STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCENTCARE HOME HEALTH OF INDIAN	**11037 BROADWAY, SUITE C , CROWN POINT, Indiana, 46307**

(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: May 4, 5, 6, 9, 10, 11, 12, 13, 16, 17 (2022). Facility Number: IN008882 Provider Number: 157436 Current Census: 176 At this Emergency Preparedness survey, At Home Quality Care was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR §484.102.	E0000		
E0001	Establishment of the Emergency Program (EP) CFR(s): 484.102 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and	E0001		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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E0001	Continued from page 1 local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This CONDITION is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to develop and maintain a comprehensive emergency preparedness plan which included a documented, facility-based and community-based risk assessment utilizing an all-hazards approach and included strategies for addressing emergency events identified by the risk assessment (see tag E0006); to develop and maintain an emergency preparedness plan which included a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation (see tag E0009); to develop and implement individualized emergency preparedness plans for the patients which provided appropriate instructions, in the event of an emergency, to communicate with the agency (see tag E0017); to develop and maintain an emergency preparedness communication plan which included names and contact information for staff and patients' physicians (E0030); to develop and maintain an emergency preparedness communication plan which included contact information for State, tribal, regional, and local emergency preparedness staff and other sources of assistance (see tag E0031); to develop and maintain an emergency preparedness communication plan which included primary and alternate means for communicating with agency staff and Federal, State, tribal, regional and local emergency management agencies (E0032); to develop and maintain an emergency preparedness communication plan which included a method for sharing information and medical documentation for	E0001		

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E0001	Continued from page 2 patient's under the agency's care, as necessary, with other health providers to maintain the continuity of care and a means for providing information about the general condition and location of patients under the agency's care as permitted (see tag E0033); and to conduct exercises to test the emergency plan annually (see tag E0039). 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 and resulted in the agency being found out of compliance with the condition 42 CFR 484.102 Emergency preparedness.	E0001		
E0006	Plan Based on All Hazards Risk Assessment CFR(s): 484.102(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E0006		

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E0006	Continued from page 3 (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to develop and maintain a comprehensive emergency preparedness plan which included strategies for addressing emergency events identified by the risk assessment. The findings include: Review of an agency policy on 5/17/2022, titled "Emergency Management Plan" revised December 2019, stated, "… Based on the hazard vulnerability analysis and community planning activities, the organization's general emergency plan may be enhanced or revised according to identified	E0006		

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E0006	Continued from page 4 potential emergencies and planning activities…." Review of an undated agency document on 5/9/2022, titled "Hazard and Vulnerability Assessment Tool Naturally Occurring Events" indicated there was 0% risk of a hurricane, 28% risk of extreme cold, and 11% risk of extreme heat. Review of an agency document titled "Emergency Preparedness" revised November 2017, indicated emergency procedures for a hurricane. Review failed to evidence strategies for addressing the extreme heat and cold as identified by the risk assessment. During an interview on 5/9/2022, at 10:09 AM, the administrator indicated procedures for extreme temperatures should be included in the emergency preparedness plan and indicated the agency did not need to prepare for hurricanes based on location. The administrator indicated corporate made an all-inclusive plan for all the branches.	E0006		
E0009	Local, State, Tribal Collaboration Process CFR(s): 484.102(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis	E0009		

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E0009	Continued from page 5 facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to develop and maintain an emergency preparedness plan which included a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency. The findings include: Review of an agency policy on 5/17/2022, titled "Emergency Management Plan" revised December 2019, stated, "… Staff will work with regional or county emergency management planning agencies, where available, in: Establishing priorities among the potential emergencies identified in the hazard vulnerability analysis … Defining organization's role in relation to the community-wide emergency management program, use of volunteers, other emergency staff, including state or federally-designated health care professionals to address the agency's surge needs … Developing an "all-hazards" command structure within the organization that links with the community's command structure…." Review of an undated agency document titled "Emergency Preparedness Packet" failed to evidence a plan which included the cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials in an effort to maintain an integrated response during a disaster or emergency. During an interview on 5/9/2022, at 10:09 AM, the administrator indicated the agency does not currently collaborate with local or State emergency preparedness officials.	E0009		
E0017	HHA Comprehensive Assessment in Disaster CFR(s): 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this	E0017		

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E0017	Continued from page 6 section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure individual emergency preparedness plans prepared during the comprehensive assessment included specific patient care information and evacuation location plans in 12 of 17 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 15, 16). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled "Emergency Management Plan" which stated, "... Individualized plans for patients during a natural or man-made disaster will be included as part of the comprehensive patient assessment ... The organization educates patients and their families on emergency preparedness at the time of admission including where they can go to shelter and what is required by the shelter ...." 2. Clinical record review for patient #2 was completed on 05/13/2022. Record review evidenced an emergency preparedness plan which indicated the assisted living facility the patient resided in would have an evacuation plan in place, but failed to specify where patient would be evacuated. 3. Clinical record review for patient #4 was completed on 05/13/2022. Record review evidenced an emergency preparedness plan which indicated patient would be evacuated to a local shelter in an emergency, but failed to specify which local shelter patient would evacuate to or include an address. 4. Clinical record review for patient #9 was completed on 05/13/2022. Record review evidenced an emergency preparedness plan which indicated patient would be evacuated to the hospital in emergency but failed to specify which hospital location. 5. Clinical record review for patient #15 was completed on 05/13/2022. Record review evidenced an emergency preparedness	E0017		

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E0017	Continued from page 7 plan which indicated patient would be evacuated to person K's (patient #15's family member) house, but failed to include the specific location or address patient would evacuate to. 6. Clinical record review for patient #16 was completed on 05/15/2022. Record review evidenced an emergency preparedness plan which indicated patient would be evacuated to a local shelter, but failed to indicate to which shelter patient would evacuate, and failed to include an address. During an interview on 05/09/2022 at 11:17 AM, administrator A indicated the patient's individualized emergency preparedness plans are developed based on patient needs and discussed with the patient on start of care. Administrator A indicated the individualized emergency preparedness plans should include location patient is evacuating to. 7. During an observation of care in the home for patient #6, start of care 4/7/2022, on 5/11/2022, at 9:19 AM, the agency's folder was observed in the patient's home and the page titled "Emergency Preparedness Plan" was observed to be blank. Clinical record review on 5/10/2022, evidenced an agency document titled "Episode Emergency Preparedness Report" for episode 4/7/2022 – 6/5/2022. This document indicated the evacuation location to include the address was not addressed. 8. During an observation of care in the home for patient #7, start of care 12/23/2021, on 5/6/2022, at 11:47 AM, the patient was observed to have an open area to the right buttock. Registered Nurse (RN) C was observed cleansing the open with normal saline (a wound cleansing solution) and applying desitin (a moisture barrier). The patient was observed to have a plastic tube inserted into the penis with dark yellow liquid draining into a clear plastic bag hanging on the side of the patient's bed. The agency's folder was observed in the patient's home and the page titled "Emergency Preparedness Plan" was observed to be blank and did not include the wound care and urinary drainage bag. Clinical record review on 5/9/2022, evidenced an agency document titled "Episode Emergency Preparedness Report" for episode 4/22/2022 – 6/20/2022, indicated the patient's evacuation location was the nephew's home and indicated the address was not assessed. Reviewed failed to indicate the evacuation location for the patient. 9. Clinical record review on 5/11/2022, for patient #10, start of care 4/25/2022, evidenced an agency document titled "Episode Emergency Preparedness Report" for episode 4/25/2022 – 6/23/2022, which indicated the address for the evacuation location was not assessed. Review failed to evidence the patient's	E0017		

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E0017	Continued from page 8 emergency preparedness plan was complete and individualized. 10. Clinical record review on 5/11/2022, for patient #11, start of care 4/29/2022, evidenced an agency document titled “Episode Emergency Preparedness Report” for episode 4/29/2022 – 6/27/2022, which indicated the address for the evacuation location was not assessed. Review failed to evidence the patient’s emergency preparedness plan was complete and individualized. 11. Clinical record review on 5/12/2022, for patient #14, start of care 5/4/2022, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 5/4/2022 – 7/2/2022. This document indicated the skilled nurse was needed for central line (a plastic tube inserted into a vein that goes up to the heart) care and labs. Review of an agency document titled “Episode Emergency Preparedness Report” for episode 5/4/2022 – 7/2/2022, evidenced the patient’s evacuation location was the hospital and indicated the address was not assessed. Review failed to evidence the name of the hospital and location. Review failed to evidence the patient’s emergency plan included the central line care and supplies needed. 12. During an interview on 5/11/2022, at 2:12 PM, the clinical manager indicated the individualized emergency plan should be completed in the home folder. At 4:14 PM, the clinical manager said the individualized emergency preparedness plan should be specific. 13. During observation of a home visit for patient #1 on 5/5/2022 at 12:00 PM, the patient's agency folder was reviewed. Review of the folder evidenced a page titled, “Emergency Preparedness Plan”, which was observed to be blank. 14. Observation of a home visit for patient #3 on 5/6/2022 at 10:28 AM failed to evidence a home folder. Observation of the home visit failed to evidence an individualized emergency preparedness plan. 15. During observation of a home visit for patient #5 on 5/9/2022 at 2:35 PM, the patient's agency folder was reviewed. Review of the folder evidenced a page titled, "Emergency Preparedness Plan", which was observed to be blank.	E0017		
E0030	Names and Contact Information CFR(s): 484.102(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1),	E0030		

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E0030	Continued from page 9 §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff.	E0030		

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E0030	Continued from page 10 (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E0030		

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E0030	Continued from page 11 (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to develop and maintain an emergency preparedness communication plan which included names and contact information for staff and patients' physicians. The findings include: Review of an agency policy on 5/17/2022, titled "Emergency Management Plan" revised December 2019, stated, "… The organization will maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and is reviewed and updated annually. The plan includes the following: Names and contact information for the following: Staff … Patients' physician …." During an interview on 5/9/2022, at 10:09 AM, when queried what the agency considered to be its communication plan, the administrator provided an untitled, undated document which the administrator identified as the call tree. Review of the untitled, undated agency document identified by the administrator as the call tree, failed to evidence the contact information for registered nurse (RN) T, RN U, and RN V. This document failed to evidence contact information for patients' physicians. During an interview on 5/9/2022, at 10:09 AM, the administrator indicated RN T and RN V were hired 5/2/2022 and RN U was hired in April 2022.	E0030		
E0031	Emergency Officials Contact Information	E0031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCENTCARE HOME HEALTH OF INDIAN	11037 BROADWAY, SUITE C , CROWN POINT, Indiana, 46307

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E0031	Continued from page 12 CFR(s): 484.102(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.	E0031		

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E0031	Continued from page 13 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to develop and maintain an emergency preparedness communication plan which included contact information for State and regional emergency preparedness staff and other sources of assistance. The findings include: Review of an agency policy on 5/17/2022, titled "Emergency Management Plan" revised December 2019, stated, "… The organization will maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and is reviewed and updated annually. The plan includes the following: … Contact information for the following: Federal, state, tribal, regional and/or local emergency preparedness staff …." Review on 5/9/2022, of an agency document titled "Emergency Preparedness Packet" failed to evidence the contact information for the state and regional emergency preparedness staff. Review of an undated agency document titled "Emergency Preparedness" failed to evidence the contact information for the state and regional emergency preparedness staff. During an interview on 5/9/2022, at 10:09 AM, the administrator indicated he did not see contact information for the state and regional emergency preparedness staff.	E0031		
E0032	Primary/Alternate Means for Communication CFR(s): 484.102(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following:	E0032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

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E0032	Continued from page 14 (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to develop and maintain an emergency preparedness communication plan which included an alternate means for communicating with agency staff and Federal, State, tribal, regional, and local emergency management agencies. The findings include: Review of an agency policy on 5/17/2022, titled "Emergency Management Plan" revised December 2019, stated, "… The organization will maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and is reviewed and updated annually. The plan includes the following: … Primary and alternate means for communicating with the staff, federal, State, tribal, regional and local emergency management agencies …." Review on 5/9/2022, of an undated agency document titled "Emergency Preparedness Packet" indicated the agency was to ensure alternate contact method was available with a review date of 10/8/2020. Review failed to evidence an alternate means of communicating with staff and emergency preparedness officials. During an interview on 5/9/2022, at 10:09 AM, when queried what was the agency's alternate means of communicating with agency staff and emergency preparedness officials, the administrator stated, "Other than phone? I'd say email but we'd need to get those."	E0032		
E0033	Methods for Sharing Information CFR(s): 484.102(c)(4)-(5) §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6),	E0033		

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E0033	Continued from page 15 §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to develop and maintain an emergency preparedness communication plan which included a method for sharing information and medical documentation for patients under the agency's	E0033		

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E0033	Continued from page 16 care, as necessary, with other health providers to maintain the continuity of care and a means for providing information about the general condition and location of patients under the agency's care as permitted. The findings include: Review of an agency policy on 5/17/2022, titled "Emergency Management Plan" revised December 2019, stated, "… The organization will maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and is reviewed and updated annually. The plan includes the following: … A means for providing information about the general condition and location of patients under the organization's care as permitted…." Review on 5/9/2022, of an undated agency document titled "Emergency Preparedness Packet" and an undated agency document titled "Emergency Preparedness" failed to evidence a method for sharing information and medical documentation for patients under the agency's care with other health care providers to maintain continuity of care. During an interview on 5/9/2022, at 10:09 AM, the administrator indicated he did not see anything regarding the sharing of patient information with other health care providers as needed.	E0033		
E0039	EP Testing Requirements CFR(s): 484.102(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not	E0039		

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E0039	Continued from page 17 accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale	E0039		

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E0039	Continued from page 18 community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using	E0039		

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E0039	Continued from page 19 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

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E0039	Continued from page 20 [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the	E0039		

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E0039	Continued from page 21 emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0039	Continued from page 22 (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional	E0039		

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ACCENTCARE HOME HEALTH OF INDIAN	11037 BROADWAY, SUITE C , CROWN POINT, Indiana, 46307

(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
E0039	Continued from page 23 exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:	E0039		

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E0039	Continued from page 24 (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to participate in a full-scale community-based or facility-based exercise every 2 years to test the emergency plan. The findings include: Review of an agency policy on 5/17/2022, titled "Emergency Management Plan" revised December 2019, stated, "… The agency participates in a full-scale exercise that is community-based or individual, facility-based if a community based exercise is not accessible…." Review of the agency's emergency preparedness binder on 5/9/2022, failed to evidence a full-scale community-based or facility-based exercise in the last 2 years. During an interview on 5/9/2022, at 10:09 AM, the administrator indicated the agency has conducted tornado and fire drills but had not conducted a full-scale community-based or facility-based exercise.	E0039		
G0000	INITIAL COMMENTS This visit was a for a fully extended Federal and State Home Health Agency (HHA) Recertification/Re-Licensure Survey completed by the Indiana Department of Health (IDOH). Survey Dates: May 4, 5, 6, 9, 10, 11, 12, 13, 16, 17 (2022). Facility Number: IN008882 Provider Number: 157436 Current Census: 176 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. During this Federal Recertification Survey, AccentCare Home Health was found to be out of compliance with Conditions of Participation: 42 CFR §484.60 Condition of participation: Care planning, coordination of services, and quality of care, 42 CFR §484.65	G0000		

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G0000	Continued from page 25 Condition of participation: Quality assessment and performance improvement (QAPI), 42 CFR §484.75 Condition of participation: Skilled professional services, 42 CFR §484.105 Condition of participation: Organization and administration of services, and 42 CFR §484.102 Condition of participation: Emergency preparedness. Based on the Condition-level deficiencies during the May 17, 2022 survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on May 9, 2022. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning May 17, 2022, and continuing through May 16, 2022. Quality Review Completed 06/06/2022	G0000		
G0412	Written notice of patient's rights CFR(s): 484.50(a)(1)(i) (i) Written notice of the patient's rights and responsibilities under this rule, and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to provide written notice of patient's rights and responsibilities which were understandable to patients with limited English proficiency in 1 of 5 discharge records reviewed (#15). The findings include: Record review evidenced an agency policy revised December 2019, titled "Informed Consent/Refusal of Services" which stated, "… Upon admission and throughout the course of care/service, the patient and family/caregiver will be: … Given information in an understandable language, to make informed decisions regarding the care/service being provided …." Record review evidenced an admission packet obtained 05/04/2022, which contained a document titled "Home Health Care Patient/Client Bill of	G0412		

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G0412	Continued from page 26 Rights" which stated, "... Patients have the right to be informed of the right to access auxiliary aids and language services and how to access these services ...." Clinical record review for patient #15 was completed on 05/13/2022. Clinical record review evidenced a referral/history and physical dated 02/25/2022 which stated, "… Utilized telephone interpreter for Spanish translation …." Clinical record review evidenced a coordination note dated 03/08/2022, which stated, "… Daughter available to translate aware of services to begin and agrees …." Clinical record review evidenced a signed consent dated 03/08/2022, which stated, "… My copies of the following are in the AccentCare welcome/admission booklet proved to me: … Patient Rights and Responsibilities …." Record review failed to evidence patient had been provided or informed of right to receive rights and responsibilities in primary language of Spanish. During an interview on 05/11/2022 at 2:54 PM, clinical manager B indicated patient #15 should have received their rights and responsibilities as well as consents in Spanish. Clinical manager B indicated she did not know if this patient received their rights and responsibilities in Spanish.	G0412		
G0478	Investigate complaints made by patient CFR(s): 484.50(e)(1)(i) (i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics: This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure complaints made by the patient were investigated in 5 of 6 clinical records reviewed with a patient complaint. (#3, 8, 10, 11, 16) The findings include: 1. Review of an agency policy on 5/17/2022, titled "Complaint/Grievance Process" revised December 2019, stated, "… The supervisor will investigate the grievance within five (5) days after receipt of such grievance … The Executive Director/Administrator or designee will then investigate the grievance and contact the patient or his/her representative regarding the grievance in an attempt to resolve the differences. …	G0478		

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G0478	Continued from page 27 Complaints and any action taken will be documented on a complaint form…." 2. Clinical record review of an agency document on 5/4/2022, titled "Complaint Report" dated 2/9/2022, evidenced patient #8, start of care 11/2/2021, indicated the patient was upset that the nurse had no knowledge of an increase to the wound vac (a medical device that applies low suction to a wound to aid in healing) pressure. Review indicated the patient was upset the nurse could not provide wound vac therapy because there was a lack of supplies. Review failed to evidence an investigation of the patient's complaint. 3. Clinical record review of an agency document on 5/4/2022, titled "Complaint Report" dated 4/27/2022, evidenced patient #10, start of care 4/25/2022, was upset with the agency and was considering leaving the agency. Review indicated the patient was upset the therapist was reluctant to wrap her legs during wound care and talked to the patient in an angry tone. Review indicated the patient had a complaint the therapist caused her pain during wound treatment and the therapist ignored her complaint when she told the therapist of the pain. Review failed to evidence the complaint was investigated. Review of an agency document on 5/3/2022, titled "Complaint Report" dated 5/3/2022, evidenced the patient had a complaint the nurse was overstepping by wanting to call the physician and adding a social worker. Review indicated the physical therapist was "too rough" while providing wound care. Review failed to evidence the complaint was investigated to include speaking with the nurse and physical therapist. 4. Clinical record review of an agency document on 5/4/2022, titled "Complaint Report" dated 5/4/2022, evidenced the caregiver for patient #11, start of care 4/29/2022, had a complaint about the timeliness of and the way in which the clinician who completed the physical assessment was talking to the patient. The document failed to indicate the complaint was investigated to include speaking with the patient and clinician who completed the assessment. Review of an agency document titled "Visit Note Report", dated 4/29/2022, and identified to be the initial comprehensive assessment, indicated the patient was alert and oriented to person, place, and time. 5. Clinical record review of an agency document on 5/4/2022, titled "Complaint Report" dated 1/11/2022, evidenced patient #16, start of care 12/22/2021, complained about being exposed to COVID-19 by agency's staff and requested to be discharged from the agency. Review failed to evidence an investigation of the complaint. 6.	G0478		

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G0478	Continued from page 28 During an interview on 5/4/2022, at 12:50 PM, the clinical manager indicated she understood now why details are needed on the complaint report. 7. During an interview on 5/4/2022, at 12:50 PM, the administrator stated, “There is nothing there for investigation follow-up.”8. Clinical record review on 5/10/2022, for patient #3, start of care 10/30/2021, certification period 4/28/2022 to 5/26/2022, primary diagnosis of Type 2 Diabetes Mellitus (a medical condition in which your body does not use insulin properly, resulting in unusual blood sugar levels) with foot ulcer (open sore), evidenced an agency document titled, “Visit Note Report”, dated 4/25/2022, signed by RN (registered nurse) C. This note had a subsection titled, “Narrative”, which stated, “ … CARE COORDINATION:ARRIVED TO ROOM. PATIENT STATES … HAD THINGS TAKEN FROM … ROOM. CNA PRESENT AND. [sic] NOTIFIED HR”. Review of the agency’s complaint log from 12/1/2021 to 5/4/2022 failed to evidence any complaints from patient #3. During an interview on 5/13/2022, at 11:56 AM, the clinical manager indicated all patient complaints should be reported to the clinical manager, investigated, resolved, and documented in the complaint log. When queried, the clinical manager indicated the process would not change if the patient lived in an assisted living facility. The clinical manager indicated the agency failed to investigate the patient’s complaint.	G0478		
G0484	Document complaint and resolution CFR(s): 484.50(e)(1)(ii) (ii) Document both the existence of the complaint and the resolution of the complaint; and This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to document the resolution of the complaint in 4 of 5 clinical records reviewed with patient complaints entered on the agency complaint log. (#3, 8, 10, 16) The findings include: 1. Review of an agency policy on 5/17/2022, titled “Complaint/Grievance Process” revised December 2019, stated, “… The supervisor will investigate the grievance within five (5) days after receipt of such grievance and will make every effort to resolve the grievance to the patient’s satisfaction. Verbal or written response with complaint resolution will be communicated to the	G0484		

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G0484	Continued from page 29 patient or family member and be documented in the complaint log within ten (10) days of receipt. … The Executive Director/Administrator or designee will then investigate the grievance and contact the patient or his/her representative regarding the grievance in an attempt to resolve the differences. … Complaints and any action taken will be documented on a complaint form….” 2. Clinical record review of an agency document on 5/4/2022, titled “Complaint Report” dated 2/9/2022, evidenced patient #8, start of care 11/2/2021, indicated the patient was upset that the nurse had no knowledge of an increase to the wound vac (a medical device that applies low suction to a wound to aid in healing) pressure. Review indicated the patient was upset the nurse could not provide wound vac therapy because there was a lack of supplies. Review failed to evidence a documented resolution with the patient. 3. Clinical record review of an agency document on 5/4/2022, titled “Complaint Report, dated 4/27/2022, evidenced patient #10, start of care 4/25/2022, was upset with the agency and was considering leaving the agency. Review indicated the patient was upset the therapist was reluctant to wrap her legs during wound care and talked to the patient in an angry tone. Review indicated the patient had a complaint the therapist caused her pain during wound treatment and the therapist ignored her complaint when she told the therapist of the pain. Review failed to evidence the resolution of the complaint was documented. 4. Clinical record review of an agency document on 5/4/2022, titled “Complaint Report” dated 1/11/2022, evidenced patient #16, start of care 12/22/2021, complained about being exposed to COVID-19 by agency’s staff and requested to be discharged from the agency. Review failed to evidence a documented resolution of the complaint was documented. 5. During an interview on 5/4/2022, at 12:50 PM, the clinical manager indicated she understood now why details are needed on the complaint report. 6. Clinical record review on 5/10/2022, for patient #3, start of care 10/30/2021, certification period 4/28/2022 to 5/26/2022, primary diagnosis of Type 2 Diabetes Mellitus (a medical condition in which your body does not use insulin properly, resulting in unusual blood sugar levels) with foot ulcer (open sore), evidenced an agency document titled, “Visit Note Report”, dated 4/25/2022, signed by RN (registered nurse) C. This note had a subsection titled, “Narrative”, which stated, “ … CARE COORDINATION:ARRIVED TO ROOM. PATIENT STATES … HAD	G0484		

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G0484	Continued from page 30 THINGS TAKEN FROM … ROOM. CNA PRESENT AND. [sic] NOTIFIED HR". Review of the agency's complaint log from 12/1/2021 to 5/4/2022 failed to evidence any complaints from patient #3. During an interview on 5/13/2022, at 11:56 AM, the clinical manager indicated all patient complaints should be reported to the clinical manager, investigated, resolved, and documented in the complaint log. When queried, the clinical manager indicated the process would not change if the patient lived in an assisted living facility. The clinical manager indicated the agency failed to resolve the patient's complaint.	G0484		
G0514	RN performs assessment CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the initial assessment was conducted within 48 hours of referral, within 48 hours of patient's return home, or on the physician ordered start of care date in 2 of 12 active clinical records reviewed (#2, 10). The findings include: 1. Review evidenced an agency policy revised December 2019, titled "Initial and Comprehensive Assessment" which stated, "… The initial assessment visit must be performed either within 48 hours of the referral, within 48 hours of the patient's return home, or on the start of care date ordered by the physician …." 2. Clinical record review for patient #2 was completed on 05/13/2022. Record review evidenced a referral order/history and physical, which indicated patient was discharged home from a hospital on 03/25/2022. Record review evidenced a start of care assessment was completed on 03/29/2022, 4 days after discharge home. During an interview on 05/10/2022 at 2:27 PM, when queried when patients	G0514		

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G0514	Continued from page 31 should be seen upon discharge, clinical manager B indicated within 24 – 48 hours. Clinical manager B did not know why this patient was seen 4 days after discharge. 3. Clinical record review on 5/11/2022, for patient #10, start of care 4/25/2022, evidenced an agency document titled “Client Coordination Note Report” dated 4/22/2022, which indicated the patient was accepted for service. Review evidenced an agency document titled “Visit Note Report” electronically signed by physical therapist (PT) G and dated 4/25/2022, was identified to be a PT admission comprehensive assessment. This document indicated the patient’s start of care was 4/25/2022. Review failed to evidence the initial assessment was within 48 hours of referral. During an interview on 5/12/2022, at 1:17 PM, the clinical manager indicated she was unsure how soon the initial assessment must be completed from the time of referral. The clinical manager indicated the start of care comprehensive assessment was the initial assessment. 17-14-1(a)(1)(A)	G0514		
G0528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment included a complete physical assessment in 5 of 12 active clinical records reviewed. (#5, 6, 10, 11, 14) The findings include: 1. Review of an agency policy on 5/17/2022, titled “Initial and Comprehensive Assessment” revised December 2019, stated, “… During the initial and comprehensive patient assessment, all baseline data to be used in measuring the patient’s progress to goals and other relevant information will be documented in the patient’s clinical record, including at least the following information … A physical assessment, including … height/weight … and other relevant data related to pertinent physical findings….” 2. Clinical record review on 5/10/2022, for patient #6, start of care 4/7/2022, evidenced an agency document titled	G0528		

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G0528	Continued from page 32 "Home Health Certification and Plan of Care" for certification period 4/7/2022 – 6/5/2022, which was signed by registered nurse (RN) N on 4/7/2022. This document indicated the skilled nurse was to perform wound care to gangrenous (death of tissue due to lack of blood flow or infection) wounds to the left great, 2nd, and 3rd toes. Review evidenced agency documents titled "Skilled Visit Note", which were signed by RN N and dated 4/7/2022, and identified to be an admission comprehensive assessment, and document dated 4/15/2022, and identified to be a resumption of care comprehensive assessment. These documents indicated the RN was unable to assess the measurements for the wounds to the left great and 2nd toes. Review failed to evidence an assessment of the left 3rd toe. During an observation at the patient's home on 5/11/2022, at 9:00 AM, the patient was observed to have a yellow, dry scabbed area on the top of the left 3rd toe. During an interview on 5/11/2022, at 3:56 PM, the clinical manager indicated all wounds should be assessed and indicated the comprehensive assessment did not include an assessment of the left 3rd toe. At 4:19 PM, the clinical manager indicated wounds should be measured at least once a week and especially at the comprehensive assessments since that is the baseline for the wounds. 3. Clinical record review on 5/11/2022, for patient #10, start of care 4/25/2022, evidenced an agency document titled "Visit Note Report" electronically signed by physical therapist (PT) G and dated 4/25/2022, which was identified to be a PT admission comprehensive assessment. This document indicated the patient had a wound to the right great toe, left buttock, right buttock, 2 wounds to the right leg, and 2 wounds to the left leg. Review failed to evidence the comprehensive assessment included the assessment of the patient's wounds. During an interview on 5/12/2022, at 12:23 PM, the clinical manager indicated the PT should assess any wounds at the start of care. 4. Clinical record review on 5/11/2022, for patient #11, start of care 4/29/2022, evidenced an agency document titled "Visit Note Report" dated 4/29/2022, and identified to be a RN admission	G0528		

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G0528	Continued from page 33 comprehensive assessment. This document indicated the height and weight was not assessed. Review indicated the patient's diagnoses included, but were not limited to, Stevens Johnson syndrome (a rare but serious condition that affects the skin and mucous membranes, which causes a painful rash that spreads and blisters). This document indicated the patient had a rash and blisters and failed to evidence the location of the rash and blisters and the assessment of the rash and blisters. During an interview on 5/13/2022, at 9:41 AM, the clinical manager indicated the height and weight should be assessed. At 10:05 AM, the clinical manger indicated the comprehensive assessment should include the location and description of the rash and blisters. 5. Clinical record review on 5/12/2022, for patient #14, start of care 5/4/2022, review evidenced an agency document titled "Visit Note Report" dated 5/4/2022, and identified to be a RN admission comprehensive assessment. This document indicated the patient received 1 liter of normal saline for hydration via IV (intravenous, a medical technique of delivering medication, hydration, and nutrition directly into the vein) as needed via the central line (a plastic tube inserted into a vein and up to the heart to deliver medication, hydration, and nutrition). This document indicated "none" for the patient's medical equipment and failed to evidence the central line supplies. This document failed to include the flow rate of the 1 liter of normal saline to be provided via IV. Review failed to evidence the RN assessed the patient's height and weight. During an interview on 5/13/2022, at 10:43 AM, the clinical manager indicated the assessment did not include the delivery rate of the IV fluids and whether the fluids were provided via IV pump or gravity. The clinical manager indicated the assessment should include all of the supplies needed for the patient to include the central line supplies. During an interview on 5/13/2022, at 1:20 PM, RN K indicated the patient received the IV fluids via pump and did not know the flow rate but thought it ran for 10 hours. 6. Clinical record review on 5/11/2022, for	G0528		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

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ACCENTCARE HOME HEALTH OF INDIAN	**11037 BROADWAY, SUITE C , CROWN POINT, Indiana, 46307**

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G0528	Continued from page 34 patient #5, start of care 1/11/2022, certification period 3/12/2022 to 5/10/2022, primary diagnosis of Type 2 Diabetes Mellitus (a medical condition in which your body does not use insulin properly, resulting in unusual blood sugar levels) with Hyperglycemia (high blood sugar), evidenced an agency document titled, “HOME HEALTH CERTIFICATION AND PLAN OF CARE”, signed by the physician on 3/17/2022. The plan of care stated, “ … COMPREHENSIVE RECERTIFICATION OASIS COMPLETED … PATIENT IS AT LOW RISK FOR HOSPITALIZATION OR EMERGENCY DEPARTMENT USE….” Clinical record review evidenced a group of agency documents titled, “Coordination Notes Report”. An entry dated 3/18/2022, signed by OT (occupational therapist) I stated, “ … PATIENT WAS REFERRED … AFTER RECENT HOSPITALIZATION FOR SYNCOPAL EPISODE [passing out] AND PNEUMONIA. PATIENT ALSO HAS PMHX [past medical history] OF CKD [chronic kidney disease] … RECEIVES DAILYSIS [sic] FOR ON M [Monday], W [Wednesday] AND FRIDAY. 02 [oxygen] USE IDDM [insulin dependent diabetes mellitus], CHF [congestive heart failure] AND HTN [hypertension]….” During an interview on 5/13/2022, at 12:02 PM, the clinical manager indicated the risk assessment on the plan of care was based on the clinician’s comprehensive assessment at the beginning of the certification period. When queried, the clinical manager indicated a patient who was on dialysis, insulin-dependent diabetic, oxygen dependent, had CHF and hypertension, and was recently hospitalized for pneumonia and syncopal episode, should be considered a high risk for hospitalization or emergency department use. 17-14-1(a)(1)(A) 17-14-1(a)(1)(B)	G0528		
G0536	A review of all current medications CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the	G0536		

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G0536	Continued from page 35 comprehensive assessment included a review of all patients medications, and failed to ensure the medication review identified potential adverse effects and drug reactions, including significant drug interactions and duplicative drug therapy in 8 of 17 clinical records reviewed (#3, 4, 6, 7, 9, 11, 14, 16). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled “Medication Profile” which stated, “… A drug regimen review will be performed at the time of admission, when updates to the comprehensive assessments are performed … The review will identify drug/food interactions, potential adverse effects and drug reactions, ineffective drug therapy, duplicative drug therapy, and noncompliance with drug therapy … Any conclusions and findings of patient medication use or monitoring should be communicated to the pharmacist when appropriate, and other clinicians ….” 2. Clinical record review for patient #4 was completed on 05/13/2022. Record review evidenced a start of care assessment dated 04/06/2022, which stated, “… Drug Regimen review: Did a complete drug regimen review identify potential clinically significant medication issues: … No issues found during review ….” Review of a web-based source on 05/15/2022, https://www.drugs.com/interactions-check.php, evidenced the following interactions between medications on patient #4’s home health medication list: 2 major drug-drug interactions between escitalopram (antidepressant) and duloxetine (antidepressant), and hydroxychloroquine (medication for arthritis) and escitalopram, and 14 moderate drug-drug interactions between, levothyroxine (for low thyroid levels) and ferrous sulfate (iron), hydroxychloroquine and duloxetine, clonidine (for high blood pressure) and duloxetine, omeprazole (to lower stomach acid) and escitalopram, glipizide (to lower blood sugar) and escitalopram, omeprazole and ferrous sulfate, clonidine and glipizide, pravastatin (to lower cholesterol) and hydroxychloroquine, glipizide and hydroxychloroquine, prednisone (steroid) and amlodipine (to lower blood pressure), glipizide and prednisone, clonidine and prednisone, levothyroxine and omeprazole, and glipizide and levothyroxine. This source also evidenced duplicative drug therapy between duloxetine and escitalopram, both antidepressants. On 05/11/2022 at 11:36 AM, a request was made by surveyor to clinical manager B for additional documentation of drug regimen review addressing the interactions	G0536		

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G0536	Continued from page 36 and duplicative drug therapy. No further information was provided to surveyors at time of exit. 3. Clinical record review was completed on 05/13/2022 for patient #9. Record review evidenced a comprehensive assessment completed on 04/08/2022, which stated, "… Did a complete drug regimen review identify potential clinically significant medication issues? … No issues found during review …." Review on 05/13/2022 of the following web-based source, https://www.drugs.com/interactions-check.php, evidenced the following drug interactions between medications on patient's home health medication list: 1 major drug interaction between hydroxychloroquine (medication for rheumatoid arthritis) and tramadol (pain medication) and 8 moderate drug-drug interactions between levothyroxine (thyroid medication) and calcium carbonate, calcium carbonate and hydroxychloroquine, levothyroxine and multivitamin, levothyroxine and ferrous sulfate (iron), calcium carbonate and ferrous sulfate, oxymetazoline (for stuffy nose) and midodrine (to increase blood pressure), levothyroxine and pantoprazole (for stomach acid), and ferrous sulfate and pantoprazole. During an interview on 05/11/2022 at 10:40 AM, clinical manager B stated, when queried how clinicians complete a drug regimen review, "… they compare discharge medication list to what's in the home, most interactions pop up when they put in the medication list … the doctor is contacted via phone or fax if interactions are found …." Surveyor requested documentation of physician notification or acknowledgement of drug interactions on 05/11/2022 at 10:46 AM. No documentation of drug regimen review or acknowledgment of interactions was provided by exit. 4. Clinical record review for patient #16 was completed on 05/13/2022. Record review evidenced a start of care assessment completed on 12/22/2021, which stated, "… Did a complete drug regimen review identify potential clinically significant medication issues? … No issues found during review …." Review on 05/15/2022 of the following web-based source, https://www.drugs.com/interactions-check.php, evidenced the following drug interactions between medication on patient's home health medication list: 1 major drug interaction between amiodarone (antiarrhythmic for irregular heartbeat) and furosemide (water pill), and 19 moderate interactions between levothyroxine (for low thyroid level) and ferrous sulfate (iron),	G0536		

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G0536	Continued from page 37 duloxetine (antidepressant) and apixaban (blood thinner), spironolactone (water pill) and apixaban, amiodarone and apixaban, gabapentin (for nerve pain) and duloxetine, spironolactone and duloxetine, metoprolol (for blood pressure and heart rate) and duloxetine, furosemide and duloxetine, amiodarone and duloxetine, amiodarone and atorvastatin (for cholesterol), magnesium oxide and ferrous sulfate, spironolactone and metformin (to lower blood sugar), levothyroxine and metformin, furosemide and metformin, levothyroxine and magnesium oxide, metoprolol and spironolactone, amiodarone and levothyroxine, furosemide and metoprolol, and amiodarone and metoprolol. During an interview on 05/16/2022 at 10:05 AM, clinical manager B indicated that the physician should be notified if drug interactions are noted on the start of care assessment and she did not know why the medication review stated no issues found. 5. Clinical record review on 5/11/2022, for patient #6, start of care 4/7/2022, evidenced an agency document titled “Client Medication – Drug Interaction Report” dated 5/11/2022. This document indicated there was a severe medication interaction between Clopidogrel (a medication used to prevent blood clots and strokes by thinning the blood) and Eliquis (a medication used to prevent blood clots and strokes by thinning the blood). This document indicated the patient was at a greater risk for potential bleeding. Review of an agency document titled “Client Medication Report”, electronically signed by registered nurse (RN) N and dated 4/7/2022, indicated Clopidogrel was effective 4/5/2022 and Eliquis was effective 3/24/2022. Review evidenced an agency document titled “Visit Note Report” electronically signed by RN N, dated 4/7/2022, and identified as the start of care comprehensive assessment. Review indicated there were no issues found during the medication review. Review failed to evidence the RN reviewed the medications for potential drug interactions. During an interview on 5/11/2022, at 4:35 PM, the clinical manager indicated the RN should see a pop-up in the electronic medical record when entering the medications into the medication list if there are any interactions. 6. Clinical record review on 5/9/2022, for patient #7, start of care 12/23/2021, evidenced an untitled document from the office of the nurse practitioner responsible for the plan of care with a home visit date of 4/4/2022. This document indicated the patient’s medications included, but were not limited to, Humalog (a type of insulin for the treatment of	G0536		

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G0536	Continued from page 38 high blood sugar), Lantus (a type of insulin), Omega 3 (fish oil, a dietary supplement), ferrous sulfate (an iron supplement), Ondansetron (a medication used to treat nausea and vomiting), and polyethylene glycol (a medication used to treat constipation). During an observation of care at the patient's home on 5/6/2022, at 11:47 AM, the patient's caregiver provided the patient's current medications for review. Humalog, Lantus, fish oil, ferrous sulfate, Ondansetron, and polyethylene glycol were observed in the patient's medications. Review of an agency document titled "Client Medication List", dated 4/19/2022, failed to evidence Humalog, Lantus, fish oil, ferrous sulfate, ondansetron, and polyethylene glycol. Review failed to evidence all the patient's current medications were reviewed to identify potential adverse effects and drug reactions. Review evidenced Aspirin (a medication used to treat pain and fever) 325 milligrams by mouth daily was listed twice. Review failed to evidence the medications were reviewed to identify duplication of drug therapy. During an interview on 5/10/2022, at 12:17 PM, the clinical manager indicated all medications used by the patient should be reviewed and any differences should be reconciled and clarified with the physician. The clinical manager indicated aspirin should not have been listed twice and the duplication should have been caught during the medication review. During an interview on 5/11/2022, at 2:25 PM, the clinical manager indicated the agency needed to educate the nurses to review and reconcile all the medications being taken by the patient as part of the medication reconciliation at every visit. 7. Clinical record review on 5/13/2022, for patient #11, start of care 4/29/2022, evidenced an agency document titled "Client Medication – Drug Interaction Report" which indicated a severe drug interaction between tramadol (a pain relief medication) and cyclobenzaprine (a muscle relaxant medication). This document indicated the drugs may increase the risk of seizures. Review of an agency document titled "Client Medication Report" electronically signed by RN D and dated 4/29/2022, indicated tramadol and cyclobenzaprine were included in the patient's medications. Review evidenced an agency document titled "Visit Note Report" electronically signed by RN D, dated 4/29/2022, and identified to be a RN admission comprehensive assessment. This document indicated the RN identified no issues during the medication review and failed to evidence the medications were reviewed to identify potential drug interactions.	G0536		

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G0536	Continued from page 39 During an interview on 5/13/2022, at 9:44 AM, the clinical manager indicated the RN should have reviewed the medications for potential interactions. 8. Clinical record review on 5/12/2022, for patient #14, start of care 5/4/2022, evidenced an agency document titled “Client Medication Report” electronically signed by RN K on 5/6/2022. This document evidenced the patient’s medications included, but were not limited to, lorazepam (a medication used to treat anxiety), hydromorphone (a medication used to treat severe pain), and desvenlafaxine (a medication used to treat depression). Review on 5/12/2022, of a web-based reference at https://www.webmd.com/interaction-checker/default.htm titled "Drug Interaction Report” indicated 1 serious drug interaction between lorazepam and hydromorphone. This document indicated the two medications used together could cause central nervous system depression to include respiratory distress and even death. Review indicated a moderate drug interaction between lorazepam and desvenlafaxine and indicated a possibility of increased side effects to include dizziness, drowsiness, and confusion. Review indicated a moderate drug interaction between desvenlafaxine and hydromorphone and indicated an increased risk of serotonin syndrome (a brain chemical that when increased may cause symptoms such as confusion, hallucinations, seizures, changes in blood pressure, increased heart rate, fever, excessive sweating, nausea, vomiting, and diarrhea). Review evidenced an agency document titled “Visit Note Report” electronically signed by RN K, dated 5/4/2022, and identified to be a RN admission comprehensive assessment. This document indicated the RN identified no issues during the medication review and failed to evidence the medications were reviewed to identify potential drug interactions. During an interview on 5/13/2022, at 12:47 PM, person X, corporate employee, indicated all medication interactions should populate in the electronic medical record system, even a minor interaction. Person X indicated the patient’s medications were not showing any drug interactions and stated, “That’s concerning that medication interactions aren’t alerting.” Person X indicated she would check into the issue. 9. Clinical record review on 5/10/2022, for patient #3, start of care 10/30/2021, certification period 4/28/2022 to 5/26/2022, primary diagnosis of Type 2 Diabetes Mellitus (a medical condition in which your body does not use insulin properly, resulting in unusual blood sugar	G0536		

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G0536	Continued from page 40 levels) with foot ulcer (open sore), evidenced a medication list received from assisted living facility T on 5/6/2022. The medication list stated, " … ACETAMINOPHEN [a pain medication and fever reducer] 325 MG [milligram] TABLET …TAKE 2 TABLETS (650 MG TOTAL) BY MOUTH EVERY 4 HOURS AS NEEDED FOR PAIN … Start Date: 10/26/2021 … AMMONIUM LACTATE 12% [a medication to treat dry, scaly skin] APPLY TO BLE [bilateral lower extremities][both legs] SKIN DAILY… Start Date: 10/26/2021 … VENELEX OINTMENT … APPLY TOPICALLY TO BILATERAL [left and right] LOWER LEGS AND RIGHT HEAL (sic) AND TOES EVERY 12 HOURS … start date 10/26/2021 … RETACRIT [a medication that helps the body produce more red blood cells] 10,000 UNIT / ML [units per milliliter] VIA INJECT 1.5ML SUBCUTANEOUSLY [injected under the skin] ON MONDAY, WEDNESDAY, AND FRIDAY … Start Date: 10/26/2021 … FERROUS SULFATE 325 MG TABL [tablet] … TAKE ONE TABLET BY MOUTH TWICE DAILY … Start Date: 10/26/2021 … MICRO-GUARD 2% POWDER [a powder that fights fungal infections] … APPLY TOPICALLY TO SKIN OF BILATERAL BREAST FOLDS AND ABDOMINAL FOLDS TWICE DAILY…." Clinical record review evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 5/2/2022. The plan of care had a subsection titled, "Medications:". Review of the medication list failed to evidence acetaminophen, ammonium lactate, Venelex ointment, Retacrit, ferrous sulfate, and Micro-guard powder. During an interview on 5/13/2022, at 11:24 AM, the clinical manager indicated the nurse should review the patient's medications at each visit, reconcile the medication list with what is in the patient's home, and review the list for potential interactions and side effects. When informed of the findings, the clinical manager indicated the nurse failed to perform a complete review of the patient's medications. 17-14-1(a)(1)(B)	G0536		
G0546	Last 5 days of every 60 days unless: CFR(s): 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.	G0546		

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G0546	Continued from page 41 This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to complete an updated comprehensive assessment in 1 of 1 clinical records reviewed in which there was a significant change in condition (#4). The findings include: Record review evidenced an agency policy revised December 2019, titled "Initial and Comprehensive Assessment" which stated, "… This assessment will measure patient outcomes from data collected at the start of care and at the following defined intervals thereafter: … Significant change in condition resulting in a new case mix …." Record review evidenced an agency policy revised December 2019, titled "Reassessments/Recertification" which stated, "… Each patient will be reassessed using a comprehensive OASIS [outcome and assessment information set] assessment tool for the review and revision of the plan of care when: … There is a significant change in the patient's condition, care environment and/or support system …." Clinical record review for patient #4 was completed on 05/13/2022 for start of care 04/06/2022 and certification period 04/06/2022 – 06/04/2022. Record review evidenced a start of care comprehensive assessment dated 04/06/2022 which indicated the patient weighed 128 pounds. Clinical record review evidenced a skilled nurse visit note dated 04/18/2022 which indicated patient weighed 100 pounds. Record review failed to evidence the physician was notified of patient #4's 28 pound weight loss in 12 days and failed to evidence a comprehensive re-assessment due to a significant change in patient's condition. During an interview on 05/11/2022 at 10:54 AM, when queried what action was taken when the patient had a 28 pound weight loss, or if this was accurate, clinical manager B stated, "… we do give clinicians a scale … she might have lost that much weight, and the next step would have been to notify the physician … it was one of the reasons she was in the hospital to begin with …." When queried if a comprehensive reassessment should be completed for this patient, clinical manager B indicated yes, after speaking with the physician.	G0546		
G0564	Discharge or Transfer Summary Content CFR(s): 484.58(b)(1) Standard: Discharge or transfer summary content.	G0564		

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G0564	Continued from page 42 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the discharge summary included post-discharge goals of care and treatment preferences in * of 5 discharge records reviewed (#15, 16). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled “Discharge Summary” which stated, “… Each clinician who provides care will complete a discharge summary at the time his/her discipline is discharged, which may include as appropriate: … The progress towards goals/desired outcomes … Medical status at discharge including continuing symptom management needs … The overall status of the patient … A summary of the care or services provided ….” 2. Clinical record review for patient #15 was completed on 05/13/2022. Record review indicated patient discharged on 04/06/2022 from the home health agency to attend outpatient therapy services and pulmonary rehabilitation. Review evidenced a discharge summary, dated 04/08/2022, which failed to include post-discharge goals of care and patient treatment preferences. During an interview on 05/11/2022 at 3:00 PM, when queried what information a discharge summary should include, clinical manager B and administrator A did not know. 3. Clinical record review for patient #16 was completed on 05/15/2022. Record review evidenced patient discharged on 02/01/2022 from the agency per patient request. Record review evidenced a discharge summary dated 02/09/2022, which failed to include post-discharge goals of care and patient treatment preferences. During an interview on 05/16/2022 at 10:30 AM, clinical manager B indicated they did not know what information should be included in a discharge summary.	G0564		
G0570	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning,	G0570		

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G0570	Continued from page 43 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. This CONDITION is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure: the plan of care was reviewed by the physician, individualized and followed by all agency staff (See tag G0572); the plan of care included all required information / elements for the treatment of the patient (See tag G0574); services and treatment were provided as ordered by a physician (See tag G0578); all treatments provided by agency staff were ordered by a physician (See tag G0580); the plan of care was reviewed by the patients primary care physician at least every 60 days (See tag G0588); physicians were promptly notified of a change in the patient's condition (See tag G0590); the plan of care was revised to reflect current health status and nursing needs (See tag G0592); the integration of orders from all physicians involved in the patient's care into the plan of care (See tag G0604); coordination of care for all services provided to the patient (See tag G0606); the patient received appropriate discharge teaching (See tag G0610); the written visit schedule was provided to patients (See tag G0614); written instructions were provided to the patient for the patient's medication schedule and instructions (See tag G0616); the treatments to be administered by agency personnel were provided to the patient and caregiver in writing (See tag G0618); and the name and contact information of the clinical manager were provided in writing to the patient and caregiver (See tag G0622). The cumulative effect of these systemic problems has	G0570		

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G0570	Continued from page 44 resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination of Care and Quality of Care. A deficient practice citation was also evidenced at this standard as follows: Based on record review and interview, the home health agency failed to ensure patients were only accepted for treatment on the basis the agency could meet the patient's medical, nursing, and rehabilitative needs in 3 of 8 active clinical records reviewed with wounds (#7, 9, 10) and 2 of 5 closed clinical records reviewed. (#14, 16). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled “Intake Process” which stated, “… The organization accepts only those patients whose needs can be met by the services it provides ….” 2. Clinical record review for patient #9 was completed on 05/13/2022, for start of care 04/08/2022, certification period 04/08/2022 – 06/06/2022. Record review evidenced an unsigned referral order from entity B (skilled nursing facility) received on 04/06/2022 for home health care services which stated, “… Patient may discharge home with HH [home health]: PT [physical therapy], OT [occupation therapy], CNA [certified nurse assistant/home health aide], and nursing for skilled services ….” Clinical record review evidenced a plan of care dated 04/08/2022, which stated, “… Frequency/Duration of Visits: … SN [skilled nursing] 1W1 [1 time a week for 1 week] … PT Effective 04/10/2022 1W1 ….” Record review failed to evidence patient received HHA or OT therapy services during certification period 04/08/2022 – 06/06/2022. Record review failed to evidence orders for OT or HHA services as ordered on referral. During an interview on 05/04/2022 at 2:59 PM, administrator A indicated the agency did not have a home health aide on staff from October 2021 until April 18, 2022. Administrator A indicated the only home health aide on staff is currently in orientation in Illinois and does not see patients independently. During an interview on 05/13/2022 at 10:05 AM, clinical manager B indicated the transitional care coordinator is supposed to let patients know before the start of care assessment that the agency does not currently offer aide services. Clinical manager B indicated she did not know if patient #9 was informed prior to start of care that there were no home health aide services available. Clinical manager B	G0570		

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G0570	Continued from page 45 indicated she did not know why OT was not ordered for patient #9. 3. Clinical record review for patient #16 was completed on 05/16/2022. Record review evidenced a referral order dated and electronically signed on 12/20/2021 by physician G. This document stated, "… Therapy/Assistance in Home: … PT [physical therapy] – eval and treat … OT [occupational therapy] eval and treat … Home Health Aide … Skilled Nursing …." Clinical record review evidenced a plan of care for start of care 12/22/2021 and certification period 12/22/2021 – 02/19/2022. This document indicated the following therapies were ordered: skilled nurse, physical therapy, and occupational therapy. Record review failed to evidence home health aide services were ordered or provided to patient during certification period of 12/22/2021 – 02/19/2022. During an interview on 05/16/2022 at 10:10 AM, when queried how patient was accepted by the home health agency for aide services when the agency had no home health aides on staff, clinical manager B stated, "… the doctor or case manager had to tell her we did not have any at that time … but it's not documented …." 4. Clinical record review on 5/9/2022, for patient #7, start of care 12/23/2021, evidenced an untitled document from skilled nursing facility N, dated 12/13/2021, which indicated the physician ordered the patient was to receive home health aide services. Review of an agency document titled "Visit Note Report", with a visit date of 4/19/2022 and identified to be a registered nurse (RN) recertification comprehensive assessment, indicated the patient was dependent for grooming, dressing, bathing, toileting, bed positioning, and was bedbound. This document indicated the patient should be considered for a home health aide referral. Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/22/2022 – 6/20/2022. This document stated, "… Home health aide service for assistance with personal care and ADL's [activities of daily living] …." Review failed to evidence home health aide visits were provided. This document indicated social work services were ordered 1 time a week for 1 week. Review failed to evidence social work services were provided. During an interview on 5/6/2022, at 12:25 PM, the patient's caregiver indicated she could use some help at the home due to her own physical and medical issues and was not able to get the patient out of bed on her own. During an interview on 5/10/2022, at 12:14 PM, the clinical manager indicated the agency did not have a home health aide at the time of patient's	G0570		

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G0570	Continued from page 46 admission. At 12:24 PM, the clinical manager indicated the agency had not yet provided the patient home health aide services and indicated the patient probably needed custodial care to help offload some of the care from the caregiver. At 1:32 PM, the clinical manager indicated the agency just hired a social worker and the visits were not showing in the social worker's calendar. During an interview on 5/11/2022, at 2:32 PM, the clinical manager indicated the social worker was needed to assist the wife find some custodial care to help her with household tasks. Review of an untitled agency document indicated the hire date for social worker O was 2/7/2022. 5. Clinical record review on 5/11/2022, for patient #10, start of care 4/25/2022, evidenced an agency document titled "Visit Note Report" electronically signed by PT G and dated 4/25/2022, which was identified to be a PT admission comprehensive assessment. This document indicated the patient's diagnoses included, but were not limited to, anxiety disorder. This document indicated the patient required assistance for dressing, grooming, bathing, toileting, and ambulation and indicated the patient lived alone. This document indicated the social worker evaluation was requested to assist the patient with personal assistive services. Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/25/2022 – 6/23/2022. This document indicated the patient was to receive social work services 1 time a week for 1 week effective 5/1/2022 and home health aide services 2 times a week for 1 week effective 5/1/2022. Review failed to evidence a social worker and home health aide were provided. During an interview on 5/12/2022, at 1:01 PM, the clinical manager indicated the agency should have provided the social worker and home health aide and indicated the agency just hired a home health aide. 6. Clinical record review on 5/12/2022, for patient #14, start of care 5/4/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/4/2022 – 7/2/2022. Review indicated the patient was 18 years old and the patient's diagnoses included, but were not limited to, anxiety disorder and cancer of the right ovary. The patient's medications included lorazepam (a medication used to treat anxiety) and desvenlafaxine (a medication used to treat depression). Review of a document from hospital Y dated 3/21/2022, indicated the patient had a history of anxiety with panic attacks and	G0570		

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G0570	Continued from page 47 depression. Review indicated the patient was receiving chemotherapy (a medication used to treat cancer). Review of an agency document titled "Client Coordination Note Report" dated 4/29/2022, indicated the patient had a history of anxiety and panic attacks and indicated social anxiety occurs when more than 2 people are in the room. Review indicated staff was to speak to the patient's parents outside of the patient's room when discussing patient concerns. Review failed to evidence a referral for social work services was made. During an interview on 5/13/2022, at 11:14 AM, the clinical manager indicated patient was critical and currently dying. The clinical manager indicated the patient's parents do not want the patient to know she is dying and do not allow agency staff to discuss clinical concerns with the patient. The clinical manager indicated there have been discussions about trying to get the parents to talk to a social worker but indicated there was nothing documented in the clinical record about the attempt to offer a social worker. When queried if the patient was offered a social worker, the clinical manager indicated no, just for the parents. 17-13-1(a)	G0570		
G0572	Plan of care CFR(s): 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the patient received all services as ordered on the plan of care, and/or had an individualized plan of care which included patient-specific, measurable goals and outcomes, and/or was reviewed and signed by a doctor for 11 of 17 clinical records reviewed (#2, 4, 6, 7, 9, 10, 11, 13, 14,	G0572		

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G0572	Continued from page 48 16, 17). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled “Care Planning Process” which stated, “… Individualized Plan of Care: … the patient-specific clinical plan of care includes: … Measurable outcomes and goals identified by the organization and the patient anticipated to occur as a result of implementing and coordinating the plan of care … All clinicians will consider the conclusions of initial and ongoing assessments in their care planning process, including but not limited to: … Individualized patient needs and resultant problems related to care, functional status, and family/caregiver support system ….” 2. Clinical record review for patient #2 evidenced a plan of care for start of care 03/29/2022 and certification period 03/29/2022 – 05/27/2022. This document indicated patient was to receive physical therapy 1 time a week for 1 week, and occupational therapy 1 time a week for 3 weeks. This document included but was not limited to the following diagnoses: acute respiratory failure, pneumonia, atrial fibrillation (irregular heartbeat), heart failure, and osteoarthritis. The plan of care failed to be individualized to include any interventions or measurable outcomes/goals related to patient’s diagnoses. Clinical record review evidenced orders dated 04/03/2022, effective 04/10/2022, for physical therapy visits 2 times per week for 3 weeks. Record review failed to evidence patient received any physical therapy visits the week of 04/24/2022. Clinical record review evidenced an agency document identified as the physical therapy plan of care by clinical manager B, dated 04/05/2022, titled “Add on Discipline” which stated, “… physical therapy to provide balance training to improve stability in standing and reduce fall risk during functional activities … physical therapy to evaluate gait and provide gait training using appropriate assistive device to ensure patient safety … physical therapy to instruct in safe transfers with appropriate body mechanics and equipment ….” The physical therapy plan of care failed to be individualized to include which assistive devices patient needs/uses, baseline functional level, and description of gait at baseline. No occupational therapy plan of care was evidenced. During an interview on 05/10/2022 at 3:26 PM, when queried how this patient’s plan of care should be	G0572		

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G0572	Continued from page 49 individualized, clinical manager B stated, "… after they go in and assess the patient, they discuss with the patient which interventions they need, with this patient she has functionality needs, if they asked her what is it you're trying to do … they try to meet patient stated goals … Get caregivers to help her with that …." Clinical manager B indicated the specific therapy interventions would be on the home exercise plan, which is not a part of the clinical record. When queried how this patient's plan of care should have been individualized, clinical manager B stated, "… I would think she would need more education on diagnoses and medications, strength, balance, and gait …." When queried why patient did not receive services the week of 04/24/2022, clinical manager B indicated it was a missed visit due to a time conflict. Clinical manager B indicated she did not know if it was due to the staff or patient. 3. Observation of a home visit for patient #4 was conducted on 05/09/2022 at 2:30 PM to observe a routine skilled nurse visit. The registered nurse failed to be observed assessing patient's surgical wound sites during the home visit. Clinical record review for patient #4 was completed on 05/13/2022 for start of care 04/06/2022, certification period reviewed, 04/06/2022 – 06/04/2022. Record review evidenced a start of care assessment dated 04/06/2022, which indicated patient had 3 surgical wounds to her left, mid, and right lower back. This document indicated the mid lower back wound had previously dehisced (a surgical wound complication in which a closed wound separates and forms an open wound). Clinical record review evidenced a plan of care, for start of care 04/06/2022, certification period 04/06/2022 – 06/04/2022. This document failed to be signed by the physician. The plan of care included, but was not limited to the following diagnoses, hypertension (high blood pressure), type 2 diabetes (a problem affecting the body's regulation of blood sugar), anxiety, and encounter for orthopedic aftercare. This document stated, "… Skilled nursing is medically necessary for skilled observation and assessment of surgical incisions due to the reasonable potential for hospitalization, complication, exacerbation, and/or change in treatment within the next three weeks …." This document failed to be individualized to include the specific site of surgical incisions. This document stated, "… Nutritional Requirements: Regular diet …." This document failed to be individualized to include any diabetic nutritional requirements. The plan of	G0572		

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G0572	Continued from page 50 care failed to be individualized to include patient-specific interventions and/or goals related to diabetes, hypertension, orthopedic aftercare, or anxiety. This document stated, "… Skilled nurse to perform IV [intravenous catheter] site care as follows: adult PICC [peripherally inserted central catheter, a large IV catheter used for long term antibiotics]/central venous access device: change site dressing weekly and PRN [as needed] …." This document failed to be individualized to specify location of PICC line. This plan of care failed to be reviewed and signed by the physician. Clinical record review evidenced skilled nurse visits for 04/06/2022, 04/11/2022, 04/18/2022, 04/25/2022, and 05/02/2022, in which no surgical wound site assessment was completed. During an interview on 05/11/2022 at 11:00 AM, when queried how the physician reviews the plan of care, clinical manager B indicated the physician is faxed the plan of care to review and sign, and if it is not signed she would follow up with a call to the doctor's office. Clinical manager B indicated this care plan had been sent to the physician on 04/23/2022, but not reviewed or signed yet. At 11:04 AM, when queried why patient #4 was not receiving surgical site assessment as ordered on the plan of care, clinical manager B stated, "… because she refused assessment to the site from 4 people … I remember we talked about this in the case conference … It wasn't the nurse, but the patient didn't want the nurse looking at it …." When queried if the physician was notified the patient was not receiving services ordered in the plan of care, clinical manager B indicated she did not see any specific notification in the chart. At 11:29 AM, when queried how this patient's plan of care should be individualized regarding diagnoses, clinical manager B stated, "… it should have signs and symptoms of high or low blood sugar, education on diet, medication education, ensuring patient is compliant with medications, medications for hypertension, diabetes, blood glucose parameters, orders should include clinicians assessing and/or checking blood glucose …." Clinical manager B indicated the plan of care should include the specific location of the PICC line. When queried what kind of nutritional requirements a diabetic patient has, clinical manager B indicated they should be on a diabetic diet. 4. Clinical record review for patient #9 was completed on 05/13/2022, for start of care 04/08/2022, certification period 04/08/2022 – 06/06/2022. Clinical record review evidenced a plan of care dated 04/08/2022, which	G0572		

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G0572	Continued from page 51 included but was not limited to the following diagnoses: congestive heart failure (a heart condition in which the heart cannot sufficiently pump, commonly resulting in fluid overload), type 2 diabetes (problem regulating blood sugars), end stage renal disease (kidney failure), hypotension (low blood pressure), atrial fibrillation (irregular heart beat), anemia (low blood count), pressure ulcer of right buttock, stage 2 (wound caused by pressure cutting off oxygen and blood flow to the tissue), and dependence on renal dialysis (artificial kidney filtration). The plan of care indicated patient had a right chest dialysis catheter. This document stated, "… skilled nurse for observation/assessment and instruction on diabetes to include: diet, skin care, foot care, blood glucose monitoring including HGBA1C [test to measure average blood glucose level over several months] … clinician may perform finger stick to assess blood glucose levels as needed for s/s [signs/symptoms] of hypo/hyperglycemia …." The plan of care failed to be individualized to include patient's baseline blood glucose level, which sign/symptoms of hypo/hyperglycemia to check for, how frequently clinicians were to check glucose level, and what kind of diet patient was following. This document stated, "… wound care: clean buttock with soap and water, apply Desitin cream, leave open to air … perform wound care to pressure ulcer stage 2 to buttocks as follows: use clean technique. Cleanse wound with soap and water, pat area dry, apply hydrocolloid [dressing that retains moisture] dressing to area, change every 5 days and PRN [as needed] soiling or dislodgement, may secure with transparent dressing or tape …." This document failed to be individualized due to duplicative wound treatment orders which failed to specify location of wound receiving treatment. Plan of care stated, "… skilled nurse for instruction on heart failure including self monitoring techniques, diet, medications …." This document failed to be individualized to patient to include ordered diet to instruct on, which medication to educate about, and what heart failure related self-monitoring to instruct patient about. Plan of care failed to be individualized to patient to include interventions related to dialysis treatments, dialysis access care, interventions for diagnosis of hypotension, atrial fibrillation, or anemia. This document stated, "… Goals … Patient/caregiver will demonstrate 3-5 appropriate measures related to management of diabetic care … patient will attain/maintain stable physiological	G0572		

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G0572	Continued from page 52 status and s/s of improved cardiac output (vitals, labs, weight, edema, cardiovascular status ….” This document failed include measurable goals related to diabetes and heart failure, and failed to specify patient’s baseline blood glucose, weight, edema, vitals, or labs. This document failed to evidence patient-specific measurable outcomes and goals related to diagnoses of end stage renal disease, atrial fibrillation, and hypotension. During an interview on 05/12/2022 at 11:51 AM, clinical manager B indicated the patient’s individualized plan of care should include instructions and interventions related to diagnoses such as, education to get up slowly, signs and symptoms to look for such as lightheadedness on standing, educating patient on checking blood pressure, ensuring patient has a blood pressure cuff in the home, blood pressure medication parameters, information regarding which dialysis clinic patient goes to, which days patient attends dialysis, assessment orders for the dialysis catheter, signs and symptoms to look for such as swelling, orders and education for fluid restrictions, and education/orders for renal/diabetic/cardiac diet. When queried about what the plan of care should specify regarding diabetes, clinical manager B indicated the clinicians should check the patient’s blood sugar on every visit, and those orders should be included on the plan of care. When queried what wound care should encompass on the plan of care, clinical manager B stated, “… a complete order would be what type of wound, where the wound is, dressing type, how many wounds, Desitin makes me think it’s [the wound] not open and other order for hydrocolloid makes me think it is open … the clinicians are expected to follow wound care orders, and if it doesn’t match, it’s a call to the doctor to reflect the change ….” 5. Clinical record review for patient #15 was completed on 05/13/2022 for start of care 03/08/2022 and certification period 03/08/2022 – 05/06/2022. Record review evidenced a plan of care which included the following orders, skilled nurse visit 1 time per week for 4 weeks, physical therapist visit 1 time a week for 1 week, then 2 times per week for 2 weeks, then 1 time per week for 2 weeks, and occupational therapy visit 1 time per week for 7 weeks. This document included but was not limited to the following diagnosis: pneumonia due to coronavirus disease, chronic respiratory failure, pulmonary fibrosis (a lung disease that results from scarring and damage to lung tissue), pneumothorax (collapsed lung resulting from air in	G0572		

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G0572	Continued from page 53 the space around the lung), pulmonary embolism (blood clot in the lung), type 2 diabetes (a disease in which the body has trouble regulating blood sugar levels), end stage renal disease (kidney failure), dependence on supplemental oxygen, and kidney transplant status. The plan of care failed to be individualized to include interventions or measurable outcomes/goals specific to diagnoses of pneumonia, respiratory failure, pulmonary embolism, diabetes, and kidney failure. This document stated, "… physical therapist to evaluate/assess and develop physical therapy plan of care to be signed by the physician … Occupational therapist to evaluate patient for OT [occupational therapy] services and develop plan of care to be signed by the physician …." Clinical record review evidenced the patient failed to receive an occupational therapy visit the week of 03/13/2022 and failed to receive a skilled nurse visit the week of 03/20/2022 as ordered on the plan of care. Clinical record review evidenced an agency document dated 03/09/2022, identified by clinical manager B as the PT (physical therapy) plan of care, which was titled "Add on Discipline". This document stated, "… Physical therapy to establish home exercise program and provide therapeutic exercises and soft tissue/joint mobilization designed to restore functional strength and ROM [range of motion] … physical therapy to instruct in safe transfers with appropriate body mechanics and equipment … physical therapy to provide balance training … physical therapy to evaluate gait and provide gait training using appropriate assistive device …." This document failed to be individualized to include any specific interventions to be performed, assistive devices required, how patient transferred, and baseline assessment of functional status. This document stated, "… Patient will demonstrate decreased fall risk during functional activities as evidenced by increased independence to be achieved by 4 weeks … Patient will demonstrate safe gait technique and appropriate gait pattern with assistive devices as needed to minimize risk of injury as evidenced by improved gait pattern … appropriate use of assistive device by 4 weeks …." The plan of care failed to be individualized to include measurable outcomes/goals by failing to include patient's baseline independence level and which assistive devices were used. Clinical record review evidenced an agency document dated 03/12/2022, identified by clinical manager B as the OT plan of care, which was titled "Add on Discipline". This	G0572		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G0572	Continued from page 54 document stated, "… Occupational therapist to establish/upgrade home exercise program and provide therapeutic exercises and/or soft tissue/joint mobilization designed to restore functional strength and ROM …." The plan of care failed to be individualized to include any specific interventions to be provided to patient. This document stated, "… Patient will demonstrate improved function in response to specific exercise and/or manual therapy techniques as evidenced by increased independence in activities of daily living, increased independence with transfers/mobility due to increased strength, decreased reliance on caregiver assistance by EOC [end of certification period] …." The plan of care failed to be individualized to include measurable goals/outcomes, baseline functional level, and goal functional level. During an interview on 05/11/2022 at 2:15 PM, clinical manager B indicated patient #15's individualized plan of care should have included interventions and orders specific for diagnoses of respiratory failure, diabetes, kidney failure and pulmonary embolism, such as checking blood glucose, educating patient on diabetic/renal diet, fluid restrictions, watching for edema, checking weights and vitals, and signs and symptoms to look for. At 2:30 PM, when queried what should normally be included on a PT/OT plan of care, clinical manager B stated, "… interventions, goals patient has talked about, a home exercise program, how we are achieving goals, what the plan is …." At 2:52 PM, when queried why this patient did not receive OT services the week of 03/13/2022 or skilled nurse services the week of 03/27/2022, clinical manager B indicated the OT visits were decreased. When queried why the visits were decreased, clinical manager B indicated she did not know. During an interview on 05/10/2022 at 3:25 PM, clinical manager B indicated the PTA (physical therapy assistant) or OTA (occupational therapy assistant) knew what exercises to perform based on the home exercise plan. When documentation of the home exercise plan was requested, clinical manager B indicated this was in the patient's home. No further documentation of the therapy plan of care was submitted upon exit. 6. Clinical record review for patient #16 was completed on 05/16/2022 for start of care 12/22/2021 and certification period 12/22/2021 – 02/19/2022. Record review evidenced a referral/history and physical dated 12/20/2021. This document indicated patient's physician was physician G. Clinical record review evidenced a plan of care for start of care 12/22/2021 and	G0572		

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G0572	Continued from page 55 certification period 12/22/2021 – 02/19/2022. This document included but was not limited to the following diagnoses: encounter for change of surgical wound dressing, hypertensive heart disease (high blood pressure resulting in heart disease), congestive heart failure (heart failure in which the heart cannot pump blood sufficiently), abscess of buttock (infected area on or under skin), type 2 diabetes (problem regulating sugar levels in the blood), atrial fibrillation (irregular heartbeat), arthritis (joint disease which causes joint pain), hyperlipidemia (high cholesterol), and bradycardia (low heart rate). This document indicated patient was to receive skilled nursing visits 2 times per week for 3 weeks, 1 time per week for 1 week, and 2 times per week for 2 weeks, physical therapy visits 1 time per week for 2 weeks, 2 times per week for 1 week, and 1 time per week for 1 week, and occupational therapy visit 1 time per week for 1 week. This document stated, "… skilled nurse to cleanse wound to right hip with NS [normal saline], prepare peri-wound area with drape, fill entire cavity with black foam, apply tubing and cover with transparent drape, apply negative pressure device at 125 mmhg [millimetres of mercury], for 22 – 24 hours/day, change dressing 2x/week, may use the following protocol as an alternative dressing as needed: cleanse wound with NS and gauze, pat dry with gauze, pack lightly with NS moist fluffed gauze, cover with dry gauze, secure with tape …." The plan of care failed to be individualized to include an indication for as needed dressing, and any ordered wound measurements frequencies. This document stated, "… Goals … Patient will demonstrate improved wound status as evidenced by a decrease in size by end of certification period, drainage of wound, absence of infection …." The plan of care failed to be individualized to include baseline wound size, or goal wound measurements. This document failed to be individualized to include any interventions/orders and/or measurable outcomes/goals related to diagnoses of congestive heart failure, atrial fibrillation, arthritis, or bradycardia. This document failed to be individualized to include orders for vital signs or blood glucose measurements. Clinical record review failed to evidence patient received wound dressing change 2 times per week the week of 01/09/2022, as ordered on plan of care. Clinical record review failed to evidence patient received any occupational therapy visits as ordered on the plan of care. During an interview on 05/16/2022 at	G0572		

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G0572	Continued from page 56 9:48 AM, when queried how this plan of care should be individualized to the patient, clinical manager B indicated it should have included interventions for glucose checks, wound measurements once a week, leg measurements, diet and medication education, assessment of pulses, signs and symptoms to look for like dizziness, increased drainage, and pain. When queried why patient did not receive any occupational therapy visits, clinical manager B stated, "… I don't see it in the documents, but she is very particular, I want to say she refused …." 7. Clinical record review on 5/10/2022, for patient #6, start of care 4/7/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/7/2022 – 6/5/2022. This document indicated physical therapy (PT) services were to be provided 1 time a week for 2 weeks and then 1 time every other week for 2 weeks effective 4/10/2022. This document indicated the PT was to develop the PT plan of care and have it signed by the physician. This document failed to include the individual PT interventions that were to be provided to the patient. Review failed to evidence a PT visit since the evaluation on 4/15/2022 and failed to evidence PT services were provided per the plan of care. This document indicated skilled nursing services were to be provided 1 time a week for 2 weeks, 3 times a week for 1 week, 2 times a week for 1 week, and then every other week for 4 weeks. Review failed to evidence skilled nursing services were provided 2 times a week as directed in the plan of care during the week of 4/24/2022. Review of an agency document titled "Client Coordination Note Report" entered by RN J and dated 4/28/2022, indicated a missed nursing visit and indicated the reason for the missed visit was overcapacity. Review failed to evidence the patient was offered to reschedule a nursing visit. During an interview on 5/11/2022, at 4:26 PM, the clinical manager indicated the plan of care did not include individual PT interventions and indicated there should be. At 4:32 PM, the clinical manager indicated she was unsure why PT services had not been provided as ordered. The clinical manager indicated overcapacity meant the clinician had too many patients to complete the visit as scheduled and indicated the visit should have been rescheduled by the scheduler so another clinician could have picked up the visit. During an interview on 5/12/2022, at 6:53 PM, PT G indicated the PT plan of care is the therapy evaluation and indicated the PT interventions should be on the evaluation. PT G indicated the PT	G0572		

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G0572	Continued from page 57 plan of care was a template auto-populated depending on what diagnosis the PT clicks on during the assessment. Review evidenced an agency document titled “Visit Note Report” electronically signed by PT P and dated 4/15/2022, and identified to be PT add-on evaluation. This document failed to evidence a signature from the physician responsible for the plan of care. 8. Clinical record review on 5/9/2022, for patient #7, start of care 12/23/2021, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 4/22/2022 – 6/20/2022. This document stated, “… Home health aide service for assistance with personal care and ADL’s [activities of daily living] ….” Review failed to evidence home health aide visits were provided. During an interview on 5/10/2022, at 12:28 PM, the clinical manager indicated the agency just announced a home health aide was hired and indicated the skilled nurse maybe thought the aide was ready to provide home visits. The clinical manager indicated the order for home health aide services should not have been included on the plan of care. 9. Clinical record review on 5/16/2022, for patient #10, start of care 4/25/2022, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 4/25/2022 – 6/23/2022. This document indicated the patient was to receive skilled nursing services 2 times a week for 2 weeks and then 1 time a week for 2 weeks. Review failed to evidence the patient received a skilled nurse visit during the week of 5/8/2022 as directed in the plan of care. Review evidenced the patient was to receive PT services 1 time a week for 1 week, 2 times a week for 1 week, 1 time a week for 1 week, 1 time a week every other week for 2 weeks, 1 time a week every 3 weeks for 3 weeks, and 1 time a week for 1 week. Review failed to evidence PT services were provided 2 times during the week of 5/1/2022 and no PT visits were provided during the week of 5/8/2022 as directed in the plan of care. Review evidenced the patient was to receive occupational therapy (OT) services 1 time a week for 2 weeks, 1 time a week every other week for 2 weeks, 1 time a week for 1 week, and 1 time every other week for 4 weeks. Review failed to evidence the patient had received OT services during the week of 5/1/2022 and 5/8/2022. During an interview on 5/12/2022, at 1:10 PM, the clinical manager indicated there was a OT missed visit on 5/6/2022, and indicated there were no other attempts by the OT to provide an OT visit as directed. During an interview on 5/16/2022, at	G0572		

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G0572	Continued from page 58 12:40 PM, the clinical manager indicated she did not know what happened regarding why the patient did not receive a skilled nurse visit. The clinical manager indicated there was a missed visit for PT on 5/13/2022 and indicated there were no other attempts by the PT to provide a PT visit as directed. 10. Clinical record review on 5/11/2022, for patient #11, start of care 4/29/2022, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 4/29/2022 – 6/27/2022, which indicated the patient was to receive skilled nursing services 1 time a week for 1 week and then 2 times a week for every other week for 2 weeks. Review failed to evidence a skilled nursing visit was provided since the initial comprehensive assessment on 4/29/2022. During an interview on 5/13/2022, at 10:30 AM, the clinical manager indicated no other skilled nursing visits were provided. 11. Clinical record review on 5/12/2022, for patient #14, start of care 5/4/2022, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 5/4/2022 – 7/3/2022. This document indicated the patient was to receive skilled nursing services 2 times a week for 1 week and 1 time a week for 1 week. Review failed to evidence 2 nursing visits were provided during the week of 5/1/2022 and failed to evidence a nursing visit was provided during the week of 5/8/2022 as directed in the plan of care. During an interview on 5/13/2022, at 11:14 AM, the clinical manager indicated the patient was out of town and indicated there was not a physician order to hold services. 12. Clinical record review on 5/12/2022 for patient #13, start of care 2/19/2022, certification period 12/19/2022 to 4/19/2022, primary diagnosis of Unspecified fracture of left femur (thighbone), evidenced an untitled agency document, identified by the clinical manager as the nursing plan of care. The plan of care was signed by the clinical manager and RN (registered nurse) C on 3/3/2022. Review of the plan of care failed to evidence a physician signature. During an interview on 5/13/2022 at 3:01 PM, the clinical manager indicated all plans of care should be signed by the physician. 13. Clinical record review on 5/13/2022 for patient #17, start of care 12/3/2021, certification period 12/3/2021 to 1/31/2022, primary diagnosis of Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts evidenced an agency document titled, “HOME HEALTH CERTIFICATION AND PLAN OF CARE”. Review of the plan of care	G0572		

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G0572	Continued from page 59 failed to evidence a physician signature. During an interview on 5/13/2022 at 3:01 PM, the clinical manager indicated all plans of care should be signed by the physician. Review of the plan of care evidenced a subsection titled, “Orders of Discipline and Treatments:”, which stated, “ … ASSESSMENT COMPLETED … FOR HOME HEALTH SKILLED SERVICES … FOLLOWING DC [discharge] FROM HOSPITAL, SNF [skilled nursing facility], REHAB, ER/OFFICE VISIT….” During an interview on 5/17/2022 at 10:00 AM, the clinical manager indicated the plan of care should be individualized to the patient. When informed of the findings, the clinical manager indicated the writer must have used a pre-made template, and not individualized it to the patient. Clinical record review evidenced an untitled agency document, identified by the clinical manager as the physical therapy plan of care. The plan of care was signed by the clinical manager and PT (physical therapist) G on 3/3/2022. Review of the plan of care failed to evidence a physician signature. During an interview on 5/13/2022 at 3:01 PM, the clinical manager indicated all plans of care should be signed by the physician. 17-13-1(a)	G0572		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements;	G0574		

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G0574	Continued from page 60 (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. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the plan of care included, all pertinent diagnoses, types of services, supplies, and equipment needed, frequency and duration of visits to be made, nutritional requirements, all medications and treatments, a description of the patient's risk for hospitalization and interventions to address the underlying risk factors, safety measures to protect against injury, patient information related to any advanced directives, and patient-specific interventions and education in 17 of 17 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled "Care Planning Process" which stated, "… The patient-specific clinical plan of care includes: … Pertinent primary and secondary diagnoses … All patient care orders including verbal orders … Food or drug allergies … Measurable outcomes and goals identified by the organization and the patient anticipated to occur as a result of implementing and coordinating the plan of care … Functional limitations … Safety measures to protect against injury … Nutritional requirements … Medications and treatments … Orders for patient-specific home	G0574		

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G0574	Continued from page 61 health services and responsible discipline(s), treatments and procedures, including amount, frequency, and duration … Patient-specific interventions and education … Supplies and equipment required … Patient and caregiver education and training to facilitate timely discharge … Frequency and duration of visits … Prognosis … Rehabilitation potential … A description of the patient's risk for emergency department visits and hospital readmissions and all necessary interventions to address the underlying risk factors … Information related to advance directives ….” 2. Observation of a home visit for patient #2 was conducted on 05/05/2022 at 1:15 PM to observe a routine physical therapy assistant visit. During the visit, a medication list dated 04/26/2022, from entity F (assisted living center) was reviewed, which included the following medications not included on patient's plan of care medication list: Norco (pain medication) 5-325 mg (milligrams) every 12 hours, and loperamide (antidiarrheal) 2 mg 4 times daily as needed. A facesheet from entity F indicated patient #2's code status was DNR (do not resuscitate). Clinical record review for patient #2 was completed on 05/13/2022 for start of care, 3/29/2022 and certification period 03/29/2022 – 05/27/2022. Record review evidenced a referral/history and physical dated 03/25/2022. This document included the following diagnoses not listed on the agency's plan of care: gout (disease causing joint pain), hypertension (high blood pressure), diverticulitis (inflammation of the intestines) and UTI (urinary tract infection). This document listed the following allergies not included on the agency's plan of care: cephalosporins (antibiotics), levofloxacin (antibiotic), augmentin (antibiotic), rocephin (antibiotic), gabapentin (nerve pain medication), sulfa drugs (antibiotic). Clinical record review evidenced a start of care assessment dated 03/29/2022, which listed the following risks for hospitalization: multiple hospitalizations in the past 6 months, currently taking 5 or more medications, decline in mental/emotional/behavioral status, difficulty with medical instructions, and 2+ emergency department visits within the past 6 months. Clinical record review evidenced a plan of care dated 03/29/2022, for start of care 03/29/2022 and certification period 03/29/2022 – 05/27/2022. This document stated, “… Advanced directives: None … Allergies … None ….” This document failed to evidence the patient's risk for	G0574		

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G0574	Continued from page 62 hospitalization or address any underlying risks for hospitalization. During an interview on 05/10/2022 at 2:56 PM, clinical manager B indicated all diagnoses, allergies, advanced directives, and medications should be included on patient's plan of care. When queried if the plan of care included risk for hospitalization and interventions to address the risk factors, administrator A and clinical manager B indicated they did not see any. 3. Observation of a home visit for patient #4 was conducted on 05/09/2022 at 2:30 PM to observe a routine skilled nurse visit. During the visit, the patient indicated that she took medication for arthritis. The nurse administered vancomycin (antibiotic), and confirmed patient received intravenous vancomycin daily for surgical site infection to her lower back. During the visit, the patient indicated she ambulated with a walker and a cane. Other medical equipment noted during the visit included an intravenous pole, intravenous dressing change kit, and intravenous tubing. Clinical record review for patient #4 was completed on 05/13/2022 for start of care 04/06/2022, certification period reviewed 04/06/2022 – 06/04/2022. Record review evidenced a history and physical from hospital D, dated 03/29/2022, which indicated patient had a diagnosis of degenerative arthritis. Clinical record review evidenced an order signed by physician E on 04/04/2022, which stated, "… vancomycin [antibiotic] 1 g [gram] q24 [every 24 hours] x 6 weeks IV …." Clinical record review evidenced a start of care assessment completed on 04/06/2022, which included the following hospitalization risk factors: unintentional weight loss of a total of 10 pounds or more in the past 12 months, multiple hospitalizations in the past 6 months, decline in mental, emotional, or behavioral status in the past 3 months, difficulty with medical instruction, and taking 5 or more medications. Clinical record review for patient #4 was completed on 05/13/2022. Record review evidenced a plan of care for start of care 04/06/2022, and certification period 04/06/2022 – 06/04/2022. This document failed to include a description of the patient's risk for hospitalization and interventions to address underlying risk factors. This document failed to include vancomycin as ordered. This document failed to include degenerative arthritis as a diagnosis. During an interview on 05/11/2022 at 10:47 AM, clinical manager B indicated the vancomycin should be included on the plan of care. At 11:19 AM, clinical manager B indicated the plan	G0574		

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G0574	Continued from page 63 of care should include all diagnoses including arthritis, and all medical equipment in the home, including a cane, walker, dressing change kits, and IV pole and tubing. Clinical manager B indicated the risk for hospitalization and interventions to address the underlying risk factors should be included on the plan of care. 4. Clinical record review for patient #9 was completed on 05/13/2022 for start of care 04/08/2022, certification period reviewed 04/08/2022 – 06/06/2022. Record review evidenced an unsigned referral order from entity B (skilled nursing facility) received on 04/06/2022 for home health care services which stated, "… Patient may discharge home with HH [home health]: PT [physical therapy], OT [occupational therapy], CNA [certified nurse assistant/home health aide], and nursing for skilled services …." Clinical record review evidenced a start of care assessment completed on 04/08/2022 which indicated patient had a moderate/high risk for hospitalization due to 2 or more falls or injuries within the past year, 2 or more emergency department visits in the past 6 months, difficulty with medical instruction, decline in mental/emotional/behavioral status, multiple hospitalizations in the past 6 months, currently taking 5 or more medications, and currently reporting exhaustion. This document listed the following devices or aids used by the patient, manual wheelchair, mechanical lift, and walker. This document indicated patient #9 had 3 wounds to the right buttock. Clinical record review evidenced a plan of care for start of care 04/08/2022, and certification period 04/08/2022 – 06/06/2022. This document stated, "… DME [durable medical equipment and Supplies]: alcohol, vital signs equipment, walker, wheelchair, gloves … Nutritional Requirements: as per MD order …." This document failed to specify what diet was ordered by the physician. This document failed to include mechanical lift in DME. This document failed to include hospitalization risk or any interventions to address the risk factors. This document stated, "… wound care: clean buttock with soap and water, apply Desitin cream, leave open to air … perform wound care to pressure ulcer stage 2 to buttocks as follows: use clean technique. Cleanse wound with soap and water, pat area dry, apply hydrocolloid [dressing that retains moisture] dressing to area, change every 5 days and PRN [as needed] soiling or dislodgement, may secure with transparent dressing or tape …." The plan of care failed to include wound care dressing orders for	G0574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G0574	Continued from page 64 all 3 wounds. The plan of care failed to include Desitin on the medication list. The plan of care failed to include orders for home health aide or occupational therapy as ordered on referral. Clinical record review evidenced a referral document from hospital C dated 04/21/2022, which indicated the patient was taking the following medications upon discharge, not included in the plan of care: digoxin (a medication which helps the heart pump stronger and more regularly) 62.5 mcg (micrograms) daily orally, droxidopa (a medication to increase blood pressure) 100 mg (milligrams) 3 times daily, and zinc oxide to be applied daily to the sacral area to prevent skin breakdown. During an interview on 05/10/2022 at 10:47 AM, clinical manager B indicated all the medication patient is taking should be listed on the patient's plan of care. At 3:15 PM, when queried what DME should be included on the plan of care, clinical manager B stated, "… in the charting it includes all necessary equipment, and equipment the patient already has …." During an interview on 05/11/2022 at 11:22 AM, clinical manager B indicated the patient's hospitalization risk should be included on the plan of care as well as interventions to prevent risk factors. During an interview on 05/12/2022 at 11:51 AM, when queried what wound care should encompass on the plan of care, clinical manager B stated, "… a complete order would be what type of wound, where the wound is, dressing type, how many wounds, Desitin makes me think it's [the wound] not open and other order for hydrocolloid makes me think it is open … the clinicians are expected to follow wound care orders, and if it doesn't match, it's a call to the doctor to reflect the change …." At 11:54 AM, clinical manager B indicated the diet ordered should be included on the plan of care, and if the clinician doesn't have a diet order, they should be calling a physician to get the order. 5. Clinical record review for patient #15 was completed on 05/13/2022. Record review evidenced a start of care assessment dated 03/08/2022, which included the following equipment/supplies: walker, bedside commode, elevated toilet seat, tub chair, glucometer, grab bars and reacher. This document listed the following signs or symptoms that categorized the patient as a risk for hospitalization: currently taking 5 or more medications, currently reported exhaustion, and difficulty with medical instruction. Clinical record review evidenced a document identified by administrator A as the referral/history and physical. This document	G0574		

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G0574	Continued from page 65 included the following diagnoses not included on the agency's plan of care: hypertension (high blood pressure), hyperlipidemia (high level of cholesterol in blood), anxiety, and hyponatremia (low sodium levels in blood). Clinical record review evidenced a plan of care for start of care 03/08/2022 and certification period 03/08/2022 – 05/06/2022. This document stated, "… DME [durable medical equipment] and supplies: none …." Plan of care failed to include appropriate DME. This document failed to include patient's risk for hospitalization and interventions to address the risk factors. During an interview on 05/11/2022 at 2:52 PM, clinical manager B indicated the plan of care should include all diagnoses and DME required by patient. When queried what interventions should be included on patient's plan of care to address the underlying hospitalization risk factors, clinical manager B stated, "… medication education, education on energy conservation, and signs and symptoms to look for …." 6. Clinical record review for patient #16 was completed on 05/16/2022. Record review evidenced a referral document dated 12/20/2022 which indicated patient was a DNR (do not resuscitate). This document included the following medications not included on the agency plan of care: Xanax (for anxiety) 0.25 mg (milligrams) nightly PRN (as needed) for sleep, Benadryl (for itching) 25 mg 2 times daily PRN, Norco (pain medication) 5-325 mg every 6 hours PRN for moderate pain, and hydrocortisone (steroid cream) 2.5% topically 4 times daily. This document indicated patient was on a heart healthy, low sodium diet. Clinical record review evidenced a start of care assessment dated 12/22/2021, which listed the following hospitalization risks: multiple hospitalizations in the past 6 months, decline in mental/emotional/behavioral status, taking 5 or more medications, and current exhaustion. Clinical record review evidenced a plan of care for start of care 12/22/2021 and certification period 12/22/2021 – 02/19/2022. This document stated, "… Nutritional Requirements: regular diet … Advanced Directives: None …." The plan of care failed to include DNR status and heart healthy diet. This document indicated the patient was taking anticoagulants but failed to include safety precautions related to bleeding precautions. This document stated, "… patient is identified as moderate/high risk for hospitalization and/or emergency department visits …." The plan of care failed to include interventions addressing the underlying risk factors for hospitalization. During an interview	G0574		

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G0574	Continued from page 66 on 05/16/2022 at 10:05 AM, clinical manager B stated, when queried why patient's referral indicated she was a DNR, and the plan of care indicated no advanced directives were on file, "… they ask the patient in the home and show it to them if it's not in the attachments … I would have to look more into it, such as if the patient told the clinician differently, or where the referral person got the info …." Clinical manager B indicated the plan of care should include all medications, allergies, durable medical equipment, and bleeding precautions. Clinical manager B indicated the plan of care should address the risk factors for hospitalization. 7. Clinical record review on 5/10/2022, for patient #6, start of care 4/7/2022, evidenced an agency document titled "Skilled Visit Note", dated 4/7/2022, and identified to be an admission comprehensive assessment. This document indicated the patient's medical supplies and equipment included a cane and walker. During an observation of care at the patient's home on 5/11/2022, at 9:00 AM, the patient was observed to have a medical shoe for his left foot. The patient was observed to have wounds to the left great, 2nd, and 3rd toes. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 4/7/2022 – 6/5/2022, which indicated the patient had gangrenous (death of tissue due to lack of blood flow or infection) wounds to the left great, 2nd, and 3rd toes. This document indicated the skilled nurse was to provide wound care at every visit. The plan of care failed to evidence goals which addressed the patient's wounds. The plan of care failed to include the cane, walker, and medical shoe for the patient's medical equipment and supplies. During an interview on 5/11/2022, at 3:54 PM, the clinical manager indicated the plan of care goals should include no signs or symptoms of a wound infection and wound improvement. The clinical manager indicated if the patient has equipment and supplies that he uses, it should be included in the plan of care. 8. During an observation of care at the home of patient #7, start of care 12/23/2021, on 5/6/2022, at 11:47 AM, the patient's medications were observed to include Lantus (a type of insulin used to treat high blood sugar by injection) and Humalog (a type of insulin administered by injection). The patient was observed to have an open area on the right buttock. RN C was observed cleansing the open area to the right buttock with a clear liquid and gauze	G0574		

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G0574	Continued from page 67 and was observed applying a white ointment from a jar labeled “Desitin [a moisture barrier]”. Patient was observed to have a plastic tube coming from his penis and attached to a clear plastic drainage bag hanging on the side of the bed with dark yellow liquid. During an interview on 5/6/2022, at 12:18 PM, the patient’s caregiver indicated she checks the patient’s blood sugar 3 times a day and provides insulin as needed by injection. Clinical record review on 5/9/2022, evidenced an agency document titled “Visit Note Report”, with a visit date of 4/19/2022 and identified to be a RN recertification comprehensive assessment. This document indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) Stage II (an open pressure ulcer with partial thickness loss of skin) to the right buttock. This document indicated the wound care to the right buttock was to cleanse with normal saline (a wound cleanser solution) or soap and water, apply calmoseptine (a medication used to treat minor skin irritations) or desitin ointment 4 times a day and as needed with each incontinent (loss of bowel and bladder control) episode. This document indicated the patient’s medical equipment and supplies included, but was not limited to, a glucometer (a medical device used to determine blood sugar level). This document indicated the patient’s blood sugar was checked 3-4 times a day. This document indicated the patient’s mental status was assessed to be forgetful, confused, depressed, agitated, and disoriented. This document indicated the patient had a foley catheter (a plastic tube inserted into the bladder and held in place with an inflated balloon to drain urine from the body). Review evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 4/22/2022 – 6/20/2022. This document indicated the patient’s primary diagnosis was atherosclerosis heart disease (a thickening or hardening of the inner lining of the artery wall due to plaque build-up) and had secondary diagnoses to include, but not limited to, diabetes (a chronic condition which affects the way the body processes blood sugar) and benign prostatic hyperplasia (an enlarged prostate which can cause a blockage of the flow of urine). This document indicated the skilled nurse was to report to the physician blood sugars outside of ordered parameters. The plan of care failed to evidence the how often the patient’s blood sugar was to be checked and failed to evidence the glucometer and	G0574		

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G0574	Continued from page 68 syringes. This document indicated the skilled nurse was to change the foley catheter monthly and inflate the balloon with 10 milliliters. The plan of care failed to be individualized to include with what the foley catheter balloon was to be inflated and failed to evidence goals related to the patient's urinary catheter. This document indicated the skilled nurse was to provide catheter care at every visit and failed to evidence the individualized catheter care that was to be provided by the skilled nurse. Review failed to evidence the goals on the plan of care were individualized related to the patient's diagnoses of atherosclerosis heart disease and diabetes. The plan of care failed to evidence the wound to the right buttock, the wound care orders, and failed to evidence goals related to the wound. This document indicated the patient's mental status was disorientated and failed to include the patient's mental status of forgetful, confused, depressed, and agitated. This document indicated the safety measures included the patient was to alert the physical therapist (PT) and this document failed to evidence the patient was to receive PT services. During an interview on 5/10/2022, at 12:28 PM, the clinical manager indicated the foley catheter balloon was to be inflated with normal saline (a salt water solution). The clinical manager indicated the diabetic supplies should be included in the plan of care. The clinical manager indicated the agency was providing more education to staff about making the plans of care more specific to the patient. At 12:37 PM, the clinical manager indicated the wound to the right buttock and the wound care was not included in the plan of care and it should be. The clinical manager indicated the agency was trying to shorten the length of the plan of care since clinicians had complained about how long the plans of care were. The clinical manager indicated she was unsure why the complete mental status of the patient was not included in the plan of care. During an interview on 5/11/2022, at 2:08 PM, the clinical manager indicated the plan of care should include goals related to the wound such as wounds to heal, no signs and symptoms of infections, and caregiver to demonstrate wound care. The clinical manager indicated the plan of care should include the patient was to have no blood, pain or leakage for goals related to the foley catheter. At 2:14 PM, the clinical manager indicated the plan of care should indicate the specific catheter care to be provided and indicated it is usually to change the collection bag weekly and as needed. At 2:29 PM,	G0574		

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G0574	Continued from page 69 the clinical supervisor indicated she was unsure why the safety measures included the PT was to be alerted and indicated the patient was not receiving PT services this certification period. The clinical manager indicated maybe it was a carry-over from the previous plan of care. 9. Clinical record review on 5/11/2022, for patient #10, start of care 4/25/2022, evidenced an agency document titled “Visit Note Report” electronically signed by PT G and dated 4/25/2022, which was identified to be a PT admission comprehensive assessment. This document indicated the patient had a wound to the right great toe, left buttock, right buttock, 2 wounds to the right leg, and 2 wounds to the left leg. This document failed to evidence the patient received oxygen therapy. Review evidenced agency documents titled “Visit Note Report” electronically signed by RN K. Document dated 4/27/2022 indicated the patient had pitting edema (excess fluid built up in the body and when pressure is applied, causes an indentation) at a degree of 2+ on a scale of 0 to 4+. Document dated 5/3/2022, indicated the patient had pitting edema 3+ on a scale of 0 to 4+ and the legs were reddened. Review evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 4/25/2022 – 6/23/2022. This document indicated the patient’s diagnoses included, but were not limited to, diabetes and congestive heart failure (a chronic condition which the heart does not pump efficiently causing a build-up of fluid and can cause leg swelling). Review indicated the patient’s medication included, but was not limited to, insulin (an injected medication to treat high blood sugar). Review indicated the licensed professional was to report to the physician blood sugars higher or lower than parameters and failed to evidence the plan of care included how often the patient was to check the blood sugar. This document indicated the PT may perform oxygen saturation levels with oxygen use. Review failed to evidence the patient used supplemental oxygen. Review indicated the skilled nurse was required for wound care and was to clean the wounds with normal saline, apply Silvadene (a topical antibiotic), and wrap with kerlix (rolled gauze) daily. Review failed to evidence the plan of care included the location of the wounds to where the wound treatment was to be performed. Review failed to evidence the plan of care included interventions to address the patient’s diagnosis of congestive heart failure and pitting edema. During an interview on 5/12/2022, at 12:31	G0574		

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G0574	Continued from page 70 PM, the clinical manager indicated the patient did not use oxygen and should not have been included in the plan of care. The clinical manager indicated the plan of care should include the locations of the wound for where wound care was to be performed. When queried how the wounds on the buttocks were to be wrapped with kerlix, the clinical manager indicated she did not think the wound treatment in the plan of care was for the wounds to the buttocks. At 12:44 PM, the clinical manager indicated the plan of care should include the frequency of which the patient was to check the blood sugar. The clinical manager indicated the plan of care should include educating the patient to elevate the legs and assess for edema and fluid intake. 10. Clinical record review on 5/11/2022, for patient #11, start of care 4/29/2022, evidenced an agency document titled “Visit Note Report” dated 4/29/2022, and identified to be a RN admission comprehensive assessment. This document indicated the patient’s medical equipment included a glucometer (a medical device to test blood sugar levels), cane, elevated toilet seat, and grab bars. Review indicated the patient’s diagnoses included, but were not limited to, Stevens Johnson syndrome (a rare but serious condition that affects the skin and mucous membranes, which causes a painful rash that spreads and blisters) and diabetes. This document indicated the patient had an ulcerated epiglottis (a flap of cartilage at the root of the tongue which covers the windpipe when swallowing) and indicated the patient had a rash and blisters. This document indicated the patient checked blood sugar levels daily. Review of an agency document titled “Home Health Certification and Plan of Care” for certification period 4/29/2022 – 6/27/2022, failed to include the glucometer, cane, elevated toilet seat, and grab bars in the patient’s medical equipment. This document indicated the licensed professional was to notify the physician for blood sugar levels outside of ordered parameters. Review failed to evidence the plan of care included goals related to the patient’s diagnoses of Stevens Johnson syndrome and diabetes. During an interview on 5/13/2022, at 9:42 AM, the clinical manager indicated the patient’s medical equipment listed on the comprehensive assessment should have been included in the plan of care. At 10:02 AM, the clinical manager indicated the plan of care should include goals that addressed the patient’s diagnoses. 11. Clinical record review on 5/12/2022, for patient #14, start of care 5/4/2022, evidenced an agency	G0574		

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G0574	Continued from page 71 document titled “Visit Note Report” dated 5/4/2022, and identified to be a RN admission comprehensive assessment. This document indicated the patient received 1 liter of normal saline for hydration via IV (intravenous, a medical technique of delivering medication, hydration, and nutrition directly into the vein) as needed. Review evidenced a document from hospital Y and dated 4/29/2022, which indicated the patient required home health to obtain lab specimens and the blood work was to be obtained on 4/30/2022 and 5/3/2022. Review evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 5/4/2022 – 7/2/2022. This document indicated parameters for blood sugar levels and failed to evidence a diagnosis of diabetes. This document indicated the skilled nurse was needed for central line (a plastic tube inserted into a vein that goes up to the heart) care and labs. Review failed to evidence the plan of care included central line supplies for the patient’s required medical supplies. Review failed to evidence the plan of care included the patient’s IV hydration of 1 liter of normal saline. Review indicated the patient was 18 years old and the patient’s diagnoses included, but were not limited to, anxiety disorder and cancer of the right ovary. The patient’s medications included lorazepam (a medication used to treat anxiety) and desvenlafaxine (a medication used to treat depression). Review failed to evidence interventions and goals related to the patient’s diagnosis of anxiety. Review failed to evidence the lab orders for blood work on 4/30/2022 and 5/3/2022 to be drawn by the nurse. During an interview on 5/13/2022, at 10:39 AM, the clinical manager indicated the plan of care should not include blood sugar parameters. The clinical manager indicated the central line supplies were supplied by another vendor and indicated the central line supplies should be included in the plan of care as medical supplies required by the patient. The clinical manager indicated the nursing interventions should include the assessment of patient’s anxiety, assess medication compliance and any potential medication side effects, and educate the patient on the medication. At 11:16 AM, the clinical manager indicated the order for the blood work should have been included on the plan of care. During an interview on 5/13/2022, at 1:20 PM, RN K indicated the patient receives the IV fluids via pump after days the patient receives chemotherapy (a medication that treats cancer) and did not know	G0574		

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G0574	Continued from page 72 the flow rate but thought it ran for 10 hours. 12. Clinical record review on 5/5/2022, for patient #1, start of care 2/15/2022, certification period 4/16/2022 to 6/14/2022, primary diagnosis of End stage renal disease (when the kidneys have stopped working), evidenced an agency document titled, “HOME HEALTH CERTIFICATION AND PLAN OF CARE”, signed by the physician on 4/22/2022. The plan of care had a subsection titled, “Medications”, which stated, “ … CARVEDILOL [a medication used to treat blood pressure and heart failure] 25 MG [milligram] TABLET TWICE A DAY … TAKE 1 TABLET BY MOUTH TWICE A DAY WITH MEALS … CARVEDILOL 25 MG TABLET … TAKE 1 FULL TABLET ON NON-DIALYSIS DAYS AND 0.5 TABLET ON DIALYSIS DAYS….” During observation of a home visit on 5/5/2022, at 12:00 PM, the patient was observed wearing oxygen at 2 liters per minute per nasal cannula. During observation of the visit, the home medication list was reviewed. The medication list stated, “ … Carvedilol 25 MG – Full tablet on non-dialysis day - ½ tablet on dialysis day….” During an interview on 5/5/2022, at 12:15 PM, patient #1 indicated they had been on oxygen continuously since January 1, 2022. During an interview on 5/5/2022, at 12:55 PM, patient #1 indicated they took Carvedilol once a day, as written on the home medication list. During an interview on 5/11/2022, at 12:05 PM, the clinical manager indicated the plan of care should include all patient medications currently in the home and how the patient takes them. When informed of the findings, the clinical manager indicated oxygen should be included in the medication list. Clinical record review evidenced an untitled document, identified by the clinical manager as the physical therapy plan of care, dated 4/12/2022. Review of the plan of care failed to evidence patient-specific interventions and education. During an interview on 5/11/2022, at 12:08 PM, the clinical manager stated about the plan of care, “how to get to goals should be included”. 13. Clinical record review on 5/10/2022, for patient #3, start of care 10/30/2021, certification period 4/28/2022 to 6/26/2022, primary diagnosis of Type 2 Diabetes Mellitus (a medical condition in which your body does not use insulin properly, resulting in unusual blood sugar levels) with foot ulcer (open sore), evidenced an agency document titled, “HOME HEALTH CERTIFICATION AND PLAN OF CARE”, signed by the physician on 5/2/2022. This plan of care had a subsection titled, “Orders of Discipline and Treatments:” which stated, “ … SKILLED NURSE FOR INSTRUCTIONS ON … ADMINISTRATION OF INSULIN, BLOOD	G0574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCENTCARE HOME HEALTH OF INDIAN	**11037 BROADWAY, SUITE C , CROWN POINT, Indiana, 46307**

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G0574	Continued from page 73 GLUCOSE TESTING…." Review of the plan of care failed to evidence the patient took insulin. Review of the plan of care failed to evidence orders for blood glucose testing. During an interview on 5/6/2022 at 10:41 AM, patient #3 indicated they were told by their physician that they did not have to check their blood sugar, and that they were not taking insulin. On 5/13/2022 at 11:30 AM, when informed of the findings, the clinical manager indicated skilled nurse instruction on administration of insulin and blood glucose testing should not be in the patient's plan of care. Clinical record review for patient #3, certification period 4/28/2022 to 6/26/2022, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", which stated, " … Allergies: NKA [no known allergies]….".Clinical record review evidenced a medication list received from assisted living facility T on 5/6/2022, which indicated the patient had the following allergies: Cat dander, chocolate, dust, mold antigen, and nickel. During an interview on 5/10/2022 at 3:12 PM, the clinical manager indicated the plan of care should include all patient allergies including but not limited to medications, foods, and environmental allergens. Clinical record review for patient #3, certification period 4/28/2022 to 6/26/2022, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", which stated, "DME [durable medical equipment] and Supplies: ALCOHOL; DME-VITAL SIGNS EQUIPMENT; DME-WALKER; GLOVES; WOUNDCARE [sic] SUPPLIES…." During observation of a home visit on 5/6/2022 at 10:28 AM, a wheelchair was observed in the patient's room. During an interview on 5/6/2022 at 10:48 AM, patient #3 indicated they used the wheelchair daily. During an interview on 5/10/2022 at 3:21 PM, the clinical manager indicated the plan of care should include all equipment in the home for the patient. 14. During observation of a home visit for patient #5 on 5/9/2022, at 2:30 PM, the patient was observed using oxygen per nasal cannula. A continuous glucose monitor was observed on the back of the patient's upper arm. The following pieces of durable medical equipment were observed in the patient's home: walker, oxygen tank, CPAP machine [a device used to help keep airways open while the wearer is asleep], reachers, shower chair, bedside commode, and grab bars in the bathroom. What was identified by the patient as a dialysis fistula was observed to the patient's left arm. Clinical record review on 5/11/2022, for patient #5, start of care 1/11/2022, certification period 3/12/2022	G0574		

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G0574	Continued from page 74 to 5/10/2022, primary diagnosis of Type 2 Diabetes Mellitus (a medical condition in which your body does not use insulin properly, resulting in unusual blood sugar levels) with Hyperglycemia (high blood sugar), evidenced an agency document titled, “Visit Note Report … Visit Type: … OT [occupational therapy] ADD-ON EVALUATION”, dated 3/17/2022, which stated, “ … RECEIVES DAILYSIS [sic] ON M [Monday], W [Wednesday] AND FRIDAY, O2 [oxygen] USE … CURRENTLY HAS MANUAL W/C [wheelchair], BEDSIDE COMMODE, ROLLATOR AND TUB CHAIR….” Clinical record review evidenced an agency document titled, “HOME HEALTH CERTIFICATION AND PLAN OF CARE”, signed by the physician on 3/17/2022. Review of the plan of care failed to evidence the patient used oxygen and a continuous glucose monitor. Review of the plan of care failed to evidence the patient had an oxygen tank, CPAP machine [a device used to help keep airways open while the wearer is asleep], reachers, shower chair, bedside commode, and grab bars in the bathroom. Review of the plan of care failed to evidence nurse assessment of blood glucose readings. Review of the plan of care failed to evidence the patient was receiving dialysis. During an interview on 5/10/2022 at 3:21 PM, the clinical manager indicated the plan of care should include all equipment in the home for the patient. During an interview on 5/13/2022 at 12:20 PM, the clinical manager indicated the plan of care should include how frequently a nurse should assess and document the patient’s blood glucose readings in order to determine if they are within the established parameters. 15. Clinical record review on 5/7/2012, for patient #8, start of care 11/2/2021, certification period 3/2/2022 to 4/30/2022, primary diagnosis of Unspecified fracture of the left femur (thighbone), evidenced an agency document titled, “Home Health Updated Plan of Care Report”, which stated, “ … SKILLED NURSE, PATIENT OR CAREGIVER TO PERFORM / TEACH WOUND CARE TO LEFT UPPER THIGH SURGICAL INCISION AS FOLLOWS: USE CLEAN TECHNIQUE. CLEANSE WITH NS [normal saline], APPLY DRY GAUZE OR BANDAID, USING CLEAN / ASEPTIC TECHNIQUE. PREVENA INCISION WOUND VAC [a wound management system that is placed over a closed surgical incision] TO COME OFF 4-28-22 THEN START DRESSINGS. MAY DISCONTINUE WOUND CARE WHEN WOUND CLOSED OR HEALED. (04/24/2022)….” Review of the plan of care failed to evidence the frequency of dressing changes. During an interview on 5/13/2022 at 2:06 PM, the clinical manager indicated all wound care orders	G0574		

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G0574	Continued from page 75 should include what was to be used, how and where it should be used, and how often wound care should be completed. Clinical record review evidenced an agency document titled, “Coordination Notes Report”. An entry dated 3/24/2022, signed by RN (registered nurse) J, stated, “ … PATIENT TO WCC [wound care clinic] TODAY….” Review of the agency document, “Home Health Updated Plan of Care Report”, failed to evidence the patient receiving wound clinic services. During an interview on 5/13/2022 at 2:06 PM, the clinical manager indicated the plan of care should include all services and therapies the patient was receiving, from the agency as well as any other entities. When queried, the clinical manager indicated the plan of care failed to evidence wound care services. 16. Clinical record review on 5/12/2022 for patient #12, start of care 4/9/2022, certification period 4/9/2022 to 6/7/2022, primary diagnosis of Respiratory failure with hypoxia (low oxygen), evidenced an agency document titled, “HOME HEALTH CERTIFICATION AND PLAN OF CARE”. The plan of care had a subsection titled, “Orders of Discipline and Treatments:”, which stated, “ … SKILLED NURSE TO CHANGE F OLEY [sic] CATHETER [a tube inserted through the urethra to drain the bladder] WITH 16F [French] [a unit of size measurement] / 10 CC MONTHLY AND PRN [as needed]….” The plan of care failed to evidence an indication for the as needed catheter change. During an interview on 5/13/2022 at 3:41 PM, the clinical manager indicated all medication and treatments ordered “as needed” should have an indication for their use. Review of the plan of care evidenced a subsection titled, “DME [durable medical equipment] and Supplies:”, which stated, “ALCOHOL; DME-VITAL SIGNS EQUIPMENT; GLOVES”. Clinical record review evidenced an agency document titled, “Visit Note Report … RN [registered nurse] ... ADMISSION….”, dated 4/9/2022, signed by RN (registered nurse) X. The visit note had a subsection titled, “EQUIPMENT / SUPPLIES”, which indicated the following DME were available in the patient’s home: standard walker, elevated toilet seat, tub chair, oxygen, and c-pap. During an interview on 5/10/2022 at 3:21 PM, the clinical manager indicated the plan of care should include all equipment in the home for the patient. Clinical record review evidenced an agency document titled, “Coordination Notes Report”. An entry dated 4/10/2022, signed by RN X, stated, “ … RED RASH TO BUTTOCKS—DESITIN BEING USED”. Review of the plan of care evidenced a subsection titled, “Medications:”. Review of the	G0574		

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G0574	Continued from page 76 medications failed to evidence Desitin. During an interview on 5/11/2022, at 12:05 PM, the clinical manager indicated the plan of care should include all patient medications currently in the home and how the patient takes them. When informed of the findings on 5/13/2021, at 3:45 PM, the clinical manager indicated Desitin should be included in the medication list. 17. Clinical record review on 5/12/2022 for patient #13, start of care 2/19/2022, certification period 12/19/2022 to 4/19/2022, primary diagnosis of Unspecified fracture of left femur (thighbone), evidenced an untitled agency document, identified by the clinical manager as the nursing plan of care, signed by the clinical manager and RN (registered nurse) C on 3/3/2022. The plan of care stated, " … SKILLED NURSE TO ASSESS / EVALUATE CO-MORBID CONDITIONS INCLUDING DIABETES … SKILLED NURSE FOR INSTRUCTIONS ON DIABETIC CARE TO INCLUDE … BLOOD GLUCOSE TESTING…." Review of the plan of care failed to evidence how often the patient's blood glucose was to be checked and who was checking it. During an interview on 5/13/2022 at 12:20 PM, the clinical manager indicated the plan of care should include how frequently a nurse should assess and document the patient's blood glucose readings in order to determine if they are within the established parameters. Review of the plan of care evidenced a subsection titled, "DME [durable medical equipment] and Supplies:", which stated, "ALCOHOL; DME-VITAL SIGNS EQUIPMENT; GLOVES". Clinical record review evidenced an agency document titled, "Visit Note Report", dated 3/2/2022, and signed by RN (registered nurse) C. The visit note had a subsection titled, "EQUIPMENT / SUPPLIES", which indicated the following DME were available in the patient's home: cane, front wheeled walker, wheelchair, elevated toilet seat, tub chair, grab bars, reacher, and glucometer (machine used to check blood sugar). During an interview on 5/10/2022 at 3:21 PM, the clinical manager indicated the plan of care should include all equipment in the home for the patient. On 5/13/2022 at 3:24 PM, when informed of the findings, the clinical manager indicated the nurse failed to ensure all DME in the patient's home was included in the plan of care. 18. Clinical record review on 5/13/2022 for patient #17, start of care 12/3/2021, certification period 12/3/2021 to 1/31/2022, primary diagnosis of Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". The plan of care had a	G0574		

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G0574	Continued from page 77 subsection titled, “Orders of Discipline and Treatments:”, which stated, “ … SKILLED NURSE TO CLEANSE WOUND … FILL ENTIRE CAVITY WITH BLACK FOAM. APPLY TUBING AND COVER WITH TRANSPARENT DRAPE. APPLY NEGATIVE PRESSURE DEVICE AS ORDERED … SKILLED NURSE TO PERFORM / TEACH WOUND CARE TO JP DRAIN SITE—KEEP INSERTION SITE CLEAN AND EMPTY DRAIN / RECORD OUTPUT AS ORDERED….” Review of the plan of care failed to evidence frequency for wound care and settings for negative pressure device. Review of the plan of care failed to evidence how to clean drain site, how often to clean it, and if a dressing should be used. During an interview on 5/17/2022 at 10:04 AM, the clinical manager indicated all wound care orders should include frequency of the wound care provided and all wound care orders for a negative pressure device should include settings for the device. The clinical manager indicated orders for drain care should include what should be used to clean the site, how often it should be cleaned, and if a dressing should be used. Review of the plan of care evidenced a subsection titled, “Medications:”, which stated, “ … NORMAL SALINE FLUSH 0.9% INJECTION SYRINGE … 10 ML [milliliters] AS DIRECTED….”. Review of the medication order failed to evidence frequency of the saline flush. During an interview on 5/17/2022 at 10:16 AM, the clinical manager indicated all medication orders should include the name of the medication, the route, the dose, and the frequency of use of the medication. 17-13-1(a)(1)(D)(i, ii, ix, x, xiii)	G0574		
G0578	Conformance with physician orders CFR(s): 484.60(b) Standard: Conformance with physician or allowed practitioner orders. This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure conformance with physician orders in 1 of 3 home visits conducted with a registered nurse (RN). (#7) The findings include: Review of an agency policy obtained 5/12/2022, titled “Physician Participation in Plan of Care” revised December 2019, stated, “… A physician will direct the care of every home health care patient … The care will be provided in compliance with the	G0578		

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G0578	Continued from page 78 therapeutic and diagnostic orders ….” During an observation of care for patient #7, start of care 12/23/2021, on 5/6/2022, at 11:47 AM, RN C was observed cleansing the wound to the right buttock with a clear liquid RN C identified as normal saline. Clinical record review on 5/9/2022, evidenced an untitled agency document identified by the clinical manager to be a verbal order, dated 4/46/2022 and electronically signed by licensed practical nurse (LPN) F, stated, “… Skilled nurse cleanse with soap and water then apply calmoseptine [a medicated ointment for mild skin irritation] or desitin [a barrier ointment to protect skin] with every incontinence episode ….” Review failed to evidence RN C cleansed the wound with soap and water as ordered. During an interview on 5/10/2022, at 1:30 PM, the clinical manager indicated the order was for the wound to the patient’s right buttock. The clinical manager indicated the care provided should be as ordered.	G0578		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure treatments were administered only as ordered by a physician in 5 of 8 active clinical records reviewed with a wound or catheter (#3, 7, 8, 9,12). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled “Physician Participation in Plan of Care” which stated, “… The attending physician will participate in the care planning process by initiating, reviewing and revising the plan of care (therapeutic and diagnostic orders) … The care will be provided in compliance with the therapeutic and diagnostic orders and accepted standards and practice ….” 2. Clinical record review for patient #9 was completed on 05/13/2022. Record review evidenced a plan of care for start of care 04/08/2022 and certification period 04/08/2022 – 06/06/2022. This document stated, “… wound care: clean buttock with soap and water, apply Desitin cream, leave open to air … wound care to pressure ulcer stage 2 to	G0580		

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G0580	Continued from page 79 buttocks as follows: use clean technique, cleanse wound with soap and water, pat area dry, apply hydrocolloid dressing to area, change every 5 days and PRN [as needed] soiling or dislodgement ….” Record review evidenced a skilled nurse visit note, dated 04/25/2022, which stated, “… Cleaned with NS [normal saline] covered with foam dressing, did not apply Desitin due to new open areas ….” Record review failed to evidence any new physician orders for applying foam dressing to wound. During an interview on 05/12/2022 at 11:35 AM, clinical manager B indicated the clinicians are expected to follow the physician orders from the plan of care only. When queried if new orders were received for foam wound treatment and when they should be incorporated into the plan of care, clinical manager B indicated she did not see if the doctor had called back and provided orders, but as soon as the clinician gets the orders, they should incorporate them into the plan of care. 3. During an observation of care for patient #7, start of care 12/23/2021, on 5/6/2022, at 12:35 PM, registered nurse (RN) C was observed pouring a clear liquid labeled “Normal Saline [a salt water solution]” into a clear plastic bottle. RN C was observed drawing up clear liquid from plastic bottle into a syringe and was then observed inserting the liquid from the syringe into a port on a plastic tube inserted into the patient’s penis. RN C was then observed connecting a drainage bag attached to a plastic tube to the plastic tube extending from the patient’s penis. Clinical record review on 5/9/2022, evidenced an agency document titled “Visit Note Report”, electronically signed by RN C and dated 5/6/2022. This document indicated the patient’s foley catheter (a plastic tube inserted into the bladder and held in place by an inflated balloon to drain urine from the body) was irrigated. Review failed to evidence a physician’s order for the irrigation of the foley catheter. During an interview on 5/10/2022, at 1:06 PM, the clinical manager indicated she did not see a physician order for the foley catheter irrigation and indicated there should be a physician order before irrigating the foley catheter. 4. Clinical record review on 5/10/2022, for patient #3, start of care 10/30/2021, certification period 2/27/2022 to 4/27/2022, primary diagnosis of Type 2 Diabetes Mellitus (a medical condition in which your body does not use insulin properly, resulting in unusual blood sugar levels) with foot ulcer (open sore), evidenced an agency document titled, “HOME HEALTH CERTIFICATION AND PLAN OF CARE”, signed by	G0580		

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G0580	Continued from page 80 the physician on 3/17/2022. This plan of care had a subsection titled, “Orders of Discipline and Treatments:” which stated, “ … SKILLED NURSE TO CLEAN WOUND ON LEFT HEEL WITH NS [normal saline] AND APPLY DRY, NON-ADHERENT DRESSING, CHANGE DAILY AND PRN [as needed]….” Clinical record review for patient #3, certification period 4/28/2022 to 5/26/2022, evidenced an agency document titled, “HOME HEALTH CERTIFICATION AND PLAN OF CARE”, signed by the physician on 5/2/2022. The plan of care failed to evidence orders for wound care. Clinical record review evidenced an untitled document, identified by the clinical manager as a physician’s order, dated 3/21/2022, and signed by the physician. The order stated, “ … SKILLED NURSE OR CAREGIVER TO CLEANSE LEFT HEEL WITH NS [normal saline] OR STERILE WATER, PAT DRY, THEN APPLY SANTYL [a wound ointment] TO WOUND BED THEN CALCIUM ALGINATE [an absorbent wound dressing], THEN PLACE DRY GAUZE PAD AND WRAP WITH KERLIX [wrapped gauze roll] 3 TIMES WEEKLY AND AS NEEDED FOR SOILAGE OR DISLODGEMENT….” During an interview on 5/13/2022, at 11:27 AM, the clinical manager indicated the plan of care should include all current orders for patient care. When queried, the clinical manager indicated the physician orders from 5/2/2022 were the current wound care orders, and the plans of care for both certification periods reviewed (2/27/2022 to 4/27/2022 and 4/28/2022 to 5/26/2022), did not include wound care orders. The clinical manager indicated the nurse performed wound care not ordered in the plan of care. 5. Clinical record review on 5/7/2012, for patient #8, start of care 11/2/2021, certification period 3/2/2022 to 4/30/2022, primary diagnosis of Unspecified fracture of the left femur (thighbone), evidenced an agency document titled, “Home Health Updated Plan of Care Report”, which stated, “ … SKILLED NURSE, PATIENT OR CAREGIVER TO PERFORM / TEACH WOUND CARE TO LEFT UPPER THIGH SURGICAL INCISION AS FOLLOWS: USE CLEAN TECHNIQUE. CLEANSE WITH NS [normal saline], APPLY DRY GAUZE OR BANDAID, USING CLEAN / ASEPTIC TECHNIQUE. PREVENA INCISION WOUND VAC [a wound management system that is placed over a closed surgical incision] TO COME OFF 4-28-22 THEN START DRESSINGS. MAY DISCONTINUE WOUND CARE WHEN WOUND CLOSED OR HEALED. (04/24/2022)….” Clinical record review evidenced an agency document titled, “Visit Note Report”, dated 4/28/2022, signed by RN (registered nurse) J, which stated, “ … PATIENT HAS WOUND LOCATED LEFT UPPER THIGH SURGICAL INCISION, LEFT LATERAL [on the side] TH8GH [sic] SURGICAL INCISION, ET [and] LEFT LATERAL KNEE	G0580		

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G0580	Continued from page 81 SURGICAL INCISION … PROVIDED CARE: VISIT DONE FOR INCISION CARE TO LLE [left leg]. REMOVED OLD DRESSINGS, CLEANSED WITH NORMAL SALINE TO ALL INCISIONS, APPLIED ABD PADS, COVERED WITH WOUND VAC DRAPE PER PATIENT REQUEST….” Clinical record review failed to evidence wound care orders for the left lateral thigh and left lateral knee surgical incisions. During an interview on 5/13/2022 at 2:06 PM, the clinical manager indicated the nurse failed to perform wound care only as ordered by the physician. 6. Clinical record review on 5/12/2022 for patient #12, start of care 4/9/2022, certification period 4/9/2022 to 6/7/2022, primary diagnosis of Respiratory failure with hypoxia (low oxygen), evidenced an agency document titled, “HOME HEALTH CERTIFICATION AND PLAN OF CARE”. The plan of care had a subsection titled, “Orders of Discipline and Treatments:”, which stated, “ … SKILLED NURSE TO CHANGE F OLEY [sic] CATHETER [a tube inserted through the urethra to drain the bladder] WITH 16F [French] [a unit of size measurement] / 10 CC MONTHLY AND PRN [as needed]….” Clinical record review evidenced an agency document titled, “Visit Note Report”, dated 5/3/2022, and signed by RN (registered nurse) C, which stated, “ … FOLEY REMOVED AND NEW 16F COUDE CATHETER [a catheter specifically designed to maneuver around obstructions or blockages in the urethra] INSERTED AND SECURED IN PLACE WITH SECUREMENT DEVICE….” Clinical record review failed to evidence an order to use a Coude catheter. During an interview on 5/13/2022 at 3:34 PM, the clinical manager indicated the nurse should change the catheter only as ordered by the physician. 17-13-1(a)	G0580		
G0588	Reviewed, revised by physician every 60 days CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure the plan of care was reviewed and revised by the physician who is responsible for the home health plan of care in 1 of 5 discharge	G0588		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

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G0588	Continued from page 82 records reviewed (#16). The findings include: Record review evidenced an agency policy revised December 2019, titled “Physician participation in plan of care” which stated, “… the attending physician will participate in the care planning process by initiating, reviewing, and revising the plan of care (therapeutic and diagnostic orders) ….” Clinical record review for patient #16 was completed on 05/15/2022 for start of care 12/22/2021 and certification period 12/22/2021 – 02/19/2022, discharge date 02/01/2022. Record review evidenced a referral order dated 12/20/2021, which listed patient’s physician as physician G. Clinical record review evidenced a plan of care for start of care 12/22/2021 and certification period 12/22/2021 – 02/19/2022 which failed to be signed by a physician the entire certification period. This document listed physician H as patient #16’s physician. A fax status report was reviewed and failed to evidence the plan of care was sent to any physician to be reviewed or revised. During an interview on 05/16/2022 at 10:20 AM, when queried why the plan of care and referral order listed 2 different physicians, clinical manager B indicated she did not know. Clinical manager B stated, when queried how the physician reviews and revises the plan of care, “… through the start of care and the recerts [recertification assessments], they expect them to sign it within 5 days of getting order ….” Clinical manager B indicated the plan of care is faxed to the physician for review, and if not signed, she follows up with a call to the office. Clinical manager B indicated she did not know how physician G could review and revise the plan of care if it was sent to physician H.	G0588		
G0590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the physician was promptly notified of changes in the patient’s condition that suggest outcomes are not being	G0590		

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G0590	Continued from page 83 achieved and/or the plan of care should be revised in 5 of 10 clinical records reviewed receiving wound care services (#4, 7, 9, 14, 17). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled “Monitoring Patient’s Response/Reporting to Physician” which stated, “… The patient’s physician will be contacted on the same day when any of the following occur: … significant changes in the patient’s condition … Inability to achieve goals within the specified time frame … Changes in the patient’s expected response to treatment or medications ….” 2. Clinical record review for patient #4 was completed on 05/13/2022. Record review evidenced a plan of care for start of care 04/06/2022 and certification period 04/06/2022 – 06/04/2022 which stated, “… Skilled nursing is medically necessary for skilled observation and assessment of surgical incisions due to the reasonable potential for hospitalization, complication, exacerbation, and/or change in treatment within the next three weeks ….” Clinical record review evidenced skilled nurse visits for 04/06/2022, 04/11/2022, 04/18/2022, 04/25/2022, and 05/02/2022, in which no surgical wound site assessment was completed due to patient refusal of skilled nurse assessments. Record review failed to evidence physician was notified of change in patient’s needs that suggested the outcomes were not being achieved or the plan of care needed revision. During an interview on 05/11/2022 at 11:04 AM, when queried why patient #4 was not receiving surgical site assessment as ordered on the plan of care, clinical manager B stated, “… because she refused assessment to the site from 4 people … I remember we talked about this in the case conference … It wasn’t the nurse, but the patient didn’t want the nurse looking at it ….” When queried if the physician was notified the patient was not receiving services ordered in the plan of care, couldn’t meet surgical site outcomes, and plan of care needed revision, clinical manager B indicated she did not see any specific notification in the chart. 3. Clinical record review for patient #9 was completed on 05/13/2022. Record review evidenced a start of care assessment dated 04/08/2022 which indicated the following measurements to wound #1 to right upper buttocks stage 2: 1cm (centimeter) x 0.4cm x 0.1cm. Clinical record review evidenced a plan of care for start of care 04/08/2022 and certification period 04/08/2022 – 06/06/2022. This	G0590		

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G0590	Continued from page 84 document stated, "… Goals … No falls/injuries within 60 days … Decrease in wound size … patient will receive safe and effective aide care for bathing, grooming, and dressing until there is evidence that a caregiver can assist or patient is safe/capable of performing self care within 60 days …." Clinical record review evidenced an agency document dated 04/13/2022, titled "Client Occurrence Report", which indicated patient #9 fell on 04/13/2022. This document indicated, while being assisted to the bathroom by spouse, patient's leg gave out and patient scooted to the stairs. Record review failed to evidence physician notification of fall or need for revision to plan of care regarding inability to achieve goal of no falls within 60 days as per plan of care. Clinical record review evidenced patient was admitted to entity C (hospital) on 04/13/2022. Record review evidenced a history and physical dated 04/14/2022, which stated, "… patient states she slipped and fell last am, was not dizzy, hurt her back and shoulders as well as her legs … now being admitted for pain management and chronic hypotension [low blood pressure] …." Record review evidenced patient #9 was discharged on 04/21/2022 from entity C, and resumed home health services on 04/22/2022, with no changes to her plan of care regarding falls or hypotension, and no evidence of physician notification regarding revision of plan of care to meet patient's needs. Record review evidenced a resumption of care assessment dated 04/22/2022, which included the following wound measurements for wound #1 right upper buttock stage 2: 1.2cm x 0.7cm x 0.1cm. No physician notification was evidenced for increasing size of wound, and failure to progress toward goal of decreasing wound size. Clinical record review evidenced a skilled nurse visit note dated 04/25/2022, which indicated the following measurements to wound #1 right upper buttock stage 2: 2.8cm x 0.8cm x 0.1cm. This document stated, "… Due to new open areas, [physician I] called message left …." No documentation was evidenced demonstrating physician I was made aware of increasing wound size, patient not meeting wound care goals, or worsening in status requiring revision of plan of care. During an interview on 05/12/2022 at 11:17 AM, when queried what would be expected if patient was not meeting goals, or a wound was worsening, clinical manager B indicated she would expect the clinician to contact the physician to update the plan of care. Clinical manager B indicated she did not know if the physician was contacted or not.	G0590		

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G0590	Continued from page 85 4. Clinical record review on 5/9/2022, for patient #7, start of care 12/23/2021, evidenced an untitled document from skilled nursing facility N, dated 12/13/2021, which indicated the physician ordered the patient was to receive home health aide services. Review evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 4/22/2022 – 6/20/2022, and signed by the nurse practitioner on 4/28/2022. This document stated, “… Home health aide service for assistance with personal care and ADL’s [activities of daily living] ….” Review failed to evidence home health aide visits were provided. This document indicated social work services were ordered 1 time a week for 1 week. Review failed to evidence social work services were provided. Review failed to evidence the physician was notified that the agency was not able to provide the services as ordered. During an interview on 5/10/2022, at 12:24 PM, the clinical manager indicated the agency had not yet provided the patient home health aide services and indicated the patient probably needed custodial care to help offload some of the care from the caregiver. At 1:32 PM, the clinical manager indicated the agency just hired a social worker and the visits were not showing in the social worker’s calendar. During an interview on 5/11/2022, at 2:32 PM, the clinical manager indicated the social worker was needed to assist the wife find some custodial care to help her with household tasks and indicated no social work services had been provided yet. The clinical manager indicated the agency had not notified the physician or nurse practitioner the ordered home health aide services and social work services had not been provided as ordered. 5. Clinical record review on 5/12/2022, for patient #14, start of care 5/4/2022, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 5/4/2022 – 7/3/2022. This document indicated the patient was to receive skilled nursing services 2 times a week for 1 week and 1 time a week for 1 week. Review failed to evidence 2 nursing visits were provided during the week of 5/1/2022 and failed to evidence a nursing visit was provided during the week of 5/8/2022 as directed in the plan of care. During an interview on 5/13/2022, at 11:14 AM, the clinical manager indicated she just was made aware on 5/12/2022 that the patient was out of town when she called RN K. The clinical manager indicated she was not	G0590		

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G0590	Continued from page 86 sure when the patient went out of town and indicated there was not any communication in the clinical record from RN K that the patient was out of town. During an interview on 5/13/2022, at 1:20 PM, RN K indicated she called the patient's caregiver on 5/8/2022 to schedule a nursing visit and was informed by the patient's caregiver that the patient was out of the state and left on 5/6/2022. Review failed to evidence the physician was notified the patient was out of state and nursing services were not provided as ordered in the plan of care. 6. Clinical record review on 5/13/2022 for patient #17, start of care 12/3/2021, certification period 12/3/2021 to 1/31/2022, primary diagnosis of Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". The plan of care had a subsection titled, "Orders of Discipline and Treatments:", which stated, " … SKILLED NURSE FOR OBSERVATION AND ASSESSMENT OF IV ACCESS SITE … SKILLED NURSE TO … MEASURE BICEP IMMEDIATELY PROXIMAL TO [above] INSERTION SITE Q [each] VISIT…." Clinical record review evidenced a group of agency documents titled, "Visit Note Report", signed by the nurse. The notes had a subsection titled, "INFUSION THERAPY". A note dated 12/27/2021 indicated the bicep measurement was 35 centimeters. A note dated 1/3/2022 indicated the bicep measurement was 38 centimeters. Review of the visit notes and coordination notes failed to evidence physician notification of the 3 cm increase in the patient's bicep measurement. During an interview on 5/17/2022 at 10:24 AM, the clinical manager indicated the nurse should report an increase in bicep measurement because it could mean the PICC [peripherally inserted central catheter] was infiltrated [not working correctly, causing medication to enter the surrounding tissues instead of the bloodstream], and may need to be removed. When informed of the findings, the clinical manager indicated the nurse failed to notify the physician of the change in the patient's status, and any change in measurement over 2 centimeters should have been reported. 17-13-1(a)(2)	G0590		
G0592	Revised plan of care CFR(s): 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated	G0592		

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G0592	Continued from page 87 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. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the plan of care was revised to reflect the patient's current status in 2 of 8 active clinical records reviewed with wounds. (#7, 10) The findings include: 1. Review of an agency policy obtained 5/12/2022, titled "Care Planning Process" revised December 2019, stated, "… The plan of care will be revised as frequently as deemed necessary by the clinicians based on the ongoing assessments of the patient…." 2. During an observation of care for patient #7, start of care 12/23/2021, on 5/6/2022, at 11:55 AM, the patient was observed to have an abrasion to the right hip with a dry scab. RN C was observed measuring the abrasion to the right hip. During the observation of care, RN C asked the patient's caregiver how the patient obtained the abrasion to the right hip. The patient's caregiver indicated it could have been from the strap from the brief or from when the dog jumped onto the patient's hospital bed. Clinical record review on 5/9/2022, evidenced an agency document titled "Visit Note Report", dated 5/6/2022 and electronically signed by RN C, indicated the wound to the right hip measured 10 cm in length, 0.2 cm in width, and 0.1 cm in depth. This document indicated the area was a stage 1 (reddened, nonblanching, intact skin) pressure ulcer. Review evidenced an agency document titled "Home Health Updated Plan of Care Report" dated 5/10/2022. This document failed to indicate the plan of care had been revised to reflect the wound to the right hip. During an interview on 5/10/2022, at 1:35 PM, the clinical manager indicated the plan of care should be revised to include the new wound identified by the RN on 5/6/2022. 3. Clinical record review on 5/11/2022, for patient #10, start of care 4/25/2022, evidenced agency documents titled "Visit Note Report". Document electronically signed by PT G and dated 4/25/2022, indicated the PT assessed the patient's pain to be 8 on a scale of 0-10. Document electronically signed by occupational therapist (OT) I and dated 4/27/2022, indicated the OT assessed the patient's pain to be an 8 on a scale of 0-10. Document electronically signed by RN K and dated 4/29/2022,	G0592		

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G0592	Continued from page 88 indicated the patient's pain was 8 on a scale of 0-10. Document electronically signed by RN K and dated 5/3/2022, indicated the patient's pain was 9 on a scale of 0-10. Document electronically signed by RN C and dated 5/6/2022, indicated the patient's pain was 8 on a scale of 0-10. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 4/25/2022 – 6/23/2022, indicated the goals included, but were not limited to, the patient will verbalize effective pain control and a decrease in pain to acceptable levels. Review failed to evidence the plan of care was revised to assist the patient in meeting the goals of decreased pain levels. During an interview on 5/12/2022, at 1:18 PM, the clinical manager indicated the plan of care should have been updated to include possible additional pain medications or a change in pain parameters of when to notify the physician related to the patient's pain. 17-14-1(a)(1)(C)	G0592		
G0604	Integrate all orders CFR(s): 484.60(d)(2) Integrate orders from all physicians or allowed practitioners involved in the plan of care to assure the coordination of all services and interventions provided to the patient. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the integration of orders from all physicians involved in the patient's care into the plan of care to assure coordination of all services and interventions provided to the patient in 1 of 8 active clinical records reviewed with wounds. (#6) The findings include: Review of an agency policy on 5/17/2022, titled "Monitoring Patient's Response/Reporting to Physician" revised December 2019, stated, "… The organization shall communicate with all physicians involved in the plan of care to avoid duplication or contradictory physician orders and to assure that all patient needs are being met. All physician orders shall be integrated into the plan of care…." Clinical record review on 5/10/2022, for patient #6, start of care 4/7/2022, evidenced a document from the office of physician U titled	G0604		

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G0604	Continued from page 89 "Referral" dated 4/7/2022. This document indicated nurse practitioner V at the office of physician U ordered wound care to the foot wounds to be cleansed with betadine (a wound cleansing solution), apply dry gauze between toes, wrap leg with kerlix (a type of gauze wrap) and ace wrap (a compression wrap) daily. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 4/7/2022 – 6/5/2022, failed to evidence the wound order to the foot wounds as ordered by nurse practitioner V. During an interview on 5/11/2022, at 9:00 AM, the patient indicated the wound care was directed by physician U. During an interview on 5/11/2022, at 4:39 PM, the clinical manager indicated she was unsure why the wound order from nurse practitioner V was not included in the plan of care and indicated the nurse should have clarified the wound order. 17-12-2(h)	G0604		
G0606	Integrate all services CFR(s): 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure coordination of care by all disciplines in 2 of 2 clinical records reviewed with dialysis treatment (#1, 5), 3 of 9 active clinical records reviewed with physical therapy services (#6, 11, 12), and 1 of 5 closed clinical records reviewed. (#14) The findings include: 1. Review of an agency policy on 5/17/2022, titled "Care/Service Coordination" stated, "… Timely and ongoing communication is the responsibility of each team member and will be appropriate to the needs and abilities of the patient … The clinician/technician will be responsible for facilitating communications about changes in the patient's status among the assigned personnel…." 2. Clinical record review on 5/10/2022, for patient #6, start of care 4/7/2022,	G0606		

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G0606	Continued from page 90 evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 4/7/2022 – 6/5/2022, which indicated the patient was to receive skilled nursing and physical therapy (PT) services. Review evidenced an untitled agency document the clinical manager identified as a verbal order electronically signed by licensed practical nurse (LPN) F dated 4/12/2022. This document indicated the patient was admitted to the hospital on 4/8/2022. Review failed to evidence the LPN coordinated care with the PT and the registered nurse (RN) case manager to inform them of the patient’s hospital admission. During an interview on 5/11/2022, at 4:00 PM, the clinical manager indicated there was no documentation in the clinical record the LPN communicated the patient’s hospital admission was communicated to the PT and RN case manager. Review of an agency document titled “Client Coordination Note Report” entered by physical therapy assistant (PTA) H and dated 4/20/2022, indicated the patient declined PT services and wanted occupational therapy (OT). The clinical record failed to evidence the PTA coordinated care with the PT regarding the patient’s refusal of PT services. During an interview on 5/11/2022, at 3:51 PM, the clinical manager indicated the PTA should coordinate care with the PT regarding refusal of PT services. 3. Clinical record review on 5/11/2022, for patient #11, start of care 4/29/2022, evidenced an agency document titled “Client Coordination Notes Report”, entered by LPN F and dated 5/12/2022. This document indicated the patient moved to Illinois. Review failed to evidence LPN F coordinated care with the case manager regarding the patient’s move. During an interview on 5/13/2022, at 10:35 AM, the clinical manager indicated there was no care coordination with the team in the clinical record. 4. Clinical record review on 5/12/2022, for patient #14, start of care 5/4/2022, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 5/4/2022 – 7/3/2022. This document indicated the patient was to receive skilled nursing services 2 times a week for 1 week and 1 time a week for 1 week. Review failed to evidence 2 nursing visits were provided during the week of 5/1/2022 and failed to evidence a nursing visit was provided during the week of 5/8/2022 as directed in the plan of care. During an interview on 5/13/2022, at 11:14 AM, the clinical manager indicated she just was made aware on 5/12/2022 that the patient was out of town when she called RN K. The clinical manager indicated	G0606		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0606	Continued from page 91 she was not sure when the patient went out of town and indicated there was not any communication in the clinical record from RN K that the patient was out of town. During an interview on 5/13/2022, at 1:20 PM, RN K indicated she called the patient's caregiver on 5/8/2022 to schedule a nursing visit and was informed by the patient's caregiver that the patient was out of the state and left on 5/6/2022. 5. Clinical record review on 5/5/2022, for patient #1, start of care 2/15/2022, certification period 4/16/2022 to 6/14/2022, primary diagnosis of End stage renal disease (when the kidneys have stopped working), evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 4/22/2022. The plan of care had a subsection titled, "Orders of Discipline and Treatments:", which stated, " … PATIENT CONTINUING WITH DIALYSIS ON M/W/F [Monday, Wednesday, and Friday]…." Review of all visit notes and coordination notes for 4/12/2022 to 5/5/2022 failed to evidence coordination of care with the dialysis center. Review of the patient's electronic medical record (Home Care Home Base) failed to evidence coordination of care with the dialysis center. During an interview on 5/11/2022, at 11:52 AM, the clinical manager indicated the nurse should coordinate care with the dialysis center for all patients receiving dialysis and should document that communication in a coordination note. Observation of a home visit for patient #1 was conducted on 5/5/2022, at 12:00 PM. At 12:52 PM, PT [physical therapist] G placed their thermometer, pulse oximeter, blood pressure cuff, stethoscope, and gloves on a barrier on the patient's kitchen counter. PT G stated, "It's a reassessment visit. I don't have to do the vitals. Do you want me to?". The surveyor told PT G to do what they would normally do. PT G stated, "I won't do them then", and returned the equipment to their bag. At 1:19 PM, when PT G was preparing to leave visit, the patient asked PT G if they had a blood pressure cuff. PT G stated, "I already put it away". Person R, family of patient #1, placed their own automatic blood pressure cuff on the patient's left arm. Person R indicated the patient's blood pressure was 198/90 at the nurse's visit earlier that day. PT G asked person R if the nurse called the doctor. Person R stated, "No". After the automatic blood pressure cuff reading was complete (167/97), PT G left the patient's home. During an interview on 5/5/2022, at 1:25 PM, PT G indicated staff coordinates patient care via phone or email, but the communication should be in	G0606		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

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ACCENTCARE HOME HEALTH OF INDIAN	11037 BROADWAY, SUITE C , CROWN POINT, Indiana, 46307

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G0606	Continued from page 92 the patient's record. PT G indicated the nurse did not communicate with them about the patient's high blood pressure. PT G stated, "The nurse should have called, that was too high". During an interview on 5/11/2022, at 11:52 AM, the clinical manager indicated interdisciplinary care was coordinated weekly, but if there was an immediate concern, the clinicians should call each other right away. The clinical manager indicated an elevated blood pressure was an immediate concern. 6. Clinical record review on 5/11/2022 for patient #5, start of care 1/11/2022, certification period 3/12/2022 to 5/10/2022, primary diagnosis of Type 2 Diabetes Mellitus (a medical condition in which your body does not use insulin properly, resulting in unusual blood sugar levels) with Hyperglycemia (high blood sugar), evidenced an agency document titled, "Visit Note Report … Visit Type: … OT [occupational therapy] ADD-ON EVALUATION", dated 3/17/2022, which stated, " … RECEIVES DAILYSIS [sic] ON M [Monday], W [Wednesday] AND FRIDAY…."Clinical record review of all visit notes and coordination notes for 3/12/2022 to 5/10/2022 failed to evidence coordination of care with the dialysis center. Review of the patient's electronic medical record (Home Care Home Base) failed to evidence coordination of care with the dialysis center. During an interview on 5/11/2022, at 11:52 AM, the clinical manager indicated the nurse should coordinate care with the dialysis center for all patients receiving dialysis and should document that communication in a coordination note. 7. Clinical record review on 5/12/2022 for patient #12, start of care 4/9/2022, certification period 4/9/2022 to 6/7/2022, primary diagnosis of Respiratory failure with hypoxia (low oxygen), evidenced an agency document titled, "Visit Note Report", dated 5/2/2022, and signed by COTA (certified occupational therapy assistant) Y. The visit note had a subsection titled, "Narrative", which stated, " … CARE COORDINATION: PATIENT STATED … IS ANXIOUS … TAKING TOK [sic] MANY MEDICATIONS AND THATS [sic] WHY … RED BLOOD CELL COUNT WAS LOW, WRITER SUGGESTED … MOVE … APPOINTMENT UP AND EDUCATED ON WHEN TO CALL 911." The visit note had a subsection titled, "CARE COORDINATION", which stated, "INDICATE IF YOU COMMUNICATE WITH OTHER DISCIPLINES INVOLVED IN THIS CASE: NO". Clinical record review failed to evidence communication with the therapist, nurse, or physician about the patient's concern about medications. During an interview on 5/13/2022, at 3:39 PM, the clinical manager indicated if a patient expressed concerns about medications, the	G0606		

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G0606	Continued from page 93 COTA should communicate with the lead therapist or nurse seeing the patient. 17-12-2(g)17-12-2(h)	G0606		
G0610	Patients receive education and training CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the patient received appropriate discharge teaching in 1 of 5 discharged records reviewed (#13). The findings include: Record review on 5/17/2022 evidenced an agency policy titled, “PATIENT EDUCATION RELATED TO DISCHARGE PLANNING”, revised 12/2019, which stated, “ … Patients will receive instructions upon discharge to facilitate self-care and health care follow-up….” Record review evidenced an agency policy titled, “DISCHARGE PLANNING”, revised 12/2019, which stated, “PURPOSE To promote patient independence, safety, and use of community resources prior to patient discharge from the organization … All communication and information regarding discharge planning will be documented in the clinical record….” Clinical record review on 5/12/2022 for patient #13, start of care 2/19/2022, certification period 12/19/2022 to 4/19/2022, primary diagnosis of Unspecified fracture of left femur (thighbone), evidenced an agency document titled, “Visit Note Report”, dated 4/15/2022, signed RN (registered nurse) C, which stated, “ … Visit Type: RN19 – DC [discontinuation] OF SN [skilled nursing] SERVICES (NOT FROM AGENCY) … Narrative … SN DISCHARGE … ABLE TO MONITOR BS [blood sugar] AND REPORT SIGNS AND SYMPTOMS OF ANY ABNORMALITIES … UNDERSTANDS … CAN CALL IF SN NEEDED….” Review of the visit notes and coordination notes	G0610		

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G0610	Continued from page 94 failed to evidence the nurse instructing the patient on self-care, reporting to physician, and when to seek emergency care. During an interview on 5/13/2022 at 2:52 PM, the clinical manager indicated discharge teaching should include what signs and symptoms the patient should watch for, when to call the physician, and when to call 911. When informed of the findings, the clinical manager indicated the nurse failed to provide appropriate discharge instructions to the patient. 17-14-1(a)(1)(G)	G0610		
G0614	Visit schedule CFR(s): 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure a written schedule was provided to patients in 6 of 7 home visits conducted (#1, 2, 3, 4, 6, 7). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled “Care Planning Process” which stated, “… The organization shall provide the patient and caregiver with a copy of written instructions outlining: … Visit schedule, including frequency of visits by personnel and personnel acting on behalf of the organization ….” 2. During an observation of care at the home of patient #6, start of care 4/7/2022, on 5/11/2022, at 9:19 AM, the agency’s folder was observed in the patient’s home. A blank calendar was observed inside of the folder. No written visit schedule was observed to have been provided to the patient. 3. During an observation of care in the home for patient #7, start of care 12/23/2021, on 5/6/2022, at 11:47 AM, the agency’s folder was observed in the patient’s home. A blank calendar was observed inside of the folder. No written visit schedule was observed to have been provided to the patient. 4. During an interview on 5/10/2022, at 10:11 AM, the clinical manager indicated staff is to write their upcoming visits on the calendar inside of the agency folder in the	G0614		

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G0614	Continued from page 95 patient's home. 5. Observation of a home visit for patient #2 was conducted on 05/05/2022 at 1:15 PM. During the visit, the patient stated she did not have any home folder or written information from the home health agency. Observation failed to evidence patient received in writing a schedule of visits. During an interview on 05/10/2022 at 3:43 PM, clinical manager B indicated if during a home visit, the patient does not have their written schedule or home folder anymore, the clinician should give them a new one. 6. Observation of a home visit for patient #4 was conducted on 05/09/2022 at 2:30 PM. During the visit, an AccentCare admission folder was reviewed. Observation failed to evidence patient received a written schedule. During an interview on 05/10/2022 at 10:15 AM, clinical manager B indicated patients are notified in writing of the frequency of visits and when personnel are coming via the calendar in the admission folder, or they send the patient's a schedule. 7. Observation of a home visit for patient #1 was performed on 5/5/2022 at 12:00 PM. The surveyor confirmed the time of the visit with the clinical manager on 5/5/2022. PT (physical therapist) G was observed arriving to the patient's home at 12:50 PM. Review of the agency's folder in the home failed to evidence a calendar or schedule of visits. During an interview on 5/5/2022 at 12:45 PM, the patient indicated the agency did not provide a written calendar or schedule of visits. They indicated the staff calls the night before a visit to tell them what time they will arrive. The patient stated, "They want me to eat, but they want a noon appointment", and shook their head. During an interview on 05/10/2022 at 10:15 AM, the clinical manager indicated patients are notified in writing of the frequency of visits and when personnel are coming via the calendar in the admission folder. 8. Observation of a home visit for patient #3 on 5/6/2022 at 10:28 AM failed to evidence a home folder. During an interview on 5/6/2022 at 10:58, RN (registered nurse) D indicated there was not an agency folder in the patient's home, and they would bring one back for the patient.	G0614		
G0616	Patient medication schedule/instructions CFR(s): 484.60(e)(2)	G0616		

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G0616	Continued from page 96 Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure patients were provided written medication schedule/instructions in 3 of 7 home visits conducted (#2, 6, 7). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled “Care Planning Process” which stated, “… The organization shall provide the patient and caregiver with a copy of written instructions outlining: … Patient medication schedule/instructions, including medication name, dosage and frequency and which medications will be administered by the organization’s personnel and personnel acting on behalf of the organization ….” 2. Observation of a home visit for patient #2 on 05/05/2022 at 1:15 PM. During the visit, the patient stated she did not have any home folder or written information from the home health agency. Observation failed to evidence patient had received a medication schedule or instructions in writing. During an interview on 05/10/2022 at 3:43 PM, clinical manager B indicated if during a home visit, the patient does not have their written medication schedule/instructions or home folder anymore, the clinician should give them a new home folder. 3. During an observation of care at the home of patient #6, start of care 4/7/2022, on 5/11/2022, at 9:19 AM, the agency’s folder was observed in the patient’s home. A written medication schedule and instructions were not observed in the patient’s home. 4. During an observation of care in the home for patient #7, start of care 12/23/2021, on 5/6/2022, at 11:47 AM, the agency’s folder was observed in the patient’s home. A written medication schedule and instructions were not observed in the patient’s home. 5. During an interview on 5/10/2022, at 10:11 AM, the clinical manager indicated the medications should be either written in the agency folder in the home or written out for the patient. The clinical manager indicated the staff should review this list at every visit and replace it if missing.	G0616		
G0618	Treatments and therapy services	G0618		

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G0618	Continued from page 97 CFR(s): 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure patients received in writing any treatments to be administered by personnel and personnel acting on behalf of the home health agency in 3 of 7 home visits conducted (#2, 6, 7). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled “Care Planning Process” which stated, “… The organization shall provide the patient and caregiver with a copy of written instructions outlining: … Any treatments to be administered by the organization’s personnel and personnel acting on behalf of the organization, including therapy services ….” 2. Observation of a home visit for patient #2 on 05/05/2022 at 1:15 PM. During the visit, the patient stated she did not have any home folder or written information from the home health agency. Observation failed to evidence patient had received any written information on treatments to be administered by agency personnel. During an interview on 05/10/2022 at 3:43 PM, clinical manager B indicated if during a home visit, the patient does not have their written treatment instructions or home folder anymore, the clinician should give them a new home folder. 3. During an observation of care at the home of patient #6, start of care 4/7/2022, on 5/11/2022, at 9:19 AM, the agency’s folder was observed in the patient’s home. No notice in writing of services and treatments to be provided by the agency was observed in the patient’s home. 4. During an observation of care in the home for patient #7, start of care 12/23/2021, on 5/6/2022, at 11:47 AM, the agency’s folder was observed in the patient’s home. No notice in writing of services and treatments to be provided by the agency was observed in the patient’s home. 5. During an interview on 5/10/2022, at 10:11 AM, when queried how the agency provided the patient in writing the services and treatments to be provided by the agency, the clinical manager indicated she would find out. No additional information was provided.	G0618		
G0622	Name/contact information of clinical manager	G0622		

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G0622	Continued from page 98 CFR(s): 484.60(e)(5) Name and contact information of the HHA clinical manager. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure patients received the name and contact information for the clinical manager in writing in 3 of 7 home visits conducted (#2, 6, 7). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled “Care Planning Process” which stated, “… The organization shall provide the patient and caregiver with a copy of written instructions outlining: … Name and contact information of the organization’s clinical manager ….” 2. Observation of a home visit for patient #2 on 05/05/2022 at 1:15 PM. During the visit, the patient stated she did not have any home folder or written information from the home health agency. Observation failed to evidence patient had received any written information with the clinical manager’s name or contact information. During an interview on 05/10/2022 at 3:43 PM, clinical manager B indicated if during a home visit, the patient does not have the clinical manager’s name and contact information or home folder anymore, the clinician should give them a new home folder. 3. During an observation of care at the home of patient #6, start of care 4/7/2022, on 5/11/2022, at 9:19 AM, the agency’s folder was observed in the patient’s home. No sticker was observed on the cover of the agency folder. The name of the clinical manager was not observed to have been provided in writing to the patient. 4. During an observation of care in the home for patient #7, start of care 12/23/2021, on 5/6/2022, at 11:47 AM, the agency’s folder was observed in the patient’s home. The name of the clinical manager observed inside of the agency folder was person Q. 5. During an interview on 5/10/2022, at 10:13 AM, the clinical manager indicated person Q was the previous clinical manager.	G0622		
G0640	Quality assessment/performance improvement CFR(s): 484.65	G0640		

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G0640	Continued from page 99 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the quality assurance and performance improvement (QAPI) program failed to measure, analyze and track quality indicators and other aspects of performance that enable the agency to assess processes of care, agency services and operations (see tag G642); to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement (see G644); to focus on high risk areas (see tag G648); to ensure the performance improvement activities considered incidence, prevalence and severity of problems (see tag G650); to ensure the performance improvement activities lead to an immediate correction of any identified problem that directly or potentially threatened the health and safety of the patients (see tag G652); to ensure the performance improvement activities tracked adverse patient events, analyzed their causes, and implemented preventive actions (see tag G654); to take actions aimed at performance improvement, and after implementing those actions, the agency must measure its success and track performance to ensure improvements are sustained (see tag G656); and to conduct performance improvement projects (see G658). 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	G0640		

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G0640	Continued from page 100 participation 484.65 Condition: Quality Assessment / Performance Improvement.	G0640		
G0642	Program scope CFR(s): 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to measure, analyze, and track quality indicators, including adverse events, that enable the agency to assess processes of care, agency services, and operations. The findings include: Review of an agency policy on 5/9/2022, titled "Performance Improvement Program and Annual Agency Evaluation" revised 3/1/2019, stated, "… The goals of the QAPI [quality assurance and performance improvement] Program are accomplished in various ways, including, but not limited to measuring, analyzing, and tracking quality indicators, including adverse patient events, and other aspects of performance that enable the agency to assess processes of care, services, and operations…." Review of the agency QAPI program on 5/9/2022, evidenced an agency document titled "QAPI Summary Report and Professional Advisory Committee Meeting Q1 [quarter 1]" dated 3/2/2022, which indicated the agency had 7 infections identified as "Other" and 12 patient falls. Review failed to evidence the agency analyzed and tracked the falls and infections. During an interview on 5/9/2022, at 11:36 AM, the clinical manager indicted the agency talked about the falls but indicated nothing was documented. During an interview on 5/9/2022, at 11:36 AM, the administrator indicated the agency should have	G0642		

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G0642	Continued from page 101 determined a performance improvement action to address the patient falls. 17-12-2(a)	G0642		
G0644	Program data CFR(s): 484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the detail of the data collections was approved by the governing body. The findings include: Review of an agency policy on 5/9/2022, titled "Governing Body" revised 2/15/2022, stated, "… The Governing Body assumes the following duties and responsibilities with the organization's legal documents: … Approve the Quality Assurance/Performance Improvement Program (QAPI) that: … Approves frequency and specific plan for Performance Improvement data collection …." Review of an agency document on 5/9/2022, titled "Governing Body Minutes" dated 7/13/2021, failed to evidence the governing body approved the detail of the data collection for the QAPI program. Review of the agency's QAPI binder on 5/9/2022, failed to evidence the approval of the data collection by the governing body. During an interview on 5/9/2022, at 11:36 AM, the administrator indicated he did not have any documentation of the approval of the data	G0644		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G0644	Continued from page 102 collection approved by the governing body. The administrator indicated the governing body minutes were for the entire corporation and not agency-specific. 17-12-2(a)	G0644		
G0648	High risk, high volume, or problem-prone area CFR(s): 484.65(c)(1)(i) (i) Focus on high risk, high volume, or problem-prone areas; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the performance improvement activities focused on high risk, high volume, or problem-prone areas. The findings include: Review of an agency policy on 5/9/2022, titled "Performance Improvement Program and Annual Agency Evaluation" revised 3/1/2019, stated, "… QAPI [quality assurance and performance improvement] improvement activities focus on: High risk, high volume, or problem-prone areas …." Review of the agency QAPI program on 5/9/2022, evidenced an agency document titled "QAPI Summary Report and Professional Advisory Committee Meeting Q1 [quarter 1]" dated 3/2/2022, which indicated the agency had 7 infections identified as "Other" and 12 patient falls. Review failed to evidence improvement activities for infections and falls. Review of an agency document on 5/6/2022, titled "Client Census Report" dated 5/4/2022, evidenced 12 patients with wounds. Review of an agency document on 5/6/2022, titled "QI Event Report" indicated the agency had 16 patient falls in 2022. Review of an agency document on 5/6/2022, titled "Transfer to Inpatient Facility History" indicated the agency had 76 patient hospitalizations since 1/1/2022. Review failed to evidence improvement activities for hospitalizations. During an interview on 5/9/2022, at 11:36 AM, the administrator indicated the agency has a sick patient population and indicated wounds would be an area of high risk. The administrator indicated the patient hospitalization rate was pretty high and indicated that was a work in progress. The administrator indicated there were no performance activities related to wounds, falls, and hospitalizations.	G0648		
G0650	Incidence, prevalence, severity of problems	G0650		

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G0650	Continued from page 103 CFR(s): 484.65(c)(1)(ii) (ii) Consider incidence, prevalence, and severity of problems in those areas; and This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the performance improvement activities considered incidence, prevalence, and severity of problems. The findings include: Review of an agency policy on 5/9/2022, titled "Performance Improvement Program and Annual Agency Evaluation" revised 3/1/2019, stated, "… QAPI [quality assurance and performance improvement] improvement activities focus on: … Incidence, prevalence, and severity of problem areas ..." Review of the agency QAPI program on 5/9/2022, evidenced an agency document titled "QAPI Summary Report and Professional Advisory Committee Meeting Q1 [quarter 1]" dated 3/3/2022. Review indicated the agency reported 12 patient falls and indicated all trends would be assessed. Review failed to evidence an assessment of trends for falls and failed to evidence performance activities which considered the prevalence of falls. Review of an agency document on 5/6/2022, titled "Transfer to Inpatient Facility History" indicated the agency had 76 patient hospitalizations since 1/1/2022. Review failed to evidence performance activities which considered the prevalence of the hospitalizations. During an interview on 5/9/2022, at 11:36 AM, the administrator indicated corporate puts together the data and is unaware of any trending and performance activities related to the prevalence of the problems.	G0650		
G0652	Activities lead to an immediate correction CFR(s): 484.65(c)(1)(iii) (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the performance improvement activities lead to an immediate correction of any identified problem that directly or potentially	G0652		

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G0652	Continued from page 104 threatened the health and safety of the patients. The findings include: Review of an agency policy on 5/9/2022, titled "Performance Improvement Program and Annual Agency Evaluation" revised 3/1/2019, stated, "… QAPI [quality assurance and performance improvement] improvement activities focus on: … Developing an immediate correction of any identified problem that directly or potentially threatens the health and safety of patients…." Review of an agency document on 5/6/2022, titled "Transfer to Inpatient Facility History" indicated the agency had 76 patient hospitalizations since 1/1/2022. Review failed to evidence performance activities which lead to an immediate correction of patient hospitalizations. Review of the agency's QAPI binder on 5/9/2022, failed to evidence actions taken which lead to an immediate correction of patient hospitalizations. During an interview on 5/9/2022, at 11:36 AM, the administrator indicated the agency has directed staff to inform the patient to call the agency prior to going to the hospital and indicated there was not any actions documented to address the patient hospitalizations. The administrator indicated the hospitalizations rate was high and an ongoing issue. 17-12-2(a)	G0652		
G0654	Track adverse patient events CFR(s): 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the performance improvement activities tracked adverse patient events, analyzed their causes, and implemented preventive actions. The findings include: Review of an agency policy on 5/9/2022, titled "Performance Improvement Program and Annual Agency Evaluation" revised 3/1/2019, stated, "… Performance Improvement activities track, analyze, and implement preventative/improvement activities for adverse patient events…." Review of the agency QAPI program on 5/9/2022, evidenced an agency	G0654		

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G0654	Continued from page 105 document titled “QAPI Summary Report and Professional Advisory Committee Meeting Q1 [quarter 1]” dated 3/3/2022. Review indicated the agency reported 12 patient falls and indicated all trends would be assessed. Review failed to evidence an assessment of trends for falls, failed to evidence an analysis of their causes, and failed to evidence performance activities were implemented to address patient falls. During an interview on 5/9/2022, at 11:36 AM, the administrator indicated there was no documented analysis of the trends and causes of the patient falls. During an interview on 5/9/2022, at 11:36 AM, the clinical manager indicated referring patients with falls to physical therapy and reassessing the patient’s fall risk were good ideas for actions to address patient falls. 17-12-2(a)	G0654		
G0656	Improvements are sustained CFR(s): 484.65(c)(3) The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to take actions aimed at performance improvement, and, after implementing those actions, the agency must measure its success and track performance to ensure improvements are sustained. The findings include: Review of an agency policy on 5/9/2022, titled “Performance Improvement Program and Annual Agency Evaluation” revised 3/1/2019, stated, “… Improvement and corrective actions that are implemented measure the success of improvement success and track performance to ensure that improvements are sustained….” Review of the agency QAPI program on 5/9/2022, evidenced an agency document titled “QAPI Summary Report and Professional Advisory Committee Meeting Q3 [quarter 3]” dated 9/30/2021. Review indicated the agency had 134 patient recertifications for the quarter and indicated the agency would review the plans of care for ensuring the patient needs were met to achieve desired outcomes and communicate with the physician of changes in condition. Review	G0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

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G0656	Continued from page 106 of the document stated, "… Document a detailed narrative analysis of the data compared to previous quarter. Document what the plan is to improve …." Review failed to evidence the agency documented a plan of action for improvement of the care planning process. Review failed to evidence a QAPI committee meeting for quarter 4 of 2021. Review of an agency document titled "QAPI Summary Report and Professional Advisory Committee Meeting Q4" dated 3/2/2022, evidenced 134 patient recertifications were reported for quarter 1 of 2022. Review of the document stated, "… Document a detailed narrative analysis of the data compared to previous quarter. Document what the plan is to improve …." Review failed to evidence the agency documented a plan of action for improvement of the care planning process and compared the improvement from the last documented QAPI meeting for quarter 3 of 2021 for the care planning process. During an interview on 5/9/2022, at 11:36 AM, the administrator indicated there was not a QAPI meeting to address improvements for quarter 4 of 2021 because this was during the integration to the new corporation. The administrator stated, "The meetings sort of fell apart." 17-12-2(a)	G0656		
G0658	Performance improvement projects CFR(s): 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to document the reasons for conducting the performance improvement projects and the	G0658		

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G0658	Continued from page 107 measurable progress achieved. The findings include: Review of an agency policy on 5/9/2022, titled "Performance Improvement Program and Annual Agency Evaluation" revised 3/1/2019, stated, "… The purpose of QAPI [quality assureance and performance improvement] is to use measurable improvement indicators for which there is evidence that improvement in those indicators will improve health outcomes … while adhering to state and federal regulatory requirements…." Review of the agency QAPI program on 5/9/2022, evidenced an agency document titled "Performance Improvement Plan (PIP) List" dated 3/2/2022. Review indicated the agency's performance improvement projects were individualized plan of care, improve physician orders, and improve wound care documentation. Review failed to evidence the documentation of the reasons for conducting these projects and failed to evidence measurable progress achieved. During an interview on 5/9/2022, at 11:36 AM, the administrator indicated corporate determines the performance improvement projects, implements the activities, and gathers the data. The administrator indicated there was not documentation of the reasons the projects were chosen and evidence of measurable progress achieved.	G0658		
G0682	Infection Prevention CFR(s): 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. This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections in 2 of 4 home visits with the registered nurse (RN). (#6, 7) The findings include: 1. Review of an agency policy on 5/17/2022, titled "Hand Hygiene" revised December 2019, stated, "… Hand decontamination using an alcohol-based hand	G0682		

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G0682	Continued from page 108 rub should be performed: … After contact with a patient's intact skin … After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings … When moving from a contaminated body site to a clean body site during patient care … After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient … After removing gloves ….” 2. Review of an agency policy on 5/17/2022, titled “Bag Technique” revised December 2019, stated, “… Hand washing will always be completed before opening the bag. After hand washing, the supplies and/or equipment needed for the visit will be removed from the bag….” 3. During an observation of care at the home of patient #6, start of care 4/7/2022, on 5/11/2022, at 9:03 AM, registered nurse (RN) N touched the patient's left foot with open wounds present to the left great and 2nd toes with gloved hands. RN N was observed to then remove the blood pressure cuff, thermometer, and pulse oximeter (a medical device that measures the pulse rate and oxygen saturation in the blood) from inside of the nurse's bag. RN N was not observed to have removed her gloves and performed hand hygiene after touching the patient's foot with open wounds and before entering the nurse's bag. RN N obtained the patient's temperature, blood pressure, and listened to the patient's chest, back, and abdomen with the stethoscope. At 9:28 AM, RN N entered the nurse's bag to retrieve a plastic bag. RN N was not observed removing her gloves and performing hand hygiene before entering the nurse's bag. At 9:31 AM, RN N was observed cleansing the wounds to the left great and 2nd toes with betadine (a wound cleanser solution) and gauze. RN N was observed removing her gloves and applying clean gloves. RN N was not observed to have performed hand hygiene after gloves were removed and before clean gloves were applied. At 9:38 AM, RN N was observed with gloved hands applying a clean bandage to the left toes and wrapping the left foot with rolled gauze. RN N was observed opening the package of rolled gauze and placing her right hand into the package to check the rolled gauze supply with her gloved hand. RN N was not observed to have removed her glove and perform hand hygiene after providing wound care and before entering clean wound care supplies. During an interview on 5/13/2022, at 12:36 PM, the clinical manager indicated the nurse should have removed gloves and applied hand sanitizer after touching the patient's left foot with open wounds and before entering the nurse's bag. The clinical manager indicated hand hygiene	G0682		

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G0682	Continued from page 109 should be performed after gloves are removed. 4. During an observation of care at the home of patient #7, start of care 12/23/2021, on 5/6/2022, at 11:55 AM, RN C was observed wearing gloves and rolling the patient to his right side while lying in bed and unfastened his brief. RN C poured a clear liquid from a bottle into the bottle cap and soaked a gauze sponge in the liquid in the bottle cap. RN C touched the bed rail and lowered it down and touched the bed control to lower the head of the bed. RN C used her gloved hand while holding the brief to pull a formed brown substance from in between the patient's buttocks and placed it in the brief. RN C was observed wiping the patient's open area on the right buttock with the moistened gauze. The RN was not observed removing her gloves and performing hand hygiene after touching the patient's bed rail, bed control, and brief and before cleansing the open area on the patient's right buttock. During an interview on 5/11/2022, at 2:11 PM, the clinical manager indicated the nurse should have sanitized her hands and changed gloves after touching anything before performing wound care. 17-12-1(m)	G0682		
G0684	Infection control CFR(s): 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to maintain a program for the surveillance,	G0684		

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G0684	Continued from page 110 identification, prevention, control, and investigation of infections. The findings include: Record review on 5/4/2022 evidenced an agency policy titled, "EVALUATING AND MAINTAINING RECORDS OF INFECTIONS AMONG PATIENTS", revised 12/2019, which stated, " ... All patients with a new, actual, or suspected infection will have a patient infection report completed within 24 hours of discovery...." Clinical record review on 5/13/2022 for patient #17, start of care 12/3/2021, certification period 12/3/2021 to 1/31/2022, primary diagnosis of Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts evidenced an agency document titled, “HOME HEALTH CERTIFICATION AND PLAN OF CARE”. The plan of care had a subsection titled, “Orders of Discipline and Treatments:”, which stated, “ … SKILLED NURSE TO ASSESS / EVALUATE CO-MORBID CONDITIONS INCLUDING S/P [status post] FEMPOP BYPASS GRAFT [a surgery to bypass the blocked portion of main artery in the leg] INFECTION … SKILLED INSTRUCTION … RELATED TO IV THERAPY FOR INFECTION CONDITION….” Review of what was identified by the administrator as the infection log for 12/2021 to 2/2022 failed to evidence any entries for patient #17. During an interview on 5/17/2022, at 10:02 AM, the clinical manager indicated a patient admitted with an infection, being treated with antibiotics, should be included in the infection log.	G0684		
G0700	Skilled professional services CFR(s): 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician or allowed practitioner and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care.	G0700		

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G0700	Continued from page 111 This CONDITION is NOT MET as evidenced by: Based on record review and interview, the skilled professional failed to ensure the following: failed to provide the services as indicated in the plan of care (See tag G0710); failed to provide the patient and caregiver education (See tag G0714); failed to prepare clinical notes (See tag G0716); failed to communicate with the physician and other health care practitioners (See tag G0718); failed to participate in the agency's quality assurance and performance improvement (QAPI) program (See tag G0720); and failed to supervise the licensed practical nurse (LPN) (See tag G0726). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.75 Skilled Professional Services.	G0700		
G0710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the skilled professional failed to provide services as ordered in the plan of care in 5 of 8 active clinical records reviewed with wounds (#1, 6, 7, 8, 10), 1 of 2 active clinical records reviewed with urinary catheters (a plastic tube inserted into the bladder to drain urine from the body) (#12), and 1 of 2 closed clinical records reviewed with IV (a plastic tube inserted into the vein to deliver fluids and/or nutrition) access. (#17) The findings include: 1. Review of an agency policy on 5/17/2022, revised December 2019, stated "… The care will be provided in compliance with the therapeutic and diagnostic orders and accepted standards and practice…." 2. Clinical record review on 5/10/2022, for patient #6, start of care 4/7/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification	G0710		

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G0710	Continued from page 112 period 4/7/2022 – 6/5/2022. This document indicated the licensed professional was to notify the physician for a pulse less than 60 beats per minute and for pain greater than a 7 on a scale of 0-10. This document indicated the skilled nurse was to assess the gangrenous (death of tissue due to lack of blood flow or infection) wounds to the left great, 2nd, and 3rd toes. This document indicated the skilled nurse was to perform wound care to the left great, 2nd, and 3rd toes by cleansing with normal saline (a wound cleansing solution) and apply a non-adherent dressing daily. Review of an agency document titled "Skilled Visit Note" electronically signed by registered nurse (RN) N and dated 4/22/2022, evidenced the patient's pulse was 58. Review indicated person O, a medical assistant with the corporate office, faxed the physician the notification of the pulse below parameters. Review failed to evidence the licensed RN notified the physician of the pulse below parameters as directed in the plan of care. During an interview on 5/11/2022, at 4:17 PM, the clinical manager indicated RN N did not notify the physician and person O was a back-up checkpoint and faxed the notification to the physician. Review of agency documents titled "Skilled Visit Note" electronically signed by RN N and dated 4/18/2022, indicated the RN was unable to measure the wounds. Documents dated 4/22/2022 and 5/5/2022 indicated the wounds were not due to be measured. Document electronically signed by RN J and dated 4/28/2022 and 5/2/2022, indicated the RN was unable to measure the wounds. Review failed to evidence the RN assessed the wounds as directed in the plan of care. The documents electronically signed by RN N and dated 4/7/2022, 4/18/2022, 4/22/2022, and 5/5/2022 indicated the nurse cleansed the wounds to the left great and 2nd toes with betadine (a type of wound cleansing solution), oil emulsion dressing applied, covered with ABD (an absorbent dressing that provides padding), wrapped with kerlix (a gauze wrap), and wrapped with an ACE bandage (a compression wrap). Document electronically signed by RN N and dated 4/15/2022, indicated the nurse cleansed the wounds to the left great and 2nd toes with betadine, gauze applied between all toes, ABD pad applied, and wrapped with kerlix and ACE bandage. Document electronically signed by RN J and dated 4/28/2022, failed to evidence what wound care was provided by the nurse. Document electronically signed by RN J and dated 5/2/2022, indicated the nurse cleansed the wounds to the left great and 2nd toes with	G0710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G0710	Continued from page 113 betadine, applied xeroform (a petroleum gauze) to the left great, 2nd, and 3rd toes, applied gauze, and wrapped foot with conform (a gauze wrap). Review failed to evidence the nurse performed wound care as directed in the plan of care. During an observation of care at the patient's home on 5/11/2022, at 9:31 AM, RN N was observed cleansing the left great, 2nd, and 3rd toes with a dark yellow solution from a bottle labeled "Betadine", applied a petroleum gauze to the left great and 2nd toes, covered with an ABD pad, wrapped left foot with kerlix, and then wrapped the left foot with ACE bandage. The nurse was not observed to perform wound care as directed by the plan of care. During an interview on 5/11/2022, at 4:12 PM, the clinical manager indicated wound care should be provided as directed in the plan of care and indicated maybe the nurses were following another wound care order. At 4:19 PM, the clinical manager indicated the nurse should measure the wounds at least once a week. Review of an agency document titled "Skilled Visit Note" electronically signed by RN N and dated 4/18/2022, indicated the patient's pain was assessed to be 8 on a scale of 0-10. Review failed to evidence the nurse notified the physician of the pain greater than 7 as directed in the plan of care. During an interview on 5/11/2022, at 4:44 PM, the clinical manager indicated the document did not indicate the physician was notified of the pain greater than 7. 3. Clinical record review on 5/9/2022, for patient #7, start of care 12/23/2021, evidenced an agency document titled "Visit Note Report", with a visit date of 4/19/2022 and identified to be a RN recertification comprehensive assessment. This document indicated the patient was at a high risk for developing pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin), was bed bound, was assessed to need a waffle mattress (a specialty mattress used to help decrease the risk of developing pressure ulcers), had limited mobility, and had a diagnosis to include, but not limited to, diabetes (a chronic condition which affects the way the body processes blood sugar which can delay wound healing). Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 4/22/2022 – 6/20/2022, indicated the skilled nurse was to assess and evaluate conditions that present themselves during the episode. This document indicated the nurse was to educate the caregiver on foley catheter care (a plastic tube inserted into the bladder and held in place with a balloon	G0710		

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G0710	Continued from page 114 to drain urine from the body). During an observation of care at the patient's home on 5/6/2022, at 11:47 AM, the patient was observed lying in bed wearing a t-shirt and brief. RN C was not observed to have assessed the skin under the t-shirt to assess for skin breakdown. During an interview on 5/11/2022, at 2:03 PM, the clinical manager indicated the skilled nurse should complete a skin assessment to include looking at the skin on the patient's back for breakdown. Review of agency documents titled "Visit Note Report" electronically signed by licensed practical nurse (LPN) F and dated 3/30/2022, 4/14/2022, and 4/26/2022, failed to evidence the nurse educated the caregiver on foley catheter care as directed by the plan of care. During an interview on 2/11/2022, at 2:21 PM, the clinical manager indicated the nurse should have educated the caregiver on foley catheter care and indicated she did not see that it was provided. 4. Clinical record review on 5/11/2022, for patient #10, start of care 4/25/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/25/2022 – 6/23/2022. This document indicated the licensed professional was to notify the physician for pain greater than 7 on a scale of 0-10 and for a diastolic blood pressure (the pressure against the walls of the arteries during the contraction of the heart and noted as the bottom number of the blood pressure reading) greater than 100. This document indicated the PT was to provide interventions for the treatment of Chronic Obstructive Pulmonary Disease (COPD, a group of chronic disease that cause airflow blockage and breathing-related problems) including breathing exercises and postural drainage. This document indicated the skilled nurse was to assess the integumentary (the system of the body pertaining to the skin, hair, and nails) status. Review indicated the skilled nurse was to perform wound care by cleansing the wound with normal saline or wound cleanser, apply Silvadene (an antibiotic ointment), and wrap with kerlix (a rolled gauze) daily. Review of an agency document titled "Visit Note Report" electronically signed by physical therapist (PT) G and dated 4/25/2022, was identified to be a PT admission comprehensive assessment. Review indicated the PT assessed the patient's pain to be 8 on a scale of 0-10. Review failed to evidence the PT notified the physician of the patient's pain as directed by the plan of care. Review failed to evidence the PT provided breathing exercises and postural drainage	G0710		

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G0710	Continued from page 115 interventions as directed in the plan of care. This document indicated the patient had a wound to the right great toe, left buttock, right buttock, 2 wounds to the right leg, and 2 wounds to the left leg. Review evidenced an agency document titled “Visit Note Report” electronically signed by occupational therapist (OT) I and dated 4/27/2022, which indicated the OT assessed the patient’s pain to be an 8 on a scale of 0-10. Review indicated person O, corporate medical assistant, faxed notification to the physician of the patient’s pain. Review failed to evidence the OT notified the physician of the patient’s pain as directed by the plan of care. Review evidenced agency documents titled “Visit Note Report” electronically signed by RN K. Document dated 4/27/2022, failed to evidence an assessment of the wounds as directed in the plan of care. Document dated 4/29/2022 and 5/3/2022, indicated the RN was unable to assess the wound measurements to the wounds to the right leg, left leg, and right great toe. Review indicated the RN did not apply Silvadene to the wounds as ordered and indicated the patient did not have Silvadene in the home because the patient’s grandson was to pick-up the Silvadene from the pharmacy. Review of document dated 4/29/2022 indicated the RN assessed the patient’s pain to be an 8 on a scale of 0-10 and the diastolic blood pressure to be 102. Review indicated person O, corporate medical assistant, faxed notification to the physician of the patient’s blood pressure. Review failed to evidence the RN notified the physician of the patient’s pain and blood pressure as directed by the plan of care. Document dated 5/3/2022, indicated the RN assessed the patient’s pain to be 9 on a scale of 0-10. Review indicated person O, corporate medical assistant, faxed notification to the physician of the patient’s pain. Review failed to evidence the RN notified the physician of the patient’s pain as directed by the plan of care. Review evidenced an agency document titled “Visit Note Report” electronically signed by RN C and dated 5/6/2022, which indicated the RN assessed the patient’s pain to be 8 on a scale of 0-10. Review indicated person O, corporate medical assistant, faxed notification to the physician of the patient’s pain. Review failed to evidence the RN notified the physician of the patient’s pain as directed by the plan of care. During an interview on 5/12/2022, at 12:23 PM, the clinical manager indicated the RN, PT and OT should have notified the physician of the patient’s pain and elevated blood pressure. The clinical manager indicated the	G0710		

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G0710	Continued from page 116 PT did not provide breathing exercises and postural drainage interventions. At 1:28 PM, the clinical manager indicated the RN should have contacted the MD if the patient did not have Silvadene to obtain an alternate wound care order. The clinical manager indicated she thinks the RN was unable to assess the patient's wound because the patient was angry at the nurse. 5. Clinical record review on 5/5/2022, for patient #1, start of care 2/15/2022, certification period 4/16/2022 to 6/14/2022, primary diagnosis of End stage renal disease (when the kidneys have stopped working), evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 4/22/2022. The plan of care had a subsection titled, "Orders of Discipline and Treatments:", which stated, " … SKILLED NURSE FOR OBSERVATION AND ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. SKILLED NURSE TO INTERVENE WITH INCREASED PAIN LEVEL TO MINIMIZE COMPLICATIONS … LICENSED PROFESSIONAL TO REPORT VITAL SIGNS FALLING OUTSIDE THE FOLLOWING ESTABLISHED PARAMETERS … SYSTOLICBP [sic] [systolic blood pressure] [the top number of a blood pressure] <90>160 [less than 90 or greater than 160 DIASTOLICBP [sic] [diastolic blood pressure] [the bottom number of a blood pressure] <50>100 … PAIN <2>7 [less than 2 or greater than 7] … INCREASED PAIN OR INADEQUATE PAIN CONTROL MEASURES WILL BE IDENTIFIED AND REPORTED TO THE PHYSICIAN…." Clinical record review evidenced an agency document titled, "Visit Note Report", dated 4/12/2022, and signed by the nurse. The visit note had a section titled, "Vital Signs", which indicated the patient had pain rated 9 out of 10. The subsection titled, "Comments" stated, " … FOLLOW-UP COMMENT ENTERED BY [corporate medical assistant O] on 4/13/2022 FAXED TO [physician P]". Review of the visit note and coordination notes failed to evidence skilled nurse intervention for the patient's pain. Clinical record review evidenced an agency document titled, "Visit Note Report", dated 4/28/2022, and signed by the nurse. The visit note had a section titled, "Vital Signs", which indicated the patient had pain rated 8 out of 10. The subsection titled, "Comments" stated, "MD AWARE". Review of the visit note and coordination notes failed to evidence skilled nurse intervention for the patient's pain. Clinical record review evidenced an agency document titled, "Visit Note Report", dated 5/5/2022, and signed by the nurse. The visit note had a section titled, "Vital Signs", which	G0710		

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G0710	Continued from page 117 indicated the patient's blood pressure was 198/88. The subsection titled, "Comments" stated, " … NOT YET TAKEN B/P MED FOLLOW UP COMMENT ENTERED BY [corporate medical assistant O], ADMN ON 5/6/2022 FAXED TO DR [patient #1]. Review of the visit note and coordination notes failed to evidence the nurse reported the blood pressure to the physician. During an interview on 5/11/2022 at 11:43 AM, the clinical manager indicated if a patient's vital signs are outside of established parameters, the clinician should call the physician, while still in the patient's home if possible. The clinical manager indicated if there are patient findings that, according to the plan of care should be reported to the physician, the clinician should call the doctor's office directly and document that communication in the visit note or a coordination note. 6. Clinical record review on 5/7/2012, for patient #8, start of care 11/2/2021, certification period 3/2/2022 to 4/30/2022, primary diagnosis of Unspecified fracture of the left femur (thighbone), evidenced an agency document titled, "Home Health Updated Plan of Care Report", which stated, " … SKILLED NURSE, PATIENT OR CAREGIVER TO PERFORM / TEACH WOUND CARE TO LEFT UPPER THIGH SURGICAL INCISION AS FOLLOWS: USE CLEAN TECHNIQUE. CLEANSE WITH NS [normal saline], APPLY DRY GAUZE OR BANDAID, USING CLEAN / ASEPTIC TECHNIQUE. PREVENA INCISION WOUND VAC [a wound management system that is placed over a closed surgical incision] TO COME OFF 4-28-22 THEN START DRESSINGS. MAY DISCONTINUE WOUND CARE WHEN WOUND CLOSED OR HEALED. (04/24/2022)…." Clinical record review evidenced an agency document titled, "Visit Note Report", dated 4/28/2022, signed by RN (registered nurse) J, which stated, " … PROVIDED CARE: VISIT DONE FOR INCISION CARE TO LLE [left leg]. REMOVED OLD DRESSINGS, CLEANSED WITH NORMAL SALINE TO ALL INCISIONS, APPLIED ABD PADS, COVERED WITH WOUND VAC DRAPE PER PATIENT REQUEST…." During an interview on 5/13/2022 at 2:06 PM, the clinical manager indicated the nurse failed to perform wound care as ordered by the physician. Clinical record review evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician. The plan of care had a subsection titled, "Orders of Discipline and Treatments:", which stated, " … LICENSED PROFESSIONAL TO REPORT VITAL SIGNS FOLLOWING OUTSIDE THE FOLLOWING ESTABLISHED PARAMETERS … SYSTOLICBP [sic][the top number of a blood pressure] <90>160 DIASTOLICBP [sic][the bottom number of a blood pressure] <50>100…." Clinical	G0710		

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G0710	Continued from page 118 record review evidenced an agency document titled, "Visit Note Report", dated 3/9/2022, signed by RN (registered nurse) J. The nurse's visit note had a subsection titled, "Vital Signs". In this subsection was a box titled, "Vital Sign Alert:", which stated, "Reading 162/94 … Comments SYS: NO RETURN ALL AT PRESENT [sic]". Review of the visit note and coordination notes failed to evidence the nurse reported the blood pressure to the physician. Clinical record review evidenced an agency document titled, "Visit Note Report", dated 4/22/2022, signed by RN (registered nurse) J. The nurse's visit note had a subsection titled, "Vital Signs". In this subsection was a box titled, "Vital Sign Alert:", which stated, "Reading 164/98 … Comments SYS: NO FURTHER ORDERS FOLLOW-UP COMMENT ENTERED BY [corporate medical assistant O], ON 4/25/2022…. ". Review of the visit note and coordination notes failed to evidence the nurse reported the blood pressure to the physician. During an interview on 5/11/2022 at 11:43 AM, the clinical manager indicated if a patient's vital signs are outside of established parameters, the clinician should call the physician, while still in the patient's home if possible. The clinical manager indicated if there are patient findings that, according to the plan of care should be reported to the physician, the clinician should call the doctor's office directly and document that communication in the visit note or a coordination note. On 5/13/2022 at 2:21 PM, when informed of the findings, the clinical manager indicated a medical assistant faxing a physician an elevated patient blood pressure 3 days later evidenced not following the physician's order for notification of vital signs outside of established parameters. 7. Clinical record review on 5/12/2022 for patient #12, start of care 4/9/2022, certification period 4/9/2022 to 6/7/2022, primary diagnosis of Respiratory failure with hypoxia (low oxygen), evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". The plan of care had a subsection titled, "Orders of Discipline and Treatments:", which stated, " … SKILLED NURSE TO CHANGE F OLEY [sic] CATHETER [a tube inserted through the urethra to drain the bladder] WITH 16F [French] [a unit of size measurement] / 10 CC MONTHLY AND PRN [as needed]…." Clinical record review evidence an agency document titled, "Coordination Notes Report". An entry dated 4/10/2022, signed by RN (registered nurse) X, stated, " … TREATMENTS DUE	G0710		

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G0710	Continued from page 119 MONTHLY FOLEY CHANGE DATE 4/25/22…"Clinical record review evidenced an agency document titled, "Visit Note Report", dated 4/25/2022, signed by LPN (licensed practical nurse) F. The visit note stated, " … PERFORMED-VITALS, MEDICATION RECONCILIATION…" Review of the visit note failed to evidence the nurse changed the catheter. Clinical record review evidenced the nurse did not change the patient's catheter until 5/3/2022. During an interview on 5/13/2022 at 3:34 PM, the clinical manager indicated the nurse should change the catheter only as ordered by the physician. On 5/13/2022 at 3:43 PM, when informed of the findings, the clinical manager indicated she did not know why the nurse did not change the patient's catheter as ordered. Clinical record review evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". The plan of care had a subsection titled, "Orders of Discipline and Treatments:", which stated, "SKILLED NURSE TO EVALUATE / ASSESS … CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS … SKILLED NURSE TO PERFORM OBSERVATION AND ASSESSMENT OF GENITOURINARY STATUS AND INTERVENE TO MINIMIZE COMPLICAITONS OF DISEASE PROCESS…." Clinical record review evidenced a group of documents titled, "Visit Note Report". Nurse's visit notes date dated 4/18/2022, 4/25/2022, 5/3/2022, and 5/10/2022 failed to evidence assessment of the patient's urine.During an interview on 5/13/2022 at 3:48 PM, the clinical manager indicated the nurse should assess and document the assessment of the patient's urine at every visit. 8. Clinical record review on 5/13/2022 for patient #17, start of care 12/3/2021, certification period 12/3/2021 to 1/31/2022, primary diagnosis of Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". The plan of care had a subsection titled, "Orders of Discipline and Treatments:", which stated, " … SKILLED NURSE FOR OBSERVATION AND ASSESSMENT OF IV ACCESS SITE … IV SITE CARE AS FOLLOWS: … FOR PICC [peripherally inserted central catheter] [an IV inserted for long-term use] LINE, MEASURE BICEP IMMEDIATELY PROXIMAL TO [above] INSERTION SITE Q [each] VISIT…." Clinical record review evidenced an agency document titled, "Visit Note Report", dated 12/3/2021, signed by the nurse. The assessment had a subsection titled, "INFUSION THERAPY", which stated, " … INDICATE PERIPHERALLY INSERTED CENTRAL	G0710		

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G0710	Continued from page 120 CATHETER (PICC) LOCATION: RIGHT ARM … DOCUMENT BICEP MEASUREMENT N/A….” Review of the visit note failed to evidence a bicep measurement. Clinical record review evidenced a nurse’s visit note dated 12/4/2021, signed by the nurse. The assessment had a subsection titled, “INFUSION THERAPY”, which stated, “ … INDICATE PERIPHERALLY INSERTED CENTRAL CATHETER (PICC) LOCATION: RIGHT ARM … DOCUMENT PICC LINE PATENCY NOT ACCCESSED….” Review of the visit note failed to evidence assessment of the patency of the PICC line. During an interview on 5/17/2022 at 10:22 AM, the clinical manager indicated the nurse should assess and document the appearance and patency of the PICC line at each visit. 17-14-1(a)(1)(H)17-14-1(a)(2)(F)	G0710		
G0714	Patient and caregiver education CFR(s): 484.75(b)(5) Patient and caregiver education; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the registered nurse (RN) failed to provide education to the patient in 1 of 8 active clinical records reviewed with a diagnosis of diabetes (a chronic condition which affects the way the body processes blood sugar). (#10) The findings include: Review of an agency policy on 5/17/2022, titled “Patient Education Process” revised December 2019, stated, “… the patient and family/caregiver will receive verbal, and as appropriate, written instructions on: … The medical regimen … Consequences of noncompliance ….” Clinical record review on 5/11/2022, for patient #10, start of care 4/25/2022, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 4/25/2022 – 6/23/2022. This document indicated the patient’s diagnoses included, but were not limited to, diabetes, and indicated insulin (an injected medication to treat high blood sugar) was included in the patient’s medication. Review indicated the licensed professional was to report to the physician blood sugars higher or lower than parameters. Review evidenced agency documents titled “Visit Note Report” electronically signed by RN K. Document dated 4/29/2022 and 5/3/2022, indicated the RN was unable to assess the wounds and provide wound treatment to the patient’s right and left buttock wounds because the patient	G0714		

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G0714	Continued from page 121 refused care. Review failed to evidence the RN provided education related to the patient's noncompliance of wound care. Review evidenced an agency document titled "Visit Note Report" electronically signed by RN C and dated 5/6/2022, which indicated the patient did not routinely check blood sugar levels. Review failed to evidence the RN educated the patient on the importance of checking blood sugar levels based on diagnosis of diabetes and taking insulin. During an interview on 5/12/2022, at 12:44 PM, the clinical manager indicated the nurse should educate the patient on checking the blood sugar levels regularly. At 1:27 PM, the clinical manager indicated the RN should have explained to the patient what would happen with wound care noncompliance and maybe offer a wound clinic for the patient's wound care.	G0714		
G0716	Preparing clinical notes CFR(s): 484.75(b)(6) Preparing clinical notes; This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure skilled professionals accurately and completely prepared clinical notes in 13 of 17 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 14, 15, 16). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled "Initial and Comprehensive Assessment" which stated, "… The assessment will be patient-specific and comprehensive to include the patient's need for home care, rehabilitative care, social, and discharge planning needs … During the initial and comprehensive patient assessment, all baseline data to be used in measuring the patient's progress towards goals and other relevant information will be documented in the patient's clinical record, including at least the following information, if applicable: … A physical assessment, including blood pressure, temperature, pulse, respiration, skin, pain status, height/weight, nutritional status, and other relevant data related to pertinent physical findings …." 2. Record review evidenced an agency policy revised December 2019, titled "Ongoing Assessments" which stated, "… During each home	G0716		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

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G0716	Continued from page 122 visit the appropriate clinician will re-evaluate the patient according to the problems identified during the initial visit and thereafter … The clinician will reassess the patient for: … Blood pressure, pulse, respirations, temperature … Weight (once each week, if indicated by disease process) … Pain status … Breath sounds … Skin integrity … Appetite/diet, nutritional status … Functional status … Progress toward goals and patient needs and problems ….” 3. Observation of a home visit for patient #2 was conducted on 05/05/2022 at 1:15 PM to observe a routine physical therapy assistant visit. The physical therapy assistant failed to be observed performing any standing therapy exercises during the home visit. Clinical record review for patient #2 was completed on 05/13/2022. Record review evidenced a plan of care for start of care 03/29/2022 and certification period 03/29/2022 – 05/27/2022. This document indicated patient had diagnoses of respiratory failure, atrial fibrillation (irregular heartbeat), heart failure (a problem in which the heart cannot sufficiently pump), and osteoarthritis. Clinical record review evidenced a start of care assessment electronically dated and signed on 03/29/2022 by occupational therapist I, which failed to include a weight, or oxygen saturation. This document failed to include a complete cardiovascular assessment for a patient with heart failure and atrial fibrillation, including pulses or edema. This document failed to assess patient’s risk for falls. Clinical record review evidenced a physical therapy evaluation electronically dated and signed on 04/05/2022 by physical therapist M. This document failed to include an oxygen saturation or weight. Clinical record review evidenced a physical therapist reassessment visit note electronically dated and signed by physical therapist M on 04/22/2022. This document failed to include any cardiovascular assessment. Clinical record review evidenced a physical therapy assistant visit note dated and signed by PTA (physical therapy assistant) H on 05/05/2022, which stated, "... Interventions Provided: ... Gait trained patient 100 feet using 4 wheeled rolling walker and SBA [standby assist] ... Patient requires verbal cues needed to improve heel strike, step width and posture ...." During an interview on 05/10/2022 at 2:43 PM, clinical manager B indicated this patient should have pulses, edema, weight, and oxygen saturation documented every visit. Clinical manager B indicated the fall risk assessment should be completed on start of care assessment. At 3:43 PM,	G0716		

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G0716	Continued from page 123 when queried why the PTA documented interventions that were not performed during home visit, clinical manager B and administrator A failed to respond or answer. 4. Clinical record review for patient #4 was completed on 05/13/2022. Record review evidenced a plan of care for start of care 04/06/2022 and certification period 04/06/2022 – 06/04/2022. This document indicated patient had diagnoses of high blood pressure, diabetes (a problem regulating blood sugar levels), anemia (low blood count), anxiety, a right arm PICC (peripherally inserted central catheter, a large IV in the arm used for long term antibiotics), and a surgical site wound which required assessment. Clinical record review evidenced a start of care assessment electronically dated and signed by registered nurse J on 04/06/2022, which stated, "… Vital Signs … Pain – 0 … Pain … Indicate client's current pain scale rating: 3 …." This document stated, "… Integumentary: … Total score: 14 … Based on the score, the risk level for this patient is: Moderate Risk … Indicate the Braden Risk Level Presented: Low Risk (15 – 18) …." This document stated, "… Indicate Endocrine Assessment … No problems identified …." The skilled nurse failed to accurately document the patient's pain level, Braden risk level, and failed to include a diabetic assessment of patient's blood glucose. Clinical record review evidenced a skilled nurse visit note electronically dated and signed by registered nurse J on 04/11/2022. This document stated, "… Vital Signs … Pain – 0 … Indicate patient's current pain scale rating: 5 …." The clinician failed to accurately document the patient's pain scale rating. Clinical record review evidenced a skilled nurse visit note electronically dated and signed by registered nurse J on 04/18/2022. This document stated, "… Vital Signs … Pain -2 … Indicate patient's current pain scale rating: 4 …." The clinician failed to include a full endocrine assessment, including patient's history of diabetes, and current blood sugar level. Clinical record review evidenced a skilled nurse visit note electronically signed and dated by registered nurse J on 05/02/2022. This document stated, "… Vital Signs … Pain – 2 … Indicate patient's current pain scale rating: 10 …." The clinician failed to document an accurate pain assessment, include an endocrine assessment of patient's blood sugar levels. During an interview on 05/11/2022 at 10:52 AM, when queried why the visit notes include 2 separate pain ratings, clinical manager B stated, "… I do not know, maybe	G0716		

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G0716	Continued from page 124 she asked at different times, or it changed ….” Clinical manager B indicated the clinician should be documenting a complete assessment every visit, including blood glucose levels. Clinical manager B did not know why the clinician documented patient as low risk on the Braden scale. 5. Clinical record review for patient #9 was completed on 05/13/2022 for start of care 04/08/2022 and certification period 04/08/2022 - 06/06/2022. Record review evidenced a referral document dated 02/22/2022 which indicated patient recently started hemodialysis (artificial kidney filtration), was taking anticoagulants (blood thinners) for atrial fibrillation (irregular heartbeat), had a diagnosis of congestive heart failure, and was taking medication for low blood pressure. Clinical record review evidenced a start of care assessment electronically signed and dated by registered nurse K on 04/08/2022, titled “RN [registered nurse] OASIS [outcome and assessment information set] Admission” which failed to indicate patient’s level of edema and dialysis access site assessment. This document stated, “… Falls … Systolic blood pressure: No noted drop supine/sit to stand … High risk medications: (…BP [blood pressure] …): None in the last 7 days … Predisposing diseases (include hypotension …): None present ….” This document indicated patient was a low risk for falls, and failed to include risk factors including hypotension, low blood pressure, and high risk medications. This document indicated patient had diagnosis of diabetes but failed to document patient’s baseline blood glucose levels. Clinical record review evidenced a physical therapy evaluation assessment electronically signed and dated on 04/13/2022 by physical therapist G, which stated, “… Cardiovascular Findings: Hypertension [high blood pressure] ….” This document indicated the patient’s blood pressure was 95/60. This document failed to accurately reflect patient’s cardiovascular status, including hypotension (low blood pressure). Clinical record review evidenced a resumption of care assessment electronically dated and signed by registered nurse K on 04/22/2022. This document stated, “… Braden Risk Assessment Scale … Moisture – Degree to which skin is exposed to moisture … Rarely Moist – Skin is usually dry … Genitourinary … Patient is incontinent ….” This document failed to accurately document patient’s moisture level on Braden Risk Assessment Scale. This document failed to assess patient’s weight, level of edema, dialysis access site, or blood glucose level. This document	G0716		

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G0716	Continued from page 125 indicated the patient's wound was a suspected DTI (deep tissue injury, characterized by purple, or darkened skin, in which wound bed is not open, but tissue underneath surface has been damaged), but included a depth measurement of 0.1cm (centimeters), and epithelialization (process where a wound resurfaces with new tissue) of 50 – 75%, indicating the wound was open. Clinical record review evidenced a skilled nurse visit note electronically signed and dated on 04/25/2022 by registered nurse K. This document failed to assess patient's edema, dialysis access site, or blood glucose level and listed the patient's wound as a suspected DTI. This document indicated the wound was 50 – 75% epithelialized with a depth of 0.1 cm, and small amount of serosanguinous (body fluid mixed with small amount of blood, appearing light pink and clear) drainage. This document failed to accurately reflect type of wound. During an interview on 05/12/2022 at 10:31 AM, when queried what clinicians should be assessing and documenting for patient #9 each visit, clinical manager B indicated the clinicians should be assessing/documenting weights, edema, dialysis access site, and blood glucose levels each visit. When queried about why physical therapist's 04/13/2022 visit documented hypertension, clinical manager B stated, "… Definitely had to be a mistake since she had low blood pressure ...." At 11:15 AM, when queried why the Braden Scale says patient is rarely moist if patient is incontinent, clinical manager B stated, "… I would have to ask the patient how much she urinates … have you noticed decrease in urine, assess the situation more …." At 11:25 AM, when queried what a DTI is, clinical manager B stated, "… a wound that's not blanchable … can't see under it … don't know what's under it … can be a scab or a bruise … once skin comes off can be stage 3 or 4 …." When queried what type of wound this patient has, clinical manager B indicated it could probably be staged, not listed as a DTI, since it had depth and drainage. Clinical manager B indicated maybe the clinician listed wound as a DTI so they could get wound supplies ordered. 6. Clinical record review for patient #15 was completed on 05/13/2022. Record review evidenced a plan of care for start of care 03/08/2022 and certification period 03/08/2022 – 05/06/2022. This document indicated patient had a diagnosis of diabetes (problem regulating blood sugar), respiratory failure, pneumonia, and was dependent on oxygen. Clinical record review evidenced a start of care assessment electronically signed and dated	G0716		

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G0716	Continued from page 126 by registered nurse C on 03/08/2022. This document stated, "… How frequent are blood sugars checked? … Daily …." The clinician failed to document a complete assessment of endocrine system by including patient's blood glucose reading. Clinical record review evidenced a skilled nurse visit electronically dated and signed by registered nurse C on 03/18/2022. This document failed to document complete respiratory assessment including oxygen saturation. This document failed to document a complete endocrine assessment including frequency of glucose measurement, and blood glucose reading. Clinical record review evidenced a skilled nurse visit electronically dated and signed by registered nurse C on 03/30/2022. This document failed to evidence the clinician had documented a complete endocrine assessment to include patient's blood glucose reading. Clinical record review evidenced a discharge note electronically dated and signed by registered nurse C on 04/07/2022. This document stated, "… Discharge Date: … 3/30/2022 …." Clinical record review evidenced a care coordination note electronically signed by physical therapist L on 04/06/2022. This document stated, "… Date of Discharge from Agency: 4/6/2022 … Date patient notified of discharge: 4/5/2022 … patient requested discharge: Yes … to attend outpatient therapy and pulmonary rehab [rehabilitation] …." Clinicians failed to document accurate discharge date in clinical notes. During an interview on 05/11/2022 at 2:50 PM, clinical manager B indicated the clinicians should have been documenting a full endocrine assessment, including blood glucose readings on every visit, and should be documenting an oxygen saturation every visit. At 3:07 PM, when queried what day patient was discharged, clinical manager B stated, "… the patient discharged 4/6 … we didn't find out about it … patient requested … but they go in and put it in on the last visit for discharge …." 7. Clinical record review for patient #16 was completed on 05/15/2022. Record review evidenced a plan of care for start of care 12/22/2021 and certification period 12/22/2021 – 02/19/2021. This document included but was not limited to the following diagnoses: hypertensive heart disease (high blood pressure causing heart disease), type 2 diabetes (problem regulating blood sugar levels), atrial fibrillation (irregular heart rate), and bradycardia (low heart rate). This document indicated the patient was receiving skilled nursing care for a right hip surgical wound which had a wound vac (type of dressing	G0716		

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G0716	Continued from page 127 which uses a vacuum to heal wound) in place. Clinical record review evidenced a start of care assessment electronically dated and signed on 12/22/2021 by registered nurse J. This document stated, "… Indicate endocrine assessment: No problems identified …." The clinician failed to document full endocrine assessment including patient's diagnosis of diabetes, and what blood sugar level was. This document failed to document patient's baseline weight, or any edema noted. Clinical record review evidenced a skilled nurse visit note electronically dated and signed by registered nurse N on 12/23/2021. This document failed to include any cardiac or endocrine assessment, and if wound care was provided. Clinical record review evidenced a skilled nurse visit note electronically signed and dated by registered nurse J on 12/28/2022. This document failed to include a cardiac assessment, endocrine assessment, or any wound measurements. Clinical record review evidenced a skilled nurse visit note electronically dated and signed by registered nurse C on 12/31/2022. This document failed to include any wound measurements. Clinical record review evidenced a skilled nurse visit note electronically signed and dated by registered nurse J on 01/04/2022. This document failed to be complete to include a temperature, blood glucose level or wound measurements. Clinical record review evidenced a skilled nurse visit note electronically signed and dated by registered nurse N on 01/07/2022. This document failed to be complete to include a blood glucose measurement or wound measurement. Clinical record review evidenced a skilled nurse visit note electronically signed and dated by registered nurse N on 01/14/2022. This document failed to be complete to include a blood glucose measurement or wound measurement. During an interview on 05/16/2022 at 9:48AM, when queried what clinicians should be documenting during visits, clinical manager B stated, "… baseline for heart rate, blood pressure, blood sugar, knowing how often she checks her blood sugar, checking medications she takes for heart and blood pressure, measurements for her wounds weekly, pedal pulses, edema, measurement of legs every visit …." 8. Clinical record review on 5/10/2022, for patient #6, start of care 4/7/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/7/2022 – 6/5/2022, which was signed by registered nurse (RN) N on 4/7/2022. This document indicated the skilled nurse was to perform wound	G0716		

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G0716	Continued from page 128 care to gangrenous (death of tissue due to lack of blood flow or infection) wounds to the left great, 2nd, and 3rd toes. Review of an agency document titled “Skilled Visit Note”, which was signed by RN N and dated 4/7/2022, and identified to be an admission comprehensive assessment. This document indicated the diagnosis for the primary focus for the certification period was gangrenous right great, 2nd, and 3rd toes. During an observation at the patient’s home on 5/11/2022, at 9:00 AM, the patient was observed to have wounds to the left great, 2nd, and 3rd toes. No wounds were observed to the right foot. During an interview on 5/11/2022, at 3:56 PM, the clinical manager indicated the RN must have documented the patient had wounds to the right foot in error. 9. During an observation of care for patient #7, start of care 12/23/2021, on 5/6/2022, at 11:47 AM, RN C was observed measuring the open area on the patient’s right buttock. RN C was observed cleansing the wound to the right buttock with a clear liquid RN C identified as normal saline. RN C was observed applying a white ointment to the open area to the right buttock from a jar labeled “Desitin [a medicated cream used for mild skin irritation]”. At 11:55 AM, the patient was observed to have an abrasion to the right hip with a dry scab. RN C was observed measuring the abrasion to the right hip. During an interview on 5/6/2022, at 12:40 PM, RN C indicated the measurements for the wound to the right buttock were 0.4 centimeters (cm) in length, 0.5 cm in depth, and 0.1 cm in depth and indicated the wound was a stage II to the right buttock. Clinical record review on 5/9/2022, evidenced an agency document titled “Visit Note Report”, dated 5/6/2022 and electronically signed by RN C, indicated the wound to the right buttock was healed. This document failed to indicate RN C documented the wound care provided to the open area to the right buttock as observed. The document indicated the wound to the right hip measured 10 cm in length, 0.2 cm in width, and 0.1 cm in depth. This document indicated the area was a stage 1 (reddened, nonblanching, intact skin) pressure ulcer and review failed to evidence the RN documented the assessment of the wound accurately related to the stage of the wound. During an interview on 5/10/2022, at 12:59 PM, the clinical manager indicated a scabbed area was a stage II (an open pressure ulcer with partial thickness loss of skin) wound. The clinical manager indicated a wound with depth was at least a stage II. At 1:06 PM, the clinical manager	G0716		

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G0716	Continued from page 129 indicated the RN should document wound measurements, what the wound was cleansed with, and what wound treatment was applied. Review of agency documents titled “Visit Note Report”, electronically signed by licensed practical nurse (LPN) F on 4/14/2022 and 4/26/2022, indicated the wound care provided to the right buttock was to apply calmoseptine (a medicated ointment for mild skin irritation) or desitin. Review failed to evidence the LPN prepared the clinical notes to include what wound care was provided at the visits. During an interview on 5/10/2022, at 2:03 PM, the clinical manager indicated the notes did not specify what treatment was provided and indicated the nurse should document exactly what was done. 10. Clinical record review on 5/11/2022, for patient #11, start of care 4/29/2022, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 4/29/2022 – 6/27/2022, electronically signed by RN D and the clinical manager and dated 4/29/2022. This document indicated the patient’s diagnoses included, but were not limited to, gastrostomy (a plastic tube surgically inserted into the stomach through the abdomen to provide nutrition, fluid, and medication). Review evidenced an agency document titled “Visit Note Report” electronically signed by RN D, dated 4/29/2022, and identified to be a RN admission comprehensive assessment. This document failed to evidence the patient had a gastrostomy. During an interview on 5/13/2022, at 10:05 AM, the clinical manager indicated the patient did not have a gastrostomy and the diagnosis should not be included on the plan of care. The clinical manager indicated the diagnosis was included by mistake. 11. Clinical record review on 5/12/2022, for patient #14, start of care 5/4/2022, evidenced an agency document titled “Visit Note Report” electronically signed by RN K and dated 5/4/2022, and identified to be a RN admission comprehensive assessment. This document indicated the patient had a Hickman central line (a plastic tube inserted into a vein in the chest and up to the heart to deliver medication, hydration, and nutrition) to the right upper chest. Review indicated the central line flushed easily. Review evidenced an agency document titled “Client Medication Report” electronically signed by RN K on 5/6/2022, which indicated the normal saline flush was for a PICC (peripherally inserted central catheter, a plastic tube inserted into a vein in the arm up to the heart) line flush. Review failed to evidence the RN accurately	G0716		

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G0716	Continued from page 130 documented the normal saline flush was for the Hickman central line. During an interview on 5/13/2022, at 1:20 PM, RN K indicated the patient used to have a PICC line and stated, “I didn’t catch that to change the normal saline flush from the PICC to the Hickman.” 12. Clinical record review on 5/5/2022, for patient #1, start of care 2/15/2022, certification period 4/16/2022 to 6/14/2022, primary diagnosis of End stage renal disease (when the kidneys have stopped working), evidenced an agency document titled, “HOME HEALTH CERTIFICATION AND PLAN OF CARE”, signed by the physician on 4/22/2022. The plan of care had a subsection titled, “Orders of Discipline and Treatments:”, which stated, “ … PATIENT CONTINUING WITH DIALYSIS ON M/W/F [Monday, Wednesday, and Friday]….” During observation of a home visit on 5/5/2022, at 12:00 PM, a white catheter was observed on the patient’s right upper chest. The patient indicated it was their dialysis catheter, which was inserted in January, 2022. Review of all visit notes and coordination notes for 4/12/2022 to 5/5/2022 failed to evidence presence or assessment of the dialysis catheter. Review of the patient’s electronic medical record (Home Care Home Base) failed to evidence presence or assessment of the dialysis catheter. During an interview on 5/11/2022, at 11:58 AM, the clinical manager indicated the nurse should assess and document a dialysis patient’s access site (the place in or on the patient’s body with a device that connects to the dialysis machine) at each visit. When informed of the findings, the clinical manager indicated the nurse failed to document a full assessment. Clinical record review evidenced a group of documents titled, “Visit Note Report”. A note dated 5/5/2022, signed by RN [registered nurse] D, had a subsection titled, “Wound Assessment”, which stated, “ … WOUND CARE PROVIDED … CAREGIVER OR SKILLED NURSE TO CLEANSE LEFT LOWER LEG WITH NORMAL SALINE, PAT DRY, APPLY PETROLEUM JELLY, THEN COVER WITH ABD PAD [an absorbent gauze pad] AND SECURE WITH COBAN [a self-adhering wrap dressing] DAILY AND AS NEEDED FOR SOILAGE OR DISLODGEMENT….” Review of the note failed to evidence who performed the wound care. During an interview on 5/11/2022, at 12:21 PM, the clinical manager indicated the nurse’s documentation of wound care should include who performed the care, what they used, assessment of the wound, and how the patient tolerated it. 13. Clinical record review on 5/10/2022, for patient #3, start of care 10/30/2021, certification period 4/28/2022 to 6/26/2022, primary diagnosis of Type 2 Diabetes	G0716		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0716	Continued from page 131 Mellitus (a medical condition in which your body does not use insulin properly, resulting in unusual blood sugar levels) with foot ulcer (open sore), evidenced an agency document titled, “HOME HEALTH CERTIFICATION AND PLAN OF CARE”, signed by the physician on 5/2/2022. This plan of care had a subsection titled, “Orders of Discipline and Treatments:” which stated, “ … SKILLED NURSE TO ASSESS / EVALUATE CO-MORBID CONDITIONS INCLUDING CKD [chronic kidney disease], HTN [hypertension] [a condition in which the long-term force of the blood against the artery walls is high enough that it may cause health problems, such as heart disease], DIABETES, WOUND TO LEFT HEEL AND OTHER CONDITIONS … TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS … Clinical record review evidenced an agency document titled, “Visit Note Report”, dated 5/6/2022, and signed by RN (registered nurse) D. The nurse’s visit note had a section titled, “Assessment”, which stated, “ … INTEGUMENTARY [skin] ASSESSMENT FINDINGS … NO CHANGES SINCE LAST COMPREHENSIVE ASSESSMENT … CARDIOVASCULAR ASSESSMENT … NO CHANGES SINCE LAST COMPREHENSIVE ASSESSMENT … RESPIRATORY ASSESSMENT … NO CHANGES SINCE LAST COMPREHENSIVE ASSESSMENT….” During observation of a home visit on 5/6/2022 at 10:28 AM, the patient was observed sitting on a couch, wearing long pants and a shirt with sleeves to the elbows. During the visit, RN [registered nurse] D used their stethoscope to take the patient’s blood pressure only, cleaned the stethoscope, and returned it to their bag. RN D failed to use the stethoscope to listen to the patient’s chest, back, or abdomen. Observation of the visit failed to evidence RN D moving the patient’s clothing to assess their skin. During an interview on 5/13/2022 at 11:39 AM, the clinical manager indicated a nurse should perform an integumentary assessment by visualizing the skin. The clinical manager indicated a nurse should listen to the patient’s chest, back, and abdomen as part of their full assessment. When informed of the findings, the clinical manager indicated if the nurse, for some reason, did not complete the assessment, they should document “N/A” and “not lie about it”. Clinical record review evidenced an agency document titled, “Wound Record Report”. An entry dated 3/23/2022 stated, “ … INDICATE TYPE … SUSP DTI [suspected deep tissue injury] … EPITHELIALIZATION [covered with skin] 25-<50% … TOTAL NECROTIC TISSUE SLOUGH [a stringy, dead tissue found in a wound stage 3 or higher] … 26-50%....”An entry dated 3/30/2022 stated, “ … INDICATE TYPE … SUSP DTI [suspected deep tissue	G0716		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

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G0716	Continued from page 132 injury] … EPITHELIALIZATION [covered with skin] 50-<75% … TOTAL NECROTIC TISSUE SLOUGH [a stringy, dead tissue found in a wound stage 3 or higher] … 26-50%...."An entry dated 4/1/2022 stated, " … INDICATE TYPE … SUSP DTI [suspected deep tissue injury] … EPITHELIALIZATION [covered with skin] 50-<75% … TOTAL NECROTIC TISSUE SLOUGH [a stringy, dead tissue found in a wound stage 3 or higher] … 26-50%...."An entry dated 4/6/2022 stated, " … INDICATE TYPE … SUSP DTI [suspected deep tissue injury] … EPITHELIALIZATION [covered with skin] 25-<50% … TOTAL NECROTIC TISSUE SLOUGH [a stringy, dead tissue found in a wound stage 3 or higher] … 26-50%...." An entry dated 4/11/2022 stated, " … INDICATE TYPE … SUSP DTI [suspected deep tissue injury] … EPITHELIALIZATION [covered with skin] 25-<50% … TOTAL NECROTIC TISSUE SLOUGH [a stringy, dead tissue found in a wound stage 3 or higher] … 26-50%...." Record review evidenced an article from the International Wound Journal titled, "Differential diagnosis of suspected deep tissue injury", published in August 2019, stated, " … Deep tissue injury (DTI) pressure ulcers are defined as '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…." During an interview on 5/13/2022 at 11:45 AM, the clinical manager indicated a deep tissue injury was a discoloration or closed blister with intact skin. When informed of the findings, the clinical manager indicated the nurses failed to correctly document the type and stage of the wound. Clinical record review evidenced a group of documents titled, "Visit Note Report". The visit notes had a subsection titled, "Interventions Provided". Nurse's visit notes dated 5/2/2022 and 5/6/2022 stated, "FILL MEDI-PLANNER AS NEEDED". During observation of a home visit on 5/6/2022 at 11:28 AM, a staff member from assisted living facility T brought the patient their medications. During an interview on 5/6/2022 at 10:39 AM, patient #3 indicated assisted living facility T managed their medications. During an interview on 5/13/2022 at 11:37 AM, the clinical manager indicated the documentation of interventions on a visit note indicated what the nurse did at the visit. When informed of the findings, the clinical manager indicated the nurse should not document filling the medi-planner if medications were managed by the assisted living facility. 14. During observation of a home visit for patient #5 on 5/9/2022, at 2:30 PM, a continuous glucose monitor was observed on the back of the patient's upper	G0716		

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G0716	Continued from page 133 arm. What was identified by the patient as a dialysis fistula was observed to the patient's left arm. Record review evidenced a history and physical from physician Z, dated 12/14/2021, which indicated the patient had a dialysis fistula and continuous glucose monitor Clinical record review on 5/11/2022, for patient #5, start of care 1/11/2022, certification period 3/12/2022 to 5/10/2022, primary diagnosis of Type 2 Diabetes Mellitus (a medical condition in which your body does not use insulin properly, resulting in unusual blood sugar levels) with Hyperglycemia (high blood sugar), evidenced a group of agency documents titled, "Visit Note Report". Nurse's visit notes dated 3/15/2022, 3/22/2022, 3/28/2022, 4/11/2022, and 4/26/2022 failed to evidence the continuous glucose monitor. A nurse's visit note dated 4/26/2022, failed to evidence an assessment of the dialysis fistula. 15. Clinical record review on 5/7/2012, for patient #8, start of care 11/2/2021, certification period 3/2/2022 to 4/30/2022, primary diagnosis of Unspecified fracture of the left femur (thighbone), evidenced an agency document titled, "Wound Record Report". An entry dated 3/25/2022 stated, " … INDICATE TYPE … SUSP DTI [suspected deep tissue injury] … EPITHELIALIZATION [covered with skin] 50-<75%...." Clinical record review evidenced an agency document titled, "Wound Record Report". An entry dated 3/28/2022 stated, " … INDICATE TYPE … SUSP DTI [suspected deep tissue injury] … EPITHELIALIZATION [covered with skin] 50-<75%...." This assessment indicated undermining [erosion of skin underneath the edges of a wound, resulting in open space under the surface] was present. Clinical record review evidenced an agency document titled, "Wound Record Report". An entry dated 4/1/2022 stated, " … INDICATE TYPE … CLOSED SURGICAL… EPITHELIALIZATION [covered with skin] 50-<75%...." This assessment indicated undermining [erosion of skin underneath the edges of a wound, resulting in open space under the surface] was present. Clinical record review evidenced an agency document titled, "Wound Record Report". An entry dated 4/4/2022 stated, " … INDICATE TYPE … SUSP DTI … EPITHELIALIZATION [covered with skin] 50-<75%...." This assessment indicated undermining [erosion of skin underneath the edges of a wound, resulting in open space under the surface] was present. Record review evidenced an article from the International Wound Journal titled, "Differential diagnosis of suspected deep tissue injury", published in August 2019, stated, " … Deep tissue injury (DTI) pressure ulcers are	G0716		

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G0716	Continued from page 134 defined as '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…." During an interview on 5/13/2022 at 11:45 AM, the clinical manager indicated a deep tissue injury is a discoloration or closed blister with intact skin. When queried, the clinical manager indicated a wound could not change from suspected DTI, to a closed surgical incision, and then back to a suspected DTI. The clinical manager also indicated undermining could not be assessed in a suspected DTI. When informed of the findings, the clinical manager indicated the nurses failed to correctly document the type and stage of the wound. 17-14-1(a)(1)(E)17-14-1(a)(2)(B)17-14-1(c)(5)	G0716		
G0718	Communication with physicians CFR(s): 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure clinicians communicated with all physicians involved in the plan of care, related to the current plan of care in 4 of 8 active clinical records reviewed with wounds. (#4, 7, 9, 10) The findings include: 1. Record review evidenced an agency policy revised December 2019, titled "Continuity of Care" which stated, "… The clinician will be responsible for: … communicating with all personnel caring for the patient including the physician … Updating physician's orders …." 2. Record review evidenced an agency policy revised December 2019, titled "Medication Profile" which stated, "… Any conclusions and findings of patient medication use or monitoring should be communicated to the pharmacist, when appropriate, and other clinicians …." 3. Clinical record review for patient #4 was completed on 05/13/2022. Review of a web-based source on 05/15/2022, https://www.drugs.com/interactions-check.php, evidenced the following interactions between medications on patient #4's medication list: 2 major drug-drug interactions between escitalopram (antidepressant) and duloxetine (antidepressant),	G0718		

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G0718	Continued from page 135 and hydroxychloroquine (medication for arthritis) and escitalopram, and 14 moderate drug-drug interactions between, levothyroxine (for low thyroid levels) and ferrous sulfate (iron), hydroxychloroquine and duloxetine, clonidine (for high blood pressure) and duloxetine, omeprazole (to lower stomach acid) and escitalopram, glipizide (to lower blood sugar) and escitalopram, omeprazole and ferrous sulfate, clonidine and glipizide, pravastatin (to lower cholesterol) and hydroxychloroquine, glipizide and hydroxychloroquine, prednisone (steroid) and amlodipine (to lower blood pressure), glipizide and prednisone, clonidine and prednisone, levothyroxine and omeprazole, and glipizide and levothyroxine. This source also evidenced medication list included duplicative drug therapy between duloxetine and escitalopram, both antidepressants. Clinical record review evidenced a fax status report printed 05/13/2022, which failed to evidence the medication interactions were faxed to the physician. During an interview on 05/11/2022 at 11:36 AM, clinical manager B indicated the physician should be faxed the drug interactions report for medication interactions and duplicative drug therapy. Clinical manager B indicated she did not see documentation of physician notification. 4. Clinical record review for patient #9 was completed on 05/13/2022 for start of care 04/08/2022 and certification period 04/08/2022 – 06/06/2022. Review on 05/13/2022 of the following web-based source, https://www.drugs.com/interactions-check.php, evidenced the following drug interactions between medications on patient's medication list: 1 major drug interaction between hydroxychloroquine (medication for rheumatoid arthritis) and tramadol (pain medication) and 8 moderate drug-drug interactions between levothyroxine (thyroid medication) and calcium carbonate, calcium carbonate and hydroxychloroquine, levothyroxine and multivitamin, levothyroxine and ferrous sulfate (iron), calcium carbonate and ferrous sulfate, oxymetazoline (for stuffy nose) and midodrine (to increase blood pressure), levothyroxine and pantoprazole (for stomach acid), and ferrous sulfate and pantoprazole. Record review evidenced a comprehensive assessment completed on 04/08/2022 by registered nurse K, indicated the clinician had performed a drug regimen review. Record review failed to evidence the clinician had notified the physician of the major or moderate drug interactions between patient #9's medications. Clinical record review	G0718		

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G0718	Continued from page 136 evidenced a fax status report printed 05/13/2022, which failed to evidence the medication interactions were faxed to the physician. During an interview on 05/11/2022 at 10:40 AM, clinical manager B stated, when queried what the process is if the clinician finds drug interactions, "… the doctor is contacted via phone or fax if interactions are found …." Surveyor requested documentation of physician notification or acknowledgement of drug interactions on 05/11/2022 at 10:46 AM. No documentation physician notification was provided by exit. 5. During an observation of care for patient #7, start of care 12/23/2021, on 5/6/2022, at 11:55 AM, the patient was observed to have an abrasion to the right hip with a dry scab. Registered nurse (RN) C was observed measuring the abrasion to the right hip. During the observation of care, RN C asked the patient's caregiver how the patient obtained the abrasion to the right hip. The patient's caregiver indicated it could have been from the strap from the brief or from when the dog jumped onto the patient's hospital bed. Clinical record review on 5/9/2022, evidenced an agency document titled "Visit Note Report", dated 5/6/2022 and electronically signed by RN C, indicated the wound to the right hip measured 10 cm in length, 0.2 cm in width, and 0.1 cm in depth with on onset date of 5/6/2022. Review failed to evidence the RN notified the physician of the abrasion to the right hip. During an interview on 5/10/2022, at 1:35 PM, the clinical manager indicated the RN should have notified the physician of the new wound and indicated she did not see the physician was notified. 6. Clinical record review on 5/11/2022, for patient #10, start of care 4/25/2022, with a diagnosis to include, but not limited to, congestive heart failure (a chronic condition which the heart does not pump efficiently causing a build-up of fluid and can cause leg swelling), evidenced an agency document titled "Visit Note Report" electronically signed by RN K and dated 4/27/2022. This document indicated the patient had pitting edema (excess fluid built up in the body and when pressure is applied, causes an indentation) at a degree of 2+ on a scale of 0 to 4+. Review of an agency document titled "Visit Note Report" electronically signed by RN and dated 5/3/2022, indicated the patient had pitting edema 3+ on a scale of 0 to 4+ and the legs were reddened. Review failed to evidence the RN notified the physician of the patient's increased edema. During an interview on 5/12/2022, at 12:45 PM, the clinical manager	G0718		

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G0718	Continued from page 137 indicated she did not see the RN notified the physician and indicated the RN should have notified the physician. 17-14-1(a)(1)(E)	G0718		
G0720	Participate in the HHA's QAPI program; CFR(s): 484.75(b)(8) Participation in the HHA's QAPI program; and This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure skilled professionals participated in the QAPI (quality assurance performance improvement) program. The findings include: Review of an agency policy on 5/9/2022, titled "Performance Improvement Program and Annual Agency Evaluation" revised 3/1/2019, stated, "… Agency clinical staff must participate in Accentcare's QAPI Program or Performance Improvement Activities in accordance with their job description…." During an interview at the entrance conference on 5/4/2022, at 10:14 AM, the administrator indicated skilled nursing services, physical therapy, occupational therapy, speech therapy, and social work services were provided. During an interview on 5/6/2022, at 12:27 PM, RN C indicated she was not involved in the agency's QAPI program. Review of the agency's QAPI binder on 5/9/2022, evidenced an agency document titled "Participants Signature Form" for the QAPI/Professional Advisory Committee Meeting for quarter 3 of 2022. This document failed to evidence participation from occupational therapy, speech therapy, and social worker. During an interview on 5/9/2022, at 11:36 AM, the administrator indicated he did not see participation in the QAPI from the speech therapist, occupational therapist, and social worker. During an interview on 05/09/2022 at 4:30 PM, registered nurse J indicated she was not involved in the agency's QAPI program. Registered nurse J stated, "... I wish we were able to be more involved with QAPI ...."	G0720		
G0726	Nursing services supervised by RN CFR(s): 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k).	G0726		

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G0726	Continued from page 138 This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the registered nurse (RN) failed to supervise the licensed practical nurse (LPN) in 1 of 4 clinical records reviewed with a LPN. (#7) The findings include: Review of an agency policy on 5/17/2022, titled "Scope of Services" revised December 2019, stated, "… Professional nursing services are provided in accordance with the patient's plan of care, under the supervision of a registered nurse, and include: … Supervising licensed practical/vocational nurses …."Clinical record review on 5/9/2022, for patient #7, start of care 12/23/2021, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/22/2022 – 6/20/2022. This document indicated the skilled nurse was to educate the caregiver on foley catheter care (a plastic tube inserted into the bladder and held in place with a balloon to drain urine from the body). Review of agency documents titled "Visit Note Report" electronically signed by LPN F and dated 3/30/2022, 4/14/2022, and 4/26/2022, failed to evidence the nurse educated the caregiver on foley catheter care as directed by the plan of care. Review of an agency document titled "Visit Note Report" electronically signed by RN C and dated 4/19/2022, indicated the RN supervised LPN C and indicated the LPN provided services which followed the plan of care. Review failed to evidence the RN supervised the LPN to determine the catheter education was not provided to the caregiver as directed in the plan of care. During an interview on 2/11/2022, at 2:23 PM, the clinical manager indicated the RN should look at what the LPN was doing on the visit notes and indicated the LPN would need to be educated on the tasks to be performed as directed by the plan of care. 17-14-1(a)(1)(J)-RN	G0726		
G0940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its	G0940		

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G0940	Continued from page 139 resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the organization and management of the home health agency as follows: the administrator failed to maintain the day to day operations of the agency (see tag G0948), the administrator failed to ensure the clinical manager was available during all home health agency operating hours (see tag G0950), the clinical manager failed to provide oversight for the patient and personnel assignments (see tag G0960), the clinical manager failed to provide oversight of coordination of care (see tag G0962), and the clinical manager failed to assure the implementation of the plan of care (see tag G0968). The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.105 Organization and Administration of Services. A deficient practice citation was also evidenced at this standard as follows:Based on record review and interview, the agency failed to set forth, in writing, its organizational structure, including lines of authority. The findings include: Review of an agency policy on 5/17/2022, titled “Organizational Chart” revised December 2019, stated, “… Organizations charts … will be used to define relationships and lines of authority within the organization. … The organizational chart will be reviewed, revised and dated as changes occur.” Review of pre-survey information on 5/4/2022, from the Indiana Department of Health, indicated person AA, corporate, was the alternate administrator and person BB, corporate, was the alternate clinical manager. During an interview at the entrance conference on 5/4/2022, at 10:14 AM, the administrator indicated person CC, corporate,	G0940		

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G0940	Continued from page 140 was the alternate administrator and stated the alternate clinical manager, “would fall between [person CC, corporate] and [person DD, corporate].” The administrator indicated person CC was either in Illinois or in Nebraska and is typically not on-site at the agency because she is corporate regional director of operations. The administrator indicated person DD was the clinical manager at another agency in Nebraska. During an interview on 5/4/2022, at 11:57 AM, the administrator indicated he reported directly to person CC, corporate, and indicated person CC was not part of the governing body. The administrator indicated person CC and person DD were not agency employees but corporate employees and were not involved in the agency’s day-to-day operations. The administrator indicated person BB took a different role with corporate during the transition from agency EE to the current agency in January 2022 and was no longer the alternate clinical manager. The administrator indicated person AA was no longer the alternate administrator and was with the corporate office. Requested documentation of the notification of the administration changes to the Indiana Department of Health. No further documentation was provided. A phone call was placed to the agency’s phone number, 219-750-9211, on 5/6/2022, at 10:30 AM, and person FF answered as Accentcare. Requested to speak to the clinical manager, and person FF explained she was located in Illinois and answered the incoming phone calls for the Accentcare offices in Indiana, Illinois, Michigan, and Nebraska and needed to know for which state the clinical manager was being requested. When requested the clinical manager for the agency located in Crown Point, Indiana, person FF indicated the clinical manager was off and when requested to speak to the alternate clinical manager, person FF stated, “[Licensed Practical Nurse, LPN, R] takes over clinical when [clinical manager] is not here.” Review of an agency document on 5/6/2022, titled “Indiana Team” indicated LPN R was a clinical support specialist and scheduler. During an interview on 5/6/2022, at 10:37 AM, the administrator indicated LPN R was an office nurse but not the alternate clinical manager. Review of an agency document on 5/6/2022, titled “Organizational Chart” effective 7/19/2021, indicated a position titled “Director of Patient Care Services”. During an interview on 5/6/2022, at 11:26 AM, the administrator stated, “Those boxes aren’t specific to us. We need to remove that. We don’t have a director.” Review of an	G0940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G0940	Continued from page 141 agency document provided on 5/9/2022, by the administrator titled “Appointment of Agency Executive Director/Administrator and Alternate” dated 5/3/2022, indicated in the event the administrator was not available, the clinical manager was appointed the alternate and would assume the duties and responsibilities of the administrator. This document was signed by the administrator, clinical manager, and a governing body designee. During an interview on 5/10/2022, at 12:06 PM, the administrator indicated the alternate clinical manager would be person DD, corporate, but her background check is outdated. The administrator indicated in the meantime while the background check for person DD was updated, person BB, corporate, would be the alternate clinical manager. 17-12-1(a)(1)	G0940		
G0948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the administrator failed to be responsible for the day-to-day operations of the agency. The findings include: Review of an agency policy on 5/17/2022, revised December 2019, titled “Executive Director/Administrator” revised December 2019, stated, “… Responsibilities of the position will include but not be limited to: … Planning, organizing, directing and evaluating operations to ensure the provision of adequate and appropriate care and services … Complying with applicable law and regulations of operations … Directing and monitoring performance improvement activities … Assuring the development and qualifications for professional services and the assignment of personnel ….” During an interview on 5/6/2022, at 11:15 AM, when personnel records requested, the administrator indicated he would have to request the personnel files from corporate. The administrator indicated personnel files are electronic and he did not have access to the electronic personnel records. The administrator indicated he would request the requested personnel	G0948		

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G0948	Continued from page 142 records from corporate who would then email him the records. When queried how the administrator ensure staff is qualified to provide services to patients, the administrator stated, “Corporate tells us and then the employee gets an email for orientation.” During an interview on 5/9/2022, at 11:36 AM, the administrator stated, “We aren’t involved in QAPI [quality assurance and performance improvement]. There is another department of QAPI at corporate.” The administrator indicated the corporate QAPI department gathered the data and determined the performance improvement activities. 17-12-1(c)(1)	G0948		
G0950	Ensure clinical manager is available CFR(s): 484.105(b)(1)(iii) (iii) Ensure that a clinical manager as described in paragraph (c) of this section is available during all operating hours; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the administrator failed to ensure the clinical manager was available during all operating hours. The findings include: Review of an agency policy on 5/17/2022, titled “Executive Director/Administrator” revised December 2019, stated, “… Responsibilities of the position will include but not be limited to: … Ensuring that a Clinical Manager and other appropriate staff supervision is available during all operating hours ….” During an interview at the entrance conference on 5/4/2022, at 10:14 AM, the administrator stated the alternate clinical manager, “wound fall between either [person CC, corporate] and [person DD, corporate].” The administrator indicated person CC was either in Illinois or in Nebraska and is typically not on-site at the agency because she is corporate regional director of operations. The administrator indicated person DD was the clinical manager at another agency in Nebraska. During an interview on 5/4/2022, at 11:57 AM, the administrator indicated person CC and person DD were not agency employees but corporate employees and were not involved in the agency’s day-to-day operations. A phone call was placed to the agency’s phone number, 219-750-9211, on 5/6/2022, at 10:30 AM, and person	G0950		

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ACCENTCARE HOME HEALTH OF INDIAN	11037 BROADWAY, SUITE C , CROWN POINT, Indiana, 46307

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G0950	Continued from page 143 FF answered as Accentcare. Requested to speak to the clinical manager, and person FF explained she was located in Illinois and answered the incoming phone calls for the Accentcare offices in Indiana, Illinois, Michigan, and Nebraska and needed to know for which state the clinical manager was being requested. When requested the clinical manager for the agency located in Crown Point, Indiana, person FF indicated the clinical manager was off and when requested to speak to the alternate clinical manager, person FF stated, "[Licensed Practical Nurse, LPN, R] takes over clinical when [clinical manager] is not here." Review of an agency document on 5/6/2022, titled "Indiana Team" indicated LPN R was a clinical support specialist and scheduler. During an interview on 5/6/2022, at 10:37 AM, the administrator indicated LPN R was an office nurse and not the alternate clinical manager. 17-12-1(d)	G0950		
G0960	Make patient and personnel assignments, CFR(s): 484.105(c)(1) Making patient and personnel assignments, This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the clinical manager provided oversight for the patient and personnel assignments. The findings include: Review of an agency policy reviewed on 5/17/2022, titled "Continuity of Care" revised December 2019, stated, "… The Clinical Supervisor will review the patient census and staffing levels on a daily basis and will make patient patient assignments …." During an interview on 5/5/2022, at 10:45 AM, the administrator indicated the clinicians were assigned to patients for visits by the corporate scheduler. The administrator indicated staff contacts the corporate scheduler if staff is unable to perform the visit as scheduled and the reason why. At 12:59 PM, the administrator indicated he was unsure to provide visit times for the patients for any days other than the present day since the staff does not confirm visit times with the patient until the night before. The administrator indicated newer staff will send the administrator notice each day of their visit times and indicated the older staff was not very good about sending their schedule for each day to include their visit time. During an interview on	G0960		

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ACCENTCARE HOME HEALTH OF INDIAN	11037 BROADWAY, SUITE C , CROWN POINT, Indiana, 46307

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G0960	Continued from page 144 5/6/2022, at 9:00 AM, the administrator indicated he was not sure of the visit times for patient #4, patient #5, and patient #6 scheduled for 5/9/2022. At 11:15 AM, the administrator indicated the clinical manger was working on the patient visit times for 5/9/2022 by calling the patients directly. At 1:10 PM, the administrator confirmed the home visit for patient #6, start of care 4/7/2022, on 5/10/2022 between 8:00 AM and 9:00 AM with registered nurse (RN) N. During a daily conference on 5/9/2022, at 1:30 PM , the administrator and clinical manager confirmed the home visit for patient #6 with RN N on 5/10/2022 between 8:00 AM and 9:00 AM. During an interview on 5/10/2022, at 7:48 AM, the clinical manager indicated RN N completed the home visit for patient #6 the day before. When queried why the home visit was completed on 5/9/2022 when confirmed for 5/10/2022, the clinical manager indicated she was unsure. During an interview on 5/10/2022, at 10:50 AM, the clinical manger indicated she was not aware RN N changed her visit time for patient #6 from 5/10/2022 to 5/9/2022 until she contacted RN N to get a more exact visit time. During an interview on 5/10/2022, at 10:50 AM, the administrator indicated schedule changes provided to the corporate scheduler are not communicated with the agency. The administrator stated, “We just see it on the schedule when it is rescheduled by the scheduler.” 17-14-1(a)(1)(K)	G0960		
G0962	Coordinate patient care CFR(s): 484.105(c)(2) Coordinating patient care, This ELEMENT is NOT MET as evidenced by: Based on clinical record review and interview, the clinical manager failed to provide oversight of coordination of care. The findings include: Clinical record review on 5/10/2022, for patient #6, start of care 4/7/2022, evidenced an agency document titled “Client Coordination Note Report”, dated 5/7/2022, and entered by person S. This document indicated person S notified the physician of the missed visit via fax. During an interview on 5/11/2022, at 4:27 PM, the clinical manager indicated she was unsure who person S was. When queried how she ensured the physician was	G0962		

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ACCENTCARE HOME HEALTH OF INDIAN	11037 BROADWAY, SUITE C , CROWN POINT, Indiana, 46307

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G0962	Continued from page 145 coordinated with related to the missed visit if she did not know who person S was, the clinical manager indicated that it was a good question. Review of an agency document titled “Client Coordination Note Report” entered by physical therapy assistant (PTA) H and dated 4/20/2022, indicated the patient declined physical therapy (PT) services and wanted occupational therapy (OT). The clinical record failed to evidence communication with the physician related to the patient’s refusal of PT and request for OT services. During an interview on 5/11/2022, at 3:51 PM, the clinical manager indicated she was unsure why the patient had not been provided OT services and indicated the PTA should have communicated the patient’s request to her.	G0962		
G0968	Assure implementation of plan of care CFR(s): 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the clinical manager failed to assure the implementation of the plan of care. The findings include: 1. Clinical record review on 5/10/2022, for patient #6, start of care 4/7/2022, evidenced an agency document titled “SnapShot Office Note” dated 4/6/2022. This document indicated the disciplines requested included occupational therapy (OT). Review of an agency document titled “Home Health Certification and Plan of Care” for certification period 4/7/2022 – 6/5/2022 indicated OT was to evaluate the patient for home safety and psychosocial and rehabilitative needs. Review failed to evidence OT had evaluated the patient and failed to evidence the plan of care was implemented. During an interview on 5/11/2022, at 3:50 PM, the clinical manger indicated she was unsure why OT services had not been started. 2. Clinical record review on 5/11/2022, for patient #10, start of care 4/25/2022, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 4/25/2022 – 6/23/2022. This document indicated the licensed professional was to notify the physician for pain greater than 7 on a scale of 0-10 and for a diastolic blood pressure (the pressure against the walls of the arteries during the contraction of	G0968		

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G0968	Continued from page 146 the heart and noted as the bottom number of the blood pressure reading) greater than 100. Review evidenced an agency document titled “Visit Note Report” electronically signed by occupational therapist (OT) I and dated 4/27/2022, which indicated the OT assessed the patient’s pain to be an 8 on a scale of 0-10. Review indicated person O, corporate medical assistant, faxed notification to the physician of the patient’s pain. Review failed to evidence the OT notified the physician of the patient’s pain as directed by the plan of care. Review evidenced an agency document titled “Visit Note Report” electronically signed by registered nurse (RN) K and dated 4/29/2022, which indicated the RN assessed the patient’s pain to be an 8 on a scale of 0-10 and the diastolic blood pressure to be 102. Review indicated person O, corporate medical assistant, faxed notification to the physician of the patient’s blood pressure. Review failed to evidence the RN notified the physician of the patient’s pain and blood pressure as directed by the plan of care. Review evidenced an agency document titled “Visit Note Report” electronically signed by RN K and dated 5/3/2022, which indicated the RN assessed the patient’s pain to be 9 on a scale of 0-10. Review indicated person O, corporate medical assistant, faxed notification to the physician of the patient’s pain. Review failed to evidence the RN notified the physician of the patient’s pain as directed by the plan of care. Review evidenced an agency document titled “Visit Note Report” electronically signed by RN C and dated 5/6/2022, which indicated the RN assessed the patient’s pain to be 8 on a scale of 0-10. Review indicated person O, corporate medical assistant, faxed notification to the physician of the patient’s pain. Review failed to evidence the RN notified the physician of the patient’s pain as directed by the plan of care. During an interview on 5/12/2022, at 12:42 PM, the clinical manager indicated the RN and OT should have notified the physician of the patient’s pain and elevated blood pressure as directed in the plan of care and indicated she had not been notified by person O that licensed staff was not notifying the physician of the pain and blood pressure outside of parameters. 3. During an interview on 5/12/2022, at 12:18 PM, the clinical manager stated, “This is a big learning experience. I’m taking what you guys say and I’m making a list to train staff 1 by 1.” 4. During an interview on 5/13/2022, at 11:18 AM, the clinical manager indicated the clinician completing the comprehensive assessment was responsible for	G0968		

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G0968	Continued from page 147 making the plan of care and stated, “Which doesn’t seem to be working too well.” 17-14-1(a)(1)(C)	G0968		
G0984	In accordance with current clinical practice CFR(s): 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. This ELEMENT is NOT MET as evidenced by: Based on observation, clinical record review and interview, the agency failed to ensure all services were provided in accordance with current clinical practice guidelines and accepted professional standards of practice in 1 of 7 clinical records reviewed with home visit conducted (#1). The findings include: Record review on 5/4/2022 evidenced an agency document titled, "JOB DESCRIPTION ... RN [registered nurse] CASE MANAGER....", revised 1/15/2014, which stated, " ... Standards ... Informs the physician of the results of the assessment and recommended clinical interventions ... Implements appropriate nursing interventions consistent with ... the scope of the Nurse Practice Act ... Practices nursing in accordance with the ANA Code for Nurses, Nurse Practice Act and the Patient's Bill of Rights...." Record review evidenced an agency document titled, "JOB DESCRIPTION ... PHYSICAL THERAPIST...", revised 10/2012, which stated, " ... The Staff Therapist is responsible for providing evaluation and treatment to patients ... Performs patient evaluations...." Observation of a home visit for patient #1 was conducted on 5/5/2022, at 12:00 PM. At 12:52 PM, PT [physical therapist] G placed their thermometer, pulse oximeter, blood pressure cuff, stethoscope, and gloves on a barrier on the patient’s kitchen counter. PT G stated, “It’s a reassessment visit. I don’t have to do the vitals. Do you want me to?”. The surveyor told PT G to do what they would normally do. PT G stated, “I won’t do them then”, and returned the equipment to their	G0984		

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G0984	Continued from page 148 bag. At 1:19 PM, when PT G was preparing to leave visit, the patient asked PT G if they had a blood pressure cuff. PT G stated, “I already put it away”. Person R, family of patient #1, placed their own automatic blood pressure cuff on the patient’s left arm. Person R indicated the patient’s blood pressure was 198/90 at the nurse’s visit earlier that day. PT G asked person R if the nurse called the doctor. Person R stated, “No”. After the automatic blood pressure cuff reading was complete (167/97), PT G left the patient’s home. Record review evidenced the following statement from the American Physical Therapy Association website (apta.org), “ … Taking vital signs and obtaining simple clinical measures provide valuable information about your patients that in many cases are important to evaluating and managing care appropriately. Many of these measures also can be important in screening for undiagnosed problems or identifying risk. If you don’t take these measures, significant information is lost….” The American Physical Therapy Association (APTA) also stated, “ … the measurement of vital signs is one of the minimum skills required of physical therapists and these should be measured during every visit by a new patient or existing clients….” During an interview on 5/10/2022, at 2:45 PM, the clinical manager indicated all nurses, therapists, and therapy assistants should check the patient’s vital signs at each visit. When informed of the findings on 5/11/2022, at 11:52 PM, the clinical manager shook their head and offered no further information. During observation of a home visit on 5/9/2022 at 2:30 PM, what was identified by the patient as a dialysis fistula was observed to the patient’s left arm. Record review evidenced a history and physical from physician Z, dated 12/14/2021, which indicated the patient had a dialysis fistula to the left upper arm. Review of the National Kidney Foundation website, www.kidney.org, evidenced an undated patient brochure titled, “HEMODIALYSIS ACCESS What You Need to Know”, which stated, “ … Three different types of access can be placed for hemodialysis. They are called a fistula, a graft, and a catheter	G0984		

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G0984	Continued from page 149 … never let anyone … take your blood pressure from this arm…." Clinical record review evidenced an agency document titled, "Visit Note Report", dated 4/5/2022, signed by PTA [physical therapy assistant] R. The visit note had a section titled, "Vital Signs", which indicated the blood pressure was taken on the patient's left arm. Clinical record review evidenced a visit note dated 4/11/2022, signed by RN [registered nurse] D, which indicated the blood pressure was taken on the patient's left arm. During an interview on 5/13/2022 at 12:16 PM, the clinical manager indicated a clinician should not use a patient's arm with a dialysis fistula to check their blood pressure.	G0984		
G1014	Interventions and patient response CFR(s): 484.110(a)(2) All interventions, including medication administration, treatments, and services, and responses to those interventions; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure all interventions, treatments, and responses to interventions were documented in the patient's clinical record in 1 of 7 clinical records reviewed with a home visit conducted (#3) The findings include: Record review on 5/17/2022 evidenced an agency policy titled, "MONITORING PATIENT'S RESPONSE / REPORTING TO PHYSICIAN", revised 12/2019, which stated, " … Clinicians will monitor, document, and report the patient's response to care and treatment on each home visit…." Record review evidenced an agency policy titled, "ONGOING ASSESSMENTS", revised 12/2019, which stated, " … The scope and intensity of ongoing assessments will be determined by the patient's diagnoses, condition, desire for care, response to previous care, and the care setting … Re-assessments should focus on … Patient's response to care…." Clinical record review on 5/10/2022, for patient	G1014		

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ACCENTCARE HOME HEALTH OF INDIAN	11037 BROADWAY, SUITE C , CROWN POINT, Indiana, 46307

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G1014	Continued from page 150 #3, start of care 10/30/2021, certification period 4/28/2022 to 5/26/2022, primary diagnosis of Type 2 Diabetes Mellitus (a medical condition in which your body does not use insulin properly, resulting in unusual blood sugar levels) with foot ulcer (open sore), evidenced a group of agency documents titled, “Visit Note Report”. Visit notes dated 5/2/2022 and 5/6/2022 failed to evidence the patient’s response to wound care performed by the nurse at the visit. During an interview on 5/13/2022 at 11:36 AM, the clinical manager indicated the nurse should document how the patient tolerated wound care in each visit note.	G1014		
G1022	Discharge and transfer summaries CFR(s): 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure a completed discharge summary was sent to the physician within 5 business days of the patient’s discharge in 2 of 5 discharge records reviewed (#13, 16) and failed to ensure a completed transfer summary was sent to the physician within 2 business days of becoming aware of transfer in 1 of 1 transfer records reviewed (#9). The findings include: 1. Record review evidenced an agency policy revised December 2019, titled “Transfer Summary” which stated, “… A copy of the transfer summary will be sent to the physician within 72 hours of	G1022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157436	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCENTCARE HOME HEALTH OF INDIAN	11037 BROADWAY, SUITE C , CROWN POINT, Indiana, 46307

(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
G1022	Continued from page 151 transfer ….” 2. Record review evidenced an agency policy revised December 2019, titled “Discharge Summary” which stated, “… A copy of the discharge summary will be provided to the patient’s primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the organization within 5 business days of the patient’s discharge ….” 3. Clinical record review for patient #9 was completed on 05/13/2022 for start of care 04/08/2022 and certification period 04/08/2022 – 06/06/2022. Record review evidenced an order dated 04/29/2022, which stated, “… admitted to [entity C, hospital] ….” Record review evidenced a fax report dated 05/04/2022, which indicated the transfer summary was sent to patient #9’s primary care physician 4 business days after becoming aware of transfer. During an interview on 05/12/2022 at 12:33 PM, when queried when the agency is expected to send out transfer summaries, clinical manager B and administrator A did not know. Administrator A indicated medical records is responsible for sending out transfer summaries, which is corporate, and in a centralized location. 4. Record review for patient #16 was completed on 05/15/2022. Record review evidenced a discharge summary which indicated patient was discharged from the home health agency on 02/01/2022, and the discharge summary was faxed to the physician H on 02/09/2022. Record review evidenced the agency sent out the discharge summary 6 business days after discharge. During an interview on 05/11/2022 at 3:18 PM, clinical manager B and administrator A indicated they did not know when a discharge summary should be sent since corporate medical records sends these out. 5. Clinical record review on 5/12/2022 for patient #13, start of care 2/19/2022, certification period 12/19/2022 to 4/19/2022, primary diagnosis of Unspecified fracture of left femur (thighbone), evidenced an agency document titled, “Visit Note Report … PT [physical therapy] DISCHARGE FROM AGENCY”, dated 4/22/2022 and signed by PT W. Clinical record review failed to evidence a discharge summary that was sent to the physician. Review of the patient’s electronic clinical record (Home Care Home Base) failed to evidence a discharge summary. During an interview on 5/13/2022 at 2:48 PM, the clinical manager indicated a discharge note should	G1022		

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G1022	Continued from page 152 be written by the clinician and a discharge summary sent to the physician. When queried, the clinical manager stated, “I don’t see a discharge note”, and failed to provide any further documentation. 17-15-1(a)(6)	G1022		
G1024	Authentication CFR(s): 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the clinical record entries were accurate and complete to include a title of the author in 2 of 5 closed clinical records reviewed. (#13, 14) The findings include: 1. Review of an agency policy on 5/17/2022, titled “Clinical Patient Care Records/Timeliness/Corrections” revised 4/1/2021, stated, “… All entries must be … complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation) ….” 2. Clinical record review on 5/12/2022, for patient #14, start of care 5/4/2022, evidenced an agency document titled “Client Coordination Note Report” dated 4/29/2022, indicated the requested start of care date was 4/29/2022. Review of an agency document titled “Home Health Certification and Plan of Care” for certification period 5/4/2022 – 7/3/2022, indicated the start of care date was 5/4/2022. Review evidenced an agency document titled “Visit Note Report” electronically signed by registered nurse (RN) K, dated 5/4/2022, and identified to be the RN admission comprehensive assessment. This document indicated the admission assessment date was 5/4/2022. During an interview on 5/13/2022, at 10:58 AM, when queried why the requested date of start of care was 4/29/2022 and the patient was not admitted until 5/4/2022, the clinical manager indicated the actual date of	G1024		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCENTCARE HOME HEALTH OF INDIAN	**11037 BROADWAY, SUITE C , CROWN POINT, Indiana, 46307**

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G1024	Continued from page 153 start of care and of the admission comprehensive assessment was 4/29/2022. The clinical manager indicated the nurse completed the admission assessment on paper because there was a glitch with the electronic medical record program and the clinician was unable to document the initial assessment visit and start of care date as 4/29/2022. The clinical manager indicated the paper document used by the RN was not scanned in the clinical record and there was not a copy of the paper document. During an interview on 5/13/2022, at 1:20 PM, RN K indicated she completed the initial start of care assessment on 4/29/2022 which was the patient's start of care date and indicated she did not have the paper document indicating the initial assessment was completed on 4/29/2022. Review failed to evidence the clinical record was accurate to include the start of care date of 4/29/2022. 3. Clinical record review on 5/12/2022 for patient #13, start of care 2/19/2022, certification period 12/19/2022 to 4/19/2022, primary diagnosis of Unspecified fracture of left femur (thighbone), evidenced an agency document titled, "Client Coordination Notes Report". An entry dated 2/17/2022, made by person HH, failed to evidence the title of the writer. An entry dated 2/17/2022, made by person II, failed to evidence the title of the writer. An entry dated 2/18/2022, made by person JJ, failed to evidence the title of the writer. An entry dated 2/28/2022, made by person KK, failed to evidence the title of the writer. An entry dated 2/28/2022, made by person LL, failed to evidence the title of the writer. An entry dated 3/1/2022, made by person MM, failed to evidence the title of the writer. An entry dated 3/7/2022, made by person NN, failed to evidence the title of the writer. An entry dated 3/30/2022, made by person OO, failed to evidence the title of the writer. During an interview on 5/13/2022 at 3:19 PM, the clinical manager indicated the agency failed to ensure all entries in the clinical record were signed by the writer, including the author's title. 17-15-1(a)(7)	G1024		