I d have to check their competency records to see if we are comp ing [competency-ing] them &. When asked if the HHA care plan should include all interventions patient is receiving, administrator/clinical manager A stated, & yes &. Administrator/clinical manager A indicated the

	aide should be completing only the tasks listed on the plan of care as ordered.			
G0942	Governing body 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review, and interview, the governing body failed to ensure the agency ensured the provision of all home health services occurred in a safe and effective manner. Findings include: On 03/02/2022 at 1:44 PM, an immediate jeopardy (IJ) was called, regarding an IJ cited at Conditions of Participation 42 CFR §484.55: Comprehensive Assessment of Patients; and 42 CFR §484.60: Care Planning, Coordination of Services, and Quality of Care. During this time, person P (chief operations officer, owner), administrator/clinical manager A, and person SS (chief executive officer, owner) were present. During an interview on 3/3/2022 at 1:29 PM, while discussion of the IJ occurred, person P indicated the findings during the surveyors home visit with this patient warranted the calling of an IJ. 17-12-1(b)	G0942	1. Two Members of the Governing Body attended the exit conference on 3/3/2022, then the Governing Body met on 03/04/2022 and discussed the IJ. 2. The Governing body sent additional support to the office immediately after being made aware of the IJ on 03/02/2022. The Ownership Group's Chief Clinical Officer and the Director of Human Resources arrived at the office the morning of 03/03/2022. A member of the Governing body arrived at the office on Monday 03/07/2022 and remained in the office through 03/11/2022 to oversee the implementation of the Plan of Correction to clear the IJ and provide additional training for the Administrator. The IJ was cleared on 03/09/2022. 3. The Governing Body met on 04/08/2022 and reviewed the Statement of Deficiencies and again on 04/14/2022 and reviewed the Plan of Correction prior to submission, approval of the Plan of Correction was given. 4. The Governing Body will continue to offer support to the Administrator with onsite presence from our Chief Clinical Officer at least 50% of the time during office hours until the Home Health Agency is brought into compliance and care is provided in a safe and effective manner. When the Chief Clinical officer is offsite, she will be available by Teams Meetings and telephone. 5. Once the office is brought back into substantial compliance, as evidenced by return survey indicating that the Condition level deficiencies are lifted, the Chief Clinical Officer or designee assigned by the Governing Body will make Monthly visits to the office for a period of 3 months evaluate the office compliance with the Plan of Correction. If shows 90% compliance overall for 3 months, onsite visits will be reduced to quarterly for an additional 6 months, if the office remains 90% compliant, onsite visits will be reduced to every 6 months which will be ongoing. At any time, the office falls under 90% compliance, the Governing Body will provide additional training and the plan will be repeated starting with monthly visits as outlined previously in point 5.	2022-04-14
G0948	Responsible for all day-to-day operations	G0948	1. The governing body reviewed statement of deficiencies on 04/08/2022	2022-04-13

	484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the administrator failed to be responsible for all day-to-day operations of the agency. Findings include: During an interview on 02/22/2022 at 1:20 PM, when queried if the agency had correspondence with IDOH for the addition of the branch (home health agency NN), administrator/clinical manager A stated ... I have the letter sent to state about counties ... but they had not put through for it to be a branch yet, because we were waiting for approval for counties ... that s what the owners told me ... She s [person P-co-owner, chief operating officer] sending it to me .... When queried if there had been any communication to the FI (Medicare fiscal intermediary (FI) the designated private insurance company that serve as the federal government's agents in the administration of the Medicare program) regarding the addition of a branch, administrator/clinical manager A indicated she would find out. When queried the date of the purchase of home health agency NN, administrator/clinical manager A indicated she didn t know, and these were all questions that she needed to ask to the owners. Surveyor then requested a policy on operating a branch. Upon survey exit, nothing was submitted. During an interview on 2/22/2022 at 5:15 PM, a call was placed to home health agency NN (219-736-1135). The person who answered the call stated Thank you for calling Interim ...." An agency policy received on 2/28/2022, copyright 2022 Interim HealthCare, Inc., revised 01/2022, titled CMS [Centers for Medicare and Medicaid Services] COVID-19 Vaccination Mandate stated ... Agency staff ... are not assigned to provide any care, treatment, or other services for the agency and/or its patients, until the following requirements have been met ... PHASE 1 Deadline [evidenced no date] ... agency staff must demonstrate they have ... Received a first dose or only dose of the COVID-19 primary vaccination series, OR ... Proof of a full vaccination status for COVID-19,		2. Upon notification of the IJ, the governing body deployed the Chief Clinical Officer and our Director of Human Recourses to the site to assist the Administrator in formulating and implementing the Plan of Correction. 3. The Chief Operating Officer (Governing Body Member) educated the Administrator on the responsibilities with the Administrator on 04/13/2022 4. The Administrator has verbalized understanding and has demonstrated the ability to lead day-to-day operations. 5. Chief Clinical Officer under the direction of the Governing Body will evaluate Administrator monthly on the ability to lead day to day operations for 6 months, if evaluation indicates proficiency, will reduce Evaluations to quarterly, if continues to demonstrate proficiency will reduce to annual evaluations. If at any time Administrator is less than proficient will reeducate and repeat #5 or additional corrective action will be taken.	

	OR ... Submitted a request for a medical or religious exemption from COVID-19 vaccination, OR ... Received approval and have been granted a lawful medical or religious exemption from COVID-19 vaccination, OR ... Received approval for a delay in COVID-19 vaccination as recommended by the Centers for Disease Control and Prevention (CDC) ... The office [agency] maintains ... supporting documentation of the agency s staff s vaccination status, and of all exemption requests and supporting documentation ... For agency staff that do not submit proof of vaccination and do not request an exemption are considered as unvaccinated without an exemption ... After phase 1 deadline [no date entered] ... agency staff are not eligible to provide care, treatment, or other services for the agency or its patients until they demonstrate evidence of being fully vaccinated ... The Administrator/Manager or designee ensures the following information is filed appropriately ... including but not limited to ... vaccination status, exemption requests, and any supporting documentation .... An agency document received on 2/28/2022, titled Employee Roster evidenced a list of 79 agency employees, and had 7 columns, titled from left to right, which stated, Employee Last Name ... Employee First Name ... COVID-19, Single Dose ... COVID-19, First Dose ... COVID-19, Second Dose ... COVID-19, Booster ... COVID-19, Declined. This list evidenced 18 employees have not received any doses of COVID-19 vaccine and do not have a documented pending request for exemption, or have temporary delay, and 3 employees received only the first dose of a multi-dose COVID-19 vaccine, all administered in 2021 (4/3/2021, 12/1/2021, and 12/1/2021). The agency was 73% compliant with the Phase 1 vaccination requirement, effective 2/14/2022. During an interview on 02/28/2022 at 12:05 PM with human resource (HR) manager B and administrator/clinical manager A, the agency s COVID-19 vaccine policy and employee tracking log was reviewed. An agency document was submitted by HR manager B on 2/28/2022 at 12:05 PM, titled Employee Roster . When queried, HR Manager indicated the list included all agency employees and their vaccination status. At 1:11 PM, when queried who was overseeing the COVID-19 vaccine mandate, HR manager B indicated she was. When queried if the employee list included employees at the branch office, HR manager B indicated branch employees were included on the list, and person P (Co-owner, COO, chief operating officer) and			

	person KK (CFO, chief financial officer) were handling the branch HR files for now. When queried what was the phase 1 deadline date for compliance with COVID-19 vaccination compliance, administrator/clinical manager A and HR manager B both indicated the date was 2/14/2022. 17-12-1(b)(3) 17-12-1(c)(1)			
G0972	Report all branch locations to SA 484.105(d)(1) The parent HHA is responsible for reporting all branch locations of the HHA to the state survey agency at the time of the HHA's request for initial certification, at each survey, and at the time the parent proposes to add or delete a branch. Based on observation, record review, and interview, the agency failed to report to the Indiana Department of Health (IDOH), during any time period prior to this recertification/re-licensure survey, that it operated a branch location (home health agency NN). Findings include: During an interview on 02/22/2022 at 1:20 PM, when queried if the agency had correspondence with IDOH for the addition of the branch (home health agency NN), administrator/clinical manager A stated ... I have the letter sent to state about counties ... but they had not put through for it to be a branch yet, because we were waiting for approval for counties ... that s what the owners told me ... She s [person P-co-owner, chief operating officer] sending it to me .... When queried if there had been any communication to the FI (Medicare fiscal intermediary (FI) the designated private insurance company that serve as the federal government's agents in the administration of the Medicare program) regarding the addition of a branch, administrator/clinical manager A indicated she would find out. When queried the date of the purchase of home health agency NN, administrator/clinical manager A indicated she didn t know, and these were all questions that she needed to ask to the owners. Surveyor then requested a policy on operating a branch. Upon survey exit, nothing was submitted. During this time, administrator/clinical manager A was	G0972	1. Governing Body reviewed Statement of Deficiencies 2. All staff have been educated on the process of opening a Branch Location and need to be clear on the status of branch opening before branch is officially opened. 1575 E 85 Ave, Merrillville IN location will remain closed until approval is obtained. 3. Application 855A was completed on 03/01/2022 and is awaiting processing. 4. Branch Questionnaire for a Home Health Agency (State form 53209) was completed on 3/10/2022 and mailed to the Indiana State Department of Health on 03/11/2022 5. Chief Operating Officer will continue to communicate with State Department of Health and CMS about application progress and will open branch once approval is obtained. 6. To prevent this from happening again, the Chief Operating Officer will maintain close contact with the Indiana State Department of Health and will only open an office once approval is given. There is no plan to open additional branches after the Merrillville office at this time.	2022-03-11

texting with person P, and indicated person P texted that the asset was purchased, not the license, they (home health agency NN) were operating under our license, and the agency did not submit for a branch ID yet. Person P requested the surveyor to call her cell phone via text to administrator/clinical manager A.

During a phone interview on 2/22/2022 at 2:00 PM, person P stated ... Normally when we [corporate Interim] purchase [an] office, we purchase the Medicare number as well ... This one [home health agency NN] we didn t, because it was close [geographically], so it was a branch ... we couldn t purchase the Medicare license [because] that ownership was changed within the last 36 months ... Once we were sure we were going to purchase [home health agency NN], we did a CMS 855A [the Medicare enrollment application for providers, also used to submit changes to your enrollment data] for the expanded territory ... that had to be step one, before you provide service ... We sent a letter to the State of Indiana .... She continued, and stated ... That s why when you went to [home health agency NN] they said we re closed ... They [patients formerly with home health agency NN] are admitted through South Bend [agency being surveyed] ... They were discharged then re-admitted ... They were on paper ... small Medicaid operation ... We are electronic ... [employee S, branch office manager] was supposed to have a closed sign up .... She also indicated home health agency NN was an asset purchase, they serviced patients under the South Bend license, she already started paperwork (for the addition of a branch), administrator/clinical manager A, person SS (CEO, chief clinical officer), person KK (CFO, chief financial officer), and human resource (HR) manager B have been there, they are supposed to have a sign on the door that says we are temporarily closed.

Additionally, during the phone interview on 2/22/2022 at 2:00 PM, person P also indicated the purchase of home health agency NN was less than a month ago, on the 28th of January (2022), she hasn t received information back from state on the territory addition, she wanted to make sure they were approved before they opened a branch, employees were at the branch location, they re being trained, home health agency NN was the old agency, they bought the desks and geographic territory, they re a franchise, in the process of re-opening, with a goal date of March 1st (2022), and she could make it happen by then. When the surveyor

functioning branch office, person P stated ... I would say it's not ... they are in training ... that s why it was supposed to be closed ... I think they took the sign down to tape it better ....

During an interview on 2/22/2022 at 5:15 PM, a call was placed to home health agency NN (219-736-1135). The person who answered the call stated Thank you for calling Interim ...."

During an interview on 02/28/2022 at 1:11 PM, when queried who was overseeing the COVID-19 vaccine mandate, administrator/clinical manager A indicated HR manager B was. When queried if HR manager oversaw the COVID-19 vaccination mandate for both offices, administrator/clinical manager A stated ... Yes, branch and parent .... During this time, HR manager B stated ... [person KK and person P] are handling the HR files pretty much for the branch for now ....

Review of pre-survey information from IDOH (Indiana Department of Health) evidenced a document titled, Pre survey Notes which stated, & 02/01/2022 rec d [received] 855 regarding the addition of counties to their service area & 01/28/2022 rec d correspondence from agency requesting to add the following counties: fulton, jasper, Kosciusko, lake, laporte, newton, porter, Pulaski and starke &. Review failed to evidence the home health agency had reported branch location to the state survey agency at the time the parent proposed to add a branch.

During an entrance conference on 2/14/2022 at 9:46 AM, administrator/clinical manager A stated, & the owner just bought another branch in Merrillville & it was [home health agency N] but a different owner & they sent the paperwork but haven t received a response & it s operating under the same license &.

During an interview on 2/14/2022 at 9:56 AM, administrator/clinical manager A indicated physical therapy services are provided through contract therapy A previously. No other therapy contract services documentation was received from home health agency. The agency failed to provide documentation for the branch s contracted services, thus failing to provide direct support and administrative control of branch.

During a branch visit on 2/22/2022 at 9:24 AM,

branch office manager S indicated the branch used contract therapy OO for physical therapy and occupational therapy services. Branch office manager S provided a copy of contract for review.

During the branch visit, branch office manager S indicated the agency had become a branch on 1/29/2022. When queried where license was, branch office manager S stated, & we took down the old license, we need to get a new one &. Observation failed to evidence any license at branch office.

During branch visit on 2/22/2022 at 9:45 AM, branch office manager S indicated the branch had its own on-call service, and stated, & a company takes the on call & answering service starts as soon as we leave the office &. She indicated the nurse on call would go out to see patients if needed.

During a branch visit 2/22/2022 at 9:24 AM no sign was noted on front door. Branch office manager S showed surveyor sign that had previously been on front door, which stated, & Attention: & [home health agency NN] has closed effective 1/28/2022 & If you have questions please call: & [home health agency PP] &.

During an interview on 2/22/2022 at 10:10 AM, branch office manager S stated, when queried about branch medical records, & they should be at [home health agency PP] & they are in transition & were keying them into [electronic medical record] & there are some here we re shredding & they re kept in boxes with lids &. Office manager S indicated there were patient records at the branch office which were being shredded and were stored in boxes with lids. Surveyor observed boxes with lids in the branch office.

During an interview on 2/23/2022 at 3:44 PM, administrator/clinical manager A stated, when queried why branch employees were not listed on the agencies requested employee roster, & they might not all be loaded into the system & I will need to ask & they are our employees &.

At 3:51 PM, administrator/clinical manager A

& human resources, person P [chief operations officer, owner], and person KK [chief financial officer] were working on transferring the human resources records over here &. Administrator/clinical manager A indicated she did not know if the agency hired all the branch employees.

During an interview on 2/23/2022 at 3:45 PM, Administrator/clinical manager A stated, when queried about branch patient records, & the branch patient s clinical records are at [home health agency NN] & they have not completed the process yet & we have to keep 7 years worth of medical records before shredding &.

During an interview on 2/23/2022 at 3:55 PM, administrator/clinical manager A indicated she didn t know how the branch on call worked.

A call was made to branch on call service on 2/23/2022 at 8:34 PM. Branch on call was the same answering service as the parent agency. Alternate clinical manager C called back at 8:37 PM and stated she or another nurse depending on patient s need, would go out to see patient after hours if needed while on call.

During an interview on 2/24/2022 at 3:17 PM, branch home health aide V stated, when queried what training or orientation they completed since becoming a branch, & I m going in tomorrow, probably for training & we re still paper charting right now &. Agency failed to provide direct support for employee training.

During an interview on 2/24/2022 at 3:22 PM, branch home health aide W stated, when queried what training or orientation they completed since becoming part of a branch, & they re getting everything figured out still & we re still paper charting & didn t sign any new papers or do training yet &. They indicated they were completing visits for all the patients they had been before becoming a branch. Agency failed to ensure parent provided direct support to ensure branch employees completed all training.

During an interview on 2/24/2022 at 3:31 PM, branch home health aide X stated, when queried what training or orientation they had completed since becoming part of a branch, & there hasn t

	[electronic medical record] info & tomorrow I m going in to learn how to use the phone and chart &. The agency failed to provide direct support to the branch regarding employee orientation and training.			
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure all clinical record entries were complete, and/or appropriately authenticated, dated, and timed, for 8 of 14 records reviewed (#1, 3, 5, 6, 8, 11, 12, 13). Findings include: 6. Record review for patient #1 was completed on 3/3/2022, start of care date 8/24/2021, for certification period 12/22/2021 2/19/2022. Record review evidenced a document was dated and signed by RN I on 12/20/2021 titled ... Recertification [comprehensive reassessment] . A document titled Home Health Certification and Plan of Care .... for certification period 12/22/2021 2/19/2022, was dated and signed by RN I on 12/20/2021. The agency s EMR (electronic medical record) was reviewed on 2/25/2022 at 12:15 PM, which evidenced a tab titled Schedule Event Logs (this tab reflected when a document was created, quality assurance reviewed, modified, and subsequently completed). The EMR indicated the comprehensive reassessment was completed on 12/29/2021, not 12/20/2021, and the plan of care was created on 12/29/2021, not 12/20/2021.	G1024	1. Governing Body reviewed Statement of Deficiencies 2. Policy, procedures, action, etc., in place to correct the deficiency. a. A review of the policy for updated CoP requirement for Federal/State funded programs was conducted. The policy was reviewed, and found to be in compliance with CoPs and Agency Policy. An in-service for all employees is scheduled to be held no later than 04/22/22. The purpose of the in-service is to re-educate staff on current agency policy relative to verification and appropriate authentication of visits. Employees unable to attend shall receive one on one instruction. 3. Measures to no recurrence of underlying problem(s). a. 25% QA shall be conducted on all SOC/ROC and Recertification assessments to assure policy and procedure related to this correction is being followed. 4. How will the corrective action be monitored for attaining and maintaining compliance? a. WHO will monitor it? i. QA staff or designee. These staff members will work under the direct supervision of the Agency administrator. b. HOW will they monitor it? i. QA staff or designee will review 25% of clinical records to assure that the signature on the assessment the current date/time of signature for one full quarter. Should at least 90% compliance be found during this first quarter, the clinician record review shall be reduced to an ongoing 10% review with an expected 90% threshold. QA staff shall submit threshold findings to the Administrator at least monthly. c. HOW OFTEN will they monitor it? i. Submitted monthly reports from QA on date issues will be provided to the Board at least quarterly. Staff who are not in full compliance shall be counseled, those who continue non-compliance may be terminated.	2022-04-22

	7. Record review for patient #3 was completed on 3/3/2022, start of care date 11/13/2021, transfer date 11/16/2021, for certification period 11/13/2021 1/11/2022. Record review evidenced a document was dated and signed by RN J on 11/13/2021 titled ... Start of Care [comprehensive assessment] . A document titled Home Health Certification and Plan of Care for certification period 11/13/2021 1/11/2022, was dated and signed by RN J on 11/13/2021. The agency s EMR was reviewed on 2/25/2022 at 12:20 PM, which evidenced a tab titled Schedule Event Logs . The EMR indicated the initial comprehensive assessment was completed on 11/22/2021, not 11/13/2021, and the plan of care was created on 11/22/2021, not 11/13/2021. 8. Record review for patient #11 was completed on 3/3/2022, start of care date 1/27/2022, discharge date 2/18/2022, for certification period 1/27/2022 3/27/2022. Record review evidenced a document was dated and signed by RN I on 1/27/2022 titled ... Start of Care . A document titled Home Health Certification and Plan of Care for certification period 1/27/2022 3/27/2022, was dated and signed by RN I on 1/27/2022. During an interview on 2/15/2022 at 3:18 PM, the patient s complete clinical record for certification period 1/27/2022 3/27/2022 was requested, and was received from administrator/clinical manager A at 3:51 PM. When queried why the start of care comprehensive assessment wasn t completed, administrator/clinical manager A indicated it had to be sent back to RN I to make corrections, there was an issue with the wound care, where to add the wound on the document, the nurse forgot to add the wound to the document, they were waiting for the nurse to fix it, and there could not be a plan of care generated until the comprehensive assessment was completed. The agency s EMR was reviewed on 2/25/2022 at 12:27 PM, which evidenced a tab titled Schedule Event Logs . The EMR indicated the			

	comprehensive assessment was completed on 2/15/2022 at 4:04 PM, not 1/27/2022, and the plan of care was created on 2/15/2022, not 1/27/2022. 9. Record review for patient #12 was completed on 3/3/2022, start of care date 1/12/2022, for certification period 1/12/2022 3/12/2022. Record review evidenced a document was dated and signed by RN I on 1/12/2022 titled ... Start of Care A document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022, was dated and signed by RN I on 1/12/2022. The agency s EMR was reviewed on 2/25/2022 at 12:30 PM, which evidenced a tab titled Schedule Event Logs . The EMR indicated the comprehensive assessment was completed on 1/21/2022, not 1/12/20, and the plan of care was created on 1/21/2022, not 1/12/2022. 10. Record review for patient #13 was completed on 3/3/2022, start of care date 12/16/2021, for certification period 12/16/2021 2/13/2022. Record review evidenced a document was dated and signed by RN N on 12/16/2021, titled ... Start of Care . A document titled Home Health Certification and Plan of Care for certification period 12/16/2021 2/13/2022, was dated and signed by RN N on 12/16/2021. The agency s EMR was reviewed on 2/25/2022 at 12:35 PM, which evidenced a tab titled Schedule Event Logs . The EMR indicated the comprehensive assessment was completed on 12/20/2021, not 12/16/2021, and the plan of care was created on 12/20/2021, not 12/16/2021. 10. During an interview on 02/23/2022 at 2:51 PM, when queried how the plan of care was developed, administrator/clinical manager A indicated it was generated (in the EMR) from the comprehensive assessment, and it couldn t be			

assessment was completed.

11. During an interview on 2/28/2022 at 3:30PM, when queried why comprehensive assessments/reassessments were authenticated/electronically signed by the RNs on the same day the visit occurred, instead of being dated/signed as completed after any quality assurance/modifications to the documents were made (as evidenced in the EMR task/event logs), administrator/clinical manager A indicated she didn t know why the documents were signed earlier than they were completed, she couldn t answer that, and she d have to investigate it more. Upon survey exit, nothing further was submitted.

17-15-1(a)(7)

1. Review of an agency policy received 2/14/2022, revised 4/2/2021, titled Entries into the Patient/Client Record stated, & The entry is dated with the date of care/serevice delivered & The minimum documentation of an encounter when care/service is delivered includes: & Date and time of encounter & Any late entry made to the patient/client record includes the following documentation by the employee: & Entry is clearly labeled as a late entry & The date and time that the entry should have been made & The signature of the employee making the entry and dates the entry with the actual date and time the entry is being recorded &.

2. Clinical record review was completed on 3/3/2022 for patient #5, start of care 12/7/2020, certification period 4/6/2021 5/12/2021. The agency s EMR (electronic medical record) for patient #5 was reviewed on 2/28/2022, which evidenced a tab titled Schedule Task Logs . This tab reflected when a document was created, modified, and completed. This tab evidenced a non OASIS [outcome and assessment information set] SOC [start of care, comprehensive assessment] completed by alternate clinical manager C on 1/23/2021 at 3:26 PM for start of care 12/7/2020. Agency failed to appropriately date and time the comprehensive assessment.

3. Clinical record review was completed on 3/3/2022 for patient #6, start of care date 3/15/2021, certification period 5/13/2021 7/11/2021. The agency s EMR (electronic medical record) for patient #6 was reviewed on

	Schedule Task Logs . This tab evidenced a non OASIS [outcome and assessment information set] SOC [start of care, comprehensive assessment] completed by registered nurse N on 5/13/2021 at 7:44 PM for start of care 3/15/2021. Agency failed to appropriately date the comprehensive assessment. 4. Clinical record review was completed on 3/3/2022, for patient #8, start of care 6/23/2008, certification period reviewed 12/13/21 2/10/2022. Review evidenced an agency document electronically signed by alternate clinical manager C on 2/7/2022, titled Non Oasis [Outcome and assessment information set] Recertification [comprehensive re-assessment] . The agency s EMR (electronic medical record) for patient #8 was reviewed on 2/28/2022, which evidenced a tab titled Schedule Task Logs . This tab evidenced a Non Oasis Recertification [comprehensive re-assessment] completed by alternate clinical manager C on 2/13/2022 at 3:11 PM for certification period 12/13/21 2/10/2022. Agency failed to appropriately authenticate the comprehensive re-assessment. 5. During an interview on 2/28/2022 at 3:30 PM, when queried why comprehensive assessments/reassessments were authenticated/electronically signed by the nurses on the same day the visit occurred, instead of being dated/signed as completed after any quality review/modifications to the documents were made (as evidenced in the EMR task/event logs), administrator/clinical manager A indicated she didn t know why the documents were signed earlier than they were completed, she couldn t answer that, and she d have to investigate it more.			
G1028	Protection of records 484.110(d) Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164. Based on observation and interview, the home health agency failed to ensure clinical records	G1028	1. The records at 1575 E. 85 Ave, Merrillville, Indiana location belong to B & B Interim Healthcare of Merrillville. All records in boxes at that location have been sent to secured storage by the owner of that Home Health Agency. 2. After uploading to electronic record, the records will be shredded. The Clinical record room was locked. All records in the nursing office were placed in a secure locked location. Completed 3/7/2022 3. The DHCS will provide all agency staff with reeducation regarding the document “Notice of Privacy Practice” to ensure all employees are	2022-04-15

	unauthorized use in the office setting. Findings include: 17-15-1(c) Review of an agency document revised 9/2013, titled Notice of Privacy Practices stated, & Interim HealthCare is committed to protecting the confidentiality of your health information. We have policies and safeguards in place to ensure your privacy. Interim HealthCare is also required by state and federal laws to protect the confidentiality of your health information. A visit to the home health agency NN (identified as a branch by home health agency) was completed 2/22/2022 at 9:15AM. During the visit, an interview was conducted with office manager S at 9:24 AM. Office manager S indicated the clinical records were being entered electronically in South Bend to the electronic medical record and then shredded. Office manager S indicated there were patient records at the branch office which were being shredded and were stored in boxes with lids. Surveyor observed boxes with lids containing clinical records at branch office. Agency failed to ensure client records were stored in a secure, locked location. During an observation on 2/14/2022, at 11:15AM, surveyors observed the clinical record room, the door was ajar, not locked, six discharge records noted in envelopes on a desk. Overhead filing cabinet to the right which contained patient records was not locked. Surveyors observed stacks of client records on the desk with patient information face up. Agency failed to ensure clinical records were stored in a secure, locked location.		compliant with ensuring protection of health information and patient records are secured and remain confidential. All agency staff were also educated on the requirement of keeping the medical record room always locked. 4. Office staff members will be assigned to check the medical record room daily to ensure it remains locked and secure. Logging will be completed by staff member assigned to check records room daily until 100% compliance is maintained for three consecutive months. DHCS will review log weekly to ensure compliance with all checks. If at any time the agency falls out of 100% compliance, agency staff will be reeducated on keeping medical record room always locked and # 4 above will be repeated. 5. All results of logs will be reported to the Governing Body, Administrator, DHCS, and QAPI committee for review and recommendations	

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