DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157211	A. BUILDING 00 B. WING	08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOME NURSING SERVICES	528 W WASHINGTON BLVD FORT WAYNE, IN 46802

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E 0000 Bldg. 00	A Federal Focused Infection Control Emergency Preparedness was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: August 18, 19, 20, 21, 24, 25, 26, 27; 2020 Facility Number: IN005372 Provider Number: 157211 Unduplicated admissions past 12 months: 104 Total Active Patients: 169 At this Focused Infection Control Emergency Preparedness survey, in regards to staffing and implementation of staffing, Home Nursing Services, was found not to be in compliance with 42 CFR 484.102 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies.	E 0000	Home Nursing Services (the “Agency”) is submitting the following Plan of Correction/Plan of Removal in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction/Plan of Removal is not intended as an admission, does not constitute an admission by and should not be construed as an admission by the Agency that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to patients of the Agency. The Agency does not, at this time, have an avenue at which to challenge these findings and, therefore, the Agency’s failure to dispute or challenge the alleged deficiencies cannot be taken as an admission that the alleged facts occurred as presented in the statements. Compliance has been and will be achieved no later than the last completion date identified in the Plan of Correction. The Agency desires this Plan of Correction to be considered its Allegation of Compliance.”	
E 0019	418.113(b)(2), 484.102(b)(2) Homebound HHA/Hospice Inform EP Officials			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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Bldg. 00	[(b) Policies and procedures. The [facilities] 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:] *[For homebound Hospice at §418.113(b)(2), PACE at §460.84(b)(4), and HHAs at §484.102(b)(2):] The procedures to inform State and local emergency preparedness officials about [homebound Hospice, PACE or HHA] patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment. Based on record review and interview, the home health agency failed to ensure the emergency preparedness plan contained procedures to inform State and local emergency preparedness officials of homebound home health patients in need of evacuation. Findings include: An undated agency policy, titled "Emergency Management Policy," Number B-400, stated " ... Home Nursing Services will have an identified plan in place to insure [sic] the safety and well-being of clients and employees during periods of an emergency or disaster that disrupts Home Nursing Services' services ... Special Instructions ... 16. The emergency plan will identify the links to local community organizations	E 0019	The agency added homebound classification to the census that is kept in the emergency preparedness plan. The plan has been updated with the procedures to inform state and local emergency preparedness officials if homebound patients are in need of evacuation. The emergency plan will be reviewed as needed, at least annually, to check compliance and update contact agency numbers. The Administrator is responsible for the emergency preparedness plan.	10/30/2020

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	that may be needed to assist Home Nursing Services in responding to client needs ..." The home health agency's undated emergency preparedness plan was reviewed on 8/26/20 on 11:50 AM. The agency's emergency preparedness plan failed to indicate a plan or procedure for the agency to inform State and local emergency preparedness officials of homebound home health patients in need of evacuation. An interview was conducted with the administrator and Director of Nursing (DON) on 8/26/20 at 2:20 PM. During the interview, the DON indicated the agency's emergency preparedness plan was enacted in 2018, but was unable to provide an exact date or month. The administrator indicated the emergency preparedness plan included contact numbers for emergency management agencies and officials, as well as patient current addresses. The administrator and DON failed to indicate the location within the emergency preparedness plan of the agency's plan or procedure to inform State and local emergency preparedness officials of homebound home health patients in need of evacuation.		The emergency preparedness plan will be updated by 10/30/2020.	
E 0039 Bldg. 00	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct			

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	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.			

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*[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

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	care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using 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			

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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 LTC Facilities at §483.73(d):]

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	(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.			

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	*[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.			

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	*[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.			
	Based on record review and interview, the home health agency failed to maintain documentation of the agency's self-analysis of 1 of 1 emergency events reported. Findings include: An undated agency policy, titled "Emergency Management Policy," Number B-400, stated "... Home Nursing Services will have an identified plan in place to insure [sic] the safety and well-being of clients and employees during periods of an emergency or disaster that disrupts Home Nursing Services' services ... Special Instructions ... 18. If the emergency management plan is implemented, it will be evaluated for	E 0039	The agency developed a form to be used as a post event assessment tool. The form will guide the agency through a thorough analysis of the event and responses that worked well or could need improvement. The emergency plan will be reviewed as needed, at least annually, to check compliance and update contact agency numbers. The Administrator is responsible for the emergency preparedness plan.	10/30/2020

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	effectiveness and documentation will be on file ..." The home health agency's undated emergency preparedness binder was reviewed on 8/26/20 on 11:50 AM. The binder indicated the agency's emergency preparedness plan (EPP) was enacted on 9/11/19 for a power outage. The emergency preparedness binder failed to indicate an analysis of the emergency event was performed by agency staff. An interview was conducted with the administrator and Director of Nursing (DON) on 8/26/20 at 2:20 PM. During the interview, the agency staff indicated the emergency preparedness plan was enacted in 2019 for a power outage, and the agency administrative staff performed an analysis of the event. The agency staff was unable to provide any evidence indicating an analysis of the emergency event was performed.		The emergency preparedness plan will be updated by 10/30/2020	
G 0000 Bldg. 00	This was a Federal and State complaint and focused COVID-19 infection control survey of a home health agency. The survey was fully extended on 8/20/20 at 3:58 PM. IN00321620; Substantiated with findings IN00321165; Substantiated with findings IN00307591; Substantiated with findings Survey Dates: August 18, 19, 20, 21, 24, 25, 26, 27; 2020 Facility Number: IN005372	G 0000	Home Nursing Services (the "Agency") is submitting the following Plan of Correction/Plan of Removal in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction/Plan of Removal is not intended as an admission, does not constitute an admission by and should not be construed as an admission by the Agency that the findings and allegations contained	

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	Provider Number: 157211 Unduplicated admissions past 12 months: 104 Skilled patients: 181 Home Health Aide Only Patients: 136 Personal Service Only Patients: 0 Total Active Patients: 169 Sample selection: Records with home visits: 3 Records without home visits: 2 Discharge records: 3 Total records reviewed: 8 Based on the Condition-level deficiencies during the August 27, 2020 survey, Home Nursing Services was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on August 20, 2020. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, Home Nursing Services is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for the two years beginning August 27, 2020 and continuing through August 27, 2022 for being found out of compliance with the Conditions of Participation 42 CFR 484.60 Care Planning, coordination, quality of care, and 484.105 Organization and administration of services. These deficiencies reflect State findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. QR completed by Area 2		herein are accurate and true representations of the quality of care and services provided to patients of the Agency. The Agency does not, at this time, have an avenue at which to challenge these findings and, therefore, the Agency's failure to dispute or challenge the alleged deficiencies cannot be taken as an admission that the alleged facts occurred as presented in the statements. Compliance has been and will be achieved no later than the last completion date identified in the Plan of Correction. The Agency desires this Plan of Correction to be considered its Allegation of Compliance."	
G 0454	484.50(d)(1) HHA can no longer meet the patient's needs			

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Bldg. 00	The transfer or discharge is necessary for the patient's welfare because the HHA and the physician who is responsible for the home health plan of care agree that the HHA can no longer meet the patient's needs, based on the patient's acuity. The HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHA's capabilities;			
	Based on record review and interview, the home health agency failed to transfer or discharge a patient when the agency could no longer meet the patient's needs for 1 of 3 discharge records reviewed (#5), in a total sample of 8 records. Findings include: An undated agency policy, titled "Client Transfer," number C-840, stated " ... A client may be transferred ... in response to client's request and/or identified need that cannot be met by the Home Nursing Services. A transfer from the Home Nursing Services to another provider will be documented as a discharge from the Home Nursing Services ...." The clinical record of Patient #5 was reviewed on 8/24/20, and indicated a start of care date of 4/26/19, and a discharge date of 7/21/20. The record indicated a recertification assessment was completed by Employee H, Registered Nurse on 4/17/20. A "Transfer to an Inpatient Facility" was completed on 4/18/20 by Employee H, and indicated the patient was admitted to a hospital for "diabetes out of control." A Plan of Care for the certification date of 4/20/20 - 6/18/20 was completed and signed by Employee H on 4/17/20, and was signed by the patient's physician on 4/30/20. A review of the "Client Monthly Schedule" for April and May 2020 indicated the	G 0454	Inservice RN case managers (RNCM) and office staff on COP and policy review on transfer and discharges. 10% of transfers and discharges will be audited by Clinical Director for six months. The Administrator is responsible for overseen the Clinical Director’s audits of discharges and transfers. Inservice of RNCM on 10/5, and 10/19, remaining office staff by 10/30/2020.	10/30/2020

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	patient had visits scheduled on 4/20/20, 4/22/20, 4/24/20, 4/27/20, 4/29/20, 5/1/20, 5/4/20, 5/6/20, and 5/8/20. The patient had no further visits scheduled after 5/8/20. The record failed to evidence any further documentation regarding when the patient was released from the hospital, or if the patient went into a rehabilitation center post hospitalization. A notation was made to the "Client Monthly Schedule" on 5/5/20 by Employee G, which indicated the patient called and requested to be transferred to another agency. The record failed to evidence a reason for the transfer request. The clinical record contained a "Physician's Order," signed by Employee H on 7/21/20 and the patient's physician on 7/22/20. The order stated "6/18/20 Discharge from Home Nursing services r/t [related to] client having a new Home care agency with therapy services." An "All Discipline Discharge Summary and OASIS-D1 DC" was completed by Employee H on 7/21/20. The discharge summary failed to indicate a reason for discharge. The clinical record failed to indicate any agency employee followed up with patient on the request to be transferred, or notified the patient of her pending discharge from the agency prior to the date of discharge. An interview was conducted with the alternate Director of Nursing (ADON) on 8/26/20 at 4:26 PM. During the interview, the ADON indicated Patient #5 was admitted to the hospital on 4/20/20, was discharged from the hospital to an inpatient rehabilitation facility, and then was discharged home with rehabilitative services. The ADON reported the patient did not receive services after 4/20/20, and was discharged on 6/18/20 "because that is when the next plan of care was due."			

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G 0484 Bldg. 00	484.50(e)(1)(ii) Document complaint and resolution (ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview, the home health agency failed to ensure all complaint investigations and resolutions were documented, and the complainant was notified of the complaint's resolution, for 4 of 29 complaints reviewed which involved patients #4, 5, 10, 11. Findings include: 1. An undated agency policy, titled "Client/Family Complaint/Grievance Policy," policy number C-381, stated " ... A grievance is any formal or informal written or verbal expression of dissatisfaction with care or service that is expressed by the client/family that is not solved at that time by staff present ... Any complaint that fits the grievance definition will require a written response to the person complaining ... The grievance ... will be documented on the grievance form by the person receiving the complaint/grievance and forwarded as soon as possible to the appropriate director or to the management team for investigation action and trending ... Grievances will be addressed by the department director and his/her designee and response made to the complainant within seven (7) calendar days of receipt ... Grievances are considered completed when an approved response has been mailed to the client complainant ..." 2. An undated agency document, titled "Home Care Client Rights and Responsibilities," stated " ... Complaints, Incident Reporting, and Grievance ... As a consumer receiving services from Home	G 0484	Administrator and Clinical Director reviewed company compliant policy. A new complaint investigation document will be utilized with areas to document required aspects of complaint policy. For six months, the Administrator will review 100% of complaints and verify with 10% of complainants that a resolution was communicated. New form and auditing starts 10/19/2020.	10/19/2020

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	Nursing Services you may register any complaint or grievance about treatment or care that is (or fails to be) furnished, or regarding lack of respect for property without reprisal or discrimination ... The Clinical Director or the Administrator of Home Nursing Services will initiate an investigation of complaints or grievances and respond to the person placing the complaint/grievance ..." 3. The complete agency complaint log from 8/1/19 through 8/1/20 was reviewed on 8/18/20 at 12:07 PM. The complaint log included a "Client Complaint" form completed on 1/20/2020 at 9:15 AM, with the date of occurrence noted to be 1/19/2020. The complainant was Person A, case worker for Patient #10 (discharge date 2/6/20). The employee who documented the complaint was not identified within the form. The "Description of problem identified by client" indicated Employee F, Home Health Aide (HHA), "was inappropriate during yesterday's shift ... [Person A] asserts she was contacted by [Patient #10] yesterday and told the following information: While [Patient #10] was in the shower, [Employee F] was watching TV ... the TV is in the farthest area from the bathroom, so [Patient #10] wouldn't be available to hear if [Patient #10] called for help ... When [Patient #10] came out of the shower, she found [Employee F] watching a very violent show on television depicting a woman being dragged out into a field and raped. When [Patient #10] asked [Employee F] to turn it off, she claims [Employee F] refused, stating that she wanted to finish the show. [Patient #10] tried to mute the television and [Employee F] argued against that as well ... [Patient #10] tried to tell [Employee F] she could just go home, but [Employee F] said she wanted to finish watching the show. After [Employee F] left, [Patient #10] called [Person A] to report what had happened ... [Person A] said			

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	[Patient #10] did not ask for [Employee F] not to return, but she wasn't sure if it would be a good idea, given what had transpired." The administrator and Director of Nursing (DON) signed the complaint on 1/20/20. The complaint was noted to be "substantiated," but the complaint form failed to indicate the date or method of notification for the complainant or patient regarding the investigation and resolution of the complaint. The complaint failed to evidence a thorough complaint investigation evidenced by, interviews to other patients who also received care from the staff named in the complaint to identify if systemic problems existed. 4. The complaint log included a "Client Complaint" form, completed by Employee D, Registered Nurse (RN) Case Manager on 1/21/20 at 8:30 AM, with the date of occurrence also being 1/21/20. The complaint involved Patient #11 (Start of Care 9/29/19) and Employee G, HHA Scheduler. Within the form's "Description of problem identified by client," Employee D wrote "The client stated [Employee G] lied to him. He called to check his schedule [and Employee G] told him who was coming [and Employee G] stated she told him on Friday who was coming but client denies the notification from [Employee G]." The form was signed by the DON and administrator on 1/29/20. The complaint form failed to indicate whether the complaint was substantiated or unsubstantiated, and also failed to include a date, time, or method of notification of the complainant regarding the complaint investigation and resolution. The complaint failed to evidence a thorough complaint investigation evidenced by, staff education regarding the areas of concerns per the complaint, or interviews to other patients who also received care from the staff named in the complaint to identify if systemic problems existed.			

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	5. The complaint log included a "Client Complaint" form completed on 1/29/20 at 4:40 PM. The complaint form failed to indicate which employee received and documented the complaint, as Employee G signed the line for "Signature and title of person receiving the complaint," but the complaint was regarding Employee G, and the complaint investigation also included a handwritten statement from Employee G, which did not include any mention of receiving the complaint. The complainant was Person D, family member of Patient #4 (Discharge Date 7/15/20). The dates of occurrence were documented to be "1/27, 28, 29," and the "Description of problem as identified by client" stated "Caregiver called off for 1/27, 28, 29, but no one called from the office. On Tuesday, [Person D] called in, [Employee G] stated she just retrieved her voicemails. Did not get a call Wednesday, 1/29 about not having a substitute nurse." The compliant was documented as "Substantiated," but the complaint form failed to indicate a date, time, or method of notification of the complainant or patient regarding the complaint investigation and resolution. The complaint failed to evidence a thorough complaint investigation evidenced by staff education regarding the areas of concerns per the complaint, or interviews to other patients who also received care from the staff named in the complaint to identify if systemic problems existed. 6. The complaint log included a "Client Complaint" form completed on 4/7/20 at 12:00 PM by the administrator. The complaint was regarding Patient #5 (Discharge Date 6/19/20), who was also the complainant. The date of the occurrence was noted to be 4/6/20, and the "description of the problem as identified by client" was documented as "[Employees H and I,			

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	RNs] were at client's house while [Employee J, HHA] and [employee of local community mental health services provider] were also there. [The RNs] insisted [Patient #5] remove her pants in her living room in front of all four visitors, so they could assess her red area under her abdomen." The agency documented the complaint as unsubstantiated. The complaint form failed to include a date, time, or method of notification of the complainant regarding the complaint investigation and resolution. The DON did write "[Patient #5] was admitted to [local hospital] the next day for high blood sugars" in the "Complainant's response to implementation steps" section of the form. The complaint form was signed by the DON on 4/22/20 and the administrator on 4/30/20. The complaint failed to evidence a thorough complaint investigation evidenced by interviews of all parties present during the reported incident, staff education regarding the areas of concerns per the complaint, or interviews to other patients who also received care from the staff named in the complaint to identify if systemic problems existed. 7. The survey Entrance Conference was completed on 8/18/20 at 10:39 AM with the administrator, alternate administrator, DON, and alternate DON. During the Entrance Conference, the DON indicated patient complaints and grievances were the responsibility of "all" of the administrative team, and the complaints were "separated" by the issue reported. Complaints regarding an employee or Human Resources (HR) issue were handled by the administrator, the DON, and Employee H, HR Coordinator, while "client issues" were handled by the administrator, DON, or alternate DON. The DON reported complaints were documented on a "form we use to stay focused on complaints," and these forms were			

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	kept in the agency's complaint log. The complaint form, titled "Client Complaint," had a section to document the complaint resolution "if appropriate," according to the DON. The DON indicated if a complaint was unsubstantiated, the agency did not fill out the resolution section of the form, but they did notify the complainant of the complaint findings. The DON also indicated the agency considered complaints where a patient had requested an employee not return to provide services were "already resolved," and the patient or complainant were not notified of the complaint investigation findings or resolution. 8. An interview was conducted with Person E, family member of Patient #6 (start of care 12/31/1998), on 8/20/20 at 2:01 PM. During the interview, Person E indicated she notified the home health agency of a concern regarding Former Employee F, HHA, taking a picture of Patient #6 without obtaining consent. Person E did not recall which agency employee she reported the complaint to, but thought it was [Employee H, HR Coordinator] "or another girl ... [Patient #6]'s nursing supervisor at the time." Person E also could not recall the exact date she reported her concern, but reported it was sometime in November or December 2019. Person E indicated when she reported her concern to the agency, "No one said anything ... I told them I wanted [Former Employee F] terminated .... The office said they were going to talk to [Former Employee F] about it." Person E indicated the agency "never called back to follow up." A complete review of the agency's complaint log from 1/1/19 through 7/27/20 was reviewed on 8/18/20 at 12:07 PM. The complaint log failed to include Person E's complaint regarding Former Employee F.			

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	9. An interview was conducted on 8/26/20 at 12:10 PM with the administrator, DON, and alternate DON regarding the above complaints, and interviews were as followed: Regarding the complaint from 1/20/20 involving Patient #10, the administrator indicated the patient was advised of the resolution of the complaint because the patient "called 1 to 3 times a day for reassurance ... I'm sure we took care of [the complaint] over the phone." Regarding the complaint from 1/21/20, involving Patient #11, the administrator indicated the patient should have been notified of the agency's investigation and resolution of the complaint, and it should have been documented on the complaint log form. Regarding the complaint from 1/29/20 involving Patient #4, the administrator indicated she did not recall that particular complaint, but stated Employee G would have "followed up with the family," and indicated Employee G was able to notify complainants regarding complaint investigations and resolutions. Regarding the complaint from 4/7/20 involving Patient #5, the administrator indicated the patient was not notified of the investigation or resolution of the complaint because she "became ill and was admitted to the hospital." 17-12-3(c)(2)			
G 0528 Bldg. 00	484.55(c)(1) Health, psychosocial, functional, cognition The patient's current health, psychosocial, functional, and cognitive status;			

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	Based on observation, record review and interview, the home health agency failed to ensure all comprehensive assessments included the patients' current health and psychosocial status for 4 of 5 active records reviewed (#1, 3, 6, 8), in a total sample of 8 records. Findings include: 1. An undated agency policy, titled "Comprehensive Client Assessment," policy number C-145, stated " ... A thorough, well organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed for all clients ... Purpose ... To collect data about the client's health history, (physical, functional and psychological) [sic] ... In addition to general health status/system assessment, the Home Nursing Services comprehensive assessment with OASIS will include: ... m. Neuro/emotional/behavioral status ..." 2. The complete clinical record of Patient #1 was reviewed on 8/18/20 and 8/24/20 and indicated a start of care date of 6/22/18 for the certification period of 6/11/20 - 8/9/20, that indicated the patient's principal diagnosis as "Post-traumatic stress disorder (PTSD)." The clinical record included a comprehensive recertification assessment completed on 8/5/2020 by the alternate director of nursing (ADON) for the certification period of 8/10/2020 - 10/8/2020, which stated "Cognitive Assessment: Issues noted (otherwise functional/normal): short term memory loss, confused ... Behavioral Assessment: Depression." The comprehensive assessment failed to include an assessment of the patient's PTSD. The comprehensive assessment also included a "Medication Profile" reviewed and	G 0528	Clinical Director and Alternate Clinical Director inserviced RNCMs on 10/5 and 10/19 on assessments, with specific focus on medications and their corresponding diagnoses needs, as well as emphasizing that all tubes and catheters must recorded on the assessment along with location and care instructions. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	11/02/2020

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signed by the ADON on 8/5/20. The medication list included current patient medications Fluticasone (taken for allergies), Albuterol HFA (taken for asthma), Simvastatin (taken for high cholesterol), Cialis (taken for Erectile Dysfunction), Testosterone Cypionate (taken for low testosterone levels), Topiramate (taken for "headaches"), Gabapentin (taken for "pain"), Ropinirole (taken for "RLS" [Restless Leg Syndrome]), Flomax (taken for an enlarged prostate), Trazodone (taken for insomnia), Myrbetiq (taken for overactive bladder), Finasteride (taken for enlarged prostate), and Omeprazole (taken for gastro-esophageal reflux disorder [GERD]). Patient #1's comprehensive assessment failed to include diagnoses or assessments of the above conditions or diseases, and therefore failed to indicate a complete and thorough health and psychosocial status.

3. The clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record included a comprehensive recertification assessment completed on 7/15/20 by Employee L, Registered Nurse (RN), for the certification period of 7/16/20 - 9/13/20.

A home visit observation was conducted with Employee M, Home Health Aide (HHA) on 8/20/20 at 9:40 AM, with Patient #3. During the visit, the patient was observed to have a suprapubic catheter (tube placed through a surgically - created connection from a patient's lower abdomen to the bladder, used in patients with chronic inability to urinate).

The recertification comprehensive assessment dated 7/15/20 failed to indicate the presence of a suprapubic catheter as well as the size of the

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	catheter, frequency of catheter changes, or assessment of catheter site. The comprehensive assessment failed to indicate the patient had a wound on his left buttock, as documented as a "large pink area left buttock. Flaky [sic]" wound within the "Daily Visit Notes" on 7/16/20 by Employee M, Home Health Aide (HHA). The comprehensive assessment also included a "Medication Profile" for Patient #3, reviewed and signed by Employee L on 5/18/20 and 7/20/20. The medication list indicated the patient's current medications included Linzess (taken for constipation secondary to opioid use), Cymbalta (taken for depression), and Tramadol (taken for pain). The patient's comprehensive assessment failed to indicate diagnoses or assessments of constipation or depression. Within the "Pain Overview" section of the comprehensive assessment, the nurse checked the statement "This patient is pain free currently and does not take any medications for pain," despite the patient being on Tramadol. The comprehensive assessment failed to include a complete and thorough health and psychosocial status of Patient #3. 4. The clinical record of Patient #6 was reviewed on 8/24/20 and 8/25/20, and indicated a start of care date of 12/31/98. The clinical record included a certification period of 7/1/20 - 8/29/20, and a comprehensive recertification assessment was completed on 6/29/20 by Employee N, RN. Under the "Pain Assessment" section of the comprehensive assessment, the nurse documented "No issues noted: Location. Severity (0-10). Description. Level of control. Controlled with [sic]." The comprehensive assessment also included a "Medication Profile" for Patient #6, reviewed and signed by the nurse on 6/29/20. The medication list indicated the patient's current			

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medications included Bisacodyl (taken for constipation), Diazepam (taken for anxiety), Docusate Sodium (taken for constipation), Levoxyl (taken for underactive thyroid), and Omeprazole (taken for GERD). The patient's comprehensive assessment failed to contain a complete pain assessment, and failed to indicate diagnoses or assessment of constipation, anxiety, underactive thyroid, and GERD. Patient #6's comprehensive assessment failed to include a complete and thorough health and psychosocial status.

5. The complete clinical record of Patient #8 was reviewed on 8/24/20, and indicated a start of care of 4/8/08. The clinical record included a certification period of 8/11/20 - 10/10/20, and a comprehensive recertification assessment completed on 8/7/20 by Employee E, RN.

A home visit observation was conducted with Employee O, Licensed Practical Nurse (LPN) on 8/24/20 at 7:50 AM, with Patient #8. During the home visit, Patient #8 was observed to have a MIC-KEY feeding tube.

The comprehensive assessment dated 8/7/20 failed to include presence or assessment of the patient's MIC-KEY feeding tube, including location, assessment of the site, and instructions on care and medication administration. Within the "Nutritional Assessment" section of the comprehensive assessment, the nurse documented "Patient obtains nutrients: Orally ... Prescribed Consistency: N/A; no restrictions. Liquids," and within the "Nutritional Requirements" section, the nurse documented "Regular balanced diet no restrictions [sic]. Meds per g tube." The patient's "Individual Emergency Preparedness Plan," prepared and signed by the

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patient's guardian on 10/31/17, stated "Food needs to be chopped before feeding [Patient #8]. Feed with rubber, non-breakable spoon, small bites. Use straw for drinks." The comprehensive assessment failed to include the patient's specific instructions for feeding. The comprehensive assessment also included a "Medication Profile" for Patient #8, reviewed and signed by the nurse on 8/11/20. The medication list indicated the patient's current medications included Pulmicort (taken for asthma), Clonazepam (taken for anxiety), Provigel (documented use for "ADHD [Attention Deficit Hyperactivity Disorder]"), Singular (taken for asthma), Milk of Magnesia (taken for constipation), Execederin [sic] (taken for pain), Tylenol (taken for pain), Advil (taken for pain), Propanol (documented use listed as "beta blocker," can be taken for high blood pressure, tremors, angina, and irregular heart rhythms), Loperamide (taken for diarrhea), Pepto Bismol (taken for diarrhea), Floranex (taken for seasonal allergies), Flonase (taken for seasonal allergies), Famotidine (taken for GERD), and Suphedrine Plus (taken for allergies). The patient's comprehensive assessment failed to include diagnoses or assessments of the above conditions. Patient #8's comprehensive assessment failed to include a complete and thorough health and psychosocial status.

6. An interview was conducted on 8/25/20 at 3:47 PM with the administrator, alternate administrator, DON, and ADON. During the interview, the administrator indicated the comprehensive assessment should include an assessment of all current patient conditions.

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

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G 0530 Bldg. 00	484.55(c)(2) Strengths, goals, and care preferences The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA;			
	Based on record review and interview, the home health agency failed to ensure all comprehensive assessments included patients' strengths, progress towards goals, and care preferences for 5 of 5 active records reviewed (#1, 2, 3, 6, 8), in a total sample of 8 records. Findings include: 1. An undated agency policy, titled "Comprehensive Client Assessment," policy number C-145, stated " ... A thorough, well organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed for all clients ... The assessment identifies facilitating factors and possible barriers to client reaching his or her goals ... Purpose ... To make care, treatment, or service decisions based on information developed about each client's needs and the individual's response to care ..." An undated agency policy, titled "Client Reassessment/Update of Comprehensive Assessment," policy number C-155, stated " ... Purpose ... To identify progress toward goals ... Special attention will be paid to client-centered goal setting, clarifying the client's personal goals and his/her expectations of the home care services ... The assessment will identify the problems, needs, and strengths of the client ... The initial and ongoing assessments include consideration	G 0530	RNCMs were inserviced on 10/5 and 10/19 and reviewed polices to include patient directed strengths and goals, and progress towards documented goals. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	11/02/2020

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	of the following: ... b. Description of any applicable strength the client has including physical, psychosocial, and or [sic] spiritual resources that increase their ability to respond effectively to treatment and ability to learn ... f. Progress toward goals since previous assessment ..." 3. The clinical record of Patient #1 was reviewed on 8/18/20 and 8/24/20, and indicated a start of care date of 6/22/18. The clinical record included a comprehensive recertification assessment completed on 8/5/2020 by the alternate director of nursing (ADON) for the certification period of 8/10/2020 - 10/8/2020, which indicated diagnoses (but not limited to) "Post-traumatic stress disorder [PTSD] ... Type 1 diabetes mellitus with diabetic nephropathy ... Essential (primary hypertension) ... Chronic pain syndrome." The comprehensive assessment failed to indicate progress towards the patient's goals or their care preferences 4. The clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20, and indicated a start of care of 8/22/19. The clinical record included a comprehensive recertification assessment completed on 6/11/20 by Employee N, Registered Nurse (RN), for the certification period of 6/17/20 - 8/15/20 which indicated diagnoses (but not limited to) "Cerebral palsy ... Paraplegia ... Major depressive disorder." The comprehensive assessment failed to indicate the patient's progress towards their goals and care preferences. 5. The clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record included a comprehensive recertification assessment completed on 7/15/20 by Employee L, Registered Nurse (RN), for the certification period of 7/16/20 -			

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	9/13/20 which indicated diagnoses (but not limited to) "Multiple sclerosis ... Immobility syndrome (paraplegic) ... Neuromuscular dysfunction of bladder." The comprehensive assessment failed to indicate patient strengths, progress towards their goals, and patient care preferences. 6. The clinical record of Patient #6 was reviewed on 8/24/20 and 8/25/20, and indicated a start of care of 12/31/98. The clinical record included a comprehensive recertification assessment completed on 6/29/20 by Employee N, RN, for the certification period of 7/1/20 - 8/29/20 which indicated diagnoses (but not limited to) "Anoxic brain damage ... Full incontinence of feces ... unspecified urinary incontinence." The comprehensive assessment stated "[Patient #6's family member would] like more hours," but failed to include further details on hours the family member is requesting, and any action made by the RN for this family request. The comprehensive assessment also failed to indicate patient strengths, progress towards goals, and additional patient or family care preferences. 7. The complete clinical record of Patient #8 was reviewed on 8/24/20, and indicated a start of care of 4/8/08. The clinical record contained a comprehensive recertification assessment completed on 8/7/20 by Employee E, RN, for the certification period of 8/11/20 - 10/10/20 which indicated diagnoses (but not limited to) "Cerebral palsy ... convulsions." The comprehensive assessment failed to indicate patient strengths, progress towards goals, and patient care preferences. 8. An interview was conducted on 8/25/20 at 3:47 PM with the administrator, alternate administrator, director of nursing (DON), and ADON. During the			

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	interview, the DON indicated a comprehensive recertification assessment should include a patient's progress towards their goals. The DON also indicated a patient's strengths noted within their comprehensive assessment were nurse identified, not patient-identified.			
G 0534 Bldg. 00	484.55(c)(4) Patient's needs The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview, the home health agency failed to ensure all comprehensive assessments included individualized patient discharge planning needs for 5 of 5 active records reviewed (#1, 2, 3, 6, 8), in a total sample of 8 records. Findings include: 1. An undated agency policy, titled "Comprehensive Client Assessment," policy number C-145, stated " ...A thorough, well organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed for all clients ... Purpose ... To identify clients medical, nursing, rehabilitative, social and discharge planning needs ... Discharge planning is initiated ..." 2. The clinical record of Patient #1 was reviewed on 8/18/20 and 8/24/20, and indicated a start of care date of 6/22/18. The clinical record included a comprehensive recertification assessment completed, on 8/5/2020 by the alternate director of nursing (ADON), for the certification period of 8/10/2020 - 10/8/2020. The comprehensive assessment included a section titled "Discharge Planning: Likely Status," which stated "The likely discharge planning status is that: patient will	G 0534	RNCMs were inserviced on 10/5 and 10/19 to include patient discharge planning to address what rationales could lead to discharges. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	11/02/2020

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remain in current living situation with ongoing assistance provided by: Federal Government, State Government. no realistic discharge in foreseeable future. [Situations that would lead to discharge include] client ... request, loss of payer source, institutionalization, death [sic]." The comprehensive assessment failed to include thorough and individualized discharge planning which included if/when the patient could be discharged with rationale.

3. The clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20, and indicated a start of care of 8/22/19. The clinical record included a comprehensive recertification assessment completed on 6/11/20 by Employee N, Registered Nurse (RN), for the certification period of 6/17/20 - 8/15/20. The comprehensive assessment included a section titled "Discharge Planning: Likely Status," which stated "The likely discharge planning status is that: patient will remain in current living situation with ongoing assistance provided by: Federal Government, State Government. patient will likely remain with long term care needs, no realistic discharge in foreseeable future. [Situations that would lead to discharge include] Client request, Loss of payer sources, Institutionalization, Death. Level of assistance anticipated that will be needed upon discharge, N/A [sic]." The comprehensive assessment failed to include thorough and individualized discharge planning which included if/when the patient could be discharged with rationale.

4. The clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record included a comprehensive recertification assessment completed on 7/15/20 by Employee L, Registered

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	Nurse (RN), for the certification period of 7/16/20 - 9/13/20. The comprehensive assessment included a section titled "Discharge Planning: Likely Status," which stated "The likely discharge planning status is that: no realistic discharge in foreseeable future. [Situations that would lead to discharge include] client request, lack of payer source, institutionalization or death [sic]." The comprehensive assessment failed to include thorough and individualized discharge planning which included if/when the patient could be discharged with rationale. 5. The clinical record of Patient #6 was reviewed on 8/24/20 and 8/25/20, and indicated a start of care of 12/31/98. The clinical record contained a comprehensive recertification assessment completed on 6/29/20 by Employee N, RN, for the certification period of 7/1/20 - 8/29/20. The comprehensive assessment included a section titled "Discharge Planning: Likely Status," which stated "The likely discharge planning status is that: patient will remain in current living situation with ongoing assistance provided by: Federal Government, State Government. patient will likely remain with long term care needs, no realistic discharge in foreseeable future. [Situations which would lead to discharge include] Family request, Loss of payer sources, Institutionalization, Death. Level of assistance anticipated that will be needed upon discharge, N/A [sic]." The comprehensive assessment failed to include thorough and individualized discharge planning which included if/when the patient could be discharged with rationale. 6. The clinical record of Patient #8 was reviewed on 8/24/20, and indicated a start of care of 4/8/08. The clinical record contained a comprehensive recertification assessment completed on 8/7/20 by			

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	Employee E, RN, for the certification period of 8/11/20 - 10/10/20. The comprehensive assessment included a section titled "Discharge Planning: Likely Status," which stated "The likely discharge planning status is that: patient will remain in current living situation with ongoing assistance provided by: State Government. patient will likely remain with long term care needs, no realistic discharge in foreseeable future. Level of assistance anticipated that will be needed upon discharge, N/A [sic]." The comprehensive assessment failed to include thorough and individualized discharge planning which included if/when the patient could be discharged with rationale. 7. An interview was conducted on 8/25/20 at 3:47 PM with the administrator, alternate administrator, director of nursing (DON), and ADON. During the interview, the DON indicated the comprehensive assessment should include discharge planning needs. The ADON indicated most patients require long term care, and the agency was "not looking to discharge [the patients] ... the only reason we put in for [possible] discharge is [the patient losing their] payer source." 17-14-1(a)(1)(B)			
G 0536 Bldg. 00	484.55(c)(5) A review of all current medications A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the registered nurse (RN) failed to ensure the	G 0536	RNCMs were inserviced on 10/5 and 10/19 on medications,	11/02/2020

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	comprehensive assessment contained a complete review of medications and the medication list was maintained for 5 of 5 active records reviewed (#1, 2, 3, 6, 8), in a total sample of 8 records. Findings include: 1. An undated agency policy titled "Comprehensive Client Assessment," number C-145, stated "... A thorough, well organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed for all clients ... The Comprehensive Assessment will include a review of all medications the client is using (prescription and non-prescription). This assessment will identify the potential adverse effects and drug reactions, including ineffective therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with therapy ... In addition to general health status/system assessment, the Home Nursing Services comprehensive assessment tool ... will include: ... o. Medications ... reconciliation and follow up ..." 2. The clinical record of Patient #1 was reviewed on 8/18/20 and 8/24/20, and indicated a start of care date of 6/22/18. The clinical record included a comprehensive recertification assessment, completed on 8/5/2020 by the alternate director of nursing (ADON), for the certification period of 8/10/2020 - 10/8/2020. The comprehensive assessment included a "Medication Profile" for Patient #1, signed by the ADON on 8/5/20. The Medication Profile included an order for "Cialis [used for Erectile Dysfunction] ... 5 mg ... 2 tabs [tablets] one hour before sexual activity ... PRN [as needed] ... PO [by mouth]." The medication list failed to include an indication for the patient's PRN medication.		indication for use, review of interactions, and proper completion of med profile. Also inserviced on the frequency of maintaining the med profile to prevent duplication of orders. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	

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3. The clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20, and indicated a start of care of 8/22/19. The clinical record included a comprehensive recertification assessment completed on 6/11/20 by Employee N, Registered Nurse (RN), for the certification period of 6/17/20 - 8/15/20. The comprehensive assessment included a "Medication Profile" for Patient #2, signed by Employee N on 6/11/20. The Medication Profile included an order for "Ibuprofen [used for pain] ... 200 mg [milligrams] 1 tab q [every] 4 hrs [hours] ... PRN ... PO, " but failed to include an indication for the use of the medication. Additionally, the form included a section titled "Drug Regimen Review," where the staff could check "Yes" or "No" to indicate if the patient experienced "side effects to current drug regimen," if the patient demonstrated "non compliance [sic] with medication use as prescribed by the physician," and if a "Drug Interaction Review," including review for "Potential adverse effects, duplicate, ineffective drug therapy [sic], and contradictions identified," was completed. The drug regimen review failed to evidence whether the patient experienced side effects with their current drug regimen, demonstrated noncompliance with medication use, or if a "Drug Interaction Review" was completed.

4. The clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record included a comprehensive recertification assessment completed on 7/15/20 by Employee L, Registered Nurse (RN), for the certification period of 7/16/20 - 9/13/20. The comprehensive assessment included a "Medication Profile" for Patient #3, signed by Employee L on 11/19/20 [sic], 1/18/20, 3/18/20, 5/18/20, and 7/20/20 which included orders for

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	"Linzess [used for constipation secondary to opioid use] ... [Dose] 1 [sic] ... [Amount] cap [capsule] ... QD PRN [once a day as needed] ... PO ... Tramadol [used for pain] ... 50 mg ... 1 tab ... PRN ... PO," but failed to include an indication for the use of the medication. Additionally, the drug regimen review failed to evidence whether the patient experienced side effects with their current drug regimen, demonstrated noncompliance with medication use, or if a "Drug Interaction Review" was completed. 5. The clinical record of Patient #6 was reviewed on 8/24/20 and 8/25/20, and indicated a start of care of 12/31/98. The clinical record included a comprehensive recertification assessment completed on 6/29/20 by Employee N, RN, for the certification period of 7/1/20 - 8/29/20. The comprehensive assessment included a "Medication Profile," signed by Employee N on 6/29/20. The Medication Profile form included two orders for "Keppra [medication used to prevent seizures] ... 1000 mg [milligrams] ... 1 tablet ... BID [twice a day] ... PO [by mouth]." The RN failed to maintain the patient's medication list to prevent duplication of orders. 6. The clinical record of Patient #8 was reviewed on 8/24/20, and indicated a start of care of 4/8/08. The clinical record contained a comprehensive recertification assessment completed on 8/7/20 by Employee E, RN, for the certification period of 8/11/20 - 10/10/20. The comprehensive assessment included a "Medication Profile," signed by Employee E on 8/11/20. The Medication Profile included orders for "Pulmicort [used for asthma] ... 0.5mg/2ml [milliliters] ... 1 vial ... PRN [as needed] ... [Route] nebulizer ... Milk of Magnesia [used for constipation] ... [Dose] REG ... 5-10 mls ... PRN ... [Route] G-tube ...			

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	Execederin [sic, used for pain] ... [Dose] REG ... 2 tabs [tablets] q [every] 4-6 hours ... PRN ... [Route] G-tube," "Tylenol [used for pain] ... 325 mg ... 2 tabs q 4-6 hours ... PRN ... [Route] G-tube ... Advil [used for pain] ... 200 mg ... 2 tabs q 4 h [hours] ... PRN ... [Route] G-tube ... Loperamide [used for diarrhea] ... 2 mg ... 1 tab ... PRN ... [Route] G-tube ... Pepto Bismal [sic, used for diarrhea] ... 20ml ... daily ... PRN ... [Route] G-tube." The medication list failed to include an indication for the patient's PRN medication. 7. An interview was conducted on 8/25/20 at 3:47 PM with the administrator, alternate administrator, director of nursing (DON), and ADON. During the interview, the DON indicated medication reviews were documented by the nurse on the "Medication Profile form" within the "Drug Regimen Review" section. The administrator also indicated all orders for PRN medications should include indications for when to administer the medication. 8. An interview was conducted on 8/26/20 at 9:13 AM with the administrator, DON, and ADON. During the interview, the DON indicated the medication list should be maintained and accurate. 17-14-1(a)(1)(B)			
G 0538 Bldg. 00	484.55(c)(6)(i,ii) Primary caregiver(s), if any 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 record review and interview, the home health agency failed to ensure the comprehensive assessment included the presence of the patient's primary caregiver, the caregiver's willingness and	G 0538	RNCMs were inserviced on 10/5 and 10/19 to include documentation on patient's primary caregiver, and their	11/02/2020

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	ability to provide care, and the caregiver's availability and schedules for 5 of 5 active records reviewed (#1, 2, 3, 6, 8), in a total sample of 8 records. Findings include: 1. An undated agency policy titled "Comprehensive Client Assessment," number C-145, stated "... A thorough, well organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed for all clients ... In addition to general health status/system assessment, the Home Nursing Services comprehensive assessment tool ... will include: ... c. Living arrangement ... f. Supportive assistance ..." An undated agency policy, titled "Client Reassessment/Update of Comprehensive Assessment," policy number C-155, stated " ... The initial and ongoing assessments include consideration of the following: ... c. Involvement of family friends [sic], and other individuals or organizations ... d. Appropriateness of the level of care provided by the family or support system to safely meet the client needs ... h. Ability/willingness of the client/family to assume responsibility for healthcare needs ... Client needs and the availability and adequacy of family and support systems will be considered in the care planning process ..." 2. The clinical record of Patient #1 was reviewed on 8/18/20 and 8/24/20, and indicated a start of care date of 6/22/18. The clinical record included a comprehensive recertification assessment, completed on 8/5/2020 by the alternate director of nursing (ADON), for the certification period of 8/10/2020 - 10/8/2020. The comprehensive		availability and ability to provide care for the client. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	

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assessment failed to indicate the patient's primary caregiver, the caregiver's willingness and ability to provide care, and the caregiver's availability and schedule.

3. The clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20, and indicated a start of care of 8/22/19. The clinical record included a comprehensive recertification assessment completed on 6/11/20 by Employee N, Registered Nurse (RN), for the certification period of 6/17/20 - 8/15/20. The comprehensive assessment failed to indicate the patient's primary caregiver, the caregiver's willingness and ability to provide care, and the caregiver's availability and schedule.

4. The clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record included a comprehensive recertification assessment completed on 7/15/20 by Employee L, Registered Nurse (RN), for the certification period of 7/16/20 - 9/13/20. The comprehensive assessment failed to indicate the patient's primary caregiver, the caregiver's willingness and ability to provide care, and the caregiver's availability and schedule.

5. The clinical record of Patient #6 was reviewed on 8/24/20 and 8/25/20, and indicated a start of care of 12/31/98. The clinical record contained a comprehensive recertification assessment completed on 6/29/20 by Employee N, RN, for the certification period of 7/1/20 - 8/29/20. The comprehensive assessment failed to indicate the patient's primary caregiver, the caregiver's willingness and ability to provide care, and the caregiver's availability and schedule.

6. The clinical record of Patient #8 was reviewed on 8/24/20, and indicated a start of care of 4/8/08.

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	The clinical record contained a comprehensive recertification assessment completed on 8/7/20 by Employee E, RN, for the certification period of 8/11/20 - 10/10/20. The comprehensive assessment failed to indicate the patient's primary caregiver, the caregiver's willingness and ability to provide care, and the caregiver's availability and schedule. 7. An interview was conducted on 8/25/20 at 3:47 PM with the administrator, alternate administrator, director of nursing (DON), and ADON. During the interview, the agency staff was unable to provide an answer regarding if the comprehensive assessment should include documentation of a patient caregiver's willingness and ability to provide care to the patient, and if the comprehensive assessment should include a patient caregiver's availability and schedule.			
G 0564 Bldg. 00	484.58(b)(1) Discharge or Transfer Summary Content 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 all necessary medical information pertaining to the patient's current course of treatment was sent to the receiving facility for 1 of 2 transfer records reviewed (#7), in a sample of 8 total records. Findings include:	G 0564	A new job description was added to the responsibility of our Medical Records Coordinator to send pertinent medical records to client and or transfer agency upon discharge from our EMR program. The Clinical Director will monitor 100% of EMR discharges and	10/19/2020

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	An undated agency policy titled "Client Transfer," number C-840, stated " ... Purpose: To assure continuity of care by providing pertinent information to another home health care company or facility when a client chooses another provider ... Special Instructions ... 3. A Transfer Summary shall be completed by the Registered Nurse ... The summary will be based on data collected on the last visit and shall include documentation of services received, reason for transfer/discharge ... the client's physical and psychosocial status, current medications, continuing symptom management needs, instruction and referrals provided to the client, summary of care, any existing advance directives, an [sic] any relevant changes in caregiver support or lab results. 4. The original Transfer Summary form shall be sent to the new provider or facility ... 7. If a client transfers to another health facility or home health Home Nursing Services [sic], a copy of the summary shall be sent with the client ..." The clinical record of Patient #7 was reviewed on 8/26/20. The clinical record indicated a start of care date of 9/16/2016, and discharge date of 7/21/20. A Discharge Summary was completed on 7/21/20 at 4:39 PM by Employee N, Registered Nurse (RN). The "Discharge Reason" was documented as "Care is now going to be assumed by another agency. Reason is: Client [sic] is not receiving enough steady care. Did not have the aides to provide the hours needed. Being admitted to [Entity G, receiving Home Health Agency]." The clinical record failed to indicate the discharge summary was sent to the receiving home health agency. An interview was conducted with Person H, Director of Nursing (DON) for Entity G, and Person I, admission coordinator for Entity G, on		transfer for documentation of summaries sent, and contact 10% of transfer agency for six months to ensure documentation received. Overseeing and auditing will begin on 10/19/2020.	

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	8/26/20 at 11:21 AM. Person H indicated Patient #7's start of care date with Entity G was 7/21/20. Person I indicated Entity G, the receiving home health agency, did not receive a transfer summary or any clinical records regarding Patient H from Home Nursing Services. An interview was conducted with the administrator, DON, and alternate director of nursing on 8/26/20 at 11:52 AM. During the interview, the DON indicated the agency did not send Patient #7's transfer summary or any clinical records to Entity G, the receiving home health agency.			
G 0570 Bldg. 00	484.60 Care planning, coordination, quality of care 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 record review and interview, the home	G 0570	The Missed Visit Notification form	09/25/2020

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	health agency failed to ensure patients were admitted only when the agency could meet the patient's medical and nursing needs for 2 of 5 active records reviewed (#2, 6), failed to ensure the plan of care included all pertinent diagnoses, the patient's mental, psychosocial, and cognitive status, types of services required, frequency and duration of visits to be made, the patient's rehabilitation potential, activities permitted, a complete and accurate list of the patient's medications, all safety to protect against injury, all necessary interventions to address a patient's risk factors for emergency department visits and hospital re-admission, patient and caregiver education and training to facilitate timely discharge, and patient-specific and measurable goals (See Tag G574); failed to ensure agency services were administered only as ordered by the physician (See Tag G580), failed to ensure the plans of care included the patient's progress towards their goals (See Tag G592), and failed to complete coordination of care with other agencies who provided services to the agency's patients (See Tag G608). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.60 Care planning, coordination, and quality of care. In regards to G570, the findings include: 1. An undated agency policy, titled "Coordination of Client Services and Missed Visits," stated " ... Purpose ... to ensure appropriate, quality care is being provide to clients ... Special Instructions ... 1. Client Services Coordinator will meet daily with Clinical Director/designee regarding visit schedules ... 4. ... when clients have needs that require on-going		was revised to include an area to notate the specific way patient's needs were met in the event of a missed visit. The agency also assessed all clients' missed visits for July and August after the survey's closing and addressed all client with missed visits equaling 30% or more of approved hours for each month. Agency discharged clients where needs were not being met. The Clinical Director and Administrator will monitor missed visits percentage each month. The Clinical Director will contact clients, family, and review chart documentation to assess if needs are being met for those with elevated missed visits percentages. Missed visits percentage monitoring starting in September, 2020.	

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	services that cannot be met by the Home Nursing Services staff the Client Services Coordinator will work with Clinical Director/Designee and HR Coordinator to recruit necessary staff ... 5. Weekly the missed visits are reported to the Clinical Director/designee. A Missed Visit Report is completed and sent to the client's physician ..." 2. The clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20, and indicated a start of care of 8/22/19. The record included a Plan of Care for the certification period of 6/17/20 - 8/15/20, which indicated service orders for "HHA [Home Health Aide] 2-4 hrs [hours]/day X [for] 7 days/week for up to 28 units/week." A review of the record indicated the agency completed "Report of Missed Visit" forms for the missed visits dates of 6/26/20, 6/29/20, 7/3/20, 7/5/20, 7/24/20, 7/26/20, 7/27/20, 7/31/20, 8/1/20, 8/2/20, 8/5/20, 8/9/20, and 8/10/20. The missed visit report forms failed to indicate how the patient's needs were met. The agency's complete Complaint Log from 8/1/19 - 8/1/20 was reviewed on 8/18/20 at 12:07 PM. The log contained a "Client Complaint" form dated 7/27/20, signed by the Director of Nursing as the "person receiving the complaint." The form indicated Patient #2 was the "person reporting complaint." The "description of problem" indicated "[Patient #2] is frustrated with the [Fort Wayne] office not fulfilling staff." The "Recommendations for complaint resolution" indicated "HR Coordinator is following up with the HHA calling off frequently ... HR has this case listed with needs for recruitment." The complaint was indicated as "Substantiated" by the agency, and signed by the Director of Nursing on 7/28/20, and the Administrator on 7/31/20.			

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	An interview with Patient #2 was conducted on 8/19/20 at 9:40 AM. During the interview, the patient indicated she reported a complaint to the agency regarding staff not being "consistent" with coming to visits. When asked if the agency had resolved the issue, the patient stated "Yes ... they're still working on it." 3. The clinical record of Patient #6 was reviewed on 8/24/20 and 8/25/20, and indicated a start of care of 12/31/20. The record included a Plan of Care for the certification period of 5/2/20 - 6/30/20, which indicated service orders for "HHA 2h/7d [days] /wk [week] x 9 weeks." A review of the record indicated the agency completed "Report of Missed Visit" forms for the missed visits dates 5/6/20, 5/8/20, 5/13/20, 5/15/20, 5/16/20, 5/20/20, 5/22/20, 5/27/20, 5/29/20, 5/30/20, 6/3/20, 6/5/20, 6/10/20, 6/12/20, 6/13/20. 6/17/20, 6/19/20, 6/24/20, 6/26/20, and 6/27/20. The missed visit report forms failed to indicate how the patient's needs were met. An interview with Person E, family member of Patient #6, was conducted on 8/20/20 at 2:01 PM. During the interview, Person E indicated she consistently had to provide care to Patient #6 every "Wednesday, Friday, and every other Saturday," as the agency did not have the staffing available to provide care on those days. Person E also indicated she only received updates on the agency's progress to fill these dates when she would call in to the office and requested an update. 4. An interview with the administrator, alternate administrator, Director of Nursing (DON), and alternate Director of Nursing (ADON) was conducted on 8/25/20 at 3:47 PM. During the interview, the ADON indicated the "Report of			

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	Missed Visit" form should indicate how a patient's needs were met when a missed visit occurred. 5. An interview with the administrator, Director of Nursing (DON), and alternate Director of Nursing (ADON) was conducted on 8/26/20 at 9:13 AM. During the interview, the agency was unable to state how the agency determined if they were unable to meet the patient's needs, such as a certain number or percentage of missed visits in a certification period. The agency staff failed to provide further evidence regarding frequent missed visits and failure to meet patient needs for patients #2 and #6. 17-13-1(a)			
G 0574 Bldg. 00	484.60(a)(2)(i-xvi) Plan of care must include the following The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.			

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	(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 may choose to include.			
	Based on record review and interview, the home health agency failed to ensure the plan of care (POC) included all pertinent diagnoses, the patient's mental, psychosocial, and cognitive status, types of services required, frequency and duration of visits to be made, the patient's rehabilitation potential, activities permitted, a complete and accurate list of the patient's medications, all safety measures to protect against injury, all necessary interventions to address a patient's risk factors for emergency department visits and hospital re-admission, patient and caregiver education and training to facilitate timely discharge, and patient-specific and measurable goals for 5 of 5 active records reviewed (# 1, 2, 3, 6, 8), in a total sample of 8 records. Findings include: 1. An undated agency policy titled "Plan of Care," number C-580, stated " ... The Plan of Care is based on a comprehensive assessment and information provided by the client/family ... Special Instructions ... 2. The Plan of Care shall be completed in full to include: a. All pertinent diagnosis(es) [sic] ... b. Mental status. c. Type, frequency, and duration of all visits/services ... h. Rehabilitation potential ... j. Activities permitted or restrictions ... l. Medications ... n. Any safety measures to protect against injury. o. Instructions	G 0574	See responses to G 528, 530, 534, and 536. RNCMs were inserviced on 10/5 and 10/19 on the aspects of an individualized plan of care. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	11/02/2020

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to client/caregiver p. Treatment goals q. Instructions for timely discharge or referral. r. Discharge plans ..."

2. The complete clinical record of Patient #1 was reviewed on 8/18/20 and 8/24/20, and indicated a start of care date of 6/22/18. The clinical record contained a Plan of Care (POC) for the certification period of 8/10/20 - 10/8/20.

The POC indicated the patient's "Principal" diagnosis was "Post-traumatic stress disorder [PTSD]." It also listed the patient's "Cognitive/Psychosocial Status" as "forgetful." The POC failed to include the diagnosis of PTSD within the patient's psychosocial status.

The POC included the order for "[Type of insurance] SN [Skilled Nurse] one visit every other for medication tray set-up, monitor compliance, facilitate medication changes and refills, VS [vital signs], physical assessment, and report any abnormal findings to MD." The POC failed to indicate the duration of skilled nurse visits for this certification period.

The POC included a section titled "Discharge Plans," which stated "Discharge Planning: Likely Status: The likely discharge planning status is that:patient will remain in current living situation with ongoing assistance provided by:Federal Government, State Government. no realistic discharge in foreseeable future. [Situations that would lead to discharge include] client ... request, loss of payer source, institutionalization, death [sic]." The POC failed to include patient discharge planning and education to facilitate a timely discharge.

The POC included a section titled "Goals," which

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	stated "Client will remain in their current living situation in a safe manner with all needs met via identified and coordinated resources and our agency caregiver assistance. Client with monitor his bs [blood sugars] more closely and keep them under 200. Client will have no falls. Client will be compliant with his diet." The POC failed to include patient-specific and measurable goals with attainable dates. A comprehensive recertification assessment for this certification period was completed by the alternate Director of Nursing (ADON) on 8/10/20. The comprehensive assessment included a "Medication Profile" reviewed and signed by the ADON on 8/5/20. The medication list included current patient medications Fluticasone (taken for allergies), Albuterol HFA (taken for asthma), Simvastatin (taken for high cholesterol), Cialis (taken for Erectile Dysfunction) which failed to evidence an indication, Testosterone Cypionate (taken for low testosterone levels), Topiramate (taken for "headaches"), Gabapentin (taken for "pain"), Ropinirole (taken for "RLS" [Restless Leg Syndrome]), Flomax (taken for an enlarged prostate), Trazodone (taken for insomnia), Myrbetiq (taken for overactive bladder), Finasteride (taken for enlarged prostate), and Omeprazole (taken for gastro-esophageal reflux disorder [GERD]). Patient #1's POC failed to include diagnoses associated with the above medications. 3. The complete clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20, and indicated a start of care of 8/22/19. The clinical record included a POC for the certification period of 6/17/20 - 8/15/20, as well as a comprehensive recertification assessment completed on 6/11/20 by Employee N, RN. This comprehensive			

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assessment indicated the patient had diagnoses of tachycardia (elevated heart rate) and urinary incontinence (involuntary loss of urine), however the POC failed to include these diagnoses.

The POC included an order for the medication "Ibuprofen [used for pain or fever] 200 mg 1 tab q [every] 4 hrs [hours] PRN PO," which failed to evidence an indication.

The POC included a section titled "Discharge Plans" which stated "Discharge Planning: Likely Status: The likely discharge planning status is that: patient will remain in current living situation with ongoing assistance provided by: Federal Government, State Government. patient will likely remain with long term care needs, no realistic discharge in foreseeable future. [Situations that would lead to discharge include] Client request, Loss of payer sources, Institutionalization, Death. Level of assistance anticipated that will be needed upon discharge, N/A [sic]." The POC failed to include patient discharge planning and education to facilitate a timely discharge.

The POC included a section titled "Goals," which stated "Client will remain in their current living situation in a safe manner with all needs met via identified and coordinated resources and our agency caregiver assistance. Client will have integument remain intact (areas that are already intact), be free from systemic or local infection, and be free from injury falls [sic]. The client's hygiene and personal care needs will be met with the assistance of the home health aide and our coordinated resources as needed." The POC failed to include patient-specific and measurable goals with attainable dates.

4. The complete clinical record of Patient #3 was

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reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record included a POC for the certification period of 7/16/20 - 9/13/20, as well as a comprehensive recertification assessment completed on 7/15/20 by Employee L, RN. The comprehensive assessment completed on 7/15/20 included a "Medication Profile" for Patient #3, reviewed and signed by Employee L on 5/18/20 and 7/20/20. The medication list indicated the patient's current medications included Linzess (taken for constipation secondary to opioid use), Cymbalta (taken for depression), and Tramadol (taken for pain). The patient's POC failed to indicate diagnoses for the above medications.

The POC contained the order for skilled nursing visits "13 units for medication set up every week for medication compliance, super pubic [sic] catheter management and care. Disease education." The POC also included a "60 day summary," which stated "[Patient #3] requires assistance for bathing, and ADLs [Activities of Daily Living] which he through [sic] waiver program, [Home Nursing Services] is working on filling hours at present." The POC failed to indicate visit frequency and duration for skilled nursing and home health aide visits.

The POC indicated the patient's "Activities Permitted" were "Wheelchair and No Restrictions." The POC also included a "60 day summary," which stated "Patient is non-ambulatory, but does transfer with 1 person bearing some wt [weight]." The POC failed to include a complete and accurate list of patient activities permitted.

The POC indicated the patient's "Safety Measures" included "Universal precautions. Slow position changes. Frequent positioning/turning.

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Biohazard to be disposed in biohazard container/bag. Call 911 for emergencies. Fall Risk Impression: Overall functional fall risk impression: High fall risk." The comprehensive assessment completed on 7/15/20 by Employee L, RN, stated "Client ... has ... super pubic catheter with history of catheter disfunction, and UTIs [sic]." The POC failed to include safety measures for the patient's increased risk for infections, specifically catheter-associated urinary tract infections (CAUTIs).

The POC indicated the patient's risk for hospitalization was "moderate." The POC failed to indicate measures taken to address the patient's underlying risk factors which resulted in an increased risk for hospitalization.

The POC included a section titled "Discharge Plans," which stated "Discharge Planning: Likely Status: The likely discharge planning status is that: no realistic discharge in foreseeable future. [Situations which would lead to discharge include] client request, lack of payer source, institutionalization or death [sic]." The POC failed to indicate discharge planning or education to facilitate a timely discharge.

The POC included the section titled "Goals," which stated "ELIMINATION GI/GU [Gastrointestinal / Urogenital] GOALS ... Patient's catheter will remain patent and free from infection: by end of certification period. Patient's urinary elimination needs will be met: via proper catheterization, by end of certification period. Patient's urinary output will be: within desired range, by end of certification period. Patient's perineal area will remain clean and free from infection: by end of certification period. DISEASE MANAGEMENT GOALS ... Patient and

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	caregivers will demonstrate proper understanding of disease and disease management for: indwelling catheter, S.P [suprapubic], via by end of certification period. Patient's condition of: will be properly managed via, by end of certification period. Goal is Client's catheter is functional between monthly catheter changes and Client stay infection free. MEDICATION GOALS ... Patient will obtain proper medication dose and frequency as ordered via compliancy and: effective medication reminder/delivery system. Medications dose, timing, intent will be effective as evidenced by: signs and symptoms stable and controlled. MUCULAR-SKELETAL: GOALS ... Patient's muscular-skeletal system will be stable and have progressed to a point where patient and or caregivers can safely monitor and mitigate without intermittent skilled home visits: As evidenced by, Proper weight bearing as ordered. by end of certification period [sic throughout]." The POC failed to include individualize, patient-specific, and measurable goals with attainable dates. 5. The complete clinical record of Patient #6 was reviewed on 8/24/20 and 8/25/20. The clinical record indicated a start of care of 12/31/98, and included a Plan of Care for the certification period of 7/1/20 - 8/29/20. The comprehensive recertification assessment for this certification period was completed on 6/29/20 by Employee N, RN. The certification assessment indication the patient had a history of seizures, and diagnoses of aggressive behaviors and left-sided hemiplegia (paralysis on one side of the body) but these diagnoses were not included in the POC. The comprehensive assessment also included a "Medication Profile," which indicated the patient's current medications included			

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	Bisacodyl (taken for constipation), Diazepam (taken for anxiety), Docusate Sodium (taken for constipation), Levoxyl (taken for underactive thyroid), and Omeprazole (taken for GERD). The patient's plan of care failed to indicate diagnoses of constipation, anxiety, underactive thyroid, and GERD. The POC included the orders for "RHHA [Respite Home Health Aide] up to 60 hours/month to assist with bathing, dressing, grooming, hair/nail/skin/oral care, deodorant, checking pressure areas, foot care, elimination assist, ambulation assist, mobility assist, meal prep and feeding, encourage fluids, equipment care, general supervision and any other ADLS/IADLS [Instrumental Activities of Daily Living] to keep the client safe in her home. Authorization through 12/31/20," and "ATTC [Attendant Care] up to 30hours/week [sic] to assist with bathing, dressing, grooming, hair/nail/skin/oral care, deodorant, checking pressure areas, foot care, elimination assist, ambulation assist, mobility assist, meal prep and feeding, encourage fluids, equipment care, general supervision and any other ADLS/IADLS [Instrumental Activities of Daily Living] to keep the client safe in her home. Authorization through 12/31/20." The orders for respite home health aide and attendance care failed to indicate frequency and duration of RHHA and ATTC visits, as well as how visits are to be requested or scheduled. The POC included "Safety Measures" to be implemented as "Moderate fall risk. Universal precautions. Supervision at all times. Call 911 for emergencies, Clean Technique, Clear Pathways." The POC failed to indicate seizure precautions were implemented for the patient.			

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The POC included a section titled "Discharge Plans," which stated "Discharge Planning: Likely Status: The likely discharge planning status is that: patient will remain in current living situation with ongoing assistance provided by: Federal Government, State Government. patient will likely remain with long term care needs, no realistic discharge in foreseeable future. [Situations which would lead to discharge include] Family request, Loss of payer sources, Institutionalization, Death. Level of assistance anticipated that will be needed upon discharge, N/A [sic]." The POC failed to indicate patient and family discharge planning and education to facilitate a timely discharge.

The POC included a section titled "Goals," which stated "Client will remain in their current living situation in a safe manner with all needs met via identified and coordinated resources and our agency caregiver assistance. The client's hygiene and personal care needs will be met with the assistance of the home health aide and our coordinated resources as needed." The POC failed to indicate individualized, patient-specific, and measurable goals with an attainable date.

6. The complete clinical record of Patient #8 was reviewed on 8/24/20. The clinical record indicated a start of care of 4/8/08, and included a Plan of Care for the certification period of 8/11/20 - 10/10/20.

The comprehensive recertification assessment for this certification period was completed on 8/7/20 by Employee E, RN. The comprehensive assessment included a medication list which included Pulmicort (taken for asthma), Clonazepam (taken for anxiety), Provigel (documented use for "ADHD [Attention Deficit Hyperactivity Disorder]"), Singular (taken for asthma), Milk of

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	Magnesia (taken for constipation), Execederin [sic] (taken for pain), Tylenol (taken for pain), Advil (taken for pain), Propanol (documented use listed as "beta blocker," can be taken for high blood pressure, tremors, angina, and irregular heart rhythms), Loperamide (taken for diarrhea), Pepto Bismol (taken for diarrhea), Floranex (taken for seasonal allergies), Flonase (taken for seasonal allergies), Famotidine (taken for GERD), and Suphedrine Plus (taken for allergies). The patient's POC failed to indicate diagnoses for the above medications. The POC failed to indicate Patient #8's cognitive and psychosocial status, as well as the patient's rehabilitative status. The POC included the orders for "SN [Skilled Nurse] 3 visits/week to give meds via g tube per protocol listed below while mother is at work. physical [sic] assessment, vital signs, monitor pain if present. Report any abnormal findings to the case manager." The POC failed to indicate duration of SN visits. The POC included the section titled "Discharge Plans," which stated "Discharge Planning: Likely Status: The likely discharge planning status is that: patient will remain in current living situation with ongoing assistance provided by: State Government. patient will likely remain with long term care needs, no realistic discharge in foreseeable future. Level of assistance anticipated that will be needed upon discharge, N/A [sic]." The POC failed to indicate patient discharge planning and education to facilitate a timely discharge. The POC included the section titled "Goals," which stated "NEUROLOGICAL GOALS ...			

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	Patient's neurological system will be stable and have progressed to a point where emergency services or hospitalization will be unlikely: As evidenced by, No seizures observed or reported for a period of . GENERAL / POC GOALS ... Through proper communication, coordination of services, skilled O/A [observation / assessment] on each skilled visit, and appropriate care the patient will: will have prompt non-hospital medical attention to quickly and effectively mitigate any medical situations that can be coordinated and completed without hospitalization. This client will have no choking episodes while HNS [Home Nursing Services] is present. The g tube will remain patent. The client will be able to communicate her needs to HNS staff, including need for bathroom. thru verbal and non-verbal means. The client will continue to go on outings in the community. The client will have no falls, injuries, infections, or hospitalizations during this cert. period. The client will have no impairment of skin integrity. The client will have no seizures. The client will have less leg pain due to repositioning and ROM [Range of Motion] from HHAs. The client will go outside more as weather warms. during the course of treatment / plan of care [sic throughout]." The POC failed to indicate the patient-specific, individualize, and measurable goals that included attainable dates. 7. An interview was conducted with the administrator, alternate administrator, director of Nursing (DON), and ADON on 8/25/20 at 3:47 PM. During the interview, the Director of Nursing indicated the plan of care should include frequency and duration of visits ordered for all services, patient-specific and measurable goals, and infection control measures listed within the Safety Measures for patients that are high risk for infection. The ADON indicated patient and family			

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	education to facilitate a timely discharge is not required within the plan of care, as "most of" the agency's patients are not "planned discharge" because they require long-term care, and the agency is unable to "teach or train" the patient or family. 17-13-1(a)(1)(B), 17-13-1(a)(1)(C), 17-13-1(a)(1)(D) (I, ii, iii, v, vii, ix, x, xi)			
G 0580 Bldg. 00	484.60(b)(1) Only as ordered by a physician Drugs, services, and treatments are administered only as ordered by a physician. Based on observation, record review and interview, the home health agency failed to ensure the skilled nurse and home health aide did not provide services absent a physician order for 3 of 5 active records reviewed (#1, 2, 3), in a total sample of 8 records. Findings include: 1. An undated agency policy, titled "Physician Orders," number C-635, stated " ... All medications, treatments, and services provided to clients must be ordered by a physician, physician assistance, nurse practitioner, or clinical nurse specialist ..." An undated agency policy, titled "Plan of Care," Policy #C-580, stated "...Signed physician orders will be obtained as quickly as possible ..." 2. The clinical record of Patient #1 was reviewed on 8/18/20 and 8/24/20, and indicated a start of care date of 6/22/18. The clinical record contained a Plan of Care (POC) for the certification period of 8/10/20 - 10/8/20, which was signed by Employee N, Registered Nurse (RN), on 6/15/20. As of 8/25/20, the agency failed to obtain a verbal or	G 0580	Agency has hired a new Medical Records Coordinator who is responsible for sending the “No Interruption of Service” order, written by the RNCM, to the client’s physician, and placing it in their chart. RNCM were inserviced on 10/5 and 10/19 on how to write the “No Interruption of Service” order. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	11/02/2020

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written order for continuation of home health services from the patient's ordering physician. A home visit observation of Employee E, Registered Nurse (RN), providing skilled nurse care to Patient #1 was performed on 8/18/20 at 3:00 PM (without an order).

3. The clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20, and indicated a start of care of 8/22/19. The clinical record included a POC for the certification period of 6/17/20 - 8/15/20, which was signed by the patient's physician on 6/25/20. The clinical record indicated the patient received home health aide services on 6/17/20, 6/18/20, 6/19/20, 6/20/20, 6/21/20, 6/22/20, 6/23/20, and 6/24/20, however the clinical record failed to indicate a verbal or written order for continuation of home health services was obtained by the agency RNs between 6/17/20 and 6/25/20.

4. The clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record included a POC for the certification period of 7/16/20 - 9/13/20. The POC included a "60 day summary" which stated "[Patient #3] requires assistance for bathing, and ADLs which he through [sic] waiver program, [Home Nursing Services] is working on filling hours at present." The POC failed to include an order for home health aide services. The clinical record indicated the patient received home health aide services on 7/16/20, 7/17/20, 7/18/20, 7/20/20, 7/22/20, 7/23/20, 7/24/20, 7/25/20, 7/27/20, 7/28/20, 7/29/20, 7/30/20, 7/31/20, 8/1/20, 8/2/20, 8/3/20, 8/4/20, 8/5/20, 8/6/20, 8/8/20, 8/10/20, 8/11/20, 8/12/20, 8/13/20, 8/14/20, 8/15/20, 8/17/20, 8/18/20, and 8/19/20.

5. An interview was conducted with the

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	administrator, alternate administrator, director of Nursing (DON), and alternate Director of Nursing (ADON) on 8/25/20 at 3:47 PM. During the interview, the ADON indicated a verbal order for continuation of home health services should be obtained by the RN if a POC or written order signed by the patient's physican was not received by the start of a new certification period. The ADON indicated the verbal order should be documented by the receiving RN in a progress note or coordination of care note. 17-13-1(a)			
G 0592 Bldg. 00	484.60(c)(2) Revised plan of care 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 home health agency failed to ensure the revised plan of care contained the patient's progress towards their goals for 5 of 5 active records reviewed (#1, 2, 3, 6, 8), in a total sample of 8 records. Findings include: 1. An undated agency policy, titled "Plan of Care," Policy #C-580, stated " ... The Plan of Care ... will be consistently reviewed to ensure that client needs are met, and will be updated as necessary ... At the time of ... recertification, a written summary of the client's current status ... are submitted with the plan of care ... The summary shall include ... client response to care/services and outcome of care and services	G 0592	RNCMs were inserviced on 10/5 and 10/19 to include patient directed strengths and goals, and progress towards stated goals. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	11/02/2020

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	..." 2. The clinical record of Patient #1 was reviewed on 8/18/20 and 8/24/20, and indicated a start of care date of 6/22/18. The clinical record contained a Plan of Care (POC) for the certification period of 8/10/20 - 10/8/20. The POC failed to indicate Patient #1's progress towards their goals and outcomes. 3. The clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20, and indicated a start of care of 8/22/19. The clinical record included a POC for the certification period of 6/17/20 - 8/15/20. The POC failed to indicate Patient #2's progress towards their goals and outcomes. 4. The clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record included a POC for the certification period of 7/16/20 - 9/13/20. The POC failed to indicate Patient #3's progress towards their goals and outcomes. 5. The clinical record of Patient #6 was reviewed on 8/24/20 and 8/25/20, and indicated a start of care of 12/31/98. The clinical record included a POC for the certification period of 7/1/20 - 8/29/20. The POC failed to indicate Patient #6's progress towards their goals and outcomes. 6. The clinical record of Patient #8 was reviewed on 8/24/20, and indicated a start of care of 4/8/08. The clinical record included a POC for the certification period of 8/11/20 - 10/10/20. The POC failed to indicate Patient #8's progress towards their goals and outcomes. 7. An interview was conducted on 8/25/20 at 3:47 PM with the agency's administrator, alternate			

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	administrator, Director of Nursing (DON), and ADON. During the interview, the DON indicated the plan of care should contain the patient's progress towards their goals.			
G 0608 Bldg. 00	484.60(d)(4) Coordinate care delivery Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the home health agency failed to complete coordination of care with other agencies who provided services to the agencies patients for 3 of 3 records reviewed of shared patients (#1, 2, 3). Findings include: 1. The undated agency policy, titled "Coordination of Client Services and Missed Visits," stated " ... Purpose ... To establish effective ... coordination of client care ... To ensure continuity of care ... Special Instructions ... 3 ... the admitting Registered Nurse shall ... ensure ... f. Coordination with other agencies ...." 2. The clinical record of Patient #1 was reviewed on 8/18/20 and 8/24/20, and indicated a start of care date of 6/22/18. The clinical record contained a coordination of care agreement between Home Nursing Services and Entity J, a personal care attendant agency, dated 10/28/19. The coordination of care agreement indicated Home Nursing Services would provide Nursing services, and Entity J would provide attendant care services. The record failed to evidence any additional coordination of care was completed between the two entities.	G 0608	RNCMs were inserviced on 10/5 and 10/19 to maintain communication with agencies that provide concurrent care to our clients, as well as documenting date, nature of conversation, and other agency representative. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	11/02/2020

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	3. The clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20 and indicated a start of care date of 8/22/19. The clinical record contained a shared patient agreement, dated 5/1/2020, between the home health agency and Entity K, a waiver home services agency. The record failed to evidence any additional coordination of care was completed between the two entities.			
	4. The clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record contained a coordination of care agreement, undated, between Home Nursing Services and Entity L, a home care services agency. The coordination of care agreement indicated Home Nursing Services would provide nursing and respite HHA services, and Entity L would provide attendant care services. The record failed to evidence any additional coordination of care was completed between the two entities.			
	5. An interview was conducted with the administrator, alternate administrator, Director of Nursing (DON), and alternate Director of Nursing (ADON) on 8/25/20 at 3:47 PM. During the interview, the DON indicated the agency coordinated home care services for shared patients by calling the other agency and "we ... talk to them and tell them what we're going to do, ask what they're going to do," then complete a care coordination form.			
G 0642 Bldg. 00	484.65(a)(1),(2) Program scope 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			

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	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 indicate its quality assurance and performance improvement (QAPI) program documented which quality indicators it would track, and failed to indicate the frequency and method in which quality indicators were to be measured, analyzed, and tracked with an emphasis of infection control due to the public health emergency related to COVID-19. Findings include: 1. An undated agency policy, titled "Quality Assessment and Performance Improvement," stated "... Purpose: ... To identify indicators for improvement in the quality of care, treatment, and services ... Special Instructions ... 2. Data will be collected to allow Home Nursing Services to monitor its performance. Data will be collected, measured, and analyzed. The goal is to decide the statistical control methods, agree on how data will be collected and determine how it will be measured ..." 2. An agency document titled "Home Nursing Services Quality Management First Quarter 2020" was reviewed on 8/26/2020. The document indicated "HNS [Home Nursing Services] Agenda, Old business, Minutes, New Business, Census, 3rd Party Audits, HNS Policy Manual (QI Manual), HIPAA (Health Insurance Portability	G 0642	The agency will prepare a QAPI program meeting with an emphasis on infection control including elements to measure, analyze, and track. The Alternate Clinical Director will report the infection control and COVID-19 tracking sheets during the bi-weekly RNCM meetings to ensure accuracy. The Clinical Director is responsible for overseeing the infection control program. The QAPI program will be implemented by 11/2/2020.	11/02/2020

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	and Accountability Act), New Forms, Skin Integrity Program, Client Stats, HR Stats ... Client Hospitalizations ...Infection Reports ... Infection Control Observations and Recommendations ... Admission & Discharges ... Physician List ... Discharge Reasons ... Client Complaints." The agency document failed to indicate the date the meeting was held, the agency staff present for the meeting, the quality measures that had been and/or were. to be monitored, and how those quality measures were to be measured and analyzed. 3. An interview was conducted on 8/27/20 at 12:45 PM with the administrator, Director of Nursing (DON), and Alternate Director of Nursing (ADON). During the interview, the DON indicated the "Quality Management" committee is over the agency's QAPI program, and this committee consists of the "administrator ... [DON] ... assistant recruitment director ... HR coordinators ... client service coordinators ... Registered Nurse [RN] case managers." The DON also indicated the agency's QAPI quality indicators included "Audit admissions, audit discharges, audit 10% of census every quarter ... infections, incidents, client and employee complaints, and infections." The administrator indicated the agency's QAPI quality indicators also included "falls." The DON indicated these quality indicators are measured "weekly with the nurses," and the DON indicated she was in charge of approving the frequency and method of data collection for the quality indicators. 17-12-2(a)			
G 0682 Bldg. 00	484.70(a) Infection Prevention Standard: Infection Prevention.			

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	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 indicate all employees followed agency infection control policies and procedures and standard precautions for 3 of 3 home visit observations (#1, 3, 8). Findings include: 1. An undated agency policy, titled "Handwashing/Hand Hygiene," Policy #D-330, stated " ... Indications for hand washing and hand antisepsis: ... d. Between tasks on the same client ... f. After removing gloves ... Hand Hygiene technique ... 2. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands and rub hands together vigorously for at least 40 -60 seconds, covering all surfaces of hand and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel ..." An undated agency policy, titled "Care of Suprapubic Catheter," stated " ... cleaning of the [suprapubic catheter] site may be done by Home Health Aide [HHA] ... Procedure. Catheter Care: ... 15. Remove old dressing and discard 16. Remove gloves. 17. Wash hands. 18. Put on gloves ... 20. Cleanse the stoma site using circular motions ..." An undated agency policy, titled "Administering Medications through a Gastrostomy Tube [G-tube]," stated " ... Procedure ... 3. Assemble equipment and position the client to expose gastrostomy tube ... 5. Wash hands ... Don clean	G 0682	Agency has revised hand washing policy from 40-60 seconds to at least 20 seconds in accordance with the CDC guidelines. All employees were inserviced in March on proper hand hygiene, including proper glove donning and doffing, in response to COVID-19, so only employees observed in this survey will be trained and techniques reviewed. RNCMs will continue to monitor during supervisory visits and agency will continue to address hand hygiene in annual inservices. The Clinical Director is responsible for overseeing hand hygiene program. The Alternate Clinical Director will meet with surveyor-observed employees by 10/30/2020.	10/30/2020

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gloves ... 8. Administer medications ..."

2. A home visit observation was conducted with Patient #1 (Start of Care 6/22/18) on 8/18/20 at 3:00 PM, and Employee E, Registered Nurse (RN), was observed providing skilled care. Upon entering the home, Employee E performed hand hygiene by washing her hands with soap and water for 40 seconds. After she scrubbed her hands with soap, the RN rinsed her hands under water, dried her hands with a paper towel, turned off the faucet with the paper towel, and then used the same paper towel again to dry her hands. While setting up the patient's medication trays, the RN removed her gloves, threw the old gloves in the trash, and immediately put on new gloves. After the RN completed the medication tray set up, she removed her gloves, removed the labels off of empty medication bottles, obtained the patient's home binder, removed the patient's outdated plan of care from his home binder and replaced it with an updated plan of care from her nursing bag, reviewed the patient's home binder with the surveyor, returned the patient's medication bottles to where they were stored, then performed hand hygiene by washing her hands with soap and water. During this hand washing, the RN scrubbed her hands with soap for 21 seconds, then rinsed and dried her hands. After she completed a physical assessment, the RN prepared to leave the visit. She performed hand hygiene by washing her hands with soap and water, but only scrubbed her hands with soap for 17 seconds before rinsing and drying her hands. The RN failed to scrub her hands for 40-60 seconds per agency policy with every hand washing, and failed to perform hand hygiene immediately after she removed her gloves.

3. A home visit observation was conducted with

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	Patient #3 (Start of Care 11/19/19) on 8/20/20 at 9:40 AM, and Employee M, HHA. During the visit, the HHA went to the patient's sink to wash her hands. The HHA turned on the faucet, applied soap, scrubbed her hands for 22 seconds, rinsed, dried her hands with a paper towel, and then turned the faucet off with the paper towel. Later on during the visit, the HHA performed catheter care to the patient's suprapubic catheter. With gloves on, the HHA removed the gauze from around the catheter insertion site, threw the gauze away, applied soap to a washcloth, wiped around the stoma (surgically created opening in the lower abdomen where the suprapubic catheter is inserted) in side to side motions, repositioned the washcloth, and then wiped the stoma with the washcloth in downward motions. The HHA failed to scrub her hands for 40-60 seconds per agency policy when she performed hand hygiene, failed to remove her gloves and perform hand hygiene after removing the gauze from around suprapubic catheter, and failed to clean the patient's suprapubic catheter using circular motions from the stoma site outward. 4. A home visit observation was conducted with Patient #8 (Start of Care 4/8/08) on 8/24/20 at 7:50 AM, and Employee O, Licensed Practical Nurse (LPN). During the visit, the LPN retrieved the patient's medications to be administered, crushed the medications and mixed them with water, retrieved her stethoscope and blood pressure cuff from her nursing bag, put on gloves, and went to the patient's bedside. After the LPN obtained the patient's vital signs and performed a physical assessment, she left the patient's room, placed her blood pressure cuff back into her nursing bag, primed the tubing used for medication administration, took the tubing and medications to the patient's bedside, and administered the			

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	patient's medications through the G-tube. After the LPN competed the medication administration, she left the patient's room, rinsed out the medication cup and tubing used, placed her stethoscope back into her nursing bag, retrieved her tablet from the nursing bag, documented her visit on the tablet, returned the tablet to her nursing bag, and removed her gloves. The LPN failed to perform hand hygiene in between patient tasks, failed to perform hand hygiene and don clean gloves prior to administration of medications through the patient's G-tube, failed to clean the used stethoscope, blood pressure cuff, and tablet prior to returning them to her nursing bag, and failed to remove her gloves and perform hand hygiene after she completed patient care. 5. An interview was conducted on 8/24/20 at 4:05 PM with the administrator, director of nursing (DON), Employee E, RN, and Employee K, HR Coordinator. During the interview, Employee K stated when performing hand hygiene with soap and water, hands should be scrubbed with soap for "40- 60 seconds" prior to rinsing. Employee E indicated equipment used during a home visit should be cleaned prior to placing the equipment in the nursing bag, and when performing hand hygiene with soap and water, an employee should not dry their hands with a paper towel that had been previously used to turn off a faucet. The DON indicated staff should perform hand hygiene and apply clean gloves immediately prior to administering medications through a G-tube, staff should perform hand hygiene immediately after removing gloves, and catheter care should be performed in "circular motions." 17-12-1(m)			

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G 0684 Bldg. 00	484.70(b)(1)(2) Infection control Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention.			
	Based on record review and interview, the home health agency failed to ensure an agency-wide infection control program was maintained for the surveillance, identification, prevention, control, and investigation of patient and staff infections, for 13 active patients (Patients #3, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25) and 2 discharged patients (Patients #7, 16) documented on the agency infection control logs, and had the potential to effect all agency patients. Findings include: 1. An undated agency policy, titled "Infection Control Surveillance," number B-402, stated "Home Nursing Services will establish a continuous data monitoring and collecting system to detect infections or identify changes in infection trends ... Home Nursing Services will attempt to identify the source of infection to determine if it was acquired while the client was receiving home care (agency-acquired), from the	G 0684	Alternate Clinical Director has computerized the infection control-tracking sheet, with columns added to record employees involved. Similarly, the Alternate Clinical Director's COVID-19 tracking sheet has also been converted to an Excel form with columns for symptoms and patients to be contacted in event of reported fevers or other COVID-19-like symptoms. The Alternate Clinical Director will report the infection control and COVID-19 tracking sheets during the bi-weekly RNCM meetings to ensure accuracy. The Clinical Director is responsible for overseeing the infection control program. The tracking sheets will be	10/30/2020

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	community (community-acquired), or during a recent inpatient facility stay (nosocomial) ..." An undated agency policy, titled "Infectious Disease Reporting," number B-415, stated " ... When infections are identified and reported on the Infection Control Log, an investigation is conducted to determine possible causes ..." 2. A review of the agency's Infection Control log was conducted on 8/19/20. The log included forms titled "Home Nursing Services Infection Report" for Patient #3 (start of care 5/18/20) completed on 4/28/20 and 7/15/20 by Employee L, Registered Nurse (RN). The infection report forms indicated the patient was diagnosed with a urinary tract infection (UTI) on the date of completion of the form, and also indicated the patient had a urinary catheter. The infection report forms failed to indicate an agency investigation had been performed to determine the source of the infection, and failed to determine which employees provided care to the patient prior to his diagnosis of infection. The agency's Infection Control log contained two "Home Nursing Services Infection Report" forms for Patient #13 (start of care 11/26/14), dated "May 26" (no year noted) and "June 8" (no year noted), completed by Employee L. The infection report forms indicated the patient was diagnosed with a UTI on the date of completion of the form, and also indicated the patient had a urinary catheter. The infection report forms failed to indicate an agency investigation had been performed to determine the source of the infection, and failed to determine which employees provided care to the patient prior to her diagnosis of a UTI. 3. A review of the agency's patient and employee		computerized by 10/30/2020.	

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COVID-19 employee tracking form was conducted on 8/19/20. The patient and employee COVID-19 tracking form indicated Employee U was tested for COVID-19 on 6/28/20. The tracking form indicated Employee U had contact with Patients #14 (Start of Care 7/15/13), #15 (Start of Care 7/1/19), #16 (Date of Discharge 7/21/20) , #17 (Start of Care 6/3/17), #18 (Start of Care 6/20/11), and #19 (Start of Care 7/28/18), but failed to include the date of last patient contact by Employee U with each patient. The tracking form also indicated Patients #14, 17, and 18 were noted to be "Afeb [Afebrile, do not have a fever]" on 7/6/20; Patient #15 was noted as "Neg [negative] tested at hosp. [hospital]" (no date on this documentation), Patient #16 was noted to be inpatient at a local hospital (no date on this documentation), but failed to document any follow up with Patient #19. The agency's employee and patient COVID-19 infection tracking record failed to indicate the patients were asked if they had any symptoms of COVID-19, and failed to indicate the patients were followed up with immediately after the employee was tested for COVID-19.

The agency's patient and employee COVID-19 tracking form indicated Employee X was tested for COVID-19 on 7/6/20. The tracking form indicated Employee X had contact with Patients #13, #20 (Start of Care 11/4/19), #21 (Start of Care 5/16/18), #22 (Start of Care 10/7/19), #23 (Start of Care 8/19/19), and #24 (Start of Care 6/13/18), but failed to include Employee X's date of last patient contact with each patient. The tracking form indicated a temperature for Patient #21 was noted to be 97.7 on 7/5/20 (1 day prior to the date Employee X was placed under quarantine), a temperature for Patient #20 was noted to be 97.4 on 7/12/20, a temperature for Patient #13 was noted to be 97.4 on 7/13/20, a temperature for

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Patient #22 was noted to be 98.1 on 7/13/20 and 98.6 on 7/21/20, a temperature for Patient #23 was noted to be 97.7 on 7/13/20, and a temperature for Patient #24 was noted to be 98.1 on 7/15/20. The agency's employee and patient COVID-19 infection tracking record failed to indicate the patients were asked if they had any symptoms of COVID-19, and failed to indicate the patients were followed up with immediately after the employee was tested for COVID-19.

The agency's patient and employee COVID-19 tracking form indicated Employee Y was reported a fever of 101 on 7/15/20. The tracking form indicated Employee X had contact with Patients #7 (Date of Discharge 7/21/20), #14 (Start of Care 7/15/13), #15 (Start of Care 7/1/19), and #25 (Start of Care 10/9/19), but failed to include Employee X's date of last patient contact with each patient. Patient #15 was noted to be "tested at the hospital - Neg." The agency's employee and patient COVID-19 infection tracking record failed to indicate Patients #7, 14, and 25 were followed up with, failed to indicate any of the patients were asked if they had any symptoms of COVID-19, and failed to indicate the patients were followed up with immediately after the employee reported a fever.

5. An interview was conducted with the administrator, director of Nursing (DON), and Alternate Director of Nursing (ADON) on 8/19/20 on 4:30 PM. During the interview, the ADON indicated the agency tracked employees who provided care to patients who reported symptoms of upper and lower respiratory infections, but did not tack employees who provided care to patients who developed other infections, which included UTIs. The DON indicated the agency did not had any Performance Improvement Projects (PIP)

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	related to reducing the number of catheter-acquired urinary tract infections (CAUTIs). 6. An interview was conducted with the administrator, DON, and ADON on 8/27/20 at 12:45 PM. During the interview, the ADON indicated the agency did not have a set timeframe in which patients were to be notified and assessed when an employee who provided care for the patient was tested or reported symptoms of COVID-19. The ADON stated "We got nurses popping in and out ... we were trying to get as many [patients] called as we can." The ADON also indicated the agency nurses were advised to call and "check on" the patients, but they were not advised to do so at a specific frequency, and were not advised to document the follow up.			
G 0798 Bldg. 00	484.80(g)(1) Home health aide assignments and duties Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist).			
	Based on record review, the registered nurse (RN) failed to ensure the home health aide (HHA) care plan was individualized with specific, not generic, tasks to be completed for 4 of 5 active records reviewed (#2, 3, 6, 8), in a total sample of 8 records. Findings include:	G 0798	The EMR program used to create the home health aide assignment and duties sheet has a frequency feature. On 10/5 and 10/19, RNCM were inserviced to utilize the frequency feature on all assignment sheets. During the QA process of the	10/30/2020

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	1. An undated agency policy, titled "Home Health Aide Supervision," Policy #C-340, stated " ... Home Nursing Services shall provide Home Health Aide services under the direction and supervision of a Registered Professional Nurse ... Special Instructions 1. The Nursing Supervisor or designated Registered Nurse will give the Home Health Aide direction for client care by way of the Service Plan ..." 2. The clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20, and indicated a start of care of 8/22/19. The clinical record indicated a plan of care for the certification period of 6/17/20 - 8/15/20, which contained an order for HHA services "2-4 hrs [hours]/day X [for] 7 days/week for up to 28 units/week to assist with bathing, dressing, grooming, deodorant, hair care, skin care, shave, nail care, oral care, foot care, ROM [Range of Motion], exercise, check pressure areas, meal prep, 2000 cal [calorie]/day intake, assist with meals-choking risk/food cut into small pieces, encourage fluids, encourage caloric intake, elimination assist, ambulation assist, mobility assist, all ADLs [Activities of Daily Living], and IADLs [Instrumental Activities of Daily Living] in order to keep the client in a clean and safe environment. Use lift device for all transfer and mobility needs." The clinical record contained a document titled "Plan of Care Service Plan (Confidential)," dated and signed as reviewed by Employee N, RN, on 6/11/20. The service plan stated "HHA ... Bath: Tub/Shower - use client's shower chair ... Hygiene: Personal Care, Assist with Dressing, Hair Care - Brush, Hair Care - Other, Hair Care - Shampoo, Skin Care, Foot Care (Hygiene), Check Pressure Areas, Shave, Groom, Deodorant, Nail Hygiene - Clean, Nail Hygiene - File, Nail Hygiene		home health aide sheets, staff will monitor to make sure the frequencies are indicated by the RNCM and recorded by the home health aides. Additionally, agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing chart audit program. Assignment sheets will have frequencies added by 10/30/2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157211	A. BUILDING 00 B. WING	08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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- Report, Oral Care - Brush, Elimination Assist - Use lift device ... Activity: Ambulation Assist - Wheelchair - lift device, ROM - Active, ROM - Passive, Exercise per PT [Physical Therapy] Care Plan, Mobility Assist ... Nutrition: Diet Order - regular, cut up food, meat in small pieces, watch for choking, 2000 calories/day, encourage caloric intake; Meal Preparation, Assist with Feeding, Encourage Fluids ... Other: Grocery shopping 1 x wk [week] take client to store if needed, Laundry, Light Housekeeping - Bathroom, Light Housekeeping - Bedroom, Light Housekeeping - Change bed linen, Light Housekeeping - Kitchen, Light Housekeeping - Living Areas, Equipment Care." The HHA care plan failed to indicate the frequency each task was to be performed, and failed to indicate which type of bath was to be performed (tub or shower).

3. The clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record included a POC for the certification period of 7/16/20 - 9/13/20. The POC failed to include an order for HHA services, but did state "[Patient #3] requires assistance for bathing, and ADLs which he through [sic] waiver program, [Home Nursing Services] is working on filling hours at present [sic throughout]."

The clinical record contained an unsigned document titled "Plan of Care Service Plan (Confidential)," which stated "Bath: Tub/Shower, Bed Bath - Partial, Bed Bath - Complete ... Hygiene: Personal Care, Assist with Dressing, Hair Care - Brush, Hair Care - Shampoo, Skin Care, Foot Care (Hygiene), Check Pressure Areas, Shave, Groom, Deodorant, Nail Hygiene - Clean, Nail Hygiene - File, Nail Hygiene - Report, Oral Care - Brush, Elimination Assist ... Procedure: Catheter Care - daily, Passive assist with meds

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	(water only) - daily ... Vitals: T [Temperature] - Oral / Axillary [underarm] / Rectal ... Activity: Ambulation Assist - Wheelchair, Mobility Assist, ROM - Active, ROM - Passive, Positioning - Encourage to turn q [every] hours [sic] ... Nutrition: Meal Preparation, Encourage Fluids ... Other: Grocery Shopping, Laundry, Light Housekeeping - Bathroom, Light Housekeeping - Bedroom, Light Housekeeping - Change bed linen, Light Housekeeping - Kitchen, Light Housekeeping - Living Areas, Equipment Care." The aide care plan failed to include the frequency each task was to be performed, except for catheter care and passive assist with medications. The aide care plan also failed to indicate which type of bath was to be completed (tub, shower, partial bed bath, complete bed bath) and the frequency the HHA was to encourage the patient to turn (such as every 2 hours). 4. The clinical record of Patient #6 was reviewed on 8/24/20 and 8/25/20, and record indicated a start of care date of 12/31/98. The clinical record included a POC for the certification period of 7/1/20 - 8/29/20. The POC contained orders for HHA services "2h [hours]/7d [days]/wk [week]," "RHHA [Respite HHA] services up to 60 hours/month," and "ATTC [attendant] up to 30hours/week." The clinical record contained a document titled "Plan of Care Service Plan (Confidential)," dated and signed as reviewed on 6/29/20 by Employee N, RN. The service plan stated "Discipline: HHA/RHHA/ATTC ... Bath: Bed Bath- Partial, Bed Bath - Complete ... Hygiene: Assist with Dressing, Hair Care - Brush, Hair Care - Shampoo, Skin Care, Foot Care (Hygiene), Check Pressure Areas, Groom, Deodorant, Nail Hygiene - Clean, Nail Hygiene - File, Nail Hygiene - Report, Oral			

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	Care - Swab - After meals, Elimination Assist - Every 1.5-2 hours with peri-care [perineal care, cleaning of the external genitalia and surrounding areas] ... Vitals: T - Oral / Axillary / Rectal ... Activity: Ambulation Assist - Wheelchair, Mobility Assist - Pivot transfers ... Nutrition: Diet Order - Pureed, Meal Preparation - Follow mother's instructions, Assist with Feeding - Client must be fed. **CHOKING/ASPIRATION RISK**, Encourage Fluids ... Other: Laundry, Light Housekeeping - Bathroom, Light Housekeeping - Bedroom, Light Housekeeping - Change bed linen, Light Housekeeping - Kitchen, Equipment Care - wheelchair, recliner, hospital bed." The care plan failed to indicate which tasks were to be performed by the different services (HHA, RHHA, and ATTC), failed to indicate the frequency each task was to be performed, and failed to indicate the type of bath (partial or complete bed bath) that was to be performed. 5. The clinical record of Patient #8 was reviewed on 8/24/20, and indicated a start of care of 4/8/08. The clinical record included a POC for the certification period of 8/11/20 - 10/10/20. The POC contained an order for "HHA 54 hours per week." The clinical record contained a document titled "Plan of Care Service Plan (Confidential)," dated and signed as reviewed on 8/11/20 by Employee E, RN, on 8/11/20. The service plan stated "Discipline: HHA ... Bath: Tub/Shower, Bed Bath - Partial, Bed Bath - Complete ... Hygiene: Personal Care, Assist with Dressing, Hair Care - Brush, Hair Care - Shampoo, Skin Care, Foot Care (Hygiene), Check Pressure Areas, Groom, Deodorant, Nail Hygiene - Clean, Nail Hygiene - File, Nail Hygiene - Report, Oral Care - Brush, Elimination Assist ... Vitals: T - Oral / Axillary / Rectal ... Activity: Ambulation Assist -			

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	Wheelchair - Electric Wheelchair, Mobility Assist, ROM - Passive - arms and legs, Positioning - Assist to turn q hours [sic] - every 2 hours when in bed, Exercise per OT [Occupational Therapy] Care Plan ... Nutrition: Diet Order - Regular/Balanced, Meal Preparation, Assist with Feeding - Choke risk, Encourage Fluids ... Other: Laundry, Light Housekeeping - Bathroom, Light Housekeeping - Bedroom, Light Housekeeping - Change bed linen, Light Housekeeping - Kitchen, Light Housekeeping - Living Areas, Equipment Care - Wheelchair, Hoyer lift." The aide care plan also failed to indicate which type of bath was to be completed (tub, shower, partial or complete bed bath) and failed to indicate the frequency each task was to be performed. 17-13-2(a)			
G 0800 Bldg. 00	484.80(g)(2) Services provided by HH aide A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on observation, record review and interview, the home health aides (HHA) failed to follow the plan of care for 2 of 5 active records reviewed (#2, 3), in a total sample of 8 records. Findings include: 1. The undated agency policy titled "Home Health Aide Supervision," Number C-340, stated "Home Nursing Services shall provide Home Health Aide services ... when personal care	G 0800	The agency will separate the Tub/Shower activity into two activities to decrease confusion. Additionally, see response to G 580, as the situation observed that did not have a “No Interruption of Service” order. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased	11/02/2020

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	services are indicated and ordered by the physician ..." 2. The clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20, and indicated a start of care of 8/22/19. The clinical record indicated a plan of care for the certification period of 6/17/20 - 8/15/20, which contained an order for HHA services "2-4 hrs [hours]/day X [for] 7 days/week for up to 28 units/week." The clinical record contained a document titled "Plan of Care Service Plan (Confidential)," dated and signed as reviewed on 6/29/20 by Employee N, RN. The service plan stated "Discipline: HHA/RHHA/ATTC ... Bath: Bed Bath- Partial, Bed Bath - Complete ... Hygiene: Assist with Dressing, Hair Care - Brush, Hair Care - Shampoo, Skin Care, Foot Care (Hygiene), Check Pressure Areas, Groom, Deodorant, Nail Hygiene - Clean, Nail Hygiene - File, Nail Hygiene - Report, Oral Care - Swab - After meals, Elimination Assist - Every 1.5-2 hours with peri-care [perineal care, cleaning of the external genitalia and surrounding areas] ... Vitals: T - Oral / Axillary / Rectal ... Activity: Ambulation Assist - Wheelchair, Mobility Assist - Pivot transfers ... Nutrition: Diet Order - Pureed, Meal Preparation - Follow mother's instructions, Assist with Feeding - Client must be fed. **CHOKING/ASPIRATION RISK**, Encourage Fluids ... Other: Laundry, Light Housekeeping - Bathroom, Light Housekeeping - Bedroom, Light Housekeeping - Change bed linen, Light Housekeeping - Kitchen, Equipment Care - wheelchair, recliner, hospital bed." Home health aide notes dated 6/20/20 and 6/21/20 by Employee P, HHA, failed to indicate whether the HHA performed a tub or shower bath, and which "Light Housekeeping" tasks she performed (bedroom, bathroom, kitchen, and/or change bed		comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	

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linens).

A home health aide note dated 6/29/20 by Employee P, HHA, indicated the HHA performed "Positioning - Encourage / Assist to Turn q [every] 2 hours," however this was not included on the patient's home health aide care plan. The HHA also failed to indicate the method with which "Ambulation Assist" was performed (wheelchair, walker, or cane), if she limited or encouraged fluids, and which "Light Housekeeping" tasks she performed (bedroom, bathroom, kitchen, and/or change bed linens).

Home health aide notes dated 6/22/20, 6/23/20, 6/25/20, 6/30/20 and 7/2/20 by Employee Q, HHA, failed to indicate whether the HHA performed a tub or shower bath, the method with which "Ambulation Assist" was performed (wheelchair, walker, or cane), and which "Light Housekeeping" tasks she performed (bedroom, bathroom, kitchen, and/or change bed linens).

Home health aide notes dated 6/27/20 and 6/28/20 by Employee P, HHA, failed to indicate whether the HHA performed a tub or shower bath, the method with which "Ambulation Assist" was performed (wheelchair, walker, or cane), and which "Light Housekeeping" tasks she performed (bedroom, bathroom, kitchen, and/or change bed linens).

Home health aide notes dated 7/10/20, 8/11/20, 8/13/20, and 8/15/20 by Employee P, HHA, indicated the HHA performed "Positioning - Encourage / Assist to Turn q [every] 2 hours," however this was not included on the patient's home health aide care plan. The HHA also failed to indicate on this note if she performed a tub or shower bath, the method with which "Ambulation

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	Assist" was performed (wheelchair, walker, or cane), if she limited or encouraged fluids, and which "Light Housekeeping" tasks she performed (bedroom, bathroom, kitchen, and/or change bed linens).			
	3. The complete clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record included a POC for the certification period of 7/16/20 - 9/13/20. The POC failed to include an order for HHA services, but did state "[Patient #3] requires assistance for bathing, and ADLs which he through [sic] waiver program, [Home Nursing Services] is working on filling hours at present [sic throughout]." The record indicated the patient received HHA services on 7/16/20, 7/17/20, 7/18/20, 7/20/20, 7/22/20, 7/23/20, 7/24/20, 7/25/20, 7/27/20, 7/28/20, 7/29/20, 7/30/20, 7/31/20, 8/1/20, 8/2/20, 8/3/20, 8/4/20, 8/5/20, 8/6/20, 8/7/20, 8/8/20, 8/10/20, 8/11/20, 8/12/20, 8/13/20, 8/14/20, 8/15/20, and 8/17/20 by Employee M, HHA.			
	During a home visit observation with Patient #3 (Start of Care 11/19/19) on 8/20/20 at 9:40 AM, Employee M, HHA, was observed providing home health aide services, including emptying the patient's suprapubic catheter and performing catheter care (no order to do so).			
	4. An interview was conducted with the administrator, alternate administrator, Director of Nursing (DON), and alternate Director of Nursing (ADON) on 8/25/20 at 3:47 PM. During the interview, the DON indicated all service orders should be included on the plan of care.			
G 0804 Bldg. 00	484.80(g)(4) Aides are members of interdisciplinary team Home health aides must be members of the			

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	interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures. Based on record review and interview, the home health aide (HHA) failed to report a change in the patient's condition to a registered nurse (RN), and failed to document the date, time, and person the HHA notified the change to, for 1 of 5 active clinical records reviewed (#3), in a total sample of 8 records. Findings include: An undated agency job description, titled "Home Health Aide," stated " ... Essential Job Functions ... 5. Reports any observed or reported changes in the client's condition and/or needs to the Registered Nurse ..." The clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record included a POC for the certification period of 7/16/20 - 9/13/20. The plan of care indicated patient diagnoses, (but not limited to) "multiple sclerosis ... immobility syndrome (paraplegic) ... and neuromuscular dysfunction of bladder." A home health aide note documented on 7/20/20 by Employee M, HHA, indicated the patient had "pink flaky skin on both buttocks." Documentation prior to this visit had only indicated pink flaky skin to the left buttock. Employee M's documentation on 7/20/20 failed to indicate the HHA notified a RN of the change in the patient's skin condition.	G 0804	The Clinical Director will contact Employee M on proper notification for changes in condition. The agency also uses the weekly newsletter to raise awareness and provide education, such as proper procedure on change in conditions. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	11/02/2020

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A home health aide note documented on 8/10/20 by Employee M, HHA, indicated the patient had a "Large red area on left buttock. Raised up and irritated." HHA documentation prior to this visit had only indicated a large, pink area on the patient's left buttock. Employee M's documentation failed to indicate the HHA notified a RN of the change in the patient's skin condition.

A home health aide note documented on 8/13/20 by Employee M, HHA, indicated the patient had a "Large red area on left buttock. Dime size area starting to open up." HHA documentation prior to this visit had only indicated a "large, pink area" on the left buttock, with no open areas noted. Employee M's documentation failed to indicate the HHA notified a RN of the change in the patient's skin condition.

An interview was conducted with Employee M, HHA, on 8/20/20 at 10:05 AM. During the interview, the HHA indicated Patient #3 did have "redness" on his bottom, and it had been there for "a couple of weeks." Employee M indicated she did notify the RN on the "same day" that she first observed the change in the patient's skin, as the RN was also present in the home at the time. The HHA also indicated she notified the RN to any change in the patient's skin.

An interview was conducted with the administrator, alternate administrator, Director of Nursing (DON), and alternate Director of Nursing (ADON) on 8/25/20 at 3:47 PM. During the interview, the DON indicated the HHA should notify the RN for any change in the patient's condition, including skin or wound changes. The DON also indicated the HHA should document this notification within the patient's clinical record.

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G 0940 Bldg. 00	484.105 Organization and administration of services 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.			
	Based on record review and interview, the home health agency failed to report all branch locations to the state survey agency (See Tag G972), failed to ensure all shared patient agreements contained all shared patient agreements were authorized and signed (See Tag G978), and failed to ensure all shared patient agreements indicated the primary agency and division of roles between agencies (See G980). The cumulative effect of this systemic problem resulted in the agency being out of compliance with Condition of Participation 42 CFR 484.105 Condition of participation: Organization and administration of services. 17-12-1(a)(1), 17-12-1(a)(2)	G 0940	The agency does not maintain branch locations, and instead operates convenience sites for employees. In order to decrease the unintended appearance of operating branch locations, the agency will: Revise the EMR to delete the categorization of patients by “Office”. No agency employees will be based in the branch offices of Entity J. The agency will enter into a Memorandum of Understanding with Entity J providing for occasional use of the Entity J’s Auburn and Bluffton offices for convenience purposes. All agency patients will be instructed to call the agency for scheduling purposes.	10/30/2020

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			All agency employees will be instructed to the agency for all agency issues, including scheduling and in-services. Entity J's branch offices' voicemail greetings will be revised to delete any reference to the agency. The after-hours auto-attendant will direct agency calls to the agency On-Call Coordinator, who will have no responsibilities associated with Entity J. All hiring and onboarding of agency employees will be conducted by agency employees or within the provisions of the Memorandum of Understanding. Agency will conduct weekly calls to Entity J's branch offices. Agency will review daily reports submitted by On-Call Coordinators. Agency will require agency employees to report to the Administrator any episodes of noncompliance. The Administrator will oversee the convenience sites are not branches. Above changes will be implemented by 10/30/2020.	
G 0972 Bldg. 00	484.105(d)(1) Report all branch locations to SA The parent HHA is responsible for reporting all branch locations of the HHA to the state survey agency at the time of the HHA's request for initial certification, at each survey, and at the time the parent proposes to add or			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	delete a branch. Based on observation, record review, and interview, the home health agency failed to report all branch locations to the state survey agency for 2 of 2 branch locations [Angola, Indiana, and Bluffton, Indiana]. Findings include: The Home Health Agencies Report, received from the administrator on 8/19/20 at 9:03 AM, indicated the home health did not have any branch locations. The report indicated the agency only had one office, which was located in Fort Wayne, Indiana. A review of the agency's Electronic Medical Record (EMR) was conducted on 8/19/20 at 12:38 PM. The EMR indicated the agency's patients were categorized by "Office," with the 3 categories being "Auburn," "Bluffton," and "Fort Wayne." An interview was conducted with the administrator, Director of Nursing (DON), and alternate Director of Nursing (ADON), on 8/20/20 at 4:30 PM. During the interview, the DON indicated the home health agency did not have any other branches that provided services under the Home Nursing Services license. The DON indicated there were "offices" located in Auburn, Indiana, and Bluffton, Indiana, but the agency did not classify these as branches, as they were branches for Entity J (a personal care attendant agency). The DON stated the Auburn and Bluffton offices were used by the home health agency for "scheduling," and some employees worked out of these locations "so they don't have to drive as far." The administrator reported there were 2 home health agency employees assigned	G 0972	The agency does not maintain branch locations, and instead operates convenience sites for employees. In order to decrease the unintended appearance of operating branch locations, the agency will: Revise the EMR to delete the categorization of patients by "Office". No agency employees will be based in the branch offices of Entity J. The agency will enter into a Memorandum of Understanding with Entity J providing for occasional use of the Entity J's Auburn and Bluffton offices for convenience purposes. All agency patients will be instructed to call the agency for scheduling purposes. All agency employees will be instructed to the agency for all agency issues, including scheduling and in-services. Entity J's branch offices' voicemail greetings will be revised to delete any reference to the agency. The after-hours auto-attendant will direct agency calls to the agency On-Call Coordinator, who will have no responsibilities associated with Entity J. All hiring and onboarding of agency employees will be conducted by agency employees or within the provisions of the Memorandum of Understanding.	10/30/2020

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	to these locations (Employees R, S, both were 'HR Coordinators')." The DON indicated other agency employees worked out of the Angola and Bluffton offices because there was a "restroom ... [and] hot spot" to do their work, but the employees' home office was in Fort Wayne. The DON also indicated agency patients were assigned to the Auburn or Bluffton locations only for scheduling purposes, and all agency patients were advised to contact the agency's Fort Wayne location for any questions or concerns. The administrator indicated there was no signage for the agency at either Angola or Bluffton office. The surveyor made a call to the Entity J's Auburn office on 8/19/20 at 7:59 PM. The office was closed, and the automatic message reported the phone number was for the offices of Entity J and Home Nursing Services. The surveyor made a call to the Entity J's Bluffton office on 8/19/20 at 8:00 PM. The office was closed, and the automatic message reported the phone number was for the offices of Entity J and Home Nursing Services. An interview with Person N, an employee of Entity J who answered the after-hours call for the Bluffton branch, was conducted on 8/19/20 at 8:02 PM. Person N reported she answered after-hour calls for Entity J for patients from the Bluffton branch. Person N indicated a second Entity J employee was responsible for after-hours calls for both Entity J and Home Nursing Services for patients from the "North" office. An interview was conducted with Person O, an employee of Entity J who answered the after-hours call for the Auburn branch, was conducted on 8/19/20 at 8:06 PM. Person O		Agency will conduct weekly calls to Entity J's branch offices. Agency will review daily reports submitted by On-Call Coordinators. Agency will require agency employees to report to the Administrator any episodes of noncompliance. The Administrator will oversee the convenience sites are not branches. Above changes will be implemented by 10/30/2020.	

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	indicated she answered after-hours calls from patients of both Entity J and Home Nursing Services. An interview was conducted with Patient #3 (Start of Care 11/19/19) and Person U, family member of Patient #3, on 8/20/20 at 9:56 AM. During the interview, Person U indicated she had contacted the "Auburn office" in the past regarding Patient #3. Person U could not recall the reason she called the office. An interview was conducted with Employee M, Home Health Aide (HHA), on 8/20/20 at 10:05 AM. During the interview, the HHA indicated she contacted the "Auburn office" if she needed more personal protective equipment (PPE), and would contact the Auburn office if she needed to speak with the patient's nurse. An interview was conducted with the DON on 8/20/20 at 2:28 PM. During the interview, the DON indicated Employees R and S conducted "onboarding" and "education" to both agency and Entity J employees at the Angola and Bluffton locations. The DON also indicated Employee R conducted CPR (cardiopulmonary resuscitation) training for both the agency and Entity J employees at the Angola location. The DON reported the agency was not currently providing education for the agency employees at the Angola and Bluffton locations due to COVID-19 precautions. The agency administrator, alternate administrator, DON, and ADON were advised of the concern of operating branches without state survey office approval on 8/20/20 at 3:58 PM. The agency failed to provide further documentation to show compliance.			

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G 0978 Bldg. 00	484.105(e)(2)(i-iv) Must have a written agreement An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. The agency, organization, or individual providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid; (iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program.			
	Based on record review and interview, the home health agency failed to ensure all shared patient agreements were authorized and signed for 2 of 3 shared patient agreements (#2, 3), in a total sample of 8 records. Findings include: 1. An undated agency policy, titled "Coordination of Client Services and Missed Visits," stated " ... Special Instructions ... 3. After the initial assessment, the admitting Registered Nurse (RN) shall discuss the findings of the initial visit with the Clinical Director /designee to ensure ... f. Coordination with other agencies and institutions ..." 2. The clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20, and indicated a start of care date of 8/22/19. The clinical record contained a shared patient agreement, dated 5/1/2020,	G 0978	RNCMs were inserviced on 10/5 and 10/19 to maintain communication with agencies that provide concurrent care to our clients, as well as documenting date, nature of conversation, and other agency representative. The Administrator needs to sign all shared patient agreements. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	11/02/2020

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	between the home health agency and Entity K, a waiver home services agency. The agreement failed to be signed the administrator or designee of the home health agency, nor a representative from Entity K. 3. The clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record contained a shared patient agreement, undated, between the home health agency and Entity L, a personal services agency. The agreement failed to be signed by the administrator or designee of the home health agency, nor a representative from Entity L. The agreement also failed to be dated. 4. An interview was conducted with the administrator, alternate administrator, Director of Nursing (DON), and alternate Director of Nursing (ADON) on 8/25/20 at 3:47 PM. During the interview, the DON indicated for a shared patient, the home health agency coordinated care with the other agency by calling the other agency, "tell them what we're going to do, ask what they're going to do," and then the agency would complete the shared patient agreement form. 17-12-2(d)			
G 0980 Bldg. 00	484.105(e)(3) Primary HHA is responsible for patient care The primary HHA is responsible for patient care, and must conduct and provide, either directly or under arrangements, all services rendered to patients. Based on record review and interview, the home health agency failed to ensure all shared patient agreements indicated the primary agency, and failed to ensure all shared patient agreements indicated the division of roles for 3 of 3 shared	G 0980	The agency created a new form to use when sharing clients. This new agreement lists who the primary agency is, and divides the tasks and responsibilities between	11/02/2020

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	patient contracts (#1, 2, 3), in a total sample of 8 records. Findings include: 1. The clinical record of Patient #1 was reviewed on 8/18/20 and 8/24/20, and indicated a start of care date of 6/22/18. The clinical record contained a shared patient agreement, dated 10/28/19, between the home health agency and Entity J, a personal services agency. The agreement stated "Primary agency for this client (place a [checkmark] in appropriate box below)." The agreement failed to indicate which agency was primary, and failed to indicate a division of tasks and responsibilities between the two agencies. 2. The clinical record of Patient #2 was reviewed on 8/19/20 and 8/24/20, and indicated a start of care date of 8/22/19. The clinical record contained a shared patient agreement, dated 5/1/2020, between the home health agency and Entity K, a waiver home services agency. The agreement failed to indicate a division of tasks and responsibilities between the two agencies. 3. The complete clinical record of Patient #3 was reviewed on 8/19/20, and indicated a start of care date of 11/19/19. The clinical record contained a shared patient agreement, undated, between the home health agency and Entity L, a personal services agency. The agreement stated "Primary agency for this client (place a [checkmark] in appropriate box below)." The agreement failed to indicate which agency was primary, and failed to indicate a division of tasks and responsibilities between the two agencies. 4. An interview was conducted with the administrator, alternate administrator, Director of		the two agencies. Agency representatives from both agencies will sign to agree to the conditions of the form. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	

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	Nursing (DON), and alternate Director of Nursing (ADON) on 8/25/20 at 3:47 PM. During the interview, the DON stated for a shared patient, the home health agency coordinated care with the other agency by calling the other agency, "tell them what we're going to do, ask what they're going to do," and then the agency would complete the shared patient agreement form. The agency staff was unable to indicate the location on the shared patient contract of the division of tasks between agencies. The ADON reported the shared patient contract should indicate the primary agency. 17-12-2(e)			
N 0000 Bldg. 00	This was a state complaint investigation survey of a home health agency. IN00321620; Substantiated with findings IN00321165; Substantiated with findings IN00307591; Substantiated with findings Survey Dates: August 18, 19, 20, 21, 24, 25, 26, 27; 2020 Facility Number: IN005372 Provider Number: 157211 Unduplicated admissions past 12 months: 104 Skilled patients: 181 Home Health Aide Only Patients: 136 Personal Service Only Patients: 0 Total Active Patients: 169 Sample selection:	N 0000	Home Nursing Services (the “Agency”) is submitting the following Plan of Correction/Plan of Removal in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction/Plan of Removal is not intended as an admission, does not constitute an admission by and should not be construed as an admission by the Agency that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to patients of the Agency. The Agency does not, at this time, have an avenue at which to challenge these findings and,	

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	Records with home visits: 3 Records without home visits: 2 Discharge records: 3 Total records reviewed: 8		therefore, the Agency's failure to dispute or challenge the alleged deficiencies cannot be taken as an admission that the alleged facts occurred as presented in the statements. Compliance has been and will be achieved no later than the last completion date identified in the Plan of Correction. The Agency desires this Plan of Correction to be considered its Allegation of Compliance."	
N 0478 Bldg. 00	410 IAC 17-12-2(d) Q A and performance improvement Rule 12 Sec. 2(d) If personnel under contracts are used by the home health agency, there shall be a written contract between those personnel and the home health agency that specifies the following: (1) That patients are accepted for care only by the primary home health agency. (2) The services to be furnished. (3) The necessity to conform to all applicable home health agency policies including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency. (6) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation. (7) The procedures for payment for services furnished under the contract.			
	Based on record review and interview, the home health agency failed to ensure a written contract	N 0478	RNCMs were inserviced on 10/5 and 10/19 to maintain communication with agencies that	11/02/2020

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	was agreed upon and signed by the agency and contracted personnel that specified the necessity to conform to all applicable agency policies, the contract personnel's responsibility for participating in developing plans of care, and the procedures for submitting clinical notes for 1 of 1 contracted personnel files reviewed (Employee W). Findings include: The personnel file for Employee W, Licensed Practical Nurse, was reviewed on 8/27/20 at 1:26 PM. Employee W's personnel file contained a signed job description for "Staff Nurse (RN [Registered Nurse] / LPN" from Entity M, a medical staffing company. Employee W's personnel file failed to indicate a written contract, which specified the necessity to conform to all applicable agency policies, the contract personnel's responsibility for participating in developing plans of care, and the procedures for submitting clinical notes, was developed and agreed upon by the home health agency and the contracted employee. An interview was conducted with the administrator, Director of Nursing (DON), and alternate Director of Nursing (ADON) on 8/27/20 at 3:50 PM. The agency staff was unable to produce a written contract between the agency and Employee W. A follow up interview was conducted with the DON on 8/27/20 at 4:15 PM. The DON indicated the agency did not have a written contract between Employee W and the agency.		provide concurrent care to our clients, as well as documenting date, nature of conversation, and other agency representative. The Administrator needs to sign all shared patient agreements. Agency will audit 10% of census, quarterly, on an ongoing basis using a newly purchased comprehensive audit tool. The Clinical Director is responsible for overseeing the audits. Chart audits will be performed by 11/2/2020.	
N 0488	410 IAC 17-12-2(i) and (j) Q A and performance improvement			

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Bldg. 00	Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.			
	Based on record review and interview, the home health agency failed to develop and implement a policy which required a notice of discharge of service to the patient at least 15 calendar days before the services are stopped. Findings include: An agency policy, titled "Client Discharge Process," Number C-500, stated "... Special	N 0488	Inservice RN case managers (RNCM) and office staff on COP and policy review on transfer and discharges. 10% of transfers and discharges will be audited by Clinical Director for six months. The Administrator is responsible for overseen the Clinical Director's audits of discharges and transfers.	10/30/2020

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	Instructions. Discharge Procedure: ... 2. Clients are told in a timely manner of the need to plan for discharge or transfer to another level of care/organization. Clients are informed of the reason for discharge and anticipated needs for services after discharge ... 9. To avoid charges of 'abandonment' at the time of discharge Home Nursing Services documentation will include ... d. Documentation of all communication with the client ...." The clinical record of Patient #5 was reviewed on 8/24/20, and indicated a start of care date of 4/26/19, and a discharge date of 7/21/20. The record indicated a recertification assessment was completed by Employee H, Registered Nurse on 4/17/20. A "Transfer to an Inpatient Facility" was completed on 4/18/20 by Employee H, and indicated the patient was admitted to a hospital for "diabetes out of control." A Plan of Care for the certification date of 4/20/20 - 6/18/20 was completed and signed by Employee H on 4/17/20, and was signed by the patient's physician on 4/30/20. A review of the "Client Monthly Schedule" for April and May 2020 indicated the patient had visits scheduled on 4/20/20, 4/22/20, 4/24/20, 4/27/20, 4/29/20, 5/1/20, 5/4/20, 5/6/20, and 5/8/20. The patient had no further visits scheduled after 5/8/20. The record failed to evidence documentation regarding discharge from hospital/transfer to a rehabilitation facility. A notation was made to the "Client Monthly Schedule" on 5/5/20 by Employee G, which indicated the patient called and requested to be transferred to another agency, though no reason was documented. The clinical record contained a "Physician's Order," signed by Employee H on 7/21/20 and the patient's physician on 7/22/20. The order stated		Inservice of RNCM on 10/5, remaining staff by 10/30/2020.	

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	"6/18/20 Discharge from Home Nursing services r/t [related to] client having a new Home care agency with therapy services." An "All Discipline Discharge Summary and OASIS-D1 DC" was completed by Employee H on 7/21/20. The discharge summary failed to indicate a reason for discharge. The clinical record failed to indicate the patient was notified of the pending discharge at least 15 days prior to the end of services. An interview was conducted with the alternate Director of Nursing (ADON) on 8/26/20 at 4:26 PM. During the interview, the ADON indicated Patient #5 was admitted to the hospital on 4/20/20, was discharged from the hospital to an inpatient rehabilitation facility, and then was discharged home with rehabilitative services. The ADON reported the patient did not receive services after 4/20/20, and was discharged on 6/18/20 "because that is when the next plan of care was due."			