STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200034260A	A. BUILDING B. WING	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCENTCARE HOME HEALTH OF INDIANA	11037 BROADWAY, SUITE C, CROWN POINT, IN, 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
N0000	Initial Comments This visit was for a State re-licensure survey of a home health agency. Survey Dates: 7/28/2022, 7/29/2022, 8/1/2022, 8/2/2022, 8/3/2022, 8/4/2022, and 8/5/2022. Facility ID: 008882 Census: 90	N0000		2022-09-11
G0000	INITIAL COMMENTS This visit was for a Post Condition Revisit of a Federal Recertification Survey and State Re-licensure Survey for a home health agency conducted 5/17/2022. Survey Dates: 7/28/2022, 7/29/2022, 8/1/2022, 8/2/2022, 8/3/2022, 8/4/2022, and 8/5/2022.	G0000		2022-09-11

	Census: 90 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. During this visit, the following 4 Conditions of Participation were corrected: 42 CFR 484.102 Emergency Preparedness, 42 CFR 484.75 Skilled Professional Services, 42 CFR 484.65 Condition of participation: Quality assessment and performance improvement (QAPI), and 42 CFR 484.105 Organization and Administration of Services. In addition, 23 standard deficiencies were corrected and 2 new standard deficiencies were cited. During this Federal Post Condition Revisit 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. Based on the Condition-level deficiencies during the 5/17/2022 survey, your home health agency was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 8/5/2022. 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 5/17/2022 and continuing through 5/16/2024. Quality Review Completed 08/25/2022			
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102.	E0000		2022-09-11

	Survey Dates: 7/28/2022, 7/29/2022, 8/1/2022, 8/2/2022, 8/3/2022, 8/4/2022, and 8/5/2022. Facility ID: IN008882			
E0001	Establishment of the Emergency Program (EP) 403.748,482.15,485.625 §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 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	E0001	deficiency corrected 6/17/2022	2022-08-25

	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: Deficiency corrected 06/17/2022 Deficiency corrected 06/17/2022.			
E0006	Plan Based on All Hazards Risk Assessment 403.748(a)(1)-(2),482.15(a)(1)-(2),485.625(a)(1)-(§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.	E0006	deficiency corrected 6/17/2022	2022-08-25

	* [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. (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. Deficiency corrected 06/17/2022.			

	Deficiency corrected 06/17/2022.			
E0009	Local, State, Tribal Collaboration Process 403.748(a)(4),482.15(a)(4),485.625(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 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. Based on record review and interview, the agency failed to ensure the emergency preparedness plan included a process for collaborating with local, regional, State, and Federal emergency	E0009	The Administrator/designee willensure that the agency develops and maintains an emergency preparedness planthat includes a process for cooperation and collaboration with local, tribal, regional,State, and Federal emergency preparedness officials' efforts to maintain anintegrated response during a disaster or emergency, including documentation ofthe facility's efforts to contact such officials, when applicable. **Immediate Corrective Action:** The agency will adjust the plan toinclude a process for cooperation and collaboration with the local, regional,State, and Federal emergency preparedness officials' efforts to maintain anintegrated response during a disaster or emergency, including documentation ofthe agency's efforts by 9/11/22 and review the plan no less than annually. **Systemic changes:** The administrator/designee willensure that EPP will be reviewed/updated by 9/1122; at	2022-09-11

	an integrated response during an emergency situation. The findings include: Record review on 8/1/2022, evidenced an agency policy revised 1/2021, titled Emergency Preparedness Policy which stated, & In the event of a prolonged emergency situation, the Executive Director/administrator or designee will: Cooperate with local authorities for the safety and welfare of patient/clients and staff &. This policy failed to address cooperation/collaboration with regional, State, or Federal emergency preparedness officials. Record review on 8/1/2022, evidenced an emergency preparedness binder, revised 7/2019, which failed to include a process for collaborating and cooperating with regional, State, and Federal emergency preparedness officials to maintain an integrated response during an emergency situation. During an interview on 8/1/2022, at 3:17 PM, administrator #1 indicated the process for collaborating with regional, State, and Federal emergency preparedness officials should have been in the emergency preparedness binder but failed to evidence any documentation of this process. When queried what the specific process was for collaboration with emergency preparedness officials, administrator #1 stated, & The process is we collaborate with all the local and State organizations to ensure the emergency goes through without a hitch or to the best of its ability &. Administrator #1 indicated the agency would contact emergency preparedness officials via e-mail and telephone and indicated the agency would collaborate with local hospitals.		least annually and asindicated. The administrator/designee toensure the incorporation of state, local, and tribal entities in the servicesarea by 9/11/22. Emergency Preparednesspolicy will be revised to include the cooperation/collaboration with regional,state or Federal emergency preparedness officials by 9/11/22. Theadministrator/designee will complete the EP plan template, addressing all therequired areas and documenting actions related to the service area. **Monitoring:** The EPP plan will be reviewed foreffectiveness and appropriateness on an annual basis within the QAPI process bythe administrator/designee.	
E0017	HHA Comprehensive Assessment in Disaster	E0017	TheAdministrator/designee will	2022-09-11

	484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. Based on observation, record review, and interview, the agency failed to include individualized emergency preparedness plans for each patient as part of the comprehensive assessment in 5 of 10 clinical records reviewed. (#1, 2, 3, 7, 8) The findings include: 4. During an observation of care on 7/29/2022 at 1:38 PM, for patient #2, start of care 6/1/2022, the agency s folder was observed in the patient s home and the page titled Emergency Preparedness Plan was observed to be incomplete. The plan failed to evidence the evacuation location for the patient. Review of an agency document for patient #2, start of care 6/1/2022, titled PT-Comprehensive Assessment. This document		ensure that the agency develops and maintains apatient specific emergency plan that is pertinent to the patient'sneeds/services. **Immediate action:** 1. For Patients1,2,3,7 and 8 who remain active on services, the agency will send a RegisteredNurse or qualified therapist to assess and document the individual plan foreach within the clinical record by 9/11/22. 2. TheAdministrator/designee will run the "Emergency Preparedness Report" from theHome Care Home Base (HCHB) Electronic Medical Record (EMR) and immediatelyreview each patient's status and ensure that a plan has been developed for eachpatient and includes the evacuation address, medical supplies needed and a 3-daysupply of medications as indicated. Forany patient identified without a plan, the agency will send a Registered Nurseor qualitied therapist to assess and document the individual plan for eachwithin	

	had a subsection titled Emergency Preparedness which stated evacuation location-NA [not applicable]. This document failed to evidence patient #2 s emergency evacuation location. During an interview on 8/5/2022 at 1:49 PM, the administrator indicated the entire emergency preparedness page in the home folder should be completed. 5. Review of an agency document for patient #8, start of care 6/11/2022, titled Home Health Certification and Plan of Care. This document had a subsection titled Medications which evidenced patient #8 was on 5 L (liters) of oxygen. Review of an agency document for patient #8, start of care 6/11/2022, titled Episode Emergency Preparedness Report for episode 6/11/2022 8/9/2022, failed to evidence the patient s emergency plan included patient #8 s oxygen supplies. 6. Review of an agency document for patient 7, start of care 6/7/2022, titled Home Health Certification and Plan of Care. This document had a subsection titled Orders for Discipline and Treatment which evidenced patient #9 had an indwelling urinary catheter. Review of an agency document for patient #7, start of care 6/7/2022, titled Episode Emergency Preparedness Report for episode 6/7/2022 8/5/2022, failed to evidence the patient s emergency plan included patient #8 s urinary catheter supplies. 1. Record review on 8/1/2022, evidenced an agency policy revised 1/2021, titled Emergency Preparedness Policy which stated, & Patients/clients/caregivers are instructed on admission and periodically, if the length of stay extends beyond the first certification, about the need for establishing and keeping updated, medication, supplies and equipment		the clinical record by 9/11/22 **Systemic changes:** 1. Theadministrator/designee will ensure that EPP will be reviewed/updated at leastannually and as indicated. 2. Theadministrator/designee will ensure that 100% of active patients will have anappropriate Emergency plan by using the “Emergency Preparedness Report” fromHCHB and addressing any active patient without a plan by 9/11/22 **Monitoring:** The Administrator/designee will run the “Emergency Preparedness Report”from the Home Care Home Base (HCHB) Electronic Medical Record (EMR) for caseconference and review the patients that need an Emergency plan in the homefolder.	

	lists in the home & Patients/clients/caregivers are instructed on admission and periodically, if the length of stay extends beyond the first certification, the need for keeping 72 hours of medication, supplies and oxygen in the home & Patients/clients are given an evacuation planning information at admission &. 2. Observation of a home visit for patient #1, was conducted on 7/29/2022, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, a home health folder was reviewed. The home folder contained an undated document titled Your Patient-Specific Emergency Plan which failed to specify an evacuation location. This folder also contained an emergency preparedness plan, which was printed on 7/27/2022. Observation failed to evidence the patient had received an emergency preparedness plan which included an evacuation location prior to 7/27/2022. Clinical record review for patient #1 was completed on 8/4/2022, for certification period 6/26/2022 8/24/2022. Record review evidenced a comprehensive assessment/recertification dated 6/21/2022, which contained a section titled Emergency Preparedness , which indicated the patient was a level 1 high acuity patient. This document failed to evidence an evacuation address. During an interview on 8/1/2022, at 3:29 PM, when queried how patient s emergency preparedness plans are individualized, administrator #1 stated, & we ask each specific patient about their evacuation & where that would be & we know who requires oxygen and collaborate with DME [durable medical equipment] companies to make sure they have what they need to get through and coordinate with the local fire dept and electric company for pts who need electricity &. Administrator #1 indicated the patient s individualized emergency preparedness plans were located in the admission folder and the electronic medical record. Administrator #1 indicated the emergency plans were printed from the electronic medical record and			

	brought to the patients homes. During an interview on 8/4/2022, at 11:12 AM, when queried why patient #1 s emergency preparedness plan was printed 7/27/2022, when the comprehensive assessment was completed on 6/21/2022, administrator #1 indicated she did not know. When queried why patient #1 s emergency preparedness plan did not include an evacuation location, administrator #1 indicated she did not know. 3. Observation of a home visit for patient #3 was conducted on 8/1/2022, at 10:30 AM, to observe a routine skilled nurse visit. During the visit, a home health folder was reviewed, which contained an emergency preparedness plan, which was printed on 7/28/2022. Review of home folder failed to evidence the patient received an emergency preparedness plan which included an evacuation location prior to 7/28/2022. Clinical record review for patient #3 was completed on 8/4/2022, for certification period 6/4/2022 8/2/2022. Record review evidenced a comprehensive assessment/start of care assessment dated 6/4/2022, which contained a section titled Emergency Preparedness , which indicated the patient was a level 2 moderate acuity patient. This document failed to evidence an evacuation address. During an interview on 8/1/2022, at 3:30 PM, when queried why patient #3 s emergency preparedness plan was printed on 7/28/2022, administrator #1 indicated she printed all the patient s emergency preparedness plans and placed them in the patients folders on 7/28/2022.			
E0030	Names and Contact Information	E0030	The Administrator/designee will ensure that the EmergencyPreparedness Plan	2022-09-11

	403.748(c)(1),482.15(c)(1),485.625(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (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.		specifically includes the primary means for communicating bytaking following actions: **Immediate action:** The agency hasupdated the Emergency Preparedness Plan to specifically include the primarymeans for communicating with the agency's staff. The agency will title and date the staffPhone Tree and update by 9/11/22 as appropriate or at least annually. **Systemicchange:** The administrator/designee will ensure that EPP will bereviewed/updated at least annually and as indicated. The Emergency Preparedness Report in HCHBwill be printed weekly and added to the EPP binder to ensure all of theinformation, including the physician’s contact is included in the binder/plan. The EPP plan will be reviewed foreffectiveness, and appropriateness on an annual basis within the QAPI process.The administrator/designee will ensure alternate means of	

	*[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (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		communication isincluded in the EPP plan by 9/11/22 The administrator/designee willcomplete the EP plan template, addressing all the required areas anddocumenting actions related to the service area. **Monitoring:** Theadministrator/designee will ensure that EPP will be reviewed/updated at leastannually and as indicated. The EPP planwill be reviewed for effectiveness, and appropriateness on an annual basiswithin the QAPI process.	

following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Volunteers.

*[For OPOs at §486.360(c):] The communication plan must include all of the following:

(2) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Volunteers.

(iv) Other OPOs.

(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).

Based on record review and interview, the agency failed to ensure the emergency preparedness communication plan included names and contact information for all staff and patients physicians.

The findings include:

Record review on 8/1/2022, evidenced an emergency preparedness binder which included a staff call tree. The call tree failed to evidence name and contact information for physical therapy assistant #2. The emergency preparedness binder failed to evidence names and contact information for any patients physicians.

During an interview on 8/1/2022, at 3:32 PM, when queried which physician s and contact information were included in the emergency

	indicated the agency did not include physician names or contact information in the emergency preparedness plan. Administrator #1 indicated all employees should have been included on the call tree. When queried why physical therapy assistant #2 was not included, administrator #1 indicated she did not know who this employee was and had not met this employee. Administrator #1 indicated the call tree must not have been updated.			
E0031	Emergency Officials Contact Information 403.748(c)(2),482.15(c)(2),485.625(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.	E0031	TheAdministrator/designee will ensure that the Emergency Preparedness Planspecifically includes Contact information for the following: Federal,State, tribal, regional, and local emergency preparedness staff **Immediateaction:** The agency has updated the Emergency Preparedness Plan tospecifically include the federal, state, tribal, regional and local entitiesthat may provide support during an emergency by 9/11/22 **Systemicchanges:** The administrator/designee will ensurethat EPP will be reviewed/updated by 9/11/22; at least annually and asindicated. The administrator/designee will complete the EP plan	2022-09-11

	(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. Based on record review and interview, the agency failed to ensure the emergency communication plan included contact information for Federal, State, and/or regional emergency preparedness staff. The findings include: Record review on 8/1/2022, evidenced an emergency preparedness binder which included a section titled Emergency Services Community and Regional Resources which stated, & Complete with numbers of local, regional and national emergency resources that may be useful for the agency &. The emergency preparedness binder included websites for the Federal Emergency Management Agency (FEMA) and the Department of Homeland Security/Emergency Management but failed to include any contact information. This binder listed local and State Public Health Departments but failed to include any contact information. This binder failed to include any regional emergency preparedness staff contact information. During an interview on 8/1/2022, at 3:37 PM, administrator #1 indicated the emergency communication plan did not include contact		template,addressing all of the required areas and documenting actions related to theservice area. **Monitoring:** TheEPP plan will be reviewed for effectiveness, and appropriateness on an annualbasis within the QAPI process.	

	preparedness staff. Administrator #1 indicated the only information in the emergency preparedness communication plan regarding Federal emergency preparedness staff was the FEMA website.			
E0032	Primary/Alternate Means for Communication 403.748(c)(3),482.15(c)(3),485.625(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: (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. Based on record review and interview, the agency failed to ensure the emergency preparedness communication plan included primary and alternate means of	E0032	TheAdministrator/designee will ensure that the Emergency Preparedness Planspecifically includes the primary and alternate means for communicating bytaking following actions: **Immediate Corrective Action:** The agencyhas updated the Emergency Preparedness Plan to specifically include the primaryand alternate means for communicating with the agency's staff by 9/11/22. **Systemic changes:** The administrator/designee willensure that EPP will be reviewed/updated by 9/11/22; at least annually and asindicated. The administrator/designeewill alternate means of communication is included by 9/11/22 with state,federal, tribal and staff is included in the	2022-09-11

	Federal, State, regional, and local emergency management agencies. The findings include: Record review on 8/1/2022, evidenced an emergency preparedness binder which included a section titled Emergency Services Community and Regional Resources which stated, & Complete with numbers of local, regional and national emergency resources that may be useful for the agency &. This section included contact information for local Health department, police, fire, and emergency management agency, but failed to include an alternate means of communication. The emergency preparedness binder included websites for the Federal Emergency Management Agency (FEMA) and the Department of Homeland Security/Emergency Management but failed to include any primary or alternate contact information. This binder listed local and State Public Health Departments but failed to include any primary or alternate contact information. This binder failed to include any regional emergency preparedness staff contact information. The emergency preparedness binder included a staff call tree, which listed staff names and telephone numbers but failed to include an alternate means of communication.		emergency plan by reviewing theplan annually. The administrator/designee will complete the EP plan template,addressing all of the required areas and documenting actions related to theservice area. **Monitoring:** Theadministrator/designee will review the EPP plan to ensure state, federal,tribal, regional, and local entities are included on an annual basis within theQAPI process.	

	During an interview on 8/1/2022, at 3:40 PM, administrator #1 indicated the alternate means of communication for staff and emergency preparedness officials could be phone, email, text, or local television and radio. Administrator #1 indicated the emergency preparedness plan only included websites for Federal and State emergency preparedness officials because the agency would use the website to obtain means of communication in the event of an emergency. Administrator #1 indicated the emergency communication plan did not include contact information for State or regional emergency preparedness staff. Administrator #1 indicated the only information in the emergency preparedness communication plan regarding Federal emergency preparedness staff was the FEMA website.			
E0033	Methods for Sharing Information 403.748(c)(4)-(6),482.15(c)(4)-(6),485.625(c)(4)-(§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), §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:	E0033	deficiency corrected 6/17/2022	2022-08-25

	(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). Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.			
E0039	EP Testing Requirements 403.748(d)(2),482.15(d)(2),485.625(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).	E0039	deficiency corrected 6/17/2022	2022-08-25

*[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 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 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			

	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 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 [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 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. (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 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: (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. Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.			
G0412	Written notice of patient's rights 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; Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.	G0412	deficiency corrected 6/17/2022	2022-08-25

G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on observation, record review and interview, the agency failed to ensure patients participated in and were informed about revisions to the plan of care during treatment including frequency of visits in 3 of 7 active clinical records reviewed (#1, 3, 7) and failed to ensure the patient was notified timely of discharge in 1 of 1 physical therapy home visit record reviewed. (#2) The findings include: 5. During an observation of care on 7/29/2022 at 1:45 PM, for patient #2, start of care 6/1/2022, PT [physical therapist] #3 informed patient #2, he was being discharged from	G0434	**Immediate Actions:** The administrator/designee will ensure that all activepatients are notified of changes in frequency, services, and discharge plan beforeor during the next skilled care visit by 9/11/22. The AgencyAdministrator/designee will conduct education with all clinical and supervisorystaff regarding policies and require signed attestation of education by 9/11/22: 1. HH 2.0.1 Patient Rights Responsibility/Consents 2. HH 2.1.7 Patient Transfer/Discharge/NOMNC Notice **Systemic Change:** The administrator/designee will ensure the following processis implemented: clinicians will notify the patient of the frequency changeverbally and document that the patient was notified in the order, a Home HealthCoordination Note (HHCN). The PatientCare Manager (PCM) /Clinical	2022-09-11

	physical therapy today. When quired as to whether he had been informed of his discharge prior to this visit, patient #2 indicated they canceled his appointment the previous week, and this was the first he was hearing of being discharged. An agency document titled Client Coordination Note Report dated 7/29/2022, and entered by PT #3. This document stated Date of discharge from agency 7/29/2022 Date patient notified of discharge 7/29/2022 Patient request discharge: NO &. During an interview on 8/5/2022 at 3:29 PM, the administrator indicated she did not see any documentation patient #2 was informed of his discharge prior to 7/29/2022. 6. Clinical Record review for patient #7, start of care 7/5/2022, evidenced an agency document titled Home Health Certification and Plan of Care which evidenced the patient was to receive Skilled nursing care once a week for three weeks, once every three weeks for three weeks, one every two weeks for two weeks and then once a week for a week. Physical therapy once a week for five weeks, then once every two weeks for two weeks, Occupational therapy once a week for three weeks, and once every two weeks for two weeks &. Clinical record review for patient #7 evidenced an agency document which evidenced patient #7 s frequency of visits changed to Skilled nursing once a week for a week and once every two weeks for six weeks starting 7/17/2022, physical therapy once a week for one week once every 2 weeks for four weeks as of 7/31/2022, and Occupational therapy once every two weeks for two weeks as of 7/31/2022. Clinical record review failed to evidence patient #2 was informed of the changes in the frequency of visits. 1. Record review on 8/4/2022, evidenced an agency policy revised 2/15/2022, titled Patient s Rights, Responsibilities and Consent Home		Manager will review all orders for content and ifpatient was not documented as notified, PCM will notify the patient by telephoneand document this interaction in a coordination note. If the PCM is unable to reach thepatient/caregiver, a point care alert will be entered for the next skilled careclinician to notify the patient and document this in a coordination note and callscheduling to have the visit alert removed. Continued non-compliance withpolicies will be reported to the Administrator for further disciplinary actionas appropriate. **Monitoring:** The administrator/designee will monitor the communication ofchanges in frequency, services and discharge plan by reviewing clinicalcoordination note workflow weekly ensuring that frequency, services anddischarge plans are communicated with patients before or during the nextskilled care visit.	

	Health which stated, & The patient rights include the basic rights of the patient and any additional, specific state and program specific-rights. These rights include: & Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to the completion of all assessments, the care to be furnished & the frequency of visits & any changes in the care to be furnished &. 2. Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Patient Transfer and Discharge/NOMNC Notice which stated, & Unless these are stricter state or payer notifications requirements, the patient shall be notified of planned discharge at least 48 hours prior to a planned discharge & The patient & are included in the discharge planning process consistent with state and federal regulations, and participation or notification is documented in the medical records &. 3. Clinical record review for patient #1 was completed on 8/4/2022. Record review evidenced a plan of care for certification period 6/26/2022 8/24/2022, which indicated the patient was to receive skilled nurse visits 2 times per week for 7 weeks and 1 time per week for 2 weeks; physical therapy visits 1 time per week for 1 week, 1 time every 2 weeks for 2 weeks, 1 time per week for 2 weeks, 1 time every 2 weeks for 2 weeks, and 1 time per week for 1 week; and occupational therapy visits 1 time per week for 5 weeks and 1 time every 2 weeks for 4 weeks. Record review evidenced a physician order entered on 7/13/2022, which indicated skilled nurse visit frequency was decreasing to 1 time per week for 1 week, 2 times per week for 4 weeks, and 1 time per week for 2 weeks, as of 7/10/2022. Record review evidenced an order for home health aide services starting 7/31/2022. During an interview on 8/4/2022, at 10:00 AM, when queried why the nursing visits were decreased the week of 7/10/2022,			

order & I don t know why, I didn t take the order &. Administrator #1 indicated documentation of patient notification and consent to frequency change should be documented under coordination notes, but she didn t see any documentation indicating the patient was notified of the change in services.

During an interview on 8/5/2022, at 10:22 AM, person #1 (patient #1 s family member/power of attorney) indicated the agency had not informed him or patient #1 the frequency of visits was being decreased on 7/10/2022. Person #1 was not aware that home health aide services had been ordered starting 7/31/2022.

4. Observation of a home visit for patient #3 was conducted on 8/1/2022, at 10:30 AM, to observe a routine skilled nurse visit. During the visit, the patient was observed to be alert and oriented, chair bound, and had an attendant caregiver on duty. Person #6 (family member) was present during home visit and indicated she was also taking care of another family member, at another house who was bedbound and totally dependent. Patient #3 indicated she was supposed to receive skilled nursing visits for dressing care to her left achilles heel wound 3 times per week, but the agency had only provided skilled nursing 2 times per week. Patient #3 expressed frustration due to not receiving 3 skilled nurse visits per week as ordered. The skilled nurse indicated the plan of care stated the caregiver was trained and able to perform wound care in place of skilled nursing visits. Patient #3 indicated her caregiver had declined wound care and was not trained, and person #6 was not able to regularly do wound care due to schedule conflicts. Patient #3 indicated there had been no communication from the agency regarding frequency of visits being changed.

Clinical record review for patient #3 was completed on 8/4/2022. Record review evidenced a plan of care for certification

	indicated the patient was to receive skilled nursing visits 1 time per week for 1 week, 3 times per week for 8 weeks, and 1 time per week for 1 week; physical therapy visits 1 time per week for 5 weeks and 1 time every 2 weeks for 4 weeks; and occupational therapy visits 1 time per week for 8 weeks. Record review evidenced a physician order dated 6/26/2022, decreasing frequency of physical therapy visits effective 6/19/2022, to 1 time every other week for 2 weeks, 1 time per week for 1 week, and 1 time every 2 weeks for 4 weeks. Record review evidenced a physician order dated 7/18/2022, which decreased skilled nurse visits to 1 time per week. Record review evidenced a physician order dated 7/21/2022, effective 7/17/2022, decreasing skilled nurse visits to 2 times per week for 1 week, and 1 time per week for 2 weeks. Record review failed to evidence the patient was informed of or consented to the changes in frequency of physical therapy or skilled nursing visits. During an interview on 8/4/2022, at 11:27 AM, when queried why patient #3 had so many frequency changes, administrator #3 indicated she did not know. Administrator #3 indicated that was what was written. Administrator #3 indicated she could not see documentation indicating patient #3 was made aware of or consented to frequency changes. 410 IAC 17-12-3(b)(2)(D)(i)(BB) 410 IAC 17-12-3(b)(2)(D)(ii)(BB)			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel	N0458	deficiency corrected 6/27/2022	2022-08-25

	records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Deficiency corrected 06/27/2022. Deficiency corrected 06/27/2022.			
G0478	Investigate complaints made by patient 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: Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.	G0478	deficiency corrected 6/17/2022	2022-08-25
G0484	Document complaint and resolution 484.50(e)(1)(ii) (ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview, the agency failed to	G0484	The administrator/designee will document both the existence of the complaint and the resolution of the complaint. **ImmediateAction:**	2022-09-11

	document complaint resolution in 3 of 12 complaints for the month of July 2022. The findings include: Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Concern, Complaint or Grievance Reporting Internal and External which stated, & The home health agency shall do the following & Document both the existence of the complaint and the resolution of the complaint &. Record review on 8/2/2022, evidenced a complaint log for the month of July 2022, which contained 12 complaints. Review of the July complaint log evidenced a patient complaint dated 7/25/2022, which indicated the patient was requesting a 24-hour caregiver. This document stated, & Resolution Comments: & called the husband back &. This document failed to evidence documentation of a resolution to complaint. Complaint log evidenced a patient complaint dated 7/25/2022, which indicated the patient was requesting to know when they would receive a visit due to new insurance. This complaint failed to document resolution of complaint. Complaint log evidenced a patient complaint dated 7/2/2022, which indicated the nurse had been unable to obtain intravenous access for hydration on patient, had sent patient to the emergency room for intravenous access, but the emergency room indicated they did not see any orders for intravenous access. This complaint failed to evidence documentation of complaint resolution. During an interview on 7/28/2022, at 10:48 AM, when queried how the agency investigated and documented complaints, administrator #1 stated, & complaints are documented in our EMR [electronic medical record] & and followed up on with resolution &.		The administrator/designee will review allclients in agency by 9/11/22 for compliance with Investigation of Complaintsmade and resolution will be documented in the patient's QI section of theirmedical record. Provide clinicaleducation training to include the following topic by 9/11/22: a. HCHB job aide for enteringconcern/complaints **Systemic change:** The clinical manager will ensureconcern/complaints are resolved effectively by reviewing each in the EMR,following up with the complainant, resolving the concern and communicating withthe complainant of the resolution. Theclinical manager will run the QI report from HCHB weekly to ensure allconcern/complaints are addressed per policy. Continued non-compliance withpolicies will be reported to the Administrator for further disciplinary actionas	

	410 IAC 17-12-3(c)(2)		appropriate. **Monitoring**: The administrator/designee will ensure 100% of QI summary reports ofactive patients will be audited for no less than weekly for 60 days to ensurethat the patient/caregiver complaints are documented and resolved within thepatient's medical record until 100% threshold is met. Following the above stated audit, thisindicator will become a regular part of the quarterly audit process for theQuality Assurance Performance Improvement (QAPI) Program. Audit results to be tracked, trended, sharedwith agency leadership, and reported to the QAPI committee on a quarterlybasis. After the audit threshold is achieved compliance will be monitoredthrough the quarterly QAPI Clinical Record review and reported to PAC forreview and recommendations.	
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Deficiency corrected 07/02/2022. Deficiency corrected 07/02/2022.	G0514	deficiency corrected 6/17/2022	2022-08-25
G0528	Health, psychosocial, functional, cognition	G0528	The administrator/designee will ensure the patient's current	2022-09-11

	484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure the comprehensive assessment accurately reflected patients current health status in 2 of 7 active clinical records reviewed. (#4, 5) The findings include: 1. Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Care Planning, Coordination, and Assessment Process which stated, & The comprehensive assessment includes the following components: & physical component: & Head to toe assessment &. 2. Record review on 8/4/2022, evidenced an agency policy revised 4/1/2022, titled Documenting in the Electronic Medical Record which stated, & All entries in the electronic medical record [EMR] must be patient and visit-specific and contain the actual data collected by the provider based on the care and services provided on the day of service & The EMR quality and integrity shall be maintained by adhering to identified standards in entering complete, concise, accurate, and updated information that produces a clear and valuable medical record &. 3. Clinical record review for patient #4 was completed on 8/5/2022, for certification period 6/27/2022 8/25/2022. Record review evidenced a comprehensive reassessment dated 6/24/2022, which indicated the patient had 2 stage 2 pressure ulcers (wound caused by pressure, which breaks through the first layer of skin), 1 stage 4 pressure ulcer (wound caused by pressure, with full thickness tissue loss, exposing bone, tendon, or muscle), and 2		health, psychosocial, functional,and cognitive status are included inthe Plan of Care. **ImmediateAction:** The administrator/designee will review patients 4and 5 if still active by 9/11/22 and all patients that could be affected, toensure the Comprehensive Assessments and Plan of Care will ensurethat all clients in agency will have care conference with case manager andclinical manager to review the current plan of care and identify patient needsby 9/11/22. The physician will benotified of changes that are needed to the plan of care **Systemicchange:** The clinical manager will ensure that the patient's ComprehensiveAssessment and Plan of Care includes all elements pertinent to the patient andhas current clinical status included. The agency's EMR, HCHB, will be changedto require assessment on all body systems with all discipline visit	

	stasis ulcers (wound in leg, caused by poor venous blood flow back to the heart). This document also indicated the wound assessment section, that patient had 1 left shin arterial ulcer (wound caused by poor arterial circulation to the legs and feet), 1 right lower lateral leg venous stasis ulcer, and 1 left heel diabetic ulcer. This document failed to accurately reflect patient s health status. During an interview on 8/4/2022, at 2:33 PM, when queried how many wounds patient #4 had, administrator #1 stated, & there are 3 wounds from the wound summary, the shin left and right and heel & I see the same thing you see &. 4. Clinical record review for patient #5 was completed on 8/5/2022, for certification period 7/24/2022 9/21/2022. Record review evidenced a comprehensive reassessment dated 7/19/2022, which failed to include an assessment of the cardiovascular or genitourinary system. During an interview on 8/5/2022, at 11:15 AM, when queried which body systems should have been assessed on a comprehensive assessment, administrator #1 indicated all systems should have been assessed. Administrator #1 indicated she did not know why genitourinary and cardiovascular systems were not assessed on patient #5 s recertification assessment. 410 IAC 17-14-1(a)(1)(B)		notes. The clinical manager will review theComprehensive Assessment and Plan of Care prior to approval for completedelements. Continuednon-compliance with policies will be reported to the Administrator for furtherdisciplinary action as appropriate. **Monitoring:** The Administrator/ designee will ensure review a15% sample of clinical records each quarter for compliance until a threshold of100% is met. Clinical record reviewresults will be tabulated quarterly, and compliance threshold reported to andmonitored by the Administrator or designee, QAPI committee and the ProfessionalAdvisory Committee (PAC).	
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any	G0536	To demonstrate the commitment tocompliance and provide immediate correction, the Agency Administrator/designee will ensureClinical Staff are	2022-09-11

	potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the home health agency failed to ensure a complete review of all medications the patient was currently taking was completed by the registered nurse, in order to identify significant drug interactions, duplicative drug therapy, and/or noncompliance with drug therapy in 7 of 7 active clinical records reviewed. (#1, 2, 3, 4, 5, 6, 7) The findings include: 6. Clinical record review on 8/3/2022, for patient #2, start of care 6/1/2022, evidenced an agency document titled Client Medication Report electronically signed by PT 4 on 6/2/2022. This document evidenced the patient s medications included, but were not limited to: Aspirin (blood thinner), Atorvastatin (to treat high cholesterol), Cefpodoxime (to treat infection), Doxycycline (to treat infection), Eliquis (to prevent blood clots), Metoprolol (to treat high blood pressure) Review on 8/3/2022 of the following web-based source, https://www.drugs.com/interactions-check.php , evidenced the following drug interactions between medication on the patient s home health medication list: 1 major drug interaction between Aspirin (blood thinner) and Eliquis (to treat blood clots) An agency document titled Client Coordination Note Report, dated 7/2/2022 stated, performed Med [medication] Reconciliation on 6/29/2022 during the routine PT [physical therapy] visit. No issues or changes found. Patient continues to take all med [medication] as prescribed. This document failed to evidence the patient was		compliant with documentation/review of medication profile toinclude complete medication reconciliation, drug interactions, duplicativetherapy, and appropriate physician notification. **ImmediateActions:** The administrator/designee will reviewpatients 1, 2, 3, 4, 5, 6 and 7 if still active by 9/11/22, and all clients thatcould be affected will have medication reconciliation completed by a qualifyingclinician with notification of physician if there inconsistencies and thenprepare an updated medication list by 9/11/22.	

	no longer taking Cefpodoxime and Doxycycline and failed to evidence the major drug interaction between aspirin and Eliquis. 7. Clinical record review on 8/3/2022, for patient #7, start of care 7/5/2022, evidenced an agency document titled Client Medication Report. This document evidenced the patient s medications included, but were not limited to: Advair Diskus(for breathing), albuterol for breathing), Allopurinol (for gout), Celebrex (anti-inflammatory), codeine/guaifenesin (for cough), diltiazem (for blood pressure) Eliquis (to prevent blood clots), pirfenidone (for pulmonary fibrosis), ferrous sulfate (iron supplement), Flonase (for allergies), gabapentin (for nerve pain), hydrocodone (narcotic pain medication), Levothyroxine (for thyroid), loperamide (for diarrhea), magnesium oxide (supplement), melatonin (supplement), multivitamin, Myrbetriq (for overactive bladder) Prilosec (for stomach acid), MiraLAX (for constipation) pravastatin (for cholesterol), prednisone (for inflammation), Vitamin C (ascorbic acid), Vitamin D3. Clinical record review failed to evidence the patient s medication was checked for interactions Review on 8/3/2022 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: 5 major drug to drug interactions between: codeine and hydrocodone, diltiazem and hydrocodone, codeine and gabapentin, hydrocodone and gabapentin, hydrocodone		Schedule visit to the patient's homewill be completed to ensure that the agency's medication profile includespatient's current medications. Physicianwill be notified of all medication changes/discrepancies. The Clinical Supervisor/Clinical Manager willensure that timely contact with the physician is documented in the clinicalrecord by 9/11/22 **Systemicchange**: The Clinical Supervisor/Clinical Manager will ensure the medicationprofile was compared to the Plan of Care/ 485; ensuring all medications areaccurately and completely documented on the medication profile. All physiciannotifications of these medication issues will be validated during Plan of Carereview and ongoing orders management process via clinical manager workflow andrecord review by 9/11/22. Medicationchanges and Plan of Care changes will be printed and mailed to the patientshome daily and monitored by the administrator/designee weekly.	

	Celebrex, diltiazem and loperamide and 27 moderate drug to drug interactions between hydrocodone and Celebrex, Prilosec and ferrous sulfate, magnesium oxide and ferrous sulfate, codeine and melatonin, hydrocodone and melatonin, gabapentin and melatonin, diltiazem and Flonase, codeine and Celebrex, prednisone and Celebrex, cholecalciferol and magnesium oxide, prednisone and Miralax, albuterol and Miralax, diltiazem and Eliqius, Celebrex and Eliqius, Codeine and Myrbetriq. Myrbetriq and Esbriet, loperamide and hydrocodone, levothyroxine and hydrocodone, levothyroxine and Prilosec, diltiazem and prednisone, albuterol and loperamide, codeine and loperamide, diltiazem and fluticasone, levothyroxine and ferrous sulfate, albuterol and Advair, levothyroxine and		policies will be reported to the Administrator for furtherdisciplinary action as appropriate. **Monitoring:** 100% medication reconciliationreview of active census with focus communication to relevant physician of anyidentified medication discrepancies and tracked daily by a member of theclinical operating team. Medication reconciliation process will be repeatedcontinually until accuracy meets 100% threshold.	

	magnesium oxide, codeine and diltiazem Clinical record review failed to evidence the physician was notified of the drug interactions found. During an interview on 8/5/2022 at 9:30 AM, the administrator indicated the system did not evidence any major drug interactions. She indicated she is not sure what system but she would check to see what kind of interactions should come up in their dug review 8. Clinical record review on 8/3/2022, for patient #7, start of care 7/5/2022, evidenced an agency document titled Client Medication Report. This document evidenced the			

	included, but were not limited to: Albuterol 9 for breathing hydrocodone/acetaminophen (narcotic pain medication) Lasix (diuretic) Inrebic (chemotherapy) meclizine (for nausea), Prilosec (for increased stomach acid), potassium chloride (supplement) trazodone (for depression). Clinical record review failed to evidence the patient s medication was checked for interactions Review on 8/3/2022 of the following web-based source, https://www.drugs.com/interactions-check.php, evidenced the following drug interactions between medication on the patient s home health medication list: 2 major interactions between potassium chloride and meclizine and between hydrocodone and Inrebic. There were also 11			

	between Lasix and Prilosec, Lasix and trazodone, Lasix and albuterol, trazodone and albuterol, trazodone and meclizine, Lasix, and Hydrocodone, trazodone and hydrocodone, meclizine and hydrocodone, Prilosec and Inrebic, trazodone and Inrebic, and meclizine and Inrebic. During an interview on 8/5/2022 at 10:22 PM, the administrator indicated the system will only flag major drug interactions. 9. Clinical record review on 8/3/2022, for patient #9, start of care 6/7/2022, evidenced an agency document titled Client Medication Report This document evidenced the patient s medications included but were not			

	limited to: Acetaminophen (for pain), atorvastatin (for cholesterol), Folic acid (supplement), midodrine (for low blood pressure), mirtazapine (for depression), pantoprazole (for increased stomach acid), tramadol (for pain), docusate sodium (constipation), and risperidone (mood stabilizer).			

Review on 8/3/2022 of the following web-based source, https://www.drugs.com/interactions-check.php, evidenced the following drug interactions between medication on the patient s home health medication list: 2 major drug interactions between risperidone and tramadol, and between tramadol and mirtazapine. There are also 2 moderate drug interactions between atorvastatin and pantoprazole and between risperidone and mirtazapine.

During an interview on 8/4/2022 at 9:10 AM, the administrator indicated she would look into why the system did not know of an interaction between the medications.

1. Record review on 8/4/2022, evidenced an agency policy revised 9/1/2018, titled Medication Profile, Review, and Reporting of Findings which stated, & The qualified clinician, as part of the comprehensive assessment process & completes a Medication

	Profile for every patient by reviewing thee hospital discharge medication list, if available, and reviewing with the patient/family the medications, over-the-counter medications, supplements and/or herbs the patient reports taking to determine the current medication profile and patient understanding of the medications actions and to identify any potential adverse effects and drug reactions, including & significant drug interactions, duplicative drug therapy, and noncompliance with drug therapy & As part of each visit the skilled nurse or therapist reviews the patient s medication regimen including medication name, dosage, frequency and instructions with the patient and/or caregiver and looks for new, discontinued, or changed medication or non-adherence &. 2. Observation of a home visit for patient #1 was conducted on 7/29/2022, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, a bottle of Aleve (medication for pain/fever) was observed in patient s medication cabinet. Patient #1 indicated she used this medication sometimes as needed for pain. Clinical record review for patient #1 was completed on 8/4/2022, for certification period 6/26/2022 8/24/2022. Record review evidenced a medication list, which was signed by the registered nurse on 6/21/2022, 7/6/2022, and 7/15/2022, and indicated the nurse had reviewed on these dates, the medications for any potential adverse effects, significant drug reactions, and non-compliance with drug therapy. Record review failed to evidence any drug interactions were identified on 6/21/2022, 7/6/2022, or 7/15/2022 medication review. Review on 8/3/2022, of a web based source, https://www.drugs.com/interactions-check.php , evidenced the following 6 major drug-to-drug interactions between medications on patient #1 s medication list: potassium chloride (potassium supplement)			

	significantly increased potassium levels in blood; atorvastatin (to lower cholesterol) and teriflunomide (to treat multiple sclerosis) may cause liver damage; lisinopril and teriflunomide may cause liver damage; acetaminophen (for pain) and teriflunomide may cause liver damage; hydrocodone (for pain) and gabapentin (for nerve pain) may cause respiratory distress, coma, or death; and baclofen and hydrocodone may cause respiratory distress, coma, or death. During an interview on 8/4/2022, at 10:15 AM, administrator #1 indicated if drug-to-drug interactions are discovered during drug regimen review, the clinician enters a coordination not and sends any interactions to the physician. Administrator #1 indicated she did not see any coordination notes or physician notification of drug interactions for patient #1. When queried why the drug regimen review did not identify the major interactions, administrator #1 indicated she did not know. Administrator #1 indicated patient #1 s medication list should have included Aleve.			

	3. Observation of a home visit for patient #3 was conducted on 8/1/2022, at 10:30 AM, to observe a routine skilled nurse visit. During the visit, the following medications were observed in the patient s home, and not included on the medication list: hempvana (pain control ointment) and Tylenol arthritis (for pain). The patient indicated she took aspirin (to prevent blood clots) and oxycodone (for pain). During the visit, a home health folder was reviewed, which contained 2 medication lists. The first medication list was updated on 7/26/2022, and included the following medications: Plavix (medication to prevent blood clots), labetalol (to lower blood pressure and heart rate), gabapentin (for nerve pain), baclofen (muscle relaxer), triamterene-HCTZ (to lower blood pressure), and iron (supplement). The second medication list was updated on 7/28/2022, and mailed to patient. Patient #3 had crossed out all these medications, and stated, & it was so wrong &. Patient #3 indicated she was not taking any of those medication on the medication list dated 7/28/2022. Clinical record review for patient #3 was completed on 8/4/2022, for certification period 6/4/2022 8/2/2022. Record review evidenced a coordination note dated 7/29/2022, which indicated the patient s medications had been reconciled, but failed to include aspirin, oxycodone, hempvana, or Tylenol arthritis. During an interview on 8/4/2022, at 11:31 AM, administrator #1 indicated she did not know why patient #3 s medication reconciliation did not identify the correct medications she was taking. Administrator #1 indicated the clinicians should review the medications with the patient every visit. 4. Clinical record review for patient #4 was completed on 8/5/2022, for certification period 6/27/2022 8/25/2022. Record review evidenced a recertification comprehensive assessment dated 6/21/2022, which indicated a medication regimen review was conducted as part of the comprehensive reassessment,			

including potential drug interactions, and no issues were identified. Record review failed to evidence any coordination notes identifying major drug-drug interactions.

Review on 8/4/2022, of a web-based source, https://www.drugs.com/interactions-check.php , evidenced the following 2 major drug-drug interactions between medications on patient #4 s medication list: furosemide (to decrease swelling) and dronedarone (treats irregular heartbeat) increased risk of irregular heart rhythm, and electrolyte imbalances; and quetiapine (antipsychotic) and dronedarone increased risk of life-threatening heart arrhythmia.

During an interview on 8/4/2022, at 3:00 PM, administrator #1 indicated she did not know why there were no major drug interactions identified for patient #4. Administrator #1 indicated the clinicians perform a drug regimen review when any new medications are added, and the system they have should have identified major drug interactions.

5. Clinical record review for patient #5 was completed on 8/5/2022, for certification period 7/24/2022 9/21/2022. Record review evidenced a recertification comprehensive reassessment dated 7/19/2022, which was conducted by physical therapists #7. This document indicated a medication regimen review had been conducted to identify noncompliance with medications and no issues were identified. Review evidenced a medication list which included the furosemide (to decrease swelling). This list was signed by physical therapist #7 on 7/19/2022, and indicated all the medications were reviewed for non-compliance with drug therapy. Record review evidenced a coordination note dated 7/19/2022, signed by registered nurse #5 which stated, & patient states he is not taking furosemide due to not wanting to use the bathroom frequently &.

During an interview on 8/5/2022, at 11:16 AM,

	when queried who completed the drug regimen review on the comprehensive reassessment, administrator #1 indicated the physical therapist completed it. Administrator #1 did not know why the therapist did not identify the non-compliance on the comprehensive reassessment. 410 IAC 17-14-1(a)(1)(B)			
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessment identified the patients primary caregiver including their willingness and ability to provide care and availability and schedules in 3 of 7 active clinical records reviewed. (#1, 3, 4) The findings include: 1. Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Care Planning, Coordination, and Assessment Process which stated, & The comprehensive assessment includes the following components: & The patient s primary caregiver[s] if any, and other available supports, including their: willingness and ability to provide care, and availability and schedules &.	G0538	Thepatient's primary caregiver(s), if any, and other available supports, includingtheir: (i) Willingness and ability to provide care, and (ii) Availability and schedules. **Immediate Actions:** The administrator/designee will reviewpatient # 1, 3 and 4, if still active and all other clients that could be affected to ensure that primary caregivers are identified as indicated duringeach comprehensive assessment completed. The Agency Administrator/designee willconduct education with all clinical and supervisory staff regarding policiesand require signed attestation of education by 9/11/22: a. HH 2.1.4 Care Planning	2022-09-11

	2. Observation of a home visit for patient #1 was conducted on 7/29/2022, at 1:00 PM, to observe a routine skilled nurse visit. The patient was observed to be chairbound, and indicated she required assistance to stand and transfer to chair or bed. Clinical record review for patient #1 was completed on 8/4/2022, for certification period 6/26/2022 8/24/2022. Record review evidenced a comprehensive recertification assessment dated 6/21/2022, which indicated person #2 was patient s emergency contact and was available 24/7. This document failed to include person #2 s willingness and ability to provide care. Record review evidenced a coordination note dated 6/21/2022, which indicated the patient s caregiver was person #1. The coordination note failed to include availability or schedule of person #1. Review of the electronic medical record failed to evidence person #1 s contact information or name. During an interview on 7/29/2022, at 1:15 PM, patient #1 indicated her caregiver was person #1. Patient #1 indicated person #1 worked during the day and helped her transfer out of bed to the wheelchair in the morning, bathed her, and transferred her back to bed at night. Patient #1 indicated person #1 provided wound care when the agency missed a visit. Patient #1 indicated person #1 was more knowledgeable about her care planning and medical information. During an interview on 8/4/2022, at 10:31 AM, when queried what information regarding caregivers should be included on a comprehensive assessment, administrator #1 stated, & if there is a caregiver and what their role is & some are not involved &. Administrator #1 indicated patient #1 s caregiver was person #1, based off of the coordination note. Administrator #1 indicated there was no contact information for person #1 documented.		and Coordination **Systemic Changes:** 1. The clinical manager will review the plan of care and subsequentorders to ensure the plan is individualized for the patient including theidentification of caregivers as applicable. 2. The clinical manager will ensure all admissions/recertifications/resumptionsare reviewed with the clinician during the Assessment report. **3.** The clinical manager will ensureall patients are care conferenced at admission/recertification/resumptions andwhen there is a significant change in condition**.** 4. The clinical manager will manage daily workflow tasks in the EMR toensure all patient orders/tasks/collaborations are completed daily. 5. Continued non-compliance with policies will be reported to theAdministrator for further	

	3. Observation of a home visit for patient #3 was conducted on 8/1/2022, at 10:30 AM, to observe a routine skilled nurse visit. Patient #3 was observed to be wheelchair bound, and required assistance to stand and transfer. During the visit, person #6 (family member) was present, and indicated she worked and was a caregiver for another family member, but assisted patient #3 when she could along with the attendant caregiver who was available 5-6 days per week. Clinical record review for patient #3 was completed on 8/4/2022, for certification period 6/4/2022 8/2/2022. Record review evidenced a start of care/comprehensive assessment dated 6/4/2022, which indicated person #6 (family member) was patient #3 s emergency contact. This document failed to include information on patient #3 s caregiver including name, contact information, willingness and ability to provide care, or schedule and availability. During an interview on 8/4/2022, at 11:31 AM, administrator #1 indicated she did not see caregiver documentation in the comprehensive assessment. 4. Clinical record review for patient #4 was completed on 8/5/2022, for certification period 6/27/2022 - 8/25/2022. Record review evidenced a recertification comprehensive assessment dated 6/24/2022, which indicated patient had a diagnosis of dementia (disease which causes memory loss and impaired judgement) and resided in an assisted living facility. This document indicated person #8 was patient #4 s emergency contact. This document failed to identify patient #4 s caregiver, including their availability, willingness, ability, and schedule. During an interview on 8/4/2022, at 10:31 AM, administrator #1 indicated the caregiver		disciplinary action as appropriate. **Monitoring** TheAdministrator or designee to review a 15% of active patient clinical recordseach quarter for compliance until 100% threshold is met. Clinical record review results will betabulated quarterly, and compliance threshold reported to and monitored by theAdministrator or designee, QAPI committee and the Professional AdvisoryCommittee (PAC).	

	assessments and include information regarding their availability, ability, and willingness to assist.			
G0546	Last 5 days of every 60 days unless: 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. Based on record review and interview, the agency failed to update and revise the comprehensive assessment in 1 of 1 clinical record in which there was a significant change in condition. (#1) The findings include: Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Care Planning, Coordination, and Assessment Process which stated, & The comprehensive assessment must be updated and revised as frequently as the patient s condition warrants & but no less frequently than: & The last 5 days of every 60 days beginning with the Start of Care date, unless there is a: & Significant change in condition &. Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Significant Change in Condition which stated, & Patient encounters a health condition that results in a significant increase or change to services lasting longer than one week and has a: & New primary diagnosis and/or &	G0546	To demonstrate the commitment to compliance andprovide immediate correction, the Agency Administrator will ensure Clinical Staff arecompliant with physician notification of significant changes in patient's condition and appropriateOASIS assessment completed as indicated. **Immediateaction:** The administrator/designee will review patient #1,if still active by 9/11/22 and all clients that could be affected confirmed/reviewed that physician was not notified of patient's change in condition andappropriate OASIS was completed to reflect significant change by 9/11/22 Clinical Manager will conference every patient onservice and make any clarifications to the written plan of care as needed inorder to ensure that the	2022-09-11

	Substantial functional or clinical status decline or improvement from the most recent comprehensive assessment &. Clinical record review for patient #1 was completed on 8/4/2022, for certification period 6/26/2022 8/24/2022. Record review evidenced a recertification comprehensive assessment dated 6/21/2022, which indicated patient had a right lateral leg arterial wound which measured 4.3 cm (centimeters) x 1.3 cm x 0 cm and a right heel arterial wound which measured 2.2 cm x 1.8 cm x 0.1 cm. Record review evidenced a skilled nurse visit note dated 7/20/2022, which indicated the right lateral leg arterial wound measured 5 cm x 2 cm x 0.1 cm and the right heel arterial wound measured 2.5 cm x 2 cm x 0.1 cm. Record review evidenced a skilled nurse visit note dated 7/29/2022, which indicated the right lateral leg arterial wound measured 7 cm x 4 cm x 0.1 cm and the right heel arterial wound measured 2.4 cm x 2.6 cm x 0.1 cm. Record review failed to evidence the agency updated or revised the comprehensive assessment due to patient #1 s significant change in wound status. During an interview on 8/4/2022, at 10:58 AM, when queried what would be considered significant change in condition or major decline, administrator #1 stated, & something majorly different than the visit previously & I would ask them to do a significant change in condition oasis assessment &. When queried how the agency was meeting patient #1 s needs if her wounds were significantly larger than at the beginning of the certification period, administrator #1 stated, & The wound care clinic would be who to ask & I don t know what else we can do if the physician isn t ordering anything else &.		appropriate and any deviationsfrom the documented status will be reported to the physician for additionalorders/clarification on current patient needs **Systemicchange:** The clinical manager will ensure all changes in the patient'scondition is reported to the physician. The Deteriorating Wound report will bereviewed by the clinical manager weekly to ensure that all wounds that haveincreased in size, changed in description that indicates a deterioration isreported to the physician. The ClinicalManager will ensure that all significant changes in the patient condition areassessed by the case manager and that an OASIS follow-up is scheduled/completedand that new/changes orders are received. The clinical manager will document communication using the PhysicianCommunication Note. Continuednon-compliance with policies will be reported to the Administrator for furtherdisciplinary action as	

	During an interview on 8/5/2022, at 10:22 AM, when queried how person #1 (patient #1 s medical power of attorney/family member) felt patient #1 was progressing with her wounds with home health and wound clinic, person #1 stated, & it was okay & since you [surveyor] came, they noticed the wound was bigger and talked to [physician #4] & he sent her to the vein clinic and scheduled an appointment next Thursday to open her veins &. 410 IAC 17-14-1(a)(1)(B)		appropriate. **Monitoring** TheAdministrator or designee to review a 15% of active patient clinical recordseach quarter for compliance until 100% threshold is met. Clinical record review results will betabulated quarterly, and compliance threshold reported to and monitored by theAdministrator or designee, QAPI committee and the Professional AdvisoryCommittee (PAC).	
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the home health agency failed to ensure the discharge summary included post-discharge goals of care and treatment preferences in 1 of 2 discharge records reviewed (#2). The findings include: Review of an agency policy titled “Patient Transfer and Discharge Notice” revised 7/25/2022, stated “ … The agency shall send all necessary	G0564	To demonstrate the commitment to compliance andprovide immediate correction, the Agency Administrator will ensure Clinical Staff arecompliant with completion of discharge summary, to include but not limited to,post discharge goals of care and patient treatment preferences **ImmediateAction:** The administrator/designee will review dischargedpatient #2 by 9/11/22 and all other affected clients to ensure the Dischargeand Transfer summaries contain treatment preferences and post discharge goals9/11/22. The Agency	2022-09-11

	medical information pertaining to the 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….” Clinical record review for patient #2 start of care 6/1/2022, evidence an agency document titled "PT [Physical Therapy] Discharge from Agency", which indicated the patient was discharged on 7/29/2022. This document failed to evidence post-discharge goals and patient treatment preferences During an interview on 8/5/2022 at 1:44 PM, when the administrator was queried on what the patient's post-discharge goals and patient preferences were, she read the goals from interventions and the goals the patient met during the treatment plan. No further information was provided as to what the patient's post-discharge goals and treatment preferences were.		Administrator/designee will conduct education with allclinical and supervisory staff regarding discharge summary template by 9/11/22. **Systemicchange:** 1. TheAgency Administrator/designee will ensure the discharge summary template isrevised to include treatment preferences and post discharge goals by 9/11/22. **2.** The Administrator/designee to educate staffeducation on completion of Discharge Summaries in relation to documentation ofpost discharge goals and patient treatment preference as evidenced byattestation. 3. Continued non-compliance with policies will be reported to theAdministrator for further disciplinary action as appropriate. **Monitoring** As part of ongoingmonitoring to ensure clinical supervision is executed/performed according toAgency Transfer/Discharge policy and regulations related to required DischargeSummary documentation. The Administratoror designee will review 15% of	

			clinical records each quarter for compliancewith appropriate Discharge Summary documentation until 100% threshold is met. Clinical record review results will betabulated quarterly, and compliance threshold reported to and monitored by theAdministrator or designee, QAPI committee and the Professional AdvisoryCommittee (PAC).	
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review and interview, the home health agency failed to ensure: the patient received all services in the plan of care and the plan of care was individualized (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	G0570	The administrator/designee will ensure patients are accepted for treatment onthe reasonableexpectation that the agency can meetthe patient's medical, nursing, rehabilitative,and social needs in his or her placeof residence. Each patient must receive an individualized written plan of care,including any revisions or additions. The individualizedplan of care must specify the care and services necessaryto meet the patient-specific needs asidentified in the comprehensiveassessment, including identification ofthe responsible discipline(s), andthe measurable outcomes that the agency anticipates will occur as a result of implementing andcoordinating the plan of care. The individualizedplan of care must also specify the patient and caregiver educationand training.	2022-09-11

	staff were ordered by a physician (See tag G0580); 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); patients received education and training (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); and			

	the treatments to be administered by agency personnel were provided to the patient and caregiver in			

	writing (See tag G0618). 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 484.60 Care Planning, Coordination of Care and Quality of Care.			
G0572	Plan of care 484.60(a)(1)	G0572	The administrator/designee will ensure each patient will receivehome health services that arewritten in an individualized plan ofcare that identifies patient-specific measurable outcomes and goals, and is established, periodically reviewed, and signed bya doctor of medicine, osteopathy,or podiatry acting within the scopeof his or her state license, certification, or registration. If a physician or	2022-09-11

	Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review, and interview, the agency failed to ensure patients received the home health services which were written in an individualized plan of care that identified patient-specific measurable outcomes and goals in 6 of 10 clinical records reviewed. (#1, 3, 4, 5, 6, 10) The findings include: 7. Record review for patient #6, start of care 7/12/2022, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 7/12/2022 - 8/1/2022. This document had a subsection titled Orders of Discipline and Treatments which stated, & HHA [home health aide 1W4 [once a week for weeks &Patient will demonstrate oxygen saturation within normal limits or to patients optimal level as established by the physician &. Clinical record review for patient #6 evidenced patient #6 failed to receive a home health aide visit until 7/21/2022. During an interview on 8/5/2022 at 2:23 PM, the administrator indicated she was unsure as to why the patient did not have a visit until 7/21/2022. She indicated the schedule was not done so they could have added her to the schedule prior to 7/21/2022. Record review for patient #6 evidenced a		allowed practitioner refers a patient under a planof care that cannot be completed until after an evaluation visit, the physicianor allowed practitioner isconsulted to approve additions or modifications to the original plan. **Immediateaction:** The administrator/designee will reviewpatients #1, 3, 4, 5, 6, and 10 if still active by 9/11/22 and other clients that could be affected toensure the plan of care is followed. Theadministrator/designee will ensure that all clients in the agency will havecare conference with case manager and clinical manager to review the plan ofcare and identify patient needs by 9/11/22. The physician will be notified of changes thatare needed to the plan of care. **Systemicchange:** 1. The clinical manager will review the plan of care and subsequentorders to ensure the plan is individualized for the patient. 2. The clinical manager will ensure all	

	document titled Visit Note Report for OT [occupational therapy] Add on Evaluation dated 7/14/2022. This document had a subsection titled Respiratory which stated & Was the patient s O2 saturation assessed? No. This document failed HHA once a week for the evidence patient #6 s low O2 saturation was checked during the visit. Record review for patient #6 evidenced a document titled Visit Note Report for OT Visit + sup/re-eval [supervisory/evaluation] dated 7/29/2022.This document had a subsection titled Respiratory which stated & Was the patient s O2 saturation assessed? No. This document failed the evidence patient #6 s low O2 saturation was checked during the visit. During an interview on 8/5/2022 at 2:26 PM, the administrator indicated the staff would just assess the patient s oxygen saturation if there was a reason for concern. 8. Clinical record review for patient #10, start of care 2/15/2022, evidenced a document titled Discharge Service Communicating from hospital #10. This document evidenced patient #10 had a right chest catheter to receive dialysis. Clinical Record review for patient #10, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/15/2022 8/13/2022. This document failed to be individualized and include the patient s dialysis access, fluid restriction, and care of the dialysis access site. During an interview on 8/5/2022 at 1:34 PM, the administrator indicated the plan of care should have included education on renal disease and care of the dialysis catheter site. 1. Record review on 8/4/2022, evidenced an agency policy revised 2/15/2022, titled Patient s Rights, Responsibilities and Consent Home Health which stated, & The patient rights include the basic rights of the patient and any additional, specific state and program specific-rights. These rights include: & Receive all services outlined in the plan of care in accordance with physician orders &. 2. Record review on 8/4/2022, evidenced an		admissions/recertifications/resumptionsare reviewed with the clinician during the Assessment report. **3.** The clinical manager will ensureall patients are care conferenced at admission/recertification/resumptions andwhen there is a significant change in condition**.** 4. The clinical manager will ensure the frequency of disciplines arefollowed and appropriate for patient's condition. 5. The clinical manager will manage daily workflow tasks in the EMR toensure all patient orders/tasks/collaborations are completed daily. 6. Continued non-compliance with policies will be reported to theAdministrator for further disciplinary action as appropriate. **Monitoring** The Administrator/designee will ensure a review15% of clinical records each quarter for elements/services/treatment/patient instruction of the Plan of	

	agency policy revised 7/25/2022, titled Physician Plan of Care which stated, & This agency s policy is to establish a written plan of treatment for each patient receiving services related to the patient s illness, injury, or treatment of the patient s medical, nursing, or social needs &. 3. Observation of a home visit for patient #1 was conducted on 7/29/2022, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, the nurse was observed completing wound care to a right posterior heel wound and a right lateral lower leg wound. The skilled nurse failed to apply skin barrier/protective ointment to surrounding skin during the home visit. The skilled nurse failed to complete a head-to-toe skin assessment during the visit. Patient #1 utilized an electric wheelchair, grabber, shower chair, and Hoyer lift. Patient was observed to chair bound, and indicated her caregiver helped her transfer in and out of bed using a Hoyer lift and helped her shower using a shower chair. Patient indicated she could not walk but was able to stand and pivot for transfers. During the visit, the nurse indicated the patient had a missed visit the week of 7/24/2022, due to not being able to get ahold of the patient. Patient #1 indicated she was always home, and always had her cell phone with her, which she was observed holding. Clinical record review for patient #1 was completed on 8/4/2022. Record review evidenced a plan of care for certification period 6/26/2022 8/24/2022, which stated, & Skilled nurse patient or caregiver to perform wound care to right lateral leg arterial wound, and right heel unstageable pressure ulcer as follows: use clean technique. Cleanse wound with NS [normal saline] and apply skin protective/barrier ointment to protect surrounding skin &. This document stated, & skilled nurse to observe and assess integumentary status to identify untoward changes and intervene to minimize complications &. The plan of care indicated the patient s primary diagnosis was multiple sclerosis (a disease in which the immune system eats away at protective coverings of		Care until100% threshold is met. Clinical record review results will be tabulatedquarterly, and compliance threshold reported to and monitored by theAdministrator or designee, QAPI committee and the Professional AdvisoryCommittee (PAC).	

	nerves, impairing the communication between the brain and the body). This document failed to be individualized to include any interventions, education, or goals related to primary diagnosis. This document stated 5 times, & may perform 02 [oxygen] saturation levels at evaluation visit and PRN [as needed] for signs and/or symptoms of possible respiratory complications or with O2 use &. Record review failed to evidence patient #1 used oxygen. This document stated, & 3 PRN SN [skilled nurse] visits & to evaluate a malfunction in equipment such as wound vac [negative pressure wound dressing] or support surface &. Record review failed to evidence the patient used a wound vac. The plan of care stated 3 times, & May schedule a BH [behavioral health] RN [registered nurse] evaluation as needed during the episode to assess for impact of behavior, medications, and/or need for follow-up &. This document failed to be individualized to include any specific physical or occupational therapy interventions to be performed, assistive devices in use, baseline functional status, or exercises to perform during visits. The plan of care indicated the week of 7/24/2022, patient #1 was to receive 2 skilled nurse visits. Record review evidenced a missed visit note dated 7/27/2022, which indicated the visit was missed because staff was not able to reach patient. Surveyor called the phone number on file for patient #1, and person #1 (patient #1 s caregiver/family member) answered and indicated it was his phone number. Record review and review of electronic medical record failed to evidence patient #1 s cell-phone number or any alternate means of communication on file for patient #1. During an interview on 8/4/2022, at 9:52 AM, administrator #1 indicated the clinicians were expected to perform wound care as ordered on the plan of care. When queried why the nurse did not apply skin barrier/protective ointment during the visit, administrator #1 indicated she did not know, because the plan of care said apply the skin barrier. At 11:00 AM when queried how frequently clinicians are expected to complete head-to-toe skin assessments, administrator #1 indicated every visit. At 11:06 AM, when queried how the			

agency ensures all plans of care were individualized, administrator #1 indicated they review all the plans of care. When queried why all patients plans of care included the same O2 and behavioral health orders, administrator #1 indicated it was added to all plans of care in case any of those issues arose. Administrator #1 indicated the interventions on patient #1 s plan of care regarding a wound vac should have been removed.

4. Observation of a home visit for patient #3 was conducted on 8/1/2022, at 10:30 AM, to observe a routine skilled nurse visit. During the visit, the patient indicated she experienced 10/10 pain the previous night, and currently her pain was at a 7/10.

Clinical record review for patient #3 was completed on 8/4/2022. Clinical record review evidenced a plan of care for certification period 6/4/2022 8/2/2022, which stated, & licensed professional to report vital signs falling outside the following established parameters & pain > 7 &. The plan of care indicated the patient s primary diagnosis was urinary tract infection. The plan of care also included diagnosis of peripheral vascular disease (poor circulation in the extremities), non-pressure ulcer to left foot, and hypertension (high blood pressure). This document failed to be individualized to include any patient-specific interventions or education, related to diagnoses of hypertension, urinary tract infection, or peripheral vascular disease. This document stated 3 times, & may schedule a BH RN evaluation as needed during the episode to assess for impact of behavior, medications and/or need for follow-up &. Record review failed to evidence patient had any behavioral health history or current issues. The plan of care stated 6 times, & May perform O2 saturation levels at evaluation visit and PRN for signs and/or symptoms of possible respiratory complications or with O2 use and notify MD of O2 levels below 92 &. Record review failed to evidence patient used oxygen. The plan of care indicated the patient received occupational and physical therapy services but failed to be

interventions or orders to be performed, patient s baseline functional status, assistive devices in use, or method of transfers. Record review evidenced a skilled nurse visit note dated 8/1/2022, which failed to evidence the pain of 10/10 was reported to physician or clinical manager. Record review evidenced an order for home health aide services effective 6/12/2022, for 1 visit a week for 5 weeks, and 1 visit every other week for 2 weeks. Record review failed to evidence the patient received any home health aide visits the week of 6/12/2022 or 6/19/2022 as ordered on the plan of care.

During an interview on 8/4/2022, at 11:16 AM, administrator #1 indicated if a patient had 10/10 pain, the clinician should have notified the physician, and taken measures to decrease pain intensity. At 11:23 AM, administrator #1 did not know why patient did not receive home health aide visits the week of 6/12/2022 or 6/19/2022. When queried what should be included on a therapy plan of care, administrator #1 indicated they should have included interventions and orders for therapists to perform during visits.

5. Clinical record review for patient #4 was completed on 8/5/2022, for certification period 6/27/2022 8/25/2022. Record review evidenced a recertification comprehensive assessment which indicated the patient s primary diagnoses were diabetes (trouble regulating blood sugars), left heel ulcer (wound), hypertension (high blood pressure), and inflammation of left lower extremity. Record review evidenced a plan of care for certification period 6/27/2022 8/25/2022, which indicated patient had a history of atrial fibrillation (irregular heartbeat) and deep vein thrombosis (blood clot in vein) and was taking Xarelto (blood thinner). The plan of care failed to be individualized to include any wound care education, or measurable outcomes/goals related to wound healing or wound care. This plan of care failed to be individualized to include any interventions, education, or goals related to diagnosis of hypertension, atrial fibrillation, or deep vein thrombosis. Record review evidenced a physician order dated

	7/7/2022, which included the following wound care to left shin wound: cleanse with saline or sterile water, apply calcium alginate, cover with ABD, apply tubular elastic support bandage, change 2 times per week. Record review evidenced skilled nurse visits for the following dates, in which the nurse failed to apply Tetragrip/tubular elastic support bandage to bilateral legs: 7/11/2022, 7/19/2022, 7/27/2022, and 7/29/2022. Record review evidenced a faxed physician order from the wound clinic dated 7/25/2022, which stated, & Pt [patient] states home care is not providing her with Tetragrip Can you please make sure she gets Tetragrip? &. Record review evidenced a physician order dated 7/29/2022, in which the Tetragrip/tubular elastic support bandages were ordered. Record review evidenced a physician order dated 7/21/2022, which stated, & Order Clarification for POC [plan of care] dated 6/27/2022 8/25/2022 & obtain weights each visit &. Record review evidenced skilled nurse visit notes dated 7/27/2022 and 8/2/2022, which failed to evidence the skilled nurse obtained a weight as ordered on the plan of care. During an interview on 8/4/2022, at 3:03 PM, when queried how patient #4 s plan of care should have been individualized, administrator #1 indicated this plan of care was not complete with all orders at the time of assessment, due to an electronic medical record system glitch. Administrator #1 indicated most of the plan of care interventions would be found as orders, written at later dates. Administrator #1 indicated patient #4 s plan of care should have included education on all disease processes, wound care, education on signs and symptoms of infections, safety precautions, and goals of wound healing. At 3:13 PM, when queried why the patient had not received wound care/Tetragrip as ordered on 7/7/2022, administrator #1 indicated the Tetragrip was ordered on 7/29/2022. At 3:27 PM, when queried why the clinicians did not obtain weights as ordered, administrator #1 indicated she did not know.			

	6. Clinical record review for patient #5 was completed on 8/5/2022. Record review evidenced a plan of care for certification period 7/24/2022 9/21/2022, which included the following wound care to a skin tear on right anterior tibial area: cleanse with normal saline and pat dry, cover with gauze or band aid. The plan of care failed to be individualized to include wound care orders for new wound to left lower extremity. The plan of care indicated the patient was receiving skilled nursing, physical therapy, and occupational therapy, but failed to be individualized to include patient-specific orders or interventions to be performed by physical or occupational therapy. Review of a comprehensive reassessment dated 7/19/2022, failed to evidence patient had a wound to right anterior tibial area. The comprehensive reassessment indicated patient had a new wound to left lower extremity. During an interview on 8/5/2022, at 11:31 AM, administrator #1 indicated she did not know why the plan of care included wound care for a right tibial wound and did not see anything regarding right leg wound. At 11:42 AM, when queried how the therapy plans of care should be individualized, administrator #1 indicated the plan of care included general interventions to be performed, and the therapy assistants may decide which specific exercises to perform during the visits. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses;	G0574	Theadministrator/designee will ensure that patients have an individualized plan of care that includes: Allpertinent diagnoses; The patient'smental, psychosocial, and cognitivestatus; The types of services, supplies, and equipment required;	2022-09-11

	(ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the agency failed to ensure the individualized plan of care included the following: supplies and equipment required, safety measures to protect against injury, all pertinent diagnoses, all medications and treatments, patient and caregiver education, information related to advanced directives, and patient-specific interventions in 9 of 10 clinical records reviewed. (#1, 2, 3, 4, 5, 6, 7, 8, 9)		Thefrequency and duration of visits tobe made; Prognosis; rehabilitation potential; Functionallimitations; Activities permitted; Nutritional requirements; All medications and treatments; Safety measures to protect against injury;A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventionsto address the underlying risk factors; Patientand caregiver education and trainingto facilitate timely discharge; Patient-specificinterventions and education; measurableoutcomes and goals identified by the agency and the patient; Informationrelated to any advanceddirectives; and Any additional items the HHAor physician or allowedpractitioner may choose to include. **Immediateaction:** The administrator/designee will ensure review ofpatients # 1, 2, 3, 4, 5, 6, 7, 8 and 9, if still active and all clients thatcould be affected related to complete and individualized Plan of	

The findings include:

6. Clinical record review for patient #2, start of care 6/1/2022, evidenced an agency document titled PT [Physical Therapy] Admission dated 6/1/2022 which indicated patient #2 had a manual wheelchair and walker

Clinical record review evidenced an agency document titled Home Health Certification and Plan of Care, for certification period 6/1/2022 7/30/2022. This document stated, & DME [durable medical equipment and Supplies]: None &. This Plan of Care failed to include the patient s DME supplies.

During an interview on 8/5/2022 at 1:30 PM, the administrator indicated that all patient supplies and equipment should be listed in the plan of care.

Clinical record review on 8/3/2022, for patient #2, start of care 6/1/2022, evidenced an agency document titled Client Medication Report electronically signed by PT 4 on 6/2/2022. This document evidenced the patient s medications included, but were not limited to: Aspirin (blood thinner), Atorvastatin (to treat high cholesterol), Cefpodoxime (to treat infection), Doxycycline (to treat infection), Eliquis (to prevent blood clots), Metoprolol (to treat high blood pressure)

An agency document titled Client Coordination Note Report, dated 7/2/2022 stated, performed Med [medication] Reconciliation on 6/29/2022 during the routine PT [physical therapy] visit. No issues or changes found. Patient continues to take all med [medication] as prescribed. This document failed to evidence the patient was no longer taking Cefpodoxime and Doxycycline

During an observation of care on 7/29/2022 at 1:37 PM, patient #2 indicated he was not taking Cefpodoxime and Doxycycline. He indicated those two medications he only took for a short time in June. When he came out of the hospital.

Careelements. The administrator/designeewill ensure that all patients on census will have care conference with casemanager and clinical manager to review the plan of care and identify patientneeds by 9/11/22. The physician will benotified of changes that are needed to the plan of care.

1. The Administrator/designee will ensure the items listed above areidentified on all Plans of Care. The Agency Administrator/designee will utilizethe front- end audit tool to ensure compliance by 9/11/22.

Systemicchange:

1. The clinical manager will review the plan of care and subsequentorders to ensure the plan is individualized for the patient.

2. The clinical manager will ensure all admissions/recertifications/resumptionsare reviewed with the

	7. Clinical record review for patient #6, start of care 7/12/2022 evidenced an agency document titled RN Oasis Admission dated 7/12/2022 which indicated patient #6 had a standard walker, elevated toilet seat, tub chair, and grab bars. Clinical record review evidenced an agency document titled Home Health Certification and Plan of Care, for certification period 7/12/2022 9/9/2022. This document stated, & DME Alcohol; DME-vital signs equipment; gloves; skin cleanser &. This Plan of Care failed to include the patient s walker, elevated toilet seat, tub chair, and grab bars. During an interview on 8/5/2022 at 2:27 PM, the administrator indicated all of the patient medical equipment and supplies in the home should be listed on the plan of care.3Clinical record review for patient #6, start of care 7/12/2022 evidenced an agency document titled RN Oasis Admission dated 7/12/2022 which indicated patient #6 had a standard walker, elevated toilet seat, tub chair and grab bars. Clinical record review for patient #6 evidenced an agency document titled Home Health Certification and Plan of Care for certification period 7/12/2022 9/9/2022, which had a subsection titled Medications, which stated, Cosopt 22.3 mg [milligram] 6.8 mg/ml [milliliter] eye drops 2 drops ophthalmic (eye) bedtime & Mylanta Tonight 800 mg-270 mg -80 mg/10 ml oral suspension take 10-20 ml between meals at bedtime or as directed. This document failed to include which eye to put the Cosopt drops in and failed to ensure the Mylanta order was clear as to how much of the medication to take. During an interview on 8/5/2022 at 2:25 PM, the administrator indicated the Mylanta order needs to be more specific so the patient knows when and how much she should be taking. Clinical record review for patient #6 start of care 7/12/2022, evidenced an agency document titled Client Medication Report electronically signed by RN (Registered Nurse) #4 on 7/12/2022. This document evidenced the patient s medications included, but were not limited to: Cosopt (for glaucoma),		clinician during the Assessment report. **3.** The clinical manager will ensureall patients are care conferenced at admission/recertification/resumptions andwhen there is a significant change in condition**.** 4. The clinical manager will ensure the frequency of disciplines arefollowed and appropriate for patient's condition. 5. The clinicalmanager will manage daily workflow tasks in the EMR to ensure all patientorders/tasks/collaborations are completed daily. 6. Continued non-compliance with policies will be reported to theAdministrator for further disciplinary action as appropriate. **Monitoring:** Theadministrator/designee will ensure that record audits for Plan of Careindividualized elements until 100% threshold is met. Clinical	

	Diclofenac (topical pain gel), Famotidine (for gastrointestinal reflux), Latanoprost, Mylanta (treats increased stomach acid) Ocean Nasal (for nasal dryness), Sertraline (treats depression), and Acetaminophen (for pain). This document had duplicate listings for Cosopt, Diclofenac, famotidine, Latanoprost, Ocean Nasal and Sertraline. During an interview on 8/5/2022 at 2:22 PM, the administrator indicated there was a glitch in the system and it is pulling over the medications from the last certification and adding them to the medication list. 8. Clinical record review for patient #7, start of care 75/2022 evidenced an agency document titled RN Oasis Admission dated 7/5/2022 which indicated patient #6 had a standard walker, four-wheel walker, wheelchair, elevated toilet seat, tub chair, hospital bed, oxygen, grab bars, and reacher. Clinical record review evidenced an agency document titled Home Health Certification and Plan of Care, for certification period 7/5/2022 9/2/2022. This document stated, & DME Alcohol; DME-oxygen supplies, shower/tub equipment, vital signs equipment, walker gloves, and wound care supplies &. This Plan of Care failed to include the patient s standard and four-wheel walker, hospital bed reacher, and bedside commode. During an interview on 8/5/2022 at 9:52 AM, the administrator indicated all of the patient medical equipment and supplies in the home should be listed on the plan of care. 9. Clinical record review for patient #7, evidenced an after visit summary from Hospital #9, dated 6/1/2022, which evidenced patient #7 s medications were but not limited to: ProAir (for breathing) Oxygen at 3L, OMEGA 3 (supplement) pirfenidone (for lung disease), Zinc (supplement), Norco 5-325 mg (narcotic pain medication), Megestrol Acetate (for appetite. Clinical record review for patient #7, evidenced an agency document titled Client Medication Report this document failed to include Megestrol, Proair, zinc, and the correct dosage of Norco and Oxygen. During an interview on 8/5/2022 at 9:50 AM,		record review results will betabulated quarterly, and compliance threshold reported to and monitored by theAdministrator or designee, QAPI committee and the Professional AdvisoryCommittee (PAC).	

	the administrator indicated all of the medications should be checked and verified with the physician. Clinical record review for patient #7 evidenced an agency document titled RN Oasis Admission dated 7/5/2022. This document evidenced patient #7 had a stage two wound to the coccyx cleanse the area with soap and water, pat dry, apply skin prep to the peri-wound, and apply hydrocolloid dressing to the area. These orders and supplies failed to be included on patient #7 s plan of care. 10. Clinical record review for patient #8, start of care 2/11/2022 evidence an agency documents titled RN Resumption of Care dated 6/27/20022. This document evidenced patient #8 had a port implanted in her right chest. This document also evidenced the patient had a bedside commode, tub chair, hospital bed, CPAP, grab bars, front wheeled walker, power wheelchair, and a reacher in the home. Clinical record review for patient #8, evidenced and agency document titled Home Health Certification and Plan of Care, with a subsection titled DME and Supplies, which included Alcohol, Gloves, Ostomy supplies, vital signs equipment, wound care supplies. The supplies failed bedside commode, tub chair, hospital bed, CPAP, grab bars, front wheeled walker, power wheelchair, and reacher, and included ostomy supplies for which patient #8 did not have an ostomy. This document also failed to include patient #8 s port to her right chest. 11. Clinical record review for patient #9, start of care 6/7/2022, evidenced an agency document titled RN Oasis Admission dated 6/7/2022 which indicated patient #9 had a wheelchair, walker, hospital bed, glucometer.			

	Clinical record review evidenced an agency document titled Home Health Certification and Plan of Care, for certification period 6/7/2022 8/5/2022. This document stated, & DME [durable medical equipment and Supplies]: Alcohol, catheter supplies, gloves, skin cleanser, vital signs equipment, wound care supplies &. This Plan of Care failed to include the patient s wheelchair, walker, hospital bed, glucometer During an interview on 8/5/2022 at 9:09 AM, the administrator indicated that all patient supplies and equipment should be listed in the plan of care. 1. Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Physician Plan of Care which stated, & Components of the plan of care include the following: all pertinent diagnoses; mental, psychosocial, and cognitive status; types of services, supplies, and equipment required; visit frequency/duration; prognosis; rehabilitation potential; functional limitations; activities permitted; nutritional requirements; all medications and treatments; safety; description of risk for emergency department visits; hospital re-admission and necessary interventions to address risk factors; patient/caregiver; specific interventions and education; measurable outcomes and goals identified by the patient and the agency; and information related to any advanced directives &. 2. Observation of a home visit for patient #1 was conducted on 7/29/2022, at 1:00 PM, to observe a routine skilled nurse visit. The following DME (durable medical equipment) was observed in the home, and not included in the plan of care: hoyer lift, electric wheelchair, shower chair, lift chair, grabber, and incentive spirometer. Clinical record review for patient #1 was completed on 8/4/2022, for certification period 6/26/2022 8/24/2022. Record review evidenced a medication list dated and signed 6/21/2022, which indicated the patient was taking Brilinta (blood thinner) and Lexapro			

	(anti-depressant). Record review evidenced a coordination note dated 6/21/2022 which indicated the patient had diagnosis of depression and a coordination note dated 6/23/2022 which indicated the patient had a diagnosis of anxiety. The coordination note dated 6/21/2022, indicated the patient had advanced directives in the form of a medical power of attorney. Record review evidenced a plan of care for certification period 6/26/2022 8/24/2022, which listed the following DME and supplies: alcohol, gloves, vital signs equipment, and wound care supplies. The plan of care failed to include bleeding precautions as a safety measure. The plan of care failed to include depression or anxiety as diagnoses. The plan of care failed to include any information regarding advanced directives or medical power of attorney. During an interview on 8/4/2022, at 10:25 AM, when queried what DME should be included on the plan of care, administrator #1 indicated all DME in use in the patient s home should be included on the plan of care. At 10:30 AM, administrator #1 indicated patients taking blood thinners should have bleeding precautions included on their plan of care. At 10:44 AM, administrator #1 indicated the plan of care should include all diagnoses pertinent to the patient. At 10:45 AM, administrator #1 indicated the plan of care should include any advanced directive patients have and where they are located, as well as requesting a copy.			

	3. Observation of a home visit for patient #3 was conducted on 8/1/2022, at 10:30 AM, to observe a routine skilled nurse visit. During the visit, the patient was observed to be alert and oriented, sitting in a wheelchair. A trapeze bar was observed above patient s bed. During the home visit, the patient indicated she was taking the following medications: aspirin (to prevent blood clots), Tylenol arthritis (for pain), Ammonium Lactate (cream to treat dry skin), hempvana (for pain), Plavix (to prevent blood clots), labetalol (to lower blood pressure and heart rate), gabapentin (for nerve pain), baclofen (muscle relaxer), triamterene-HCTZ (to lower blood pressure), iron (supplement), and oxycodone (for pain). Clinical record review for patient #3 was completed on 8/4/2022, for certification period 6/4/2022 8/2/2022. Record review evidenced a start of care comprehensive assessment dated 6/2/2022, which included the following DME which was not included in the plan of care: commode and grab bars. Record review evidenced a physical therapy evaluation dated 6/8/2022, which included the following DME which was not included in the patient s plan of care: quad cane and tub chair. Record review evidenced a plan of care for certification period 6/4/2022 8/2/2022, which failed to include any of the medications patient was taking. This document listed the following medications: bethanechol chloride (to treat urinary retention), cipro (antibiotic), Flomax (for urinary retention), and saccharomyces boulardii (probiotic). During an interview on 8/4/2022, at 11:50 AM, administrator #1 indicated the plan of care should have included all medications the patient was taking. 4. Clinical record review for patient #4 was completed on 8/5/2022, for certification period 6/27/2022 8/25/2022. Record review evidenced patient #4 was hospitalized in May 2022, for cellulitis of lower extremity and placed on antibiotics. Record review evidenced			

which included a primary diagnosis of cellulitis. Record review evidenced a recertification comprehensive assessment dated 6/24/2022, which indicated the patient had primary diagnosis of diabetes (problem regulating blood sugars) with foot ulcer, and pressure ulcer (wound caused by pressure) of right lower leg. Record review evidenced a physician order dated 7/13/2022, which indicated the clinician was to apply Santyl (wound ointment which removes dead tissue from a wound) to left heel. This document indicated the patient had wounds to bilateral shins, and left heel, for which the home health agency was providing wound care. The comprehensive assessment included the following durable medical equipment which was not included on the plan of care: wheelchair, grab bars, and reacher. Record review evidenced a plan of care for certification period 6/27/2022 8/25/2022, which failed to include any wound treatment orders, patient-specific education related to wounds, or measurable outcomes and goals related to wound healing. This document failed to specify how frequently wounds were to be measured. This document failed to include the diagnosis of cellulitis. The plan of care failed to include Santyl on medication list.

During an interview on 8/4/2022, at 2:40 PM, when queried how the plan of care addressed patient s wounds, administrator #1 stated, & I don t see any wound care orders on the plan of care &. Administrator #1 indicated the orders were lost during an electronic medical record transition. At 3:07 PM, administrator #1 indicated the diagnosis of cellulitis should have been included on patient #4 s plan of care. At 3:11 PM, administrator #1 indicated Santyl should have been on the plan of care under medications.

5. Clinical record review for patient #5 was completed on 8/5/2022, for certification period 7/24/2022 9/21/2022. Record review evidenced a skilled nurse visit note dated 7/26/2022, which indicated the patient had a skin tear to his left buttock, to which the nurse applied Desitin cream. Record review evidenced a plan of care for certification period 7/24/2022 9/21/2022, which failed to

	include Desitin on the medication list. During an interview on 8/5/2022, at 11:19 AM, administrator #1 indicated Desitin should have been included on the plan of care medication list. 410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C) 410 IAC 17-13-1(a)(1)(D)(ii, ix, x)			
G0578	Conformance with physician orders 484.60(b) Standard: Conformance with physician or allowed practitioner orders. Based on observation, record review, and interview, the agency failed to ensure patient care conformed to physician orders in 3 of 10 clinical records reviewed. (#1, 4, 10) The findings include: 4. Clinical record review for patient #10, start of care 2/15/2022, evidenced an agency document titled Client Coordination Note Report dated 7/21/2022. This documents evidence patient #10 was to get Cefepime (treats infection) 2 GM on Monday, Wednesday, and Friday post dialysis. Review of patient #10 s clinical record failed to evidence if the patient received the doses of Cefepime as ordered by the physician, During an interview on 8/5/2022 at 1:46 PM, when queried as to whether the patient was receiving the Cefepime at the dialysis center she stated, I have no answer to your question.	G0578	Theadministrator/designee will ensure that the agency meets conformance with physician or allowed practitionerorders. **Immediateaction:** The administrator/designee will ensure areview of patient #, 1, 4 and 10 if still active by 9/11/22 and other clientsthat could be affected related to conformance to physician orders by 9/11/22. The administrator/designee will ensure thatall patients on census will have care conference with case manager and clinicalmanager to review the plan of care and identify patient needs by 9/11/22. The physician will be notified of changesthat are needed to the plan of care.	2022-09-11

	1. Record review on 8/4/2022, evidenced an agency policy revised 2/15/2022, titled Patient s Rights, Responsibilities and Consent Home Health which stated, & The patient rights include the basic rights of the patient and any additional, specific state and program specific-rights. These rights include: & Receive all services outlined in the plan of care in accordance with physician orders &. 2. Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Physician Plan of Care which stated, & This agency s policy is to establish a written plan of treatment for each patient receiving services related to the patient s illness, injury, or treatment of the patient s medical, nursing, or social needs & A physician & may transmit initial orders or modifications to the physician s plan of care in writing or verbally & Changes or modifications to the plan of care may be made only with the approval of the attending physician or allowed practitioner &. 3. Observation of a home visit for patient #1 was conducted on 7/29/2022, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, the nurse was observed completing would care to a right posterior heel wound and a right lateral lower leg wound. The skilled nurse failed to apply skin barrier/protective ointment to surrounding skin during the home visit. The skilled nurse failed to complete a head-to-toe skin assessment during the visit. Clinical record review for patient #1 was completed on 8/4/2022. Record review evidenced a plan of care for certification period 6/26/2022 8/24/2022, which stated, & Skilled nurse patient or caregiver to perform wound care to right lateral leg arterial wound, and right heel unstageable pressure ulcer as follows: use clean technique. Cleanse wound with NS [normal saline] and apply skin protective/barrier ointment to protect surrounding skin &. This document stated, & skilled nurse to observe and assess integumentary status to identify untoward changes and intervene to minimize		**Systemicchange:** 1. The clinical manager will review the plan of care and subsequentorders to ensure the plan is individualized for the patient. 2. The clinical manager will ensure all admissions/recertifications/resumptionsare reviewed with the clinician during the Assessment report. **3.** The clinical manager will ensureall patients are care conferenced at admission/recertification/resumptions andwhen there is a significant change in condition**.** 4. The clinical manager will ensure the frequency of disciplines arefollowed and appropriate for patient's condition. 5. The clinical manager will manage daily workflow tasks in the EMR toensure all patient orders/tasks/collaborations are completed daily. 6. Continued non-compliance with policies will be reported to theAdministrator for further	

	complications &. During an interview on 8/4/2022, at 9:52 AM, administrator #1 indicated the clinicians were expected to perform wound care as ordered on the plan of care. When queried why the nurse did not apply skin barrier/protective ointment during the visit, administrator #1 indicated she did not know, because the plan of care said apply the skin barrier. At 11:00 AM when queried how frequently clinicians are expected to complete head-to-toe skin assessments, administrator #1 indicated every visit.		disciplinary action as appropriate. **Monitoring:** The administrator/designee will ensure 100%review of patient Plans of Care until 100% of threshold is met. The audit results will be tracked, trended,shared with agency leadership, and reported to the QAPI committee on aquarterly basis. After the audit threshold is achieved compliance will bemonitored through the quarterly QAPI Clinical Record review and reported to PACfor review and recommendations.	
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the home health agency failed to administer services and treatments only as ordered by a physician in 2 of 4 active clinical records reviewed without a home visit. (#4, 5)	G0580	The administrator/designeewill ensure that drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. **Immediateaction:** The administrator/designee will ensure review ofpatients #4 and 5, if still active by 9/11/22 and all other patients that couldbe affected related adherence of skilled services ordered by the	2022-09-11

The findings include:

1. Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Physician Plan of Care which stated, & This agency s policy is to establish a written plan of treatment for each patient receiving services related to the patient s illness, injury, or treatment of the patient s medical, nursing, or social needs & A physician & may transmit initial orders or modifications to the physician s plan of care in writing or verbally & Changes or modifications to the plan of care may be made only with the approval of the attending physician or allowed practitioner &.

2. Clinical record review for patient #4 was completed on 8/5/2022. Record review evidenced a plan of care for certification period 6/27/2022 8/25/2022, which did not include any wound treatment orders.

Record review evidenced a skilled nurse visit note dated 6/28/2022, which indicated the nurse provided wound care to a left heel wound. This document stated, & cleansed area with NS [normal saline] and patted dry. Applied Santyl and Calcium Alginate directly to bed of wound. Covered with ABD [heavy drainage pad] pad and wrapped with gauze. PT [patient] tolerated &. Record review failed to evidence any wound care treatment orders were reviewed by the physician before or during 6/28/2022 skilled nurse visit.

Record review evidenced a skilled nurse visit note dated 7/1/2022, which indicated the skilled nurse applied Venelex ointment (wound ointment) to open wound on right lower lateral shin.

Record review evidenced a physician order dated 6/29/2022, which indicated right lower lateral shin wound care as follows: cleanse with dermal wound cleanser, apply calcium

physician by 9/11/22. The administrator/designee will ensure thatall patients on census will have care conference with case manager and clinicalmanager to review the plan of care and identify patient needs by 9/11/22. The physician will be notified of changesthat are needed to the plan of care.

Systemicchange:

1. The clinical manager will review the plan of care and subsequentorders to ensure the plan is individualized for the patient.

2. The clinical manager will ensure all admissions/recertifications/resumptionsare reviewed with the clinician during the Assessment report.

3. The clinical manager will ensureall patients are care conferenced at admission/recertification/resumptions andwhen there is a significant change in condition**.**

4. The clinical manager will ensure the frequency of

	rolled gauze starting at base of toes up to knee bend, apply 3 ACE wrap from the base of the toes to the knee bend. Record review evidenced a physician order dated 7/7/2022, which included the following wound care to left shin wound: cleanse with saline or sterile water, apply calcium alginate, cover with ABD, apply tubular elastic support bandage, change 2 times per week. Record review evidenced a skilled nurse visit dated 7/11/2022, which indicated the nurse completed the following wound care to left shin wound: cleansed with dermal wound cleanser, applied calcium alginate, covered with ABD pad, secured with rolled gauze, and applied 3 ACE wrap from toes to knee. This skilled nurse visit note indicated the nurse completed the following wound care to the left heel wound: cleansed with normal saline, applied Santyl and calcium alginate, covered with ABD, and wrapped with gauze. Record review evidenced a skilled nurse visit note dated 7/19/2022, which indicated the nurse wrapped the left leg and heel with gauze. During an interview on 8/4/2022, at 2:40 PM, administrator #1 indicated she did not see any wound care orders which were in effect during the 6/28/2022 skilled nurse visit. At 3:16 PM, when queried why the nurse applied Venelex during the 7/1/2022 skilled nurse visit, administrator #1 stated, & I think all the orders were not in the pathway and they were not on the plan of care and orders &. Administrator #1 indicated the nurse should have called to get wound care orders if there were none. Administrator #1 indicated the wound care orders for patient #4 were conflicting due to an electronic medical record glitch. Administrator #1 indicated the glitch was why the nurses were performing wound care other than what was ordered. Administrator #1 did not know why the nurses		disciplines arefollowed and appropriate for patient's condition. 5. The clinical manager will manage daily workflow tasks in the EMR toensure all patient orders/tasks/collaborations are completed daily. 6. Continued non-compliance with policies will be reported to theAdministrator for further disciplinary action as appropriate. **Monitoring** The Administrator/designee will conduct 100%review of adherence to the patients Plan of Care in subsequent visit notesuntil 100% threshold is met. Followingthe above stated audit, this indicator will become a regular part of thequarterly audit process for the Quality Assurance Performance Improvement(QAPI) Program. The audit results willbe tracked, trended, shared with agency leadership, and reported to the QAPIcommittee on a quarterly basis. After the audit threshold is achievedcompliance will be monitored through the quarterly QAPI Clinical Record reviewand reported to PAC for review and recommendations.	

	stockings as ordered on 7/7/2022. 3. Clinical record review for patient #5 was completed on 8/5/2022, for certification period 7/24/2022 9/21/2022. Record review evidenced a skilled nurse visit note dated 8/2/2022, which stated, & applied triamcinolone ointment to BLE [bilateral lower extremities], placed tubigrips [compression stockings] on BLE &. Record review evidenced physician order dated 8/2/2022, which included a new order for triamcinolone cream to be applied to affected are twice daily as needed for swelling, itching and redness, but failed to include location of application. Record review failed to evidence orders to apply Tubigrips. During an interview on 8/5/2022, at 11:22 AM, when queried where the triamcinolone cream was to be applied, administrator #1 indicated to the affected area. Administrator #1 indicated the order for Tubigrips should have been included in the plan of care. 410 IAC 17-13-1(a)			
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.	G0588	deficiency corrected 6/17/2022	2022-08-25

G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to promptly alert the physician to changes in the patients conditions which suggested outcomes were not being achieved in 6 of 10 clinical records reviewed. (#3, 4, 5, 6, 7, 8) The findings include: 5. Record review for patient #6, start of care 7/12/2022, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 7/12/2022 - 8/1/2022. This document had a subsection titled Orders of Discipline and Treatments which stated, Licensed Professional to report Vital Signs outside of the following established parameters & O2SAT < [less than 92 &. Record review for patient #6 evidenced a document titled Visit Note Report for PT [physical therapy] Add on Evaluation dated 7/18/2022. This document evidenced the patient's O2 was 88 [normal O2 saturation is 95 or above] with activity. This document failed the evidence the physician was notified of patient #6 s low O2 saturation during the visit.	G0590	**Immediateaction:** The administrator/designee will ensurereview of patients #3, 4, 5, 6, 7, and 8, if still active by 9/11/22 and otherpatients that could be affected related to reporting of changes in condition tophysicians by 9/11/22. The administrator/designee willensure that all patients on census will have care conference with case managerand clinical manager to review the plan of care and identify patient needs by 9/11/22. The physician will be notified of changesthat are needed to the plan of care. **Systemicchange:** 1. The clinical manager will review the plan of care and subsequentorders to ensure the physician has been notified of patient changes bymonitoring the workflow tasks related to physician notification. 2. The clinical manager will educate clinicians to report all clinicalchanges to the physician	2022-09-11

	During an interview on 8/5/2022 at 2:28 PM, the administrator indicated the physical therapist should have contacted the physician about the patient's low oxygen saturation during therapy. 6. Record review for patient #7, start of care 7/5/2022 evidenced a document titled Visit Note Report for PT [physical therapy] Add on Evaluation dated 7/8/2022. This document evidenced the patient's O2 was 91 with activity, and her blood pressure was 90/50 [normal blood pressure is 120/80]. This document failed the evidence the physician was notified of patient #6 s low O2 saturation and low blood pressure during the visit. Record review for patient #7, evidenced a document titled Visit Note Report for Skilled Nursing Visit dated 7/27/2022. This document evidenced the registered nurse assessed the patient's lungs during the visit and heard rhonchi [abnormal lung sounds. This document failed to evidence the physician was notified of the patient s abnormal lung sounds. Record review for patient #7, evidenced a document titled Visit Note Report for PT Routine visit 7/25/2022. This document evidenced the patient's O2 was 80 with activity. This document failed the evidence the physician was notified of patient #6 s low O2 saturation. 7. Clinical record review for patient #8, start of care 2/11/2022, evidenced an agency document titled Visit Note Report for a skilled nurse visit dated 7/1/2022. This document indicated the patient had pain 8/10 [on a pain scale of 1-10 very 1 is very little pain and 10 is extreme pain], and a pulse of 102. This document failed to evidence the physician was notified of the patient s pain and high pulse rate. Clinical record review for patient #8, evidenced an agency document titled Visit Note Report for a skilled nurse visit dated 6/28/2022. This document evidenced the patient had abnormal lung sounds, a cough, and left lower lobe rhonchi. This document failed to evidence the physician was notified of the abnormal lung sounds. Clinical record review for patient #8, evidenced		communication by using the CareCommunication Note and or Physician Communication Note. **3.** The clinical manager will ensureall patients are care conferenced when there is a significant change incondition**.** 4. The clinical manager will manage daily workflow tasks in the EMR toensure all patient orders/tasks/collaborations are completed daily. 5. Continued non-compliance with policies will be reported to theAdministrator for further disciplinary action as appropriate. **Monitoring:** The administrator/designeewill audit a minimum of 25% of active patient's clinical record audited for noless than 60 days or until 100% threshold is met. Following the above stated audit, this indicatorwill become a regular part of the quarterly audit process for the QualityAssurance Performance Improvement (QAPI) Program. The results will be tracked, trended, sharedwith agency leadership, and reported to the QAPI committee on a quarterlybasis. After the audit threshold is achieved compliance will be monitoredthrough the quarterly QAPI Clinical Record review and reported to PAC forreview and recommendations	

an agency document titled Visit Note Report for a skilled nurse visit dated 7/6/2022. This document evidenced the patient had abnormal lung sounds, a cough, left lower lobe and right middle and lower lobe rhonchi, and a pulse of 108. This document failed to evidence the physician was notified of the abnormal lung sounds and t her high pulse rate.

During an interview on 8/5/2022 at 10:46 AM, the administrator indicated the nurse should have notified the physician of any abnormal findings on the patient assessment.

1. Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Physician Plan of Care which stated, & Notification is required when: & The patient s response to care is not appropriate & A significant change occurs in the patient s condition & Patient findings fall within physician-ordered reporting parameters &.

2. Observation of a home visit for patient #3 was conducted on 8/4/2022, at 10:30 AM, to observe a routine skilled nurse visit. During the visit, the patient indicated her pain was 7/10 currently, and the night before had been 10/10. During wound care, the patient screamed out in pain, and grimaced.

Clinical record review for patient #3 was completed on 8/4/2022, for certification period 6/4/2022 8/2/2022. Record review evidenced a start of care/comprehensive assessment dated 6/4/2022, which indicated the patient had a left Achilles heel wound which measured 2cm (centimeters) x 2cm x 0.1 cm, and indicated the patient was experiencing pain rated 7/10, with the worst pain rated at 7/10. Record review evidenced a skilled nurse visit note dated 6/17/2022, which indicated the left Achilles heel wound measured 3.5cm x 3.5cm x 0.1cm. Record review evidenced a plan of care for certification period 6/4/2022 8/2/2022, which stated, & Goals & Patient will demonstrate improved wound status as evidenced by a decrease in size, drainage of wound, absence of infection, and decreased pain within 2 weeks &. Record review failed to evidence physician notification regarding

	6/17/2022, worsening wound and patient not meeting goal of wound healing. Record review failed to evidence the physician was notified regarding the skilled nurse visit on 8/1/2022, in which patient demonstrated her pain level had worsened from start of care assessment. During an interview on 8/4/2022, at 11:30 AM, when queried if the physician was notified of patient #3 s enlarged wound, administrator #1 indicated she did not see this documented anywhere. At 11:16 AM, administrator #1 indicated the physician should have been notified of 10/10 pain. 3. Clinical record review for patient #4 was completed on 8/5/2022, for certification period 6/27/2022 8/25/2022. Record review evidenced a recertification comprehensive assessment dated 6/24/2022, which indicated patient developed a new wound to right lateral lower shin. Record review failed to evidence the physician was notified of new wound and change in integumentary status requiring a revision to the plan of care. This document indicated the patient had a left heel wound which measured 2.5cm (centimeters) x 5cm x 0.2cm and had a scant amount of serosanguinous (clear fluid with pink tint) drainage. This document indicated the patient had a left shin wound which measured 5cm x 10cm x 0.1cm and had a moderate amount of serous (clear liquid) drainage. Record review evidenced a skilled nurse visit note dated 7/19/2022, which indicated the left heel wound had a large amount of purulent (thick, cloudy drainage, which can signal infection) drainage. This document stated, & Wound measurements on left leg are larger than previous visit due to open areas that continue to fluctuate & Patient verbalized understanding of importance in keeping wounds covered but staff at ALF [assisted living facility] reports patient will remove gauze herself after you guys see her and then she tells us that it fell off and her supplies are gone &. Record review failed to evidence physician was notified of larger wound size, purulent drainage, or patient s non-compliance with wound care. Record			

dated 8/2/2022, which indicated the left shin wound measured 6.5cm x 16cm x 0.1cm and had a large amount of purulent drainage. This document indicated the left heel wound measured 2.3cm x 4cm x 0.4cm and had a small amount of purulent drainage. Record review failed to evidence the physician was notified of enlarged wound to left shin, or deepening wound to left heel, or purulent drainage.

During an interview on 8/5/2022, at 2:44 PM, when queried if the physician was notified of patient #4 s new wound, administrator #1 indicated she did not see anything documented. At 3:22 PM, when queried if the physician was notified of patient non-compliance, purulent drainage, and larger wound size, administrator #1 indicated the physician was called to request an update about patient s doctor appointment, and to discuss a change in patient s living situation. At 3:26 PM, when queried if the physician was notified or enlarged wounds with purulent drainage on 8/2/2022, administrator #1 stated, & I don t have a fax & it must not have triggered the WAT [wound assessment tool] score, because that s what triggers the wound change which gets sent to me &.

4. Clinical record review for patient #5 was completed on 8/5/2022, for certification period 7/24/2022 9/21/2022. Record review evidenced a physical therapy note dated 7/26/2022, which stated, & communicated with pt [patient] request to increase frequency to 2x/week due to minimal progress with 1x/week current frequency &. Record review evidenced a plan of care for certification period 7/24/2022 9/21/2022, which indicated patient was to receive physical therapy visits 1 time per week for 3 weeks, and 1 time every other week for 6 weeks. Record review failed to evidence the physician was notified of patient not meeting therapy goals, and need to revise the plan of care. Record review evidenced a skilled nurse visit note dated 8/2/2022, which indicated the patient had a new stage 2 pressure ulcer to his left lower buttock. Record review failed to evidence physician notification of change in patient

	condition which required revision to the plan of care. During an interview on 8/5/2022, at 11:26 AM, when queried if the clinician had notified the physician of new stage 2 pressure ulcer, administrator #1 indicated all she saw documented was a wound care order. At 11:50 AM, when queried if there had been any follow-up or physician notification regarding patient needing more frequent therapy, administrator #1 stated, & that was just last week & I don t see follow up with that visit &. 410 IAC 17-13-11(a)(2)			
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Based on record review and interview, the agency failed to ensure the plan of care was revised to reflect current information from the patient s current comprehensive assessment and patient s current progress toward measurable outcomes and goals in the plan of care in 1 of 7 active clinical records reviewed. (#5) The findings include: Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Physician Plan of Care which stated, & The	G0592	The administrator/designee will ensure a revised plan of care must reflect current informationfrom the patient's updated comprehensive assessment and contain information concerning the patient's progresstoward the measurable outcomesand goals identified by the agency and patient in the plan of care. **Immediateaction**: The Administrator/designee will review patient # 5,if still active by 9/11/22 and clients that could be affected, ensuring therecord contains an updated assessment that contains information concerning	2022-09-11

	care plan is reviewed and updated by the certifying physician or allowed practitioner in consultation with the agency s RN [registered nurse] or qualified therapist as frequently as the patient s condition warrants, but at least every 60 days &. Clinical record review for patient #5 was completed on 8/5/2022, for certification period 5/25/2022 7/23/2022. Record review evidenced a start of care comprehensive assessment dated 5/25/2022, which indicated the patient was taking blood thinners. Record review evidenced an occurrence report dated 6/22/2022, which indicated the patient fell for the second time in 9 days on 6/18/2022, in his bedroom. This document indicated the physician was notified but failed to specify which physician. This document indicated the agency would continue fall precaution protocol and monitoring. Review of patient s visit schedule indicated the patient was receiving physical therapy and occupational therapy visits 1 time every other week, at the time of the fall. Record review failed to evidence the plan of care had been revised to reflect patient s decline in mobility status or increasing need for therapy. During an interview on 8/5/2022, at 12:06 PM, when queried if the plan of care was revised after patient #5 s falls, administrator #1 indicated it was not revised.		thepatient's progress to goals and outcomes by 9/11/22. The administrator/designee will ensure thatall patients on census will have care conference with case manager and clinicalmanager to review the plan of care and identify patient needs by 9/11/22. The physician will be notified of changesthat are needed to the plan of care. **Systemicchange:** 1. The clinical manager will review the plan of care and subsequentorders to ensure the plan is individualized for the patient. 2. The clinical manager will ensure all admissions/recertifications/resumptionsare reviewed with the clinician during the Assessment report. **3.** The clinical manager will ensureall patients are care conferenced at admission/recertification/resumptions andwhen there is a significant change in condition**.** 4. The clinical manager will	

			ensure the frequency of disciplines arefollowed and appropriate for patient's condition. 5. The clinical manager will manage daily workflow tasks in the EMR toensure all patient orders/tasks/collaborations are completed daily. 6. Continued non-compliance with policies will be reported to theAdministrator for further disciplinary action as appropriate. **Monitoring** The administrator/designee will review 15% ofclinical records each quarter until a threshold of 100% is met. Clinical record review results will betabulated quarterly, and compliance threshold reported to and monitored by theAdministrator or designee, QAPI committee and the Professional AdvisoryCommittee (PAC).	
G0604	Integrate all orders	G0604	The Administrator/designeewill ensure integration of orders from all physicians or allowed	2022-09-11

	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. Based on record review and interview, the agency failed to integrate orders from all physicians involved in the plan of care and assure coordination of all services provided to the patient in 1 of 3 active clinical records reviewed of patients who went to wound clinic. (#4) The findings include: Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Care Planning, Coordination, and Assessment Process which stated, & The case manager or primary clinician is responsible for facilitating communication about patient status changes, including a change of orders among all assigned disciplines and with the patient, physician & Agency personnel involved in patient care will communicate changes and care coordination activities to the case manager or designated clinical supervisor in a timely manner via telephone, one-on-one meetings, case conferences, and home visits &. Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Physician Plan of Care which stated, & the agency may accept a signed physician plan of care and signed orders changing the plan of care by telecommunication systems [fax] or by verifiable electronic signature & The care plan is reviewed and updated by the certifying physician or allowed practitioner in consultation with the agency s RN [registered nurse] & as frequently as the patient s condition warrants &.		practitionersinvolved in the plan of care to assure the coordination of all services andinterventions provided to the patient. **ImmediateAction:** The administrator/designee willreview patient #4 if still active by 9/11/22 and clients that could be affected to ensure theintegration of orders from all physicians involved in the patient's care intothe Plan of Care to assure coordination of all services and interventionprovided to the patient. Theadministrator/designee will ensure that patient # 4 and other active patientsare care conferenced with case manager and clinical manager to ensure allorders are accurate by 9/11/22. **Systemicchange:** The administrator/designee will ensure the Clinical Manager willreview all orders before approving them in the EMR for clinical appropriatenessand completeness to include treatments, therapies, services and ensureintegration into the plan of care. The ClinicalManager will ensure that 100% of the orders are reviewed/processed daily asthey are received. Orders that are notcomplete will be revised to contain all of the required elements withconsultation with the author.	

	Clinical record review for patient #4 was completed on 8/5/2022, for certification period 6/27/2022 8/25/2022. Record review evidenced a fax received by the home health agency on 6/29/2022, from a wound clinic. This document indicated the following wound care to left and right leg wounds: cleanse with normal saline or sterile water, calcium alginate (absorbent gel wound dressing), and ABD (heavy drainage pad). This document indicated the following wound care for left heel wound: cleanse with normal saline or sterile water, Santyl to left heel, calcium alginate, ABD, and size G Tetragrip compression stockings to right and left leg daily starting at the base of the toes up to the knees. The wound clinic order indicated dressings were to be changed 2 times per week. Record review evidenced an agency physician order dated 6/29/2022, which included the following wound care orders for bilateral leg and left heel wounds: cleanse with dermal wound cleanser, calcium alginate, ABD pad, secure with rolled gauze from toes to knees, and 3 ACE wrap from toes to knees, change 2-3 times per week. Record review evidenced the agency failed to incorporate the wound clinic dressing orders into the plan of care until 7/7/2022. During an interview on 8/4/2022, at 3:15 PM, when queried how the nurses coordinate care with the wound clinic, administrator #1 stated, & the faxes come into the office & and they are uploaded and the nurses are supposed to look at the attachments and orders prior to seeing patients &. Administrator #1 did not know why the wound care orders were not incorporated earlier into patient #4 s record. 410 IAC 17-12-2(h)		Continuednon-compliance with policies will be reported to the Administrator for furtherdisciplinary action as appropriate. **Monitoring** The Administrator /designee shall ensure review 15% of clinicalrecords each quarter for compliance with appropriate Plan of Care revisionrelated to integration of all physicians' orders onto the Plan of care until athreshold of 100% is met. Clinicalrecord review results will be tabulated quarterly, and compliance thresholdreported to and monitored by the Administrator or designee, QAPI committee andthe Professional Advisory Committee (PAC).	
G0606	Integrate all services 484.60(d)(3)	G0606	deficiency corrected 6/17/2022	2022-08-25

	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. Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.			
G0610	Patients receive education and training 484.60(d)(5) Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge. Based on record review and interview, the agency failed to ensure the patient received appropriate teaching in 2 of 7 active records reviewed (#7, #8). The findings include: 1. An agency document titled Physician Plan of Care, revised 7/25/2022, stated, " ... Notification is required when: ... Inability to carry out a prescribed treatment...." 2. Clinical Record review for patient #7, evidenced an agency document titled "Home Health Certification and Plan of Care	G0610	**Immediateaction:** The administrator/designee will review patients #7 and , if stillactive, by 9/11/22 and clients in agency that may be affected to ensure the Planof care contains clinically appropriate patient education. The administrator/designee will ensure thatpatient # 7 and 8 and other active patients are care conferenced with casemanager and clinical manager to ensure all orders are accurate by 9/11/22. **Systemicchange:** The administrator/designee will ensure the Clinical Manager reviewsthe Plan of Care for each patient to ensure that clinically appropriateeducation is included. The ClinicalManager will recommend appropriate edits of the case manager to amend the Planof Care. The	2022-09-11

	for certification period 7/5/2022 – 9/2/2022. This document had a subsection titled "Orders of Discipline and Treatment" which stated, " … Skilled Nurse to instruct on Disease Process related to COPD [chronic obstructive pulmonary disease], management techniques and treatment goals, medications...." Clinical Record review evidenced an agency document titled "Client Medicated List" which evidenced the patient was on 4 L (liters)of oxygen. Clinical record review evidenced an RN [registered nurse] Oasis Admission visit note dated 7/5/2022, which indicated the patient was using 2.5 L of oxygen. Clinical record review evidenced a physical therapy visit note dated 7/6/2022, which indicated the patient was using 3.5 L of oxygen. Clinical record review evidenced skilled nurse visit notes dated 7/11/2022 and 7/22/2022 which indicated patient was using 4.5 L of oxygen. Clinical record review evidenced		Clinical Manager will ensure that visitnotes are reviewed to ensure patient education is documented and clinicallyappropriate. Notes that do not containthe required documentation will be sent back to the clinician for revisionaccording to policy. Continued non-compliance with policies will be reported tothe Administrator for further disciplinary action as appropriate. **Monitoring** As part of ongoing monitoring to ensure clinical supervision isexecuted/performed according to the plan of care and coordinated with the casemanager/supervising nurse, the Administrator or designee will review 15% ofclinical records each quarter for compliance with appropriate patient education. Clinical record review results will be tabulated quarterly, andcompliance threshold reported to and monitored by the Administrator ordesignee,	

	dated 7/13/2022 and 7/20/2022, which indicated patient was using 4.5 L of oxygen. Clinical record review evidenced a physical therapy visit note dated 7/14/2022, which indicated the patient was not using any oxygen. Clinical record review evidenced physical therapy visits note dated 7/19/2022 and 7/25/2022, which indicated patient was using 4.5 L of oxygen. Clinical record review evidenced a skilled nurse visit note dated 7/27/2022, which indicated the patient was using 5 L of oxygen. Review of patient #7's clinical record failed to evidence any education on using her oxygen as prescribed by the physician. During an interview on 8/5/2022 at 9:27 AM, the administrator indicated there should have been some patient teaching on oxygen use and the physician should have been notified of the patient not using the correct oxygen. 3. Clinical Record review for		Professional Advisory Committee (PAC).	

	patient #8, evidenced an agency document titled “Home Health Certification and Plan of Care" for certification period 7/5/2022 – 9/2/2022. This document had a subsection titled “Orders of Discipline and Treatment” which stated, “ … O2 [oxygen] at 5 L [liters] …Inhalation therapy at 5L/min via nasal cannula 24 hours per concentrator, Skilled Nurse to instruct patient in inhalation therapy including safety measures and care of equipment….” Clinical record review evidenced a physical therapy visit note dated 7/18/2022, which indicated the patient was not using her oxygen. Clinical record review evidenced a skilled nursing visit note dated 7/15/2022, which indicated the patient was not using her oxygen. Clinical record review evidenced a skilled nursing visit note dated 7/1/2022, which indicated the patient was using 2L of oxygen.			

	Clinical record review evidenced a skilled nursing visit note dated 7/6/2022, which indicated the patient was using 4.5L of oxygen. Review of patient #8's clinical record failed to evidence any education on using her oxygen as prescribed by the physician. During an interview on 8/5/2022 at 10:31 AM, the administrator indicated there should have been some patient teaching on oxygen use and the physician should have been notified of the patient not using the correct amount of oxygen.			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review, and interview, the home health agency failed to provide patients with written visit schedules in 3 of 3 home visits conducted. (#1, 2, 3) The findings include: 4. During an observation of care on 7/29/2022 at 1:36 PM, for patient #2, start of care	G0614	The administrator/designee will ensure staff provide the patient/caregivera home folder, a visit schedule, including frequency of visits by Agency staffand written instructions. **ImmediateAction:** The administrator/designee will review patients #1, 2, and 3 ifstill active by 9/11/22 and clients that could be affected in agency by 9/11/22 and ensure that the home foldercontains a current visit schedule, including	2022-09-11

	6/1/2022, the agency s folder was observed in the patient s home. There was a blank calendar observed in the home folder. During an interview on 7/29/2022 at 1:37 PM, patient #2 indicated the agency did not provide him with a written calendar or schedule of visits. Patient #2 indicated they call the night before they are coming for a visit to schedule a time. During an interview on 8/5/2022 at 1:44 PM, the administrator indicated the calendar is not required to be filled out in the home. She indicated staff tries to keep the visits on the same day each week if it is possible. She indicated patients are called the evening before their appointment to confirm the time staff will be there. 1. Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Care Planning, Coordination and Assessment Process which stated, & Patients are informed in advance of the frequency of visits & any changes to be made in the frequency of visits &. 2. Observation of a home visit for patient #1 was conducted on 7/29/2022, to observe a routine skilled nurse visit. During the visit, a home health folder was reviewed, which contained a calendar/schedule. This document failed to include a schedule for occupational therapy visits. This document indicated for the month of July, skilled nurses were scheduled to visit every Tuesday and Thursday, and physical therapy was scheduled to visit every Wednesday. This schedule was not updated with the correct frequency orders. Clinical record review for patient #1 was completed on 8/4/2022, for certification period 6/26/2022 8/24/2022. Record review evidenced a physician order dated 7/13/2022, which indicated the patient was to receive skilled nurse visits 1 time per week for 1 week, 2 times per week for 4 weeks and 1 time per		writteninstructions. **Systemicchange:** The Administrator/designee will ensure that staffconduct a home folder audit for all patients to ensure the home folder containsa visit schedule by 9/11/22. Theclinical manager will instruct clinical staff to perform a home folder checkwith each visit to ensure the patient's schedule is accurate. Frequency changes and Plan of Care changeswill be printed and mailed to the patient's home daily and monitored by theadministrator/designee weekly. Continued non-compliance withpolicies will be reported to the Administrator for further disciplinary actionas appropriate. **Monitoring** The administrator/designee will ensure review 15% of clinicalrecords each quarter for compliance with appropriate notification of visitschedules to	

	week for 4 weeks. Record review evidenced a plan of care for certification period 6/26/2022 8/24/2022, which indicated the patient was to receive occupational therapy visits 1 time per week for 5 weeks and 1 visit every other week for 4 weeks. This document indicated the patient was to receive physical therapy visits 1 time per week for 1 week, 1 time every other week for 2 weeks, 1 time a week for 2 weeks, 1 time every other week for 2 weeks, and 1 time per week for 1 week. During an interview on 8/4/2022, at 11:58 AM, administrator #1 indicated patients written instructions should include the frequency of visits ordered and which staff will be coming. 3. Observation of a home visit for patient #3 was conducted on 8/1/2022, at 10:30 AM, to observe a routine skilled nurse visit. During the visit, a home health folder was reviewed, which contained a schedule. This schedule indicated for the month of July, skilled nursing was scheduled every Monday, Wednesday, and Friday. No schedule was observed for occupational or physical therapy. Clinical record review for patient #3 was completed on 8/4/2022, for certification period 6/4/2022 8/2/2022. Record review indicated the patient received physical and occupational therapy, and skilled nursing visits had been decreased on 7/18/2022 to 2 visits per week for 1 week and 1 visit per week for 2 weeks.		staff until 100% threshold is met. Clinical record reviewresults will be tabulated quarterly, and compliance threshold reported to andmonitored by the Administrator or designee, QAPI committee and the ProfessionalAdvisory Committee (PAC).	
G0616	Patient medication schedule/instructions 484.60(e)(2)	G0616	**ImmediateAction:** The administrator/designee will review Patients 1,2 and 3 if stillactive by 9/01122 and patients that could be affected by 9/11/22 and ensurethat the home folder contains a current	2022-09-11

	Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review, and interview, the agency failed to ensure patients were provided with written medication instructions/schedules, including medication name, dosage, and/or frequency in 3 of 3 home visits conducted. (#1, 2, 3) The findings include: 4. During an observation of care on 7/29/2022 at 1:39 PM, for patient #2, start of care 6/1/2022, 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. When patient #2 was queried as to whether patient he had a medication schedule from the agency he stated, No, they never gave me a medication list, they just brought this folder here last night when they told me I was discharged. During an interview on 8/5/2022 at 1:46 PM, the administrator stated, The medication list should be in the home folder, but I cannot make patients keep it there. 1. Record review on 8/4/2022, evidenced an agency policy revised 9/1/2018, titled Medication Profile, Review and Reporting of Findings which stated, & The agency provides the patient and caregiver[s] with access to written instructions outlining the patient s medication schedule and instructions, including medication name, dosage, and frequency, as well as which medications will be administered by the home health agency &. 2. Observation of a home visit for patient #1 was conducted on 7/29/2022, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, a home health folder was reviewed, which		and accurate medication list thatincludes frequency, dose, reason, and route. **Systemicchange:** The Administrator/designee will ensure that staffconduct a home folder audit for all patients to ensure the home folder containsa current medication by 9/11/22. Theclinical manager will instruct clinical staff to perform a home folder checkwith each visit to ensure the patient's medication list is accurate. Medication changes and Plan of Care changeswill be printed and mailed to the patient's home daily and monitored by theadministrator/designee weekly. Continued non-compliance with policies will be reported to theAdministrator for further disciplinary action as appropriate. **Monitoring** The administrator/designee will ensure review 15% of clinicalrecords each quarter for compliance with medication accuracy and homemedication list until 100% threshold is met.	

	contained a medication list. The medication list failed to include frequency of administration for the following medications: atorvastatin (to lower cholesterol), Aubagio (to treat multiple sclerosis), baclofen (a muscle relaxer), lisinopril (to lower blood pressure), and loperamide (to treat diarrhea). The medication list failed to include indications for use or frequency for the following PRN (as needed) medications: furosemide (to pull water off the body) and Klor-con (potassium supplement). During the visit, a bottle of Aleve (for fever and pain) was observed in the patient s medication cabinet. The written medication list failed to include Aleve. During an interview on 8/4/2022, at 10:09 AM, administrator #1 indicated the home medication list should have included a reason or indication for use, and frequency for PRN medications. Administrator #1 indicated the patients medication lists should include a frequency for administration. Administrator #1 indicated a complete medication order should include the medication name, dosage, route, and frequency of administration. Administrator #1 indicated all over the counter medications should have been included on the written medication list. 3. Observation of a home visit for patient #3 was conducted on 8/1/2022, at 10:30 AM, to observe a routine skilled nurse visit. During the visit, a home health folder was reviewed, which contained 2 medication lists. The first medication list was updated on 7/26/2022, and included the following medications: Plavix (medication to prevent blood clots), labetalol (to lower blood pressure and heart rate), gabapentin (for nerve pain), baclofen (muscle relaxer), triamterene-HCTZ (to lower blood pressure), and iron (supplement). The second medication list was updated on 7/28/2022, and mailed to patient. Patient #3 had crossed out all these medications, and stated, & it was so wrong &. The following medications were observed in the home, but not included on the written medication list: ammonium lactate (lotion to help with dry skin), hempvana (pain ointment) and Tylenol arthritis (for pain). The patient indicated she was taking aspirin (to		Clinical record reviewresults will be tabulated quarterly, and compliance threshold reported to andmonitored by the Administrator or designee, QAPI committee and the ProfessionalAdvisory Committee (PAC	

	prevent blood clots) about every other day, and also oxycodone (for pain) which were not included on the medication list. During an interview on 8/4/2022, at 10:05 AM, when queried what written information was provided to patients regarding medication schedule/instructions, administrator #1 stated, & we have a written information sheet we give all patients in their home folder & we instruct them to keep it in the home folder & If there is an update to the medication list it gets re-printed and sent by hand delivery or mail to the home & Sometimes I tell them to handwrite it on the med sheet &. Administrator #1 indicated the written medication instructions should have included all medications patients were taking.			
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation, record review, and interview, the agency failed to provide patients written instructions outlining any treatments to be administered by home health personnel in 2 of 3 home visits conducted. (#1, 3) The findings include: 1. Record review on 8/4/2022, evidenced an agency policy revised 7/25/2022, titled Care Planning, Coordination, and Assessment Process which stated, & Patients are informed in advance of & the care and treatment including therapy to be furnished & the treatment to be provided & The patient/caregiver shall be provided with a written plan of care no later than the next visit	G0618	The administrator/designee will ensure staff provide the patient/caregivera current treatment plan and patient instructions. **ImmediateAction:** The administrator/designee will review Patients 1 and 3, if still active by 9/11/22 and clients inagency that could be affected by 9/11/22and ensure that the home folder contains a current treatment plan and patientinstructions. **Systemicchange:** The Administrator/designee will ensure that staffconduct a home folder audit for all patients to ensure the home	2022-09-11

	after approval by the physician. The written information shall be updated as the plan of care changes &. 2. Observation of a home visit for patient #1 was conducted on 7/29/2022, to observe a routine skilled nurse visit. During the visit, a home health folder was reviewed, which failed to include any treatments to be provided by home health staff. During an interview on 8/4/2022, at 11:11 AM, when queried what written instructions the agency provided to patients regarding treatments to be administered, administrator #1 indicated the information should have been included on the patient instruction sheet. Administrator #1 indicated she did not see the treatments on patient #1 s instruction sheet. 3. Observation of a home visit for patient #3 was conducted on 8/1/2022, at 10:30 AM, to observe a routine skilled nurse visit. During the visit, a home health folder was reviewed, which failed to include any treatments to be provided by home health staff.		folder containsa current treatment plan and patient instructions by 9/11/22. The clinical manager will instruct clinicalstaff to perform a home folder check with each visit to ensure the patient'streatment plan and instructions are accurate. Treatment changes/updates and patient instructions will be printed andmailed to the patients home daily and monitored by the administrator/designeeweekly. Continued non-compliance with policies will be reported to theAdministrator for further disciplinary action as appropriate. **Monitoring** The administrator/designee will ensure review 15% of clinicalrecords each quarter for compliance with treatment plan and patient instructionteaching until 100% threshold is met. Clinical record reviewresults will be tabulated quarterly, and compliance threshold reported to andmonitored by the Administrator or designee, QAPI committee and the	

			Committee (PAC)	
G0642	Program scope 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. 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 titled "Performance Improvement Program and Annual Agency Evaluation" revised 3/1/2019, stated, "It is the policy of the agency to develop, implement and maintain an effective, ongoing data-driven Quality Assurance Quality Improvement Plan	G0642	The administrator/designee will ensure the program must at leastbe capable of showing measurable improvement in indicators for which there isevidence that improvement in those indicators will improve health outcomes,patient safety, and quality of care. Theagency will measure, analyze, and track quality indicators, including adversepatient events, and other aspects of performance that enable the agency toassess processes of care, services, andoperations. **ImmediateAction:** The Administrator/designee willensure that the agency QAPI plan includes identified clinical trends that mayaffect patient services including client falls and infections. The Q2 2022 QAPI template will be completedto include identified trends and actions to affect the PI data by 9/11/22. **Systemic change:** The administrator/designee willensure that QAPI activities are completed quarterly according to policy andthat QAPI meetings/minutes/actions are relevant to agency data collected. The QAPI template for each quarter will	2022-09-11

	[QAPI] in order to improve agency performance that includes and agency evaluation to provide the basis for future planning … The goals of the QAPI 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 7/29/2022, evidenced an agency document titled "QAPI Summary Report and Professional Advisory Committee Meeting Q1 [quarter 1]" dated 6/23/2022, which indicated the agency had 7 patient infections identified as 4 "wound" and 4 "Other" and 16 patient falls. Review failed to evidence the agency analyzed and tracked the falls and infections. During an interview on 8/3/2022, at 3:36 PM, the administrator indicated the		becompleted for each indicator/metric to ensure that improvement ismeasured. The QAPI Data will be sent tothe Area Quality specialist for review/revision quarterly before the QAPImeeting occurs. **Monitoring:** The administrator/designee and orArea Quality Specialist will review QAPI each quarter for requiredelements/actions.	

	increase in falls, but they are unable to look at everything every quarter, She indicated the agency is currently working on their plan of correction, by continuing to audit all of their charts, and will analyze infections and possibly falls in next quarter QAPI meetings. 17-12-2(a)			
G0644	Program data 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. Based on record review and interview, the home health agency failed to ensure the detail of the data collection was approved by	G0644	The administrator/designee will ensure the program utilizesquality indicator data, including measures derived from OASIS, whereapplicable, and other relevant data, in the design of its program. The agency must use the data collected to; Monitorthe effectiveness and safety of services and quality of care; and Identifyopportunities for improvement. The frequency and detail of the data collectionmust be approved by the agency's governing body. **ImmediateAction:** The Administrator/designee will	2022-09-11

	the governing body. The findings include: Review of an agency policy titled "Governing Body" revised 7/11/2022, 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 the agency's QAPI binder on 7/29/2022, failed to evidence the approval of the data collection by the governing body. Review of an agency document on 7/29/2022, titled "Governing Body Minutes" dated 7/18/2022, failed to evidence the governing body approved the data collection by the agency. During an interview on 8/3/2022, at 3:45 PM, the administrator indicated QAPI information was submitted to corporate, the meeting minutes		QAPIincludes actions that affect identified trends that are approved by theGoverning Body annually. The administrator/designee willensure that an ad hoc QAPI and PAC meeting will be held by 9/11/22. Representatives from the local Governing Bodycommittee will attend the PAC meeting. **Systemic change:** Theadministrator/designee will ensure that QAPI activities are completed quarterly/annuallyaccording to policy and that meetings/minutes/actions are provided to the localgoverning body at least annually. Thelocal governing body will participate in the quarterly/annual QAPI activitiesand participation will be documented. **Monitoring:** Theadministrator/designee and or Area Quality Specialist will review QAPI eachquarter for required elements/actions.	

	address QAPI for the entire corporation including this agency. Our QAPI was discussed and approved by the corporation's governing body. 17-12-2(a)			
G0648	High risk, high volume, or problem-prone area 484.65(c)(1)(i) (i) Focus on high risk, high volume, or problem-prone areas; 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 titled "Performance Improvement Program and Annual Agency Evaluation" revised 3/1/2019, stated, "… QAPI [quality assurance and performance improvement] improvement activities focus on: a. High risk, high volume, or problem-prone areas…." Review of the agency QAPI program on 7/29/2022, evidenced an agency document	G0648	Theadministrator/designee will ensure that high risk; high volume or problem proneareas are identified in QAPI process and addressed with actions asindicated. **Immediate Action:** TheAdministrator/designee will ensure that the agency QAPI plan includesidentified clinical trends that may affect patient services including clientfalls, hospitalizations, and infections by 9/11/22. The Administrator/designee willensure that the agency QAPI plan includes identified clinical trends that mayaffect patient services including client falls, hospitalizations, andinfections. The Q2 2022 QAPI templatewill be completed to include identified trends and actions to affect the PIdata by 9/11/22.	2022-09-11

	and Professional Advisory Committee Meeting Q1 [quarter 1]" dated 6/23/2022, which indicated the agency had 7 patient infections identified as 4 "wound" and 4 "Other" and 16 patient falls. Review failed to evidence improvement activities for infections and falls. Review of an agency document on 7/29/2022, titled "Client Census Report" dated 7/28/2022, evidenced 21 patients with wounds. Review of an agency document on 7/29/2022, titled "Transfer to Inpatient Facility History" indicated the agency had 20 patient hospitalizations since 6/17/2022. Review failed to evidence improvement activities for hospitalizations. Review of an agency document on 7/29/2022, titled "QI Event Report" indicated the agency had 8 patient falls since 6/17/2022. During an interview on 8/3/2022, at 3:27 PM, the administrator indicated the agency's patient population was high acuity. She indicated the high acuity and complex		**Systemic change:** Theadministrator/designee will ensure that QAPI activities are completed quarterlyaccording to policy and that QAPI meetings/minutes/actions are relevant toagency data collected. The QAPI templatefor each quarter will be completed for each indicator/metric to ensure thatimprovement is measured. The QAPI Datawill be sent to the Area Quality specialist for review/revision quarterlybefore the QAPI meeting occurs. **Monitoring:** Theadministrator/designee and /or Area Quality Specialist will review QAPI eachquarter meetings/minutes/actions are relevant to agency data collected for highvolume/problem areas identified.	

	indicated they have a lot of falls hospitalizations and infections. The administrator indicated they will focus on these patients in the next quarter for performance improvement.			
G0650	Incidence, prevalence, severity of problems 484.65(c)(1)(ii) (ii) Consider incidence, prevalence, and severity of problems in those areas; and 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 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 area...."	G0650	The Administrator/designee will ensure that the agency QAPI planincludes identified clinical trends that may affect patient services includingclient falls, hospitalizations, and infections. **Immediate Action:** TheAdministrator/designee will ensure that the agency QAPI plan includesidentified clinical trends that may affect patient services including clientfalls, hospitalizations, and infections by 9/11/22. The Administrator/designee willensure that the agency QAPI plan includes identified clinical trends that mayaffect patient services including client falls, hospitalizations, and infections.Trends for incidence, prevalence and severity of problem areas will be addressin performance improvement projects by 9/11/22.	2022-09-11

	Review of the agency QAPI program on 7/29/2022, evidenced an agency document titled "QAPI Summary Report and Professional Advisory Committee Meeting Q1 [quarter 1]" dated 6/23/2022. Review indicated the agency reported 16, which was an increase from 14 last quarter. patient falls. Review failed to evidence fall trends were assessed and failed to evidence performance improvement activities regarding falls. Review of an agency document on 7/29/2022, titled "Transfer to Inpatient Facility History" indicated the agency had 20 patient hospitalizations since 6/17/2022. Review failed to evidence improvement activities for hospitalizations. During an interview on 8/3/2022, at 3:36 PM, the administrator indicated she was currently working on chart audits from their plan of correction. She indicated there are so many things the agency can do performance activities on, and they cannot do them all at one time. She indicated she does track, and trend falls and		**Systemic change:** Theadministrator/designee will ensure that QAPI activities are completed quarterlyaccording to policy and that QAPI meetings/minutes/actions are inclusive ofseverity and prevalence of problems by 9/11/22. The QAPI template for each quarter will be completed for eachindicator/metric to ensure that problems are identified related toseverity/prevalence. The QAPI Data willbe sent to the Area Quality specialist for review/revision quarterly before theQAPI meeting occurs **Monitoring:** Theadministrator/designee and /or Area Quality Specialist will review QAPI eachquarter meetings/minutes/actions are inclusive of severity and prevalence ofproblems for required elements/actions.	

	that data next quarter in her QAPI data.			
G0652	Activities lead to an immediate correction 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. 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 threatened the health and safety of the patients. The findings include: Review of an agency policy 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 7/29/2022, titled Transfer to Inpatient Facility History indicated the agency had 20 patient hospitalizations since 6/17/2022. Review failed to evidence improvement activities for hospitalizations.	G0652	**ImmediateAction:** The Administrator/designee will ensure that the agency QAPI planincludes identified clinical trends that may affect patient services includingclient falls, hospitalizations, and infections. The administrator/designee will educate all staff on reporting anyidentified problem that directly or potentially threaten the health and safetyof patients to the physician, Administrator/CM/CS immediately by 9/11/22. Continuednon-compliance with policies will be reported to the Administrator for furtherdisciplinary action as appropriate. **Systemic change:** Theadministrator/designee will ensure that QAPI activities are completed quarterlyaccording to policy and that QAPI meetings/minutes/actions are inclusive ofactivities that lead to	2022-09-11

	Review of the agency s QAPI binder on 5/9/2022, failed to evidence actions taken which led to an immediate correction of patient hospitalizations. During an interview on 7/29/2022, at 3:36 PM, the administrator indicated she tracks the number of hospitalizations and if it has increased, she will then do a deep dive into the hospitalizations. That information would then be reported on next quarters QAPI report. 17-12-2(a)		immediate action/correction when directly/potentialthreat to clients in agency by 9/11/22. The QAPI template for each quarter will be completed for eachindicator/metric to ensure all problems are identified that may affect thehealth/safety of the census. The QAPIData will be sent to the Area Quality specialist for review/revision quarterlybefore the QAPI meeting occurs. **Monitoring:** TheAdministrator/designee and /or Area Quality Specialist will review QAPI eachquarter for required activities that lead to immediate action/correction whendirectly/potential threat to clients in agency.	
G0654	Track adverse patient events 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. Based on record review and interview, the agency failed to ensure the performance improvement activities tracked	G0654	**ImmediateAction:** The Administrator/designee will ensure that the agency QAPI planincludes patient adverse event, identified clinical trends that may affectpatient services including client falls 9/11/22. Review assessments, data, and surveys fortrends in falls to analyze events and provide	2022-09-11

	adverse patient events, analyzed their causes, and implemented preventive actions. The findings include: Review of an agency policy 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 7/29/2022, evidenced an agency document titled QAPI Summary Report and Professional Advisory Committee Meeting Q1 [quarter 1] dated 6/18/2022. Review indicated the agency reported 16 patient falls. Review failed to evidence the agency assessed fall trends, failed to evidence the agency analyzed the causes of the falls, and failed to evidence performance activities were implemented to address patient falls. During an interview on 8/3/2022, at 3:31 PM, the administrator indicated she investigated the falls to see if they are witnessed or unwitnessed. She looked to see if they were alone or if caregivers were present and they will see if patients need more safety information or if there was a therapy evaluation needed. 17-12-2(a)		evidence for performanceimprovement activities by 9/11/22 **Systemic change:** Theadministrator/designee will ensure that QAPI activities are completed quarterlyaccording to policy and that QAPI meetings/minutes/actions are patientadverse event, identified clinical trends that may affect patient servicesincluding client falls by 9/11/22.The QAPI template for each quarter will be completed for each indicator/metricto ensure PAE are included and analyzed. The QAPI Data will be sent to the Area Quality specialist forreview/revision quarterly before the QAPI meeting occurs. **Monitoring:** Theadministrator/designee and /or Area Quality Specialist will review QAPI eachquarter for required activities that lead to patient adverse event, identifiedclinical trends that may affect patient services	

			including client falls, hospitalizations,and infections.	
G0656	Improvements are sustained 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. Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.	G0656	deficiency corrected 6/17/2022	2022-08-25
G0658	Performance improvement projects 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. Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.	G0658	deficiency corrected 6/17/2022	2022-08-25

G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review and interview, the home health agency failed to ensure all employees practiced standard precautions and followed agency infection control policies and procedures at 1 of 1 home health visits with a physical therapist. (#2) The findings include: An agency policy procedure titled Infection Control: Hand Hygiene, revised 2/11/2020, stated & Apply a palm-full of hand rub fluid/gen int cupped hand: enough to cover/keep hands wet during procedure, rub hands together, assuring adequate cleansing of all surfaces by rubbing: 1. Palm to palm 2. Right palm over back of left hand with interlaced fingers (so fingers of right-hand scrub between fingers of left hand) and vice versa, 3. Palm to palm with fingers interlaced 4. Backs of fingers (fingernails in opposing palm. 5. Left thumb clasped in right palm with a circular motion; and vice versa. 6. Rotational rubbing, backward and forward with clasped fingers of the right hand in left palm; and vice versa 7. Approximately 20 seconds &. During a home visit observation on 7/29/2022 at 1:46 PM, physical therapist (PT) #3 was observed using hand sanitizer prior to patient care. PT #3 applied the alcohol-based hand gel	G0682	**ImmediateAction:** The Administrator/designee will ensure that infection preventionis practiced while delivering patient care. Clinicians, including PT #2 will be re- instructed in policy andacceptable standards of practice in infection control with documentation andnotifications required by 9/11/22. **Systemicchange:** The administrator/designee will ensure joint visits are assignedand completed monthly to ensure infection prevention. The assignment of joint visits will becalendared monthly and provided to the lead RN role for completion. Continued non-compliance with policies willbe reported to the Administrator for further disciplinary action asappropriate. **Monitoring:** The Administrator/designee will ensure that Joint visits	2022-09-11

	into the palms and back of his hands, failing to ensure he sanitized all surfaces of his hands. He took supplies out of his bag and obtained vital signs on patient #2. After obtaining vital signs he sanitized the palms and backs of his hands failing to sanitize all surfaces of his hands. He assisted patient #3 through his therapy and sanitized the palms and backs of his hands failing to sanitize all surfaces of his hands. He cleaned all of his vital sign equipment and put it in his bag. He sanitized the palms and backs of his hands failing to sanitize all surfaces of his hands. He typed on his electronic tablet and handed it to patient #2 for him to sign. He closed the tablet and placed it on a barrier and sanitized the palms and backs of his hands failing to sanitize all surfaces of his hands. He put away his electronic tablet and cleaned up the barriers from the patient s sofa and placed them in the trash can. He sanitized the palms and backs of his hands failing to sanitize all surfaces of his hands and left patient #2 s home. During an interview on 8/5/2022 at 1:24 PM, the administrator indicated staff should wash and sanitize all surfaces of their hands, including between their fingers. 17-12-1(m)		areassigned to 20% of clinical staff monthly to ensure compliance to infectioncontrol policy/practices by 9/11/22.	
G0684	Infection control 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:	G0684	**ImmediateAction:** The Administrator/designee will ensure and review all patientinfections ensuring they are reported effectively according to policy and VNAAmanual procedures by 9/11/22. The Administrator/designee will ensure that 100% of clinical staffreceive infection reporting	2022-09-11

	(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. Based on record review and interview, the agency failed to maintain a program for the surveillance, identification, prevention, control, and investigation of infections. The findings include: Record review on 8/4/2022 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 8/3/2022, for patient #10, evidenced an agency document titled, "Client Coordination Note Report," dated 7/12/2022, which stated, "Hospitalization Reason: UTI [Urinary tract infection and need for IV [intravenous] ABX [antibiotics].... An agency document titled, "Client Coordination Note Report," dated 7/12/2022, stated, "Add Cefepime [medication to treat infection] 2 GM [gram] in NS 120 ML [milliliter] bag infuse contents of 1 bag (2 GM) IV gravity infusion over 30 minutes on M/W/F [Monday/Wednesday/Friday] post dialysis...." Review of the "QI Event Report" which the administrator indicated had all of the infections logged from 2/18/2022 to present failed to evidence patient #10's infection.		re-education by 9/11/22 **Systemicchange:** The clinical manager will review each infection reported by thefield staff, provide and document collaboration withphysicians/facilities/clinics. Theclinical manager will pull the QI report weekly to ensure that all infectionsreported have been reviewed/assessed and clinical actions implemented asindicated. Continued non-compliance withpolicies will be reported to the Administrator for further disciplinary actionas appropriate. **Monitoring:** The administrator/designee will run the QI report from HCHB weeklyto review the infections reported and ensure they are reported to thephysician, identified as infectious or communicable and trended asindicated.	

	During an interview on 8/5/2022, at 2:28 PM, the administrator indicated patient #10 should have been included on the log. Clinical record review on 8/3/2022 for patient #9, evidenced an agency document titled, "Client Coordination Note Report dated 7/1/2022, which indicated patient #9 was hospitalized with confusion and diagnosed with a UTI. Review of the "QI Event Report" which the administrator indicated had all of the infections logged from 2/18/2022 to present failed to evidence patient #9's infection. During an interview on 8/5/2022, at 8:58 AM, the administrator indicated patient #9 should have been included on the log.			
G0700	Skilled professional services 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. Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.	G0700	deficiency corrected 6/17/2022	2022-08-25

G0710	Provide services in the plan of care 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.	G0710	deficiency corrected 6/17/2022	2022-08-25
G0714	Patient and caregiver education 484.75(b)(5) Patient and caregiver education; Based on observation, record review, and interview, the skilled professional failed to provide services as ordered in the plan of care in 1 of 2 discharged records reviewed. (#10) The findings include: Review of an agency policy, titled Patient s Rights, Responsibilities and Consent Home Health, revised 2/15/2022, stated, & These rights include: & Receive all services outlined in the plan of care in accordance with physician orders &. Clinical record review for patient #10, start of care 2/15/2022, evidenced an update to the patient s plan of care titled Add on discipline dated 6/28/2022. This document evidenced patient #10 was to receive skilled nursing services once a week for five weeks effective 6/26/2022. Patient #10 was hospitalized from 7/11/2022 7/18/2022	G0714	**Immediate action:** The administrator/designeewill review patient #10, if still active by 9/11/22 and clients that could beaffected for patient frequency of services incorporated into the plan of careby 9/11/22. Theadministrator/designee will ensure that patient # 10 and other active patientsare care conferenced with case manager and clinical manager to ensure thepatient's frequency is Patient/caregiver education is adhered to and applicableto meet to the clinical needs of the patient by 9/11/22. The physicianwill be notified of changes in the Plan of care as indicated. **Systemic change:**	2022-09-11

	Review of patient #10 s clinical record evidence an agency document titled RN Resumption of Care dated 7/21/2022. This document evidenced the patient was to receive skilled nursing devices once a week for three weeks and then once every other week for three weeks. Review of patient #10 s clinical record failed to evidence she receive any skilled nursing visits after the resumption of care on 7/21/2022. During an interview on 8/5/2022 at 2:04 PM, the administrator indicated the frequency did not pull over onto the plan of care. She indicated she would get this corrected and assign a nurse to see patient #10. 17-14-1(a)(1)(C)		The clinicalmanager will ensure the patient's frequency is adhered to and applicableto meet to the clinical needs of the patient. The clinical manger willcollaborate with the clinician during Start of Care report and Plan of Carereview to ensure all discipline frequencies are included in the plan ofcare. **Monitoring** TheAdministrator/designee will ensure a review 15% of clinical records eachquarter for patient's frequency is adhered to and applicable tomeet to the clinical needs until 100% threshold is met. Clinical record review results will be tabulated quarterly, andcompliance threshold reported to and monitored by the Administrator ordesignee, QAPI committee and the Professional Advisory Committee (PAC).	
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and	G0716	The Administrator/designee is responsible forensuring that professional clinical staff are compliant with Standard PreparingClinical Notes 484.75(b)(6) following this	2022-09-11

	interview, the agency failed to ensure clinical notes were prepared accurately and completely in 4 of 10 clinical records reviewed. (#1, 3, 5, 10) The findings include: 5. Clinical record review for patient #10, start of care 2/15/2022, evidenced a document titled Discharge Service Communicating dated 7/21/2022 from hospital #10. This document evidenced patient #10 had a right chest catheter to receive dialysis. Clinical Record review for patient #10, evidenced an agency document titled RN Resumption of Care dated 7/21/2022. This assessment failed to include the patient had a right chest catheter for dialysis administration. During an interview on 8/5/2022 at 1:34 PM, the administrator indicated the nursing assessment should have included the catheter site and observations of the site. 1. Record review on 8/4/2022, evidenced an agency policy revised 4/1/2022, titled Documenting in the Electronic Medical Record which stated, & All entries in the electronic medical record [EMR] must be patient and visit-specific and contain the actual data collected by the provider based on the care and services provided on the day of service & The EMR quality and integrity shall be maintained by adhering to identified standards in entering complete, concise, accurate, and updated information that produces a clear and valuable medical record &. 2. Observation of a home visit for patient #1 was conducted on 7/29/2022, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was observed to have 4+ pitting edema (8 millimeters of depression on skin, when pressure is applied, which takes 2 -3 minutes to rebound) to right lower leg and minimal swelling to left lower leg. Clinical record review for patient #1 was		corrective action and monitoringplan. The Administrator is responsible thatprofessional clinicians fulfill the responsibility to prepare clinical notesaccording to the standard and agency policies. **Immediateaction:** The administrator/designee will reviewpatient 1, 3, 5, and 10, if still active by 9/11/22 and clients that could beaffected to ensure that clinical notes are compliant with standard of care. **Systemicchange:** The clinical manager will ensure all notesare complete/accurate and meet the standard of documentation. If a note is found without the requireddocumentation, the clinician is notified, and education is provided asindicated then the clinician is required to make revisions to the note byfollowing the correction policy.	

	completed on 8/4/2022, for certification period 6/26/2022 8/24/2022. Record review evidenced a comprehensive reassessment dated 6/21/2022, which indicated patient was incontinent of urine during the day and night. This document also indicated in a Braden risk assessment scale that patient s skin was rarely moist, skin was usually dry, and linen only required changing at routine intervals. The comprehensive assessment indicated the patient had a suspected deep tissue injury (purple or maroon localized area of discolored intact skin due to damage of underlying soft tissue from pressure and/or shear, also referred to as unstageable deep tissue pressure injuries) to right lateral ankle. This document also indicated the patient did not have any unhealed unstageable pressure injuries. Clinical record review evidenced a skilled nurse visit note dated 7/29/2022, which indicated the patient had swelling to bilateral lower extremities but failed to indicate the grade or severity of edema. During an interview on 7/29/2022 at 4:45 PM, person #1 indicated the patient developed a right heel wound during a hospital stay. He indicated when she was home, he applied heel elevation boots, which placed pressure on the side of her leg, and caused the right ankle wounds. During an interview on 8/4/2022, at 10:42 AM, when queried if the comprehensive assessment was accurate regarding incontinence and Braden scale, administrator #1 stated, & I did not assess her & I can only tell you what is documented there &. At 10:44 AM, when queried why the comprehensive assessment failed to document the patient s deep tissue injury as a pressure ulcer, administrator #1 indicated because a deep tissue injury is not caused by pressure. At 10:49 AM, when queried what should be documented on visit notes regarding edema, administrator #1 stated, & how much edema and physician notification &.		The clinical manager will ensure allclinicians are compliant and HR actions will be initiated as needed. **Monitoring:** The Administrator/designee will conduct 100% review ofadherence to the patients Plan of Care in subsequent visit notes until 100%threshold is met. Following the abovestated audit, this indicator will become a regular part of the quarterly auditprocess for the Quality Assurance Performance Improvement (QAPI) Program. The audit results will be tracked, trended,shared with agency leadership, and reported to the QAPI committee on a quarterlybasis. After the audit threshold is achieved compliance will be monitoredthrough the quarterly QAPI Clinical Record review and reported to PAC forreview and recommendations.	

3. Observation of a home visit for patient #3 was conducted on 8/1/2022, at 10:30 AM, to observe a routine skilled nurse visit. During the visit, the patient was observed to be chair bound, alert and oriented, and had an attendant caregiver and person #6 (family member) present. Patient #3 indicated person #6 helped her bathe and complete activities of daily living. Person #6 indicated she was not available all the time since she also was a caregiver for person #7 (family member), who was totally dependent and bedbound. Patient #3 indicated her attendant caregiver and person #6 were unable to complete wound care.

Clinical record review for patient #3 was completed on 8/4/2022, for certification period 6/4/2022 8/2/2022. Record review evidenced a social work visit note dated 6/17/2022, which indicated patient #3 s primary caregiver was person #6 and person #7. Record review evidenced a skilled nurse visit note dated 6/28/2022, which indicated the wound vac was discontinued and orders were received for wound care to left Achilles heel wound and new wound to left shin but failed to evidence what specific wound care was performed during the visit to the patient s wounds. Record review evidenced a skilled nurse visit note dated 7/6/2022, which stated, & Interventions Provided & provide negative pressure wound therapy, instruct patient/caregiver on care of wound and wound vac &. Record review evidenced a case conference note dated 7/20/2022, which stated, & cg [caregiver] able to perform wound care & continue once a week for measurements and observation of the wound &.

During an interview on 8/4/2022, at 11:41 AM, when queried why the social work visit note indicated person #7 was a primary caregiver when they were totally dependent and bedbound, administrator #1 indicated if it was documented, it should have been accurate. At 11:55 AM, when queried what clinicians should

	administrator #1 indicated they should have documented wound location, what wound care was provided, and the frequency of wound care. Administrator #1 indicated she did not know why the 7/6/2022 skilled nurse visit note indicated wound vac therapy was provided when wound vac was discontinued. At 11:54 AM, when queried why the case conference indicated patient #3 s caregiver was able to complete wound care, administrator #1 stated, & I don t know & I wrote it, but I just wrote what I was told &. 4. Clinical record review for patient #5 was completed on 8/5/2022, for certification period 7/24/2022 9/21/2022 and start of care 5/25/2022. Record review evidenced a skilled nurse recertification assessment dated 7/19/2022, which indicated the patient had not received home health services in the past 60 days. Record review evidenced patient had received home health services since 5/25/2022. Review of the skilled nurse recertification assessment dated 7/19/2022, indicated patient had a new open area/wound to left lower extremity, but failed to include any additional information in note such as measurement, assessment, treatment, or specific location of wound on left lower extremity. During an interview on 8/5/2022, at 11:04 AM, when queried why 7/19/2022 assessment indicated patient had not received home health services, administrator #1 indicated it must have been a mix-up in documentation. At 11:04 AM, administrator #1 indicated documentation of a wound should include its location, type, measurements, any other attributes of the wound. 410 IAC 17-14-1(a)(2)(E)			
G0718	Communication with physicians 484.75(b)(7)	G0718	The Administrator/designeeis responsible for ensuring that all Clinical Staff are compliant with Standard484.75(b)(7)	2022-09-11

	Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and interview, the home health agency failed to ensure skilled professionals communicated with all physicians involved in the plan of care regarding the current plan of care in 1 of 7 active clinical records reviewed. (#1) The findings include: Record review on 8/5/2022, evidenced an agency policy revised 12/2019, titled Availability of Services Acceptance, Admission, Ongoing and Discharge which stated, & The agency utilizes a collaborative approach to patient care that consists of & communication with the patient s physician &. Clinical record review for patient #1 was completed on 8/4/2022, for certification period 6/26/2022 8/24/2022. Record review evidenced a coordination note for a skilled nurse visit signed and dated on 7/1/2022, which indicated the patient had abnormal breath sounds including crackles (a sound the lungs make when air sacs are filled with fluid), was short of breath at night, and experienced chest heaviness. This coordination note indicated physician #3 was notified, and a virtual visit was scheduled for 6/21/2022, with physician #3. Record review failed to evidence any follow-up communication with physician #3 regarding the 6/21/2022, virtual visit or changes to the plan of care. Clinical record review evidenced a recertification comprehensive assessment dated 6/21/2022, which indicated patient had a right lateral leg arterial wound which measured 4.3 cm (centimeters) x 1.3 cm x 0 cm and a right heel arterial wound which		Communication with the Physician following this corrective actionand monitoring plan. The Administratoris responsible for ensuring that there is communication with all physiciansinvolved in the plan of care and other health care practitioners (asappropriate) related to the current plan of care. **ImmediateActions:** The administrator/designee will review patient #1, if stillactive by 9/11/22, and clients that may be affected to ensure abnormal clinicalfindings are communicated with the physician as indicated. **Systemicchange**: The clinicalmanager will ensure by review of visit notes to ensure that all abnormalclinical findings care communicated with the physician**.** The clinical manager will review the Physician Communication notes and Care Coordination notes daily	

	measured 2.2 cm x 1.8 cm x 0.1 cm. Record review evidenced a skilled nurse visit note dated 7/20/2022, which indicated the right lateral leg arterial wound measured 5 cm x 2 cm x 0.1 cm and the right heel arterial wound measured 2.5 cm x 2 cm x 0.1 cm. Record review evidenced a skilled nurse visit note dated 7/29/2022, which indicated the right lateral leg arterial wound measured 7 cm x 4 cm x 0.1 cm and the right heel arterial wound measured 2.4 cm x 2.6 cm x 0.1 cm. Record review indicated the patient went to a wound clinic on Mondays, and was being treated at the wound clinic by physician #4. Record review failed to evidence any communication with physician #4 (wound clinic physician) regarding patient s enlarging wound. During an interview on 8/4/2022, at 10:38 AM, when queried if there was any follow-up after the physician was notified of patient s respiratory decline, administrator #1 indicated she did not know. Administrator #1 indicated the only documentation was that the patient was seeing the doctor on 6/21/2022. At 10:55 AM, when queried if physician #4 was made aware of patient s worsening wounds, administrator #1 indicated she did not know because she did not know which physician worked at the wound clinic. 410 IAC 17-14-1(a)(1)(G)		to ensureall abnormal clinical changes are communicated with physicians. **Monitoring:** TheAdministrator/designee will ensure a review 15% of clinical records eachquarter to ensure abnormal clinical findings are communicated with the physicianuntil 100% threshold is met. Clinicalrecord review results will be tabulated quarterly, and compliance thresholdreported to and monitored by the Administrator or designee, QAPI committee andthe Professional Advisory Committee (PAC).	
G0720	Participate in the HHA's QAPI program; 484.75(b)(8) Participation in the HHA's QAPI program; and Based on record review and interview, the agency failed to	G0720	The Administrator/designee is responsible for ensuring that allskilled professionals are compliant with Standard 484.75(b)(8) titled SkilledProfessionals participate in the QAPI Program following	2022-09-11

	ensure skilled professionals participated in the QAPI (quality assurance performance		this corrective actionand monitoring plan. The Administratoris responsible that agency professional staff participate in AccentCare's QAPIProgram or Performance Improvement Activities in accordance with their jobdescription. **Immediate action:** Administrator/designee will provide additional education to help ensureall clinicians understand the QAPI program including its affect and actions onclinical care and their role in the QAPI program by 9/11/22. **Systemic change:** The administrator/designee will choose one clinician perqualifying discipline to participate in QAPI activities quarterly and make QAPIassignments to chosen clinicians. Current QAPI projects will be routinely (noless than monthly) discussed with all clinicians/staff during staff meetings	

	improvement) program. The findings include: Review of an agency policy titled Performance Improvement and Annual Agency Evaluation, revised 3/1/2019, stated, Agency clinical staff must participate in Accentcare s QAPI [Quality Assurance Performance Improvement] Program or Performance Improvement Activities in accordance with their job description. During an interview on 7/29/2022 at 2:10 PM, PT #3 indicated he was unsure what QAPI was. When explained what QAPI does, he indicated he has only been an employee for a few months so he does not participate in the quality assurance. Review of the QAPI binder evidenced a document titled QAPI Professional Advisory Committee Meeting dated 6/23/2022. This document failed to evidence PT #3 s signature. During an interview on 8/4/2022 at 11:03 AM, the administrator indicated the document included the members from this agency who were part of QAPI.		**Monitoring:** Theadministrator/designee will monitor the QAPI Program for the next 2 quarters toensure that the quarterly QAPI attendance sheets reflectparticipants representing the full scope of services provided by the agency,whether employee or contracted services.	

G0726	Nursing services supervised by RN 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.	G0726	deficiency corrected 6/17/2022	2022-08-25
G0940	Organization and administration of services 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its 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. Deficiency corrected 06/16/2022. Deficiency corrected 06/16/2022.	G0940	deficiency corrected 6/17/2022	2022-08-25
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations	G0948	deficiency corrected 6/17/2022	2022-08-25

	of the HHA; Deficiency corrected 06/14/2022. Deficiency corrected 06/14/2022.			
G0950	Ensure clinical manager is available 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; Deficiency corrected 07/02/2022. Deficiency corrected 07/02/2022.	G0950	deficiency corrected 6/17/2022	2022-08-25
G0960	Make patient and personnel assignments, 484.105(c)(1) Making patient and personnel assignments, Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.	G0960	deficiency corrected 6/17/2022	2022-08-25
G0962	Coordinate patient care 484.105(c)(2) Coordinating patient care, Based on observation, record review, and interview, the clinical manager failed to coordinate patient care in 5 of 10 clinical records reviewed. (#1, 5, 6, 8, 10)	G0962	The Administrator is responsible for ensuringthat the agency will be compliant with Standard-Coordination of Patient Care484.105(c)(2) following this corrective action and monitoring plan. The Administrator is responsible that theClinical Manager provides oversight of all patient care services and	2022-09-11

	The findings include: 4. Clinical record review for patient #6, start of care 7/12/2022, evidenced agency document titled Client Coordination Note Report entered by occupational therapy assistant (OTA) #6 and dated 5/22/2022, stated Please provide details of missed visits writer attempted to call multiple times. Was unable to leave voice mail due to being full. The clinical record failed to evidence the physician was notified of the missed visit During an interview on 8/5/2022, at 2:28 PM, the administrator indicated she did not see the physician was notified of the missed visit in the notes. 5. Clinical record review for patient #8, start of care 2/11/2022, evidenced an agency document titled RN Resumption of Care, dated 6/27/2022. This document indicated patient #8, had wounds to her coccyx and right and left buttocks, and wound vac therapy for wound care. Clinical record review for patient #8 evidenced a document titled Client Coordination Note dated 7/11/2022, which indicated the physician wanted patient #8 sent to the wound clinic for evaluation of her wound. Review of the patient record failed to evidence any coordination of care with a wound clinic. During an interview on 8/5/2022 at 10:43 PM, the administrator indicated she did not know what wound clinic the patient was going to and did not see any documentation from the wound clinic. 6. Clinical record review for patient #10, start of care 2/15/2022, evidenced an agency document titled Home Health PI Certification and an of Care, for certification period 6/15/2022 -8/13/2022. This document evidenced patient #10 was dependent on renal dialysis. Review of patient #10 s clinical record failed to evidence any coordination of care with the dialysis center. During an interview on 8/5/2022 at 1:45 PM, the administrator indicated she did not know what dialysis center patient #10 went to, and		personnel,including oversight of coordinating patient care. **Immediate action:** The administrator/designee will review patients 1, 5, 6, 8 and 10, ifstill active by 9/11/22 and all other clients that could be affected in theagency to ensure implementation/execution of the plan of care. The administrator/designee will ensure thatall clients in the agency will have care conference with case manager andclinical manager to review the appropriate frequency of services and identifypatient needs by 9/11/22. The physician will be notified of changes ordeviations of the plan of care and coordinate any issues that may requirealterations to the POC. **Systemic change:** The clinicalmanager will ensure coordination of care occurs with all clients in agency bythe following: 1. Review all orders before approving them inthe EMR for	

	coordination with the dialysis center. 1. Record review on 8/3/2022, evidenced a signed job description for patient care manager, which stated, & Position Summary: & The patient care manager home health is responsible for coordination and management of patient care. The patient care manager is responsible for the supervision of clinical personnel to ensure that care and services are delivered appropriately &. 2. Observation of a home visit for patient #1 was conducted on 7/29/2022, at 1:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was observed to have a large, necrotic (dead tissue, appearing black), wound to right lateral lower leg, with 4+ pitting edema (8millimeter indentation in the skin, when pressure applied, which takes 2-3 minutes to rebound) and reddened skin surrounding. The patient also had a baseball-sized would to right heel with yellow, brown tissue covering the wound, and reddened surrounding skin. Clinical record review for patient #1 was completed on 8/4/2022, for certification period 6/26/2022 8/24/2022. Record review evidenced a recertification comprehensive assessment dated 6/21/2022, which indicated patient had a right lateral leg arterial wound which measured 4.3 cm (centimeters) x 1.3 cm x 0 cm and a right heel arterial wound which measured 2.2 cm x 1.8 cm x 0.1 cm. Record review evidenced a skilled nurse visit note dated 7/20/2022, which indicated the right lateral leg arterial wound measured 5 cm x 2 cm x 0.1 cm and the right heel arterial wound measured 2.5 cm x 2 cm x 0.1 cm. Record review evidenced a skilled nurse visit note dated 7/29/2022, which indicated the right lateral leg arterial wound measured 7 cm x 4 cm x 0.1 cm and the right heel arterial wound measured 2.4 cm x 2.6 cm x 0.1 cm. Record review indicated the patient went to a wound clinic on Mondays, and was being treated at the wound clinic by physician #4. Record review failed to evidence the clinical manager updated or revised the comprehensive assessment due to patient #1 s significant		clinical appropriateness and completeness to include treatments,therapies and services and ensure integration into the plan of care. 2. Integrates ordered servicesincluding other medical services in the coordination of care of the patient byensuring communication with staff, physicians, and/or facilities/clinics. 3. Document communication within themedical record using a coordination note and/or Physician Communication note 4. Review all elements of the planof care before approving in the EMR. **5.** Ensure all disciplines ordered will be reviewed and reconciledbased on patient's needs at comprehensive assessment. 6. Ensure medication reconciliation/interactions/duplicativetherapy reviewed and communicated with the physician.	

	change in wound status. Record review failed to evidence the clinical manager revised the plan of care or coordinated care with the wound clinic physician. Record review evidenced an agency document titled Significant Wound Score Change Report which was faxed by administrator #1 to physician #5 (patient #1 s cardiologist) on 7/19/2022. This document indicated the right lateral lower leg arterial wound size had increased on 7/15/2022, to 5 cm x 1.5 cm x 0.1 cm from 7/6/2022, in which the wound measured 3.8 cm x 1.5 cm x 0.1 cm. Record review failed to evidence any other physicians were made aware of wound changes. Record review evidenced a coordination note dated 7/29/2022, which stated, & spoke to [physician #3/primary care physician] in regards to pt [patient] wound changes from last week to this week & no new orders &. Record review failed to evidence the wound clinic physician was notified of worsening wounds, or if physician #3 was made aware of measurements of wounds. During an interview on 8/4/2022, at 10:58 AM, when queried what would be considered significant change in condition or major decline, administrator #1 stated, & something majorly different than the visit previously & I would ask them to do a significant change in condition oasis assessment &. When queried when a revision to the patient s plan of care is considered, administrator #1 indicated any variations to patient s wounds were sent to the clinical manager and the administrator and then were sent to the physician. Administrator #1 indicated they would consider revising the plan of care if there was a significant change in patient s condition or a new order. When queried how the agency was meeting patient #1 s needs if her wounds were significantly larger than at the beginning of the certification period, administrator #1 stated, & The wound care clinic would be who to ask & I don t know what else we can do if the physician isn t ordering anything else &. When queried why		**7.** Ensure scheduleincludes supervision visits as indicated **Monitoring** TheAdministrator/designee will ensure a review 15% of clinical records eachquarter for elements/services/treatment/patient instruction of the Plan of Careuntil 100% threshold is met. Clinical record review resultswill be tabulated quarterly, and compliance threshold reported to and monitoredby the Administrator or designee, QAPI committee and the Professional AdvisoryCommittee (PAC). After education on theprocess, continued non-compliance with this will result in progressivedisciplinary action up to and including potential termination.	

physician #3 was notified of wound changes if the wound clinic physician was directing wound care, administrator #1 stated, & I have no idea who [physician #3] is, and I don t know who he is or what type of physician & I ve only been here a month and I m still trying to learn names of my employees &. When queried why the wound change documentation on 7/19/2022 was faxed to physician #5 (cardiologist) instead of the wound clinic physician, administrator #1 indicated she did not know.

During an interview on 8/5/2022, at 10:22 AM, when queried how person #1 (patient #1 s medical power of attorney/family member) felt patient #1 was progressing with her wounds with home health and wound clinic, person #1 stated, & it was okay & since you came [to observe home visit on 7/29/2022], they noticed the wound was bigger and talked to [physician #4] & he sent her to the vein clinic and scheduled an appointment next Thursday to open her veins &.

3. Clinical record review for patient #5 was completed on 8/5/2022, for certification periods 5/25/2022 7/23/2022, and 7/24/2022 9/21/2022. Record review evidenced a start of care comprehensive assessment dated 5/25/2022, which indicated the patient was a low risk for falls and was taking anticoagulants (blood thinners). Record review evidenced an occurrence report dated 6/22/2022, which indicated the patient fell on 6/18/2022, for the second time in 9 days. Record review failed to evidence which physician was notified of fall or any revisions to the plan of care were made. Record review failed to evidence a comprehensive re-assessment was completed as a result of the falls. Record review evidenced the patient was receiving physical and occupational therapy 1 time every other week at the time of the falls and failed to evidence an increase in therapy visits, as a result of frequent falls. Record review evidenced a skilled nurse visit note dated 7/26/2022, which indicated patient had developed a new stage 2 pressure ulcer (wound caused by pressure, characterized by a

	Record review failed to evidence the plan of care was revised to properly manage and treat new wound. Record review failed to evidence the physician was made aware of new pressure wound. Record review failed to evidence a comprehensive re-assessment was completed based on the change in patient status. Record review evidenced a physical therapy visit note dated 7/26/2022, which indicated the patient was not making sufficient progress with therapy only 1 time per week. Record review failed to evidence communication with the physician, plan of care revisions, or increased therapy frequencies, to address increasing need for therapy. Record review failed to evidence the clinical manager coordinated patient #5 s care to meet changing needs. During an interview on 8/5/2022, at 11:26 AM, when queried if physician was notified of new stage 2 pressure ulcer on 7/26/2022, administrator #1 indicated she did not see any physician notification or coordination. At 11:50 AM, administrator #1 indicated the agency had not followed up with the 7/26/2022, physical therapist visit which indicated the patient needed more frequent therapy sessions. At 12:06 PM, administrator #1 indicated there were no changes in the plan of care or comprehensive assessment in response to patient s fall. When queried what the cause of the patient s falls was, administrator #1 indicated she did not know.			
G0968	Assure implementation of plan of care 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.	G0968	deficiency corrected 6/17/2022	2022-08-25
G0984	In accordance with current clinical practice	G0984	deficiency corrected 6/17/2022	2022-08-25

	484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.			
G1014	Interventions and patient response 484.110(a)(2) All interventions, including medication administration, treatments, and services, and responses to those interventions; Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.	G1014	deficiency corrected 6/17/2022	2022-08-25
G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the	G1022	deficiency corrected 6/17/2022	2022-08-25

	time when the HHA becomes aware of the transfer. Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.			
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Deficiency corrected 06/17/2022. Deficiency corrected 06/17/2022.	G1024	deficiency corrected 6/17/2022	2022-08-25
N9999	Final Observations Deficiency corrected 07/02/2022.	N9999	deficiency corrected 7/2/2022	2022-08-25

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