

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/15/2021
NAME OF PROVIDER OR SUPPLIER HOME NURSING SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 528 W WASHINGTON BLVD FORT WAYNE, IN 46802		
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G 000	<p>INITIAL COMMENTS</p> <p>This was a federal and state home health revisit survey to determine the removal of an Immediate Jeopardy on Conditions of Participation 42 CFR 484.55 Comprehensive Assessment and 42 CFR 484.60 Care Planning, Coordination, Quality of Care identified on 12/18/2020.</p> <p>Survey date: 02/15/2021</p> <p>Facility number: IN005372</p> <p>Provider number: 157211</p> <p>A removal plan/ plan of correction was accepted by CMS on 1/26/2021.</p> <p>After record review and interview during the onsite revisit, it was determined that the Immediate Jeopardy was not abated for the Conditions of Participation 42 CFR 484.55 Comprehensive Assessment, and 42 CFR 484.60 Care Planning, Coordination, Quality of Care, after the agency failed to ensure all patients were properly and timely assessed, failed to ensure (based on the agency IJ removal plan) all agency nurses completed training on (but not limited to) how to complete a comprehensive assessment, how to assess, measure, stage and characterize wounds, failed to ensure all patients' plans of care contained all required information to ensure patients' needs were met, and failed to ensure coordination of care was completed with outside entities to ensure all patients did not have new or worsening health conditions that could lead to an adverse event. The administrator was notified on 2/15/2021 at 4:25 PM.</p>	G 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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

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G 000 {G 510}	Continued From page 1 This deficiency reflects State Findings cited in accordance with 410 IAC 17. Comprehensive Assessment of Patients CFR(s): 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. This CONDITION is not met as evidenced by: An Immediate Jeopardy (IJ) related to comprehensive assessment and re-assessment of patients was originally identified on 12/18/2020 and remained unabated upon survey exit on 1/12/2021. The IJ remained unabated upon exit of the re-visit conducted on 2/15/2021. The administrator was notified on 2/15/2021 at 4:25 PM. The IJ remained unabated due to the agency's ongoing failure to ensure all patients had complete and accurate comprehensive assessments/re-assessments, comprehensive assessments accurately reflected the patients' current health status, comprehensive re-assessments were completed at least every 60 days, contained all required content, and failed to ensure all agency nurses completed training on (but not limited to) how to complete a comprehensive assessment, or how to assess, measure, stage and characterize wounds. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a	G 000 {G 510}			

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{G 510}	<p>Continued From page 2</p> <p>safe environment for the Condition of Participation 42 CFR 484.55 Comprehensive Assessment of Patients.</p> <p>Based on record review and interview, the registered nurse (RN) failed to ensure the comprehensive assessment/re-assessment accurately described the patient's status, to measure or describe wounds; failed to include current health of wound status and functional limitations due to wounds; failed to include interventions regarding the patient's wounds; failed to evidence medical, and nursing needs were met by identifying the patient's needs in a comprehensive assessment/re-assessment that led to hospitalization, for 3 of 3 patients' records reviewed.</p> <p>Findings include:</p> <p>1. Review of an undated agency policy C-155 titled "Comprehensive Client Assessment" stated "... A thorough, well-organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed ... no later than five (5) calendar days after start of care ... To determine the appropriate care, treatment and services to meet initial needs and his/her changing needs ... will be done at least once in every sixty (60) day period ... will include a review of all medications ... [drug regimen review-DRR] will identify all potential adverse effects and drug reactions, including ineffective therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with therapy"</p> <p>2. Review of an undated agency policy C-155 copyright Briggs Healthcare titled "Client</p>	{G 510}			

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{G 510}	<p>Continued From page 3</p> <p>Reassessment/Update of Comprehensive Assessment" stated "... Comprehensive Assessment will be updated and revised as often as the client's condition warrants due to a major decline or improvement in health status ... To identify decline or improvement ... are reassessed when significant changes occur in their condition ... [or] diagnosis"</p> <p>3. Review of an undated agency policy C-155 copyright Briggs Healthcare titled "Skilled Nursing Services" stated "... Skilled nursing services will be provided ... In determining whether a service requires the skills of a Nurse, the inherent complexity of the service, condition of the client ... Regularly reevaluates the client needs ... Provides services requiring specialized nursing skill and initiates appropriate preventive and rehabilitative nursing procedures"</p> <p>4. Review of an undated agency policy B-220 copyright Briggs Healthcare titled "Clinical Record Review" stated "... There shall be an ongoing review of client [patient] status every sixty (60) day period using the OASIS [outcome and assessment information set] follow up assessment and other pertinent documentation that support changes in client condition/and or plan of care. This data will be included in the clinical records"</p> <p>5. Record review for patient #1 was completed on 2/15/2021, start of care date 8/23/2013, for certification periods 11/14/2020 - 1/12/2021, and 1/13/2021 - 3/13/2021 for skilled nursing to set up medication boxes every other week. Review of a document dated 1/6/2021 titled "Skilled Nurse Visit Note" evidenced the patient was sent to the emergency department (ED), and stated "...</p>	{G 510}			

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{G 510}	<p>Continued From page 4</p> <p>[wound clinic C] advised client to go to the ED to r/o [rule out] infection" The document failed to evidence the wound was assessed by the nurse.</p> <p>Review of a document dated 1/8/2021 titled "Care Coordination Note" stated "Client went to the ED ... was admitted 1/7/21 ... just went back to surgery for [abdominal] wound ... debridement" The document also evidenced the patient was receiving IV (intravenous) antibiotics.</p> <p>Review of a document dated 1/10/2021 titled "SN [skilled nurse] ROC [resumption of care] OASIS and Comprehensive Assessment" failed to evidence an assessment of the patient's post-surgical abdominal wound, and failed to evidence a drug regimen review was completed and the patient was subsequently hospitalized.</p> <p>Review of an email document signed by the clinical manager (not part of patient's clinical record) dated 1/26/2021 evidenced she spoke with the patient's sister, who indicated the patient was back in the hospital because she was "so weak and not eating ...". agency was unaware the patient was re-admitted to the hospital on 1/15/2021, and the agency discharged the patient on 1/26/2021.</p> <p>During an interview on 2/15/2021 at 2:30 PM, the alternate clinical manager indicated RN C performed the comprehensive assessment on 1/10/2021, quit the same day (1/10/2021), failed to complete the document, no wound assessment was completed, stated "Yes" when asked if the wound assessment should have been included in the assessment," and that no one performed a drug regimen review. The alternate clinical manager completed the document (without</p>	{G 510}			

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{G 510}	<p>Continued From page 5</p> <p>re-assessing the patient) on 1/31/2021 (while patient remained in the hospital), no other nurse re-assessed the patient after 1/10/2021, the agency did not contact the hospital for assessment paperwork, and the patient remained in the inpatient setting upon surveyor exit on 2/15/2021.</p> <p>6. Record review for patient #2 was completed on 2/15/2021, start of care date 6/7/2017, had a certification period that ended 1/16/21 for HHA (home health aide) services 2 hours per day/7 days per week. During certification 11/18/20-1/16/21, no comprehensive re-assessment was completed.</p> <p>During an interview on 2/15/2021 at 2:30 PM, the alternate clinical manager indicated the patient was seen by a nurse for a comprehensive re-assessment on 1/9/2021, but the visit was never completed, the re-assessment was completed late on 1/29/21 by another nurse. The alternate clinical manager also indicated the patient was hospitalized on 2/1/21 for cellulitis of the right leg, and the patient remained in the hospital as of today (2/15/2021).</p> <p>The re-assessment dated 1/29/21 stated the patient had complaint of ankles hurting because of lymphedema, documentation of lymphedema non pitting by the nurse but no detail of color, odor, warmth etc. The nurse indicated the patient was a chronic "skin picker", had a lesion on his right upper back/shoulder area, right arm, and several on his legs that he chronically picked, and the client would put ointment on the lesions and cover with a band-aid if needed. The assessment failed to evidence wound assessments, or what ointment the patient applied to his lesions.</p>	{G 510}			

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{G 510}	Continued From page 6 Review of a document titled "Physician Order" order dated 2/2/21 stated "... Per [physician] office visit note dated 12/15/20 received [by the agency on] 1/29/21 via fax from [physician T] office, client was put on Keflex [antibiotic] ... for a toe infection. [Nurse practitioner U] also recommended epsom salt soaks and F/U [follow up] with podiatry if not improving" The comprehensive assessment Review of a document titled "Care Coordination Note" dated 2/4/21 stated "Client has diagnosis [sic] of cellulitis RLE [right lower extremity] and Sepsis [systemic infection]" During an interview on 2/15/2021 at 2:30 PM, RN M indicated the patient was admitted to the hospital on 2/1/2021, he was hospitalized for foot infection (cellulitis of R Leg), she did not request hospital documentation, the patient was now in rehab (since 2/7/2021) and was still receiving IV antibiotics, and she didn't know when the cellulitis started. 7. Record review for patient #3 was completed on 2/15/2021, start of care date 2/1/2018, evidenced a document titled "Home Health Certification/Recertification", certification period 1/16/2021 - 3/16/2021. The document evidenced skilled nursing services 16 hours per day, 7 days per week for total care (personal care and skilled care) including, but not limited to tracheostomy (the surgical formation of an opening into the trachea through the neck especially to allow the passage of air) care, treatment, and management, evidenced diagnoses (but not limited to) cerebral palsy, acute and chronic respiratory failure, encounter for attention to	{G 510}			

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{G 510}	<p>Continued From page 7</p> <p>gastrostomy (g-tube, an opening in the abdomen with a tube inserted directly into the stomach for administration of nutrition, fluids, and medications). The document failed to evidence the patient had any cardiac (heart) issues, diagnoses, or concerns, or the patient was taking any cardiac medications.</p> <p>Review of documents titled "Skilled Nurse Hourly Flow Sheet" for date range 1/11/2021-1/23/2021 evidenced pulse rate ranged generally between 60-100 BPM. On the "Skilled Nurse Hourly Flow Sheet" dated 1/26/2021, the patient's pulse rate ranged 101-144 BPM (significantly higher), and the physician was not notified. On the "Skilled Nurse Hourly Flow Sheet" dated 1/27/2021 at 7:00 AM, the patient's pulse rate was 152 BPM. The document evidenced the nurse got the patient up, put him in the shower, and provided care, the patient's mother contacted the physician V, who instructed patient to be seen in ED (emergency department). Patient was not put into the vehicle until 11:20 AM for transportation to the ED, and the SN failed to notify the physician of high pulses.</p> <p>During an interview on 2/15/2021 at 2:30 PM, the clinical manager indicated the patient was admitted to the hospital on 1/27/2021 for "respiratory distress," agreed the transfer OASIS and summary was left blank, and the patient was admitted to the hospital for respiratory distress.</p> <p>During an interview on 2/15/2021 at 4:18 PM, the clinical manager stated "... According to Mom [of patient], he had an MI [heart attack]." When asked if the hospital was contacted to obtain paperwork needed to accurately complete the comprehensive re-assessment, she stated "No. I</p>	{G 510}			

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{G 510}	<p>Continued From page 8 worked directly with Mom."</p> <p>Review of a document titled "Skilled Nurse Hourly Flow Sheet" dated 1/30/2021 evidenced (but not limited to) new diagnoses of sinus tachycardia (fast heart rate, regular rhythm), pericardial effusion (a condition in which extra fluid collects between the heart and the sac around the heart), pleural effusion (a condition in which excess fluid builds around the lung), and hypovolemia (abnormal decrease in the volume of blood plasma, occurs with dehydration or bleeding), and a new cardiac medication, metoprolol.</p> <p>Review of a document titled "SN ROC OASIS and Comprehensive Assessment" dated 1/30/2021, evidenced a section titled "Cardiovascular Assessment", which failed to evidence the new cardiac conditions or medication.</p> <p>Review of a document dated 2/1/2021 titled "Care Coordination Note" evidenced the physician was notified that the agency gave a 15 day discharge notice, but failed to evidence the date of the discharge. The record also failed to evidence a discharge comprehensive assessment was completed.</p> <p>8. During an interview on 2/15/2021 at 11:08 AM, the clinical manager indicated the agency would ensure the needs of its patients with skilled nursing medication tray set up would be met by re-training the nurses, and stated "... I think we need to start with the comprehensive assessment"</p> <p>9. During an interview on 2/15/2021 at 4:27 PM, the clinical manager indicated the only skilled nursing care the agency provided was patient</p>	{G 510}			

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{G 510}	<p>Continued From page 9</p> <p>medication tray set up, the agency audited for completion of a drug regimen review (DRR) every 60 days, and the alternate clinical manager indicated the DRRs weren't documented anywhere. During this time, the clinical manager stated the DRR "... consisted of a list of medications, each medication information, written in layman's terms, documentation of who's responsible for setting up the medications and managing them"</p> <p>10. During an interview on 2/15/2021 at 12:10 PM with Human Resource (HR) Coordinator F, personnel records were reviewed for proof of education/re-education on or after 12/18/2020 for (but not limited to) essential and necessary components of proper client assessment, client care and management, comprehensive assessment/re-assessment and complete documentation, and how to assess, measure, stage, and characterize wounds, as part of the agency's action plan for IJ removal. RN Y's record failed to evidence any training/in-services since 2019. LPN DD's record failed to evidence any training/in-services since 12/2018, RN FF's record failed to evidence training/in-services since 12/2018, and RN GG's record failed to evidence any training/in-services since 12/2018. During this time, the alternate clinical manager spoke on the phone with RN EE, who indicated she did not complete wound training.</p> <p>11. During an interview on 2/15/2021 at 1:34 PM, when asked what in-services the agency provided since mid-December (2020), RN AA stated "I am not sure because I don't remember. There's been several. They usually mail them to me because I don't live near there." She also stated the topics were "Elderly care, abuse and neglect, like 4 or 5</p>	{G 510}			

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{G 510}	Continued From page 10 total." 12. During an interview on 2/15/2021 at 1:57 PM, when asked what in-services the agency provided since mid-December (2020), RN GG stated "I've had in-services but I didn't get them completed I don't think." He also indicated the topics were hand-washing and COVID-19. 13. During an interview on 2/15/2021 at 2:21 PM, when asked what in-services the agency provided since mid-December (2020), RN Z indicated she started work at the agency 1/18/2021, she did orientation in-services, case conferences, and new forms. 14. During an interview on 2/15/2021 at 2:45 PM, when asked what in-services the agency provided since mid-December (2020), RN Y stated "Hmm ... none that I remember" She indicated she remembered a recent one on hand hygiene, because it was a "state requirement", and in-services are "sent to her and she sends them back". 15. During an interview on 2/15/2021 at 2:59 PM, when asked what in-services the agency provided since mid-December (2020), RN FF stated "Hmm ... I've not had any. None."	{G 510}			
{G 570}	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence.	{G 570}			

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{G 570}	<p>Continued From page 11</p> <p>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.</p> <p>This CONDITION is not met as evidenced by: An Immediate Jeopardy (IJ) related to care planning, coordination, and quality of care was originally identified on 12/18/2020 and remained unabated upon survey exit on 1/12/2021. The IJ remained unabated upon exit of the re-visit conducted on 2/15/2021. The administrator was notified on 2/15/2021 at 4:25 PM. The IJ remained unremoved due to the agency's ongoing failure to ensure all plans of care contained all required elements, plans of care weren't revised to meet the patients' needs, and the agency failed to ensure care coordination with other agencies/entities. The agency, by their own admission, indicated on an IJ removal plan submitted 1/08/21, that it would discharge at least 30% of the agency's census of 138 patients, and would give 15 day discharge notices between the dates of 1/25/2021 - 1/29/2021 (with discharges to occur between 2/9/2021 - 2/13/2021). During an interview on 2/15/2021 at 11:08 AM, the clinical manager indicated the agency had not completed any care coordination with the receiving entities/agencies for any discharged patients as of 2/15/2021.</p>	{G 570}			

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{G 570}	<p>Continued From page 12</p> <p>The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care for the Condition of Participation 42 CFR 484.60 Care planning, coordination, and quality of care.</p> <p>Based on record review and interview, the home health agency failed to ensure all patients' plans of care evidenced (but not limited to) all pertinent diagnoses, psychosocial and cognitive status, all medications and treatments, safety measures to protect against injury, description of the patients' risks for emergency department (ED) visits and hospital admission/re-admission, and all necessary interventions to address the underlying risk factors, patient/caregiver education to facilitate a timely discharge, patient specific interventions, education, measurable outcomes and goals, and information related to advance directives; failed to conform to physicians' orders; failed to ensure the plan of care was reviewed and revised at least every 60 days; failed to communicate with health care professionals, agencies or entities who would be responsible for providing care/services to the patients after discharge or transfer; failed to ensure care coordination to meet the patients' needs; and failed to evidence ongoing education to facilitate a timely discharge that led to hospitalization for 3 of 3 records reviewed.</p> <p>Findings include:</p> <p>1. Review of an undated copyrighted Briggs Healthcare policy C-580 titled "Plan of Care" stated "... Home Nursing Services staff to develop a plan of care individualized to meet [patient] specific identified needs ... to include ... specific</p>	{G 570}			

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{G 570}	<p>Continued From page 13</p> <p>procedures ... medications, treatments, and procedures ... other appropriate items ... professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care"</p> <p>2. Review of an undated copyrighted Briggs Healthcare policy C-100 titled "Services Provided" stated "... Services will be coordinated by the Registered Nurse managing the care. This will include implementing, revising, and updating the Plan of Care; physician conferencing ... conferencing with health team members to plan and evaluate client [patient] care"</p> <p>3. Review of an undated copyrighted Briggs Healthcare policy C-360 titled "Coordination of Client Services" stated "... to ensure appropriate, quality care is being provided to clients ... to establish effective interchange, reporting and coordination of client care does occur ... Coordination with other agencies and institutions ... alert physician to changes in client condition"</p> <p>4. Review of an undated agency policy C-155 copyright Briggs Healthcare titled "Skilled Nursing Services" stated "... Skilled nursing services will be provided ... In determining whether a service requires the skills of a Nurse, the inherent complexity of the service, condition of the client ... Regularly reevaluates the client needs ... Initiates the Plan of Care and necessary revisions and updates to the plan of care ... Provides services requiring specialized nursing skill and initiates appropriate preventive and rehabilitative nursing procedures ... Informs the physician and other personnel of changes in the client condition and needs ... Counsels the client and</p>	{G 570}			

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{G 570}	<p>Continued From page 14 family/caregivers in meeting their needs ... Prepares clinical and progress notes"</p> <p>5. Record review for patient #1 was completed on 2/15/2021, start of care date 8/23/2013, for certification periods 11/14/2020 - 1/12/2021, and 1/13/2021 - 3/13/2021 for skilled nursing to set up medication boxes every other week. Review of a document dated 1/6/2021 titled "Skilled Nurse Visit Note" evidenced the patient was sent to the emergency department (ED), and stated "... [wound clinic C] advised client to go to the ED to r/o [rule out] infection"</p> <p>Review of a document dated 1/8/2021 titled "Care Coordination Note" stated "Client went to the ED ... was admitted 1/7/21 ... just went back to surgery for [abdominal] wound ... debridement" The document also evidenced the patient was receiving IV (intravenous) antibiotics.</p> <p>During an interview on 2/15/2021 at 2:30 PM, the alternate clinical manager indicated the agency did not contact the hospital for care coordination or to obtain paperwork (necessary to accurately complete a comprehensive re-assessment and plan of care). Additionally, a ROC (resumption of care comprehensive assessment)/recertification visit for certification period 1/13/2021 - 3/13/2021 was completed on 1/10/2021.</p> <p>Review of a document titled "Home Health Certification/Recertification Plan of Care" for dates 1/13/2021 - 3/13/2021 failed to evidence psychosocial and cognitive status, current wound treatments, a description of the patients' risks for emergency department (ED) visits and hospital admission/re-admission, and all necessary interventions to address the underlying risk</p>	{G 570}			

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{G 570}	<p>Continued From page 15</p> <p>factors, patient/caregiver education to facilitate a timely discharge, patient specific interventions, education, measurable outcomes and goals, interventions to mitigate further wound deterioration and failed to evidence ongoing education to facilitate a timely discharge.</p> <p>Review of an email document signed by the clinical manager (not part of patient's clinical record) dated 1/26/2021 evidenced the administrator gave verbal notice to discharge to the patient via phone on 1/25/2021, the patient already found another home health agency. It further evidenced she spoke with the patient's sister, who indicated the patient was back in the hospital because she was "so weak and not eating," the agency was unaware the patient was re-admitted to the hospital on 1/15/2021, and the agency discharged the patient on 1/26/2021.</p> <p>6. Record review for patient #2 was completed on 2/15/2021, start of care date 6/7/2017, evidenced a document titled "Home Health Certification/Recertification Plan of Care" for dates 11/18/2020 - 1/16/2021, and indicated HHA (home health aide) services 2 hours per day/7 days per week for 9 weeks. No comprehensive re-assessment was performed during this certification period (thus no document to build the plan of care from). The record also evidenced a document titled "Home Health Certification/Recertification Plan of Care" for dates 1/17/2021 - 3/17/2021. The document failed to evidence skilled nursing frequency or duration of visits, failed to evidence any HHA services, frequency, or duration, wound treatments, safety measures to protect against injury, description of the patients' risks for emergency department (ED) visits and hospital</p>	{G 570}			

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{G 570}	<p>Continued From page 16</p> <p>admission/re-admission, interventions to mitigate rehospitalization, and all necessary interventions to address the underlying risk factors, patient/caregiver education to facilitate a timely discharge, patient specific interventions, education, measurable outcomes and goals, and information related to advance directives -name of power of attorney (POA) and health care representative.</p> <p>The record also failed to evidence conformance to physicians' orders, failed to ensure the plan of care was reviewed and revised at least every 60 days, failed to communicate with health care professionals, agencies or entities who would be responsible for providing care/services to the patients after discharge or transfer; failed to ensure care coordination to meet the patients' needs; and failed to evidence ongoing education to facilitate a timely discharge.</p> <p>During an interview on 2/15/2021 at 2:30 PM, the alternate clinical manager indicated the patient received HHA services two hours every morning 7 days per week for 2 hours and agency W (non-medical home care) also saw the patient. When asked what services the agency provided to the patient, she stated "I don't know." Finally, she indicated the patient was hospitalized on 2/1/21 for cellulitis of the right leg, and the patient remained in the hospital as of today (2/15/2021).</p> <p>Review of a document titled "Physician Order" order dated 2/2/21 stated "... Per [physician] office visit note dated 12/15/20 received [by the agency on] 1/29/21 via fax from [physician T] office, client was put on Keflex [antibiotic] ... for a toe infection. [Nurse practitioner U] also recommended epsom salt soaks and F/U [follow</p>	{G 570}			

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{G 570}	<p>Continued From page 17 up] with podiatry if not improving" The record failed to evidence the agency provided epsom salts soaks or was aware of the order at the time of initiation.</p> <p>Review of a document titled "Care Coordination Note" dated 2/4/21 stated "Client has diagnosis [sic] of cellulitis RLE [right lower extremity] and Sepsis [systemic infection]" The record failed to evidence care coordination to obtain hospital paperwork.</p> <p>During an interview on 2/15/2021 at 2:30 PM, RN M indicated the patient was admitted to the hospital on 2/1/2021, was hospitalized for foot infection (cellulitis of R Leg), she did not request hospital documentation, the patient was now in rehab (since 2/7/2021) and was still receiving IV antibiotics, and she didn't know when the cellulitis started.</p> <p>7. Record review for patient #3 was completed on 2/15/2021, start of care date 2/1/2018, evidenced a document titled "Home Health Certification/Recertification", certification period 1/16/2021 - 3/16/2021. The document evidenced skilled nursing services 16 hours per day, 7 days per week for total care (personal care and skilled care) including, but not limited to tracheostomy (the surgical formation of an opening into the trachea through the neck especially to allow the passage of air) care, treatment, and management, evidenced diagnoses (but not limited to) cerebral palsy, acute and chronic respiratory failure, encounter for attention to gastrostomy (g-tube, an opening in the abdomen with a tube inserted directly into the stomach for administration of nutrition, fluids, and medications). The plan of care failed to evidence</p>	{G 570}			

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{G 570}	<p>Continued From page 18</p> <p>the patient had any cardiac (heart) issues, diagnoses, or concerns, or the patient was taking any cardiac medications, and failed to evidence duration of visits, psychosocial and cognitive status, safety measures to protect against injury such as keep head of bed up at all times while eating to avoid aspiration, description of the patients' risks for emergency department (ED) visits and hospital admission/re-admission, and all necessary interventions to address the underlying risk factors, patient/caregiver education to facilitate a timely discharge, patient specific interventions, education, measurable outcomes and goals, and information related to advance directives; and failed to evidence ongoing education to facilitate a timely discharge.</p> <p>Review of documents titled "Skilled Nurse Hourly Flow Sheet" for date range 1/11/2021-1/23/2021 evidenced pulse rate ranged generally between 60-100 BPM. On the "Skilled Nurse Hourly Flow Sheet" dated 1/26/2021, the patient's pulse rate ranged 101-144 BPM (significantly higher), and the physician was not notified. On the "Skilled Nurse Hourly Flow Sheet" dated 1/27/2021 at 7:00 AM, the patient's pulse rate was 152 BPM. The document evidenced the nurse got the patient up, put him in the shower, and provided care, the patient's mother contacted the physician V, who instructed patient to be seen in ED (emergency department). Patient was not put into the vehicle until 11:20 AM for transportation to the ED. The record failed to evidence the nurse contacted the physician for abnormal findings on multiple occasion.</p> <p>During an interview on 2/15/2021 at 2:30 PM, the clinical manager indicated the patient was admitted to the hospital on 1/27/2021 for</p>	{G 570}			

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{G 570}	<p>Continued From page 19 "respiratory distress."</p> <p>During an interview on 2/15/2021 at 4:18 PM, the clinical manager stated "... According to Mom [of patient], he had an MI [heart attack]." When asked if the hospital was contacted to obtain paperwork needed to accurately complete the comprehensive re-assessment and plan of care, she stated "No. I worked directly with Mom."</p> <p>Review of a document titled "Skilled Nurse Hourly Flow Sheet" dated 1/30/2021 evidenced (but not limited to) new diagnoses of sinus tachycardia (fast heart rate, regular rhythm), pericardial effusion (a condition in which extra fluid collects between the heart and the sac around the heart), pleural effusion (a condition in which excess fluid builds around the lung), and hypovolemia (abnormal decrease in the volume of blood plasma, occurs with dehydration or bleeding), and a new cardiac medication, metoprolol. The record failed to identify the physician was contacted or the plan of care was updated or interventions put in place to assist the patient with these new diagnoses.</p> <p>Review of a document dated 2/1/2021 titled "Care Coordination Note" evidenced the physician was notified that the agency gave a 15 day discharge notice, but failed to evidence the date of the discharge.</p> <p>8. During an interview on 2/15/2021 at 9:48 AM, When asked if the agency sent discharge or transfer summaries to receiving facilities, the alternate clinical manager stated "I was off sick last week. I don't know." She also indicated she audited/reviewed plans of care that were due for recertification, but could not confirm if 100% of all</p>	{G 570}			

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{G 570}	<p>Continued From page 20</p> <p>agency plans of care had have been reviewed. When asked what the time frame discharge notices were given, she indicated the agency gave patients 15 days notice between 1/25/2021 - 1/29/2021.</p> <p>9. During an interview on 2/15/2021 at 11:08 AM, the clinical manager indicated the agency would ensure the needs of its patients with skilled nursing medication tray set up would be met by re-training the nurses, and stated "... I think we need to start with the comprehensive assessment ... then plan of care, then care coordination, discharge process" When asked what information prior to discharge was sent to the receiving agencies/facilities of discharged patients, the clinical manager stated "I don't think anything was sent. That's part of the follow up for today [2/15/2021]." During this time, documents submitted for review were letters to all 52 patients advising them of agency's intent to discharge. The document stated "... You may use your Home Nursing Services home binder to give to your next agency ... Please have them call us" The clinical manager indicated the agency had not provided care coordination with receiving agencies prior to discharge, and she was going to call them today (2/15/2021) but the surveyor showed up, and she wouldn't have time now. The agency had no way of knowing if the discharged patients needs were met upon discharge, which had the potential to lead to an adverse outcome.</p> <p>410 IAC 17-13-1(a)</p>	{G 570}			