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HOME NURSING SERVICES	528 W WASHINGTON BLVD FORT WAYNE, IN 46802

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{G 000}	INITIAL COMMENTS This was an additional federal and state post condition re-visit from a survey originally completed on 8/27/20. A post condition re-visit was conducted on 1/12/2021, during which time an immediate jeopardy (IJ) was called on 12/18/2020 for Conditions of Participation 42 CFR 484.55 Comprehensive assessment, and 42 CFR 484.60 Care Planning, coordination, quality of care. During the survey on 1/12/2021, 2 of 2 Conditions remained unabated: 42 CFR 484.60 Care planning, coordination, quality of care, and 42 CFR 484.105 Organization and administration of services; and 2 new conditions were cited: 42 CFR 484.50 Patient Rights, and 42 CFR 484.55 Comprehensive assessment of patients; 6 standards were corrected; 17 standards were re-cited; and 22 new standards were cited. The IJ was not abated upon exit on 1/12/2021 An additional federal and state home health revisit survey was completed on 2/15/2021 to determine the removal of an Immediate Jeopardy. After record review and interview during the onsite revisit, it was determined that the Immediate Jeopardy was not abated. An additional federal and state home health revisit survey was completed on 3/9/2021 to determine the removal of an Immediate Jeopardy. After record review and interview during the onsite revisit, it was determined that the Immediate Jeopardy was abated the IJ was removed on 03/09/2021 at 2:25 PM. Although the immediate jeopardy was removed, the agency remained out of compliance with Conditions of Participation 42 CFR 484.50 Patient Rights; 42 CFR 484.55 Comprehensive Assessment; 42	{G 000}		

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

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{G 000}	Continued From page 1 CFR 484.60 Care Planning, Coordination, Quality of Care; and 42 CFR 484.105 Organization and administration of services. Current Survey Dates: April 8, 9, 12, 13, 14; 2021. Facility Number: IN005372 Provider Number: 157211 Unduplicated census: 242 Active census: 75 During this survey, 1 of 4 Conditions was abated: 42 CFR 484.50 Patient Rights; and 3 of 4 Conditions remained unabated: 42 CFR 484.55 Comprehensive assessment of patients; 42 CFR 484.60 Care planning, coordination, quality of care; and 42 CFR 484.105 Organization and administration of services. 17 standards were corrected; and 19 standards were re-cited. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment. Based on the Condition-level deficiencies during the 4/14/2021 survey, Home Nursing Services was subject to a post-condition revisit survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 4/14/2021. 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 4/14,2021 and continuing through 4/14/2023 for being found out of compliance with the Conditions of Participation 42 CFR 484.50 Patient Rights; 42 CFR 484.55 Comprehensive assessment of patients; 42 CFR	{G 000}		

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{G 000}	Continued From page 2 484.60 Care Planning, coordination, quality of care; and 42 CFR 484.105 Organization and administration of services. These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to the State Form for additional State Findings	{G 000}		
G 510	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: Based on record review and interview, the registered nurse failed to ensure all comprehensive assessments included the patients' medical needs (G534), a review of all medications (G536), primary caregiver willingness, availability, and schedule (G538), completed updated comprehensive re-assessment for worsening in health status (G544), and completed updated comprehensive re-assessment during the last five days of the certification period (G546). This practice had the potential to affect all agency patients. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR 484.55 Comprehensive Assessment of Patients.	G 510		

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G 510	Continued From page 3 17-14-1(a)(1)(B)	G 510		
G 534	Patient's needs CFR(s): 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; This Element is not met as evidenced by: Based on observation, record review and interview, the registered nurse (RN) failed to ensure the comprehensive assessment contained the patient's medical and nursing needs for 5 of 5 records reviewed (#1, 2, 3, 4, 5). Findings include: 1. Review of an undated agency policy C-705 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Medication Management" stated "... Home Nursing Services has a medication management system that supports client safety and improves quality of care treatment and services ... Comprehensive client assessment ... include [sic] review of all medications ... (prescribed, samples, over the counter, herbal remedies, PRN [as needed] medications) and records this in the client record ... Information that must be available in the record ... relevant laboratory values and regularly scheduled lab testing ... The primary pharmacy will also be identified and the phone number recorded ... on the medication profile ... orders will be obtained for the use of herbal drugs or preparations ... When Home Nursing Services staff are administering medications ... Clinician will verify that the medication is ... correct ... based on the order ... Client response to medications will be assessed on each home visit ... Laboratory values will be evaluated ...." 2. Review of the FDA web page reference	G 534		

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G 534	Continued From page 4 https://www.accessdata.fda.gov/drugsatfda_docs/label/2008/012151s062lbl.pdf stated "... The recommended monitoring for potassium and creatinine is one week after initiation or increase in dose of Aldactone [spironolatactone], monthly for the first 3 months, then quarterly for a year, and then every 6 months ... Concomitant administration of potassium-sparing diuretics and ACE inhibitors or nonsteroidal anti-inflammatory drugs (NSAIDs), e.g., [aspirin], has been associated with severe hyperkalemia ... it is important to monitor serum potassium levels ... Patients who receive Aldactone should be advised to avoid potassium supplements and foods containing high levels of potassium, including salt substitutes ... Laboratory tests: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be done at appropriate intervals, particularly in the elderly ...." 3. Review of the pubmed.gov web page reference, https://pubmed.ncbi.nlm.nih.gov/17284506/ stated "... Laboratory evaluation of potassium and creatinine among ambulatory patients prescribed spironolactone: are we monitoring for hyperkalemia? ... Serum potassium and creatinine evaluation is recommended in patients prescribed spironolactone ...." 4. Review of the pubmed.gov web page reference, https://pubmed.ncbi.nlm.nih.gov/23110839/ stated "... Therapeutic drug monitoring of primidone and phenobarbital ... a first-line treatment of essential tremor ... Generally accepted therapeutic range for primidone is between 5 and 10 mg/L (23-46 mmol/L) ...."	G 534		

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G 534	Continued From page 5 5. Review of the FDA web page reference, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/208658s001lbl.pdf stated "... Geriatric patients: Higher incidence of adverse reactions related to volume depletion and reduced renal function. Assess renal function more frequently ... Obtain an eGFR at least annually in all patients taking SYNJARDY XR. In patients at increased risk for the development of renal impairment (e.g., the elderly), renal function should be assessed more frequently ...." 6. Review of dailymed web page reference, https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=2b8d9730-686b-444b-9941-7b5877255924 stated "... Glucose monitoring is recommended for all patients with diabetes ...." 7. Review of drugs.com web page reference, https://www.drugs.com/potassium_chloride.html stated "... To be sure potassium chloride is helping your condition, your blood may need to be tested often ...." 8. Review of drugs.com web page reference for depakote, https://www.drugs.com/pro/depakote.html stated "... Serum liver tests should be performed prior to therapy and at frequent intervals thereafter ...." 9. Review of drugs.com web page reference for levothyroxine/Synthroid, https://www.drugs.com/pro/synthroid.html stated "... Dosing must be individualized ... and dose adjustments made based on periodic assessment of the patient's clinical response and laboratory parameters ...." 10. Review of a U.S. National Library of Medicine web page reference for lidocaine pain patch	G 534		

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G 534	Continued From page 6 https://medlineplus.gov/druginfo/meds/a603026.html stated "... never wear patches for more than 12 hours per day. Using too many patches or leaving patches on for too long may cause serious side effects ... If you wear too many patches or wear patches for too long, too much lidocaine may be absorbed into your blood. In that case, you may experience symptoms of an overdose ... If the victim has collapsed, had a seizure, has trouble breathing, or can't be awakened, immediately call emergency services at 911 ...." 11. Review of an NIH (National Institutes of health web page reference for vitamin D, https://ods.od.nih.gov/factsheets/VitaminD-Consumer/ stated "... one way to know if you ' re getting enough [vitamin D] is a blood test that measures the amount of vitamin D in your blood ... getting too much vitamin D can be harmful. Very high levels of vitamin D in your blood (greater than 375 nmol/L or 150 ng/mL) can cause nausea, vomiting, muscle weakness, confusion, pain, loss of appetite, dehydration, excessive urination and thirst, and kidney stones. Extremely high levels of vitamin D can cause kidney failure, irregular heartbeat, and even death. High levels of vitamin D are almost always caused by consuming excessive amounts of vitamin D from dietary supplements ...." 12. Review of a Cleveland Clinic web page reference for ferrous sulfate (iron), https://my.clevelandclinic.org/health/articles/14568-oral-iron-supplementation, stated "... Your doctor will let you know how long you will have to take the iron supplement. Usually, after your hemoglobin and iron levels are back to normal, you will continue to take the iron supplement for another six months. Afterward, you will have	G 534		

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G 534	Continued From page 7 regular blood tests to measure your iron level ...." 13. Record review for patient #1 was completed on 4/14/2021, start of care date 7/15/2013, for certification periods 2/5/2021 - 4/5/2021, and 4/6/2021 - 6/4/2021, with primary diagnosis of Alzheimer's disease, unspecified. The record evidenced the agency was aware of the patient's first decline in health status on 3/11/2021 and failed to assess the patient until 3/23/2021. Additionally, the record evidenced the agency was aware of the patient's additional decline in health status (on 4/2/2021) with the development of a wound and failed to identify in a comprehensive assessment the patient's need for skilled nursing wound care, assessment, or medication management. Review of a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/6/21-6/4/21, evidenced the patient received skilled nursing services for supervisory visits, HHA (home health aide) services for personal care, and medications the patient took included (but not limited to) depakote and levothyroxine, both of which required periodic lab monitoring to ensure drug therapy effectiveness. The record failed to evidence documented lab results and failed to evidence the registered nurse monitored for therapeutic blood levels of depakote and levothyroxine or obtained blood specimens for testing. A home visit observation was completed for patient #1 on 4/13/2021 at 11:55 AM. The alternate clinical director and HHA I was present. A superficial open wound was observed on the right intergluteal cleft (butt crack), approximately 1.0 cm (centimeter) in diameter, 0.1 - 0.2 cm depth, with a pink, moist wound bed. The	G 534		

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surrounding skin was not observable due to the presence of desitin ointment (zinc oxide topical skin protectant) on the skin. The patient's daughter (also a nurse) arrived during the visit, who indicated the patient developed symptoms of a respiratory infection on or about 3/8/2021, his symptoms worsened and he was seen in a walk-in clinic (3/11/2021), was prescribed antibiotics, she had him sleep in his recliner to help him breathe easier. Additionally, she stated about a week and a half ago, he developed a pressure sore due to spending so much time in the recliner, he never had a pressure sore until the respiratory illness in March (2021). She used desitin on his buttocks and TheraHoney wound gel (for use on wounds with no drainage to moderate drainage and should be paired with an occlusive absorbent dressing) on his wound for several weeks, and the wound was on his right buttock.

Review of a document dated and signed by the alternate clinical manager on 3/11/2021 titled "Care Coordination Note" stated "... spoke with Daughter of this client.about [sic] the client possibly having aspirational [sic] pneumonia. she [sic] is trying to get transportation to the walk in [sic] clinic as opposed to going to the hospital ... sitting him in a chair and using vicks [a mentholated topical cough suppressant ointment], cough syrup for two days now and thinks he needs an antibiotic ... I told her with the pneumonia he could get bad fast ... the daughter said she would let me know what happens ...."

Review of a document dated and signed by the clinical manager on 3/12/2021 titled "Care Coordination Note" stated "... [daughter] took her father [patient] to a walk up clinic yesterday ... given a prescription for an oral antibiotic ...

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G 534	Continued From page 9 [daughter] to email the clinic paperwork to me today ...." Review of a document from walk-in clinic A dated 3/11/2021 evidenced the patient was diagnosed with bacterial lower respiratory infection, cough, fever, and was prescribed an antibiotic to treat the infection. Review of a document dated and signed 3/23/2021 by RNCM (registered nurse case manager) G titled "SN [skilled nurse] Daily Note" stated "... RNCM was notified by multiple reports [from the client's daughter, from HHA [home health aide], from other RNs] that the client's functional status has declined. He was reported to be weak, unable to get out of bed, unable to walk ... possible "aspiration pneumonia", has been to urgent care for antibiotics ... Daughter reports that client aspirated over the weekend while being fed ... Cannot walk more than a couple of steps. He was previously able to walk with assistance ... Unstable and, deteriorating ... Current Plan of Care ... May need to be modified ...." Review of a document dated and signed by HHA H on 4/6/2021 titled "Daily [home health aide/attendant care] Visit Sheet for 4/02/2021" stated "... 3 pressure sores [open wound caused by unrelieved pressure] on bottom, one open. Nurse noted ...." Review of a document dated and signed by RNCM G on 4/2/2021 titled "RN Re-Certification [comprehensive] Assessment" evidenced the patient was at risk for skin breakdown, the depth of the wound as 0.0 cm (depth was observed during home visit), indicated a pink, moist wound bed, and failed to address the condition of the	G 534		

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G 534	Continued From page 10 surrounding skin, wound care treatment with frequency, or need for monitoring lab values with medications levothyroxine and depakote. 14. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021, which evidenced the patient received skilled nursing services for supervisory visits, HHA services for personal care, and medications the patient took included (but not limited to) ferrous sulfate and vitamin D3, both of which required periodic lab monitoring to ensure drug therapy effectiveness. The document evidenced a section titled "60 Day Summary" which stated " ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ...."The comprehensive assessment failed to evidence orders for (but not limited to) skilled nursing frequency and duration of visits (which the patient would need for wound care and lab monitoring), interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, constipation, dehydration interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown, an order for the homeopathic treatment of Epsom salts and eucalyptus (the use of natural substances as remedies, such as plants and minerals), and failed to evidence pressure ulcer diagnosis(es) in the section titled "Other Pertinent Diagnoses". Additionally, the record failed to evidence documented lab results, and failed to evidence the registered nurse monitored for or received information on the patient's therapeutic blood	G 534		

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levels of ferrous sulfate and vitamin D3 or obtained blood specimens for testing; and failed to evidence any nursing visits were completed after 3/5/2021 to re-assess the patient's wound until the visit made with the surveyor on 4/14/2021.

Review of a document dated and signed by RNCM E on 3/5/2021 titled "RN Re-Certification Assessment" failed to evidence a comprehensive re-assessment including OASIS data was completed, and stated "... left heel pressure wound, 2cm round ... Ruptured blister. Dry, healing well, no signs/symptoms of infection ...." The RN failed to identify the correct location and stage of the wound, which was actually on the right foot.

During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA (home health aide) K were present. The patient was positioned sitting upright in bed with both heels elevated. The right heel evidenced intact skin with a circular hyperpigmented (darker than patient's normal skin color) area, approximately 3.0 - 4.0 cm in diameter. The left heel was observed intact with no evidence of skin breakdown. The patient indicated she had blister on her right heel from friction on the bed, but it was resolved, and she never had any breakdown on her left heel.

During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RNCM E, and HHA K were present. The patient indicated she had a problem with her right heel, not the left heel, it started about a month ago, her mom covered the wound with gauze and tape, she never had problems with skin breakdown prior to this wound, and she

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could only feel slight sensation in her feet, such as pain. RNCM E asked HHA K what she added to the hand and foot soaks. HHA K indicated she added Epsom salts with eucalyptus and spearmint and stated "... about a handful ...." RNCM E indicated she would get an order. Observed RNCM E perform a head-to-toe physical assessment on the patient. HHA K was positioned on one side of the bed, and RNCM E was positioned on the other. After a portion of the assessment was completed, HHA K removed all of the positional pillows and lowered the head of the bed so the patient could be turned onto her right side (to assess the backside of the body). RNCM E began to turn the patient without first moving her closer to her side of the bed, which would prevent the patient's face from hitting the siderail. HHA K and the patient stopped RNCM E and verbally directed her on proper turning technique. Also, during the assessment, RNCM E repeatedly left the room for several minutes to chart in the EMR (electronic medical record), and then return to continue her assessment and ask the patient additional questions. RNCM E indicated she completed the physical assessment at 10:29 AM. RNCM E failed to measure the hyperpigmented area on the patient's right heel, palpate, or check the area for blanching (indicates presence or absence of adequate blood flow to determine if a pressure injury or suspected deep tissue injury is present). RNCM E asked the patient when she was last weighed, to which the patient indicated it was a year ago when she was hospitalized for a UTI (urinary tract infection). When asked by RNCM E when her last bowel movement was, the patient stated "Monday [4/12/2021- two days ago]", and HHA K stated, "We're trying to keep her more regular." When asked by the surveyor if the RN provided any teaching, the patient stated "No." She also

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G 534	Continued From page 13 indicated she stayed in the same sitting position in bed all day on days she worked (patient does part time work on computer with the use of a pen in mouth to type) and family would reposition onto her side in the evenings. During this time, HHA K stated, "I don't think she's [patient] drinking enough." RNCM E instructed HHA K to encourage fluids. When asked by the surveyor if fluid intake was recorded/monitored, HHA K indicated it was not. At 10:52 AM, RNCM E discussed goals with the patient, indicated they were "keeping" the skin goal, instructed the patient to continue to keep her heels othe bed, and hand and feet soaks would continue. RNCM E indicated this was not a skilled patient, the document used for the assessment was titled "RN Daily Note", and this patient received aide services only. Review of a document dated and signed by RN E on 4/14/2021 titled "SN Daily Note" stated "... System Review ... Integument [skin] ... No significant issues ... Care is considered custodial ...." 15. Record review for patient #3 was completed on 4/12/2021 and again on 4/14/2021, start of care date 8/27/2019, primary diagnosis type 2 diabetes with hyperglycemia (high blood sugar), other pertinent diagnoses included (but not limited to) essential tremor, chronic combined systolic and diastolic heart failure, and vitamin D deficiency, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 2/17/2021 - 4/17/2021, which evidenced (but not limited to) the patient received skilled nursing services (but not limited to) for weekly medication tray set up, was on a low sugar/simple carbohydrate (diabetic) diet, was "relatively non-compliant" with his diet; and was prescribed (but not limited to)	G 534		

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G 534	Continued From page 14 primidone (medication to treat tremors), spironolatactone (a diuretic medication), synjardy (a diabetes medication), and detemir (an injectable diabetes medication), all of which required periodic lab monitoring. A recertification comprehensive assessment was completed on 2/12/2021. The comprehensive assessment failed to evidence documented lab results, failed to evidence the registered nurse monitored for therapeutic blood levels of primidone, spironolatactone, synjardy, and detemir, or obtained blood specimens for testing, and failed to evidence the use of a lidocaine topical patch or the indication for the use of it. Review of a drugs.com document dated 3/2/2021 titled "Drug Interaction Report" stated "... Applies to: insulin detemir, Synjardy ... Your blood glucose should be closely monitored ...." Review of a document dated 3/30/2021 titled "Skilled Nurse Visit Note" evidenced the patient was alert and oriented, had no pain, vital signs were within normal limits, and evidenced the nurse applied a lidocaine patch (a medicated topical pain patch) to the patient's left shoulder. The record failed to evidence the nurse provided any teaching regarding the medication precautions, such as to remove the patch after 12 hours, or signs and symptoms to report to the nurse or physician. Review of a document dated 4/1/2021 titled "Discharge Summary" stated "... Client found deceased in his bed by an unknown party on 3/31/2021 ...." 16. Record review for patient #4 was completed on 4/14/2021, start of care date 6/18/2020,	G 534		

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G 534	Continued From page 15 primary diagnosis type 2 diabetes with hyperglycemia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/14/2021 - 6/12/2021, which evidenced (but not limited to) the patient received skilled nursing visits every 2 weeks to fill and organize medication delivery system (pill planner box), he was prescribed (but not limited to) potassium chloride and detemir (insulin), he was non-compliant with his diabetic diet, and in a section titled "60 Day Summary" stated "... The client has set a continuing goal for himself to reduce his A1C [a laboratory blood test to determine the patient's average blood sugar for the preceding 2 to 3 months]. A recertification comprehensive assessment dated 2/11/2021, completed by RNCM E failed to evidence an assessment to determine if the patient was knowledgeable and able to safely administer insulin and monitor diabetes, failed to evidence documented lab results, and failed to evidence the registered nurse monitored for therapeutic blood levels of potassium or hemoglobin A1C. 17. Record review for patient #5 was completed on 4/14/2021, start of care date 1/11/2016, primary diagnosis fibromyalgia, other (but not limited to) diagnoses of type 2 diabetes without complications, and magnesium deficiency. Review of a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/14/2021 - 6/12/2021, which evidenced (but not limited to) the patient received skilled nursing services every 2 weeks for medication tray set up, was very non-compliant with diabetes disease management, made poor food choices, was non-compliant with a diabetic diet, refused to	G 534		

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G 534	Continued From page 16 check blood sugar levels (finger stick test in the home), pain and diabetes were not controlled, medications included (but not limited to) magnesium oxide, vitamin D3, and hydrocodone (for pain which caused constipation). A recertification comprehensive assessment was documented on 4/9/2021, from a skilled nurse visit made by RNCM E on 4/8/2021. The comprehensive assessment indicated the patient refused to check blood sugars and the nurse checked it once every 2 weeks but failed to assess the patient's ability to perform independently. It further failed to evidence documented lab results, failed to evidence the registered nurse monitored for therapeutic blood levels of magnesium, vitamin D3 or hemoglobin A1C. 18. During an interview on 4/8/2021 at 3:02 PM, the alternate clinical manager indicated the RNCMs provided a "Daily Update Report" to the alternate clinical manager every morning by 9:00 AM, one of the "reportable" concerns was any patient experiencing a change in condition, if identified, the alternate clinical manager would assign an RNCM to perform the Comprehensive Assessment the same day and notify the patient's physician of the assessment findings. When asked if she had implemented the assignment of an RNCM to perform a comprehensive re-assessment for a change in condition, and if so, for what, she stated "Not yet." 19. During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manager indicated a stage 2 pressure injury would have the top layer of skin off, a fluid filled blister would be a stage 2 pressure injury, and anything added to water during a soak should be on the care plan, and	G 534		

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G 534	Continued From page 17 there probably wasn't a drugs.com document (a web based drug interaction checker) in the chart for the comprehensive assessment completed for patient #1 on 4/2/2021 because "... this is so new for us ...." During this time, the administrator indicated the most recent nursing case manager meetings addressed client situations, new wounds, falls, clinical topics of relevance, admissions, and discharges; most recent meetings focused on plans of care, discussed the new wounds (for patients #1, 2), possible discharges for them (from the agency), the agency management made a decision to pull back from skilled care during this time, and then later decide how to move forward, there was no decision made at that time to discharge the wound patients, and the agency didn't have the staff to cover multiple weekly or even weekly visits for skilled care. 17-14-1(a)(1)(B)	G 534		
G 536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This Element is not met as evidenced by: Based on observation, record review and interview, the RNCM (registered nurse case manager) failed to identify all medications the patient was using (both prescription and non-prescription) for 3 of 5 records reviewed (#1, 2, 3); and failed to perform a drug regimen review of all medications the patient was currently taking which included (but not limited to) routine monitoring and laboratory testing for 5 of 5	G 536		

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G 536	Continued From page 18 records reviewed (#1, 2, 3, 4, 5). Findings include: 1. Review of an undated agency policy C-700 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Medication Set Up Policy" stated "... The profile will be reviewed and updated as needed to reflect current medications the client is taking ... To identify possible ineffective drug therapy, adverse reactions, significant side effects, drug allergies, and contraindicated medications ... Nurse shall record on the Medication Profile all prescribed and over-the-counter (OTC) medications ... the Nurse must add newly ordered drugs or medication changes to the Medication Profile ... Discontinued medications shall be highlighted and documented as "DC" with the appropriate date ...." 2. Review of an undated agency policy C-701 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Medication Set Up Policy" stated "... The medication list is current and updated with physician orders as changes occur ... reviewed at each visit to determine if there are new or changed medications ... Many OTC medications can interact with prescription medications ...." 3. Review of an undated agency policy C-704 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Client Information Required for Medication Management" stated "... The minimum amount of information about the client that is to be available for staff involved in medication management includes: ... All current medications including over the counter and herbal medications ... Relevant laboratory values ...."	G 536		

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G 536	Continued From page 19 4. Review of an undated agency policy C-705 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Medication Management" stated "... Home Nursing Services has a medication management system that supports client safety and improves quality of care treatment and services ... Comprehensive client assessment ... include [sic] review of all medications ... (prescribed, samples, over the counter, herbal remedies, PRN [as needed] medications) and records this in the client record ... Information that must be available in the record ... relevant laboratory values and regularly scheduled lab testing ... The primary pharmacy will also be identified and the phone number recorded ... on the medication profile ... orders will be obtained for the use of herbal drugs or preparations ... When Home Nursing Services staff are administering medications ... Clinician will verify that the medication is ... correct ... based on the order ... Client response to medications will be assessed on each home visit ... Laboratory values will be evaluated ...." 6. Review of the FDA web page reference https://www.accessdata.fda.gov/drugsatfda_docs/label/2008/012151s062lbl.pdf stated "... The recommended monitoring for potassium and creatinine is one week after initiation or increase in dose of Aldactone [spironolatactone], monthly for the first 3 months, then quarterly for a year, and then every 6 months ... Concomitant administration of potassium-sparing diuretics and ACE inhibitors or nonsteroidal anti-inflammatory drugs (NSAIDs), e.g., [aspirin], has been associated with severe hyperkalemia ... it is important to monitor serum potassium levels ... Patients who receive Aldactone should be advised to avoid potassium supplements and foods containing high levels of potassium,	G 536		

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G 536	Continued From page 20 including salt substitutes ... Laboratory tests: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be done at appropriate intervals, particularly in the elderly ...." 7. Review of the pubmed.gov web page reference, https://pubmed.ncbi.nlm.nih.gov/17284506/ stated "... Laboratory evaluation of potassium and creatinine among ambulatory patients prescribed spironolactone: are we monitoring for hyperkalemia? ... Serum potassium and creatinine evaluation is recommended in patients prescribed spironolactone ...." 8. Review of the pubmed.gov web page reference, https://pubmed.ncbi.nlm.nih.gov/23110839/ stated "... Therapeutic drug monitoring of primidone and phenobarbital ... a first-line treatment of essential tremor ... Generally accepted therapeutic range for primidone is between 5 and 10 mg/L (23-46 mmol/L) ...." 9. Review of the FDA web page reference, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/208658s001lbl.pdf stated "... Geriatric patients: Higher incidence of adverse reactions related to volume depletion and reduced renal function. Assess renal function more frequently ... Obtain an eGFR at least annually in all patients taking SYNJARDY XR. In patients at increased risk for the development of renal impairment (e.g., the elderly), renal function should be assessed more frequently ...." 10. Review of dailymed web page reference, https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=2b8d9730-686b-444b-9941-7b587725592	G 536		

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G 536	Continued From page 21 4 stated "... Glucose monitoring is recommended for all patients with diabetes ...." 11. Review of drugs.com web page reference, https://www.drugs.com/potassium_chloride.html stated "... To be sure potassium chloride is helping your condition, your blood may need to be tested often ...." 12. Review of drugs.com web page reference for depakote, https://www.drugs.com/pro/depakote.html stated "... Serum liver tests should be performed prior to therapy and at frequent intervals thereafter ...." 13. Review of drugs.com web page reference for levothyroxine/Synthroid, https://www.drugs.com/pro/synthroid.html stated "... Dosing must be individualized ... and dose adjustments made based on periodic assessment of the patient's clinical response and laboratory parameters ...." 14. Review of a U.S. National Library of Medicine web page reference for lidocaine pain patch https://medlineplus.gov/druginfo/meds/a603026.html stated "... never wear patches for more than 12 hours per day. Using too many patches or leaving patches on for too long may cause serious side effects ... If you wear too many patches or wear patches for too long, too much lidocaine may be absorbed into your blood. In that case, you may experience symptoms of an overdose ... If the victim has collapsed, had a seizure, has trouble breathing, or can't be awakened, immediately call emergency services at 911 ...." 15. Review of an NIH (National Institutes of health web page reference for vitamin D,	G 536		

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G 536	Continued From page 22 https://ods.od.nih.gov/factsheets/VitaminD-Consumer/ stated "... one way to know if you ' re getting enough [vitamin D] is a blood test that measures the amount of vitamin D in your blood ... getting too much vitamin D can be harmful. Very high levels of vitamin D in your blood (greater than 375 nmol/L or 150 ng/mL) can cause nausea, vomiting, muscle weakness, confusion, pain, loss of appetite, dehydration, excessive urination and thirst, and kidney stones. Extremely high levels of vitamin D can cause kidney failure, irregular heartbeat, and even death. High levels of vitamin D are almost always caused by consuming excessive amounts of vitamin D from dietary supplements ...." 16. Review of a Cleveland Clinic web page reference for ferrous sulfate (iron), https://my.clevelandclinic.org/health/articles/14568-oral-iron-supplementation, stated "... Your doctor will let you know how long you will have to take the iron supplement. Usually, after your hemoglobin and iron levels are back to normal, you will continue to take the iron supplement for another six months. Afterward, you will have regular blood tests to measure your iron level ...." 17. Record review of patient #1 was completed on 4/12/2021 and again on 4/14/2021, start of care date 07/15/2013, primary diagnosis of Alzheimer's disease, unspecified, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/6/21-6/4/21, which evidenced the patient received skilled nursing services for supervisory visits, HHA (home health aide) services for personal care, medications the patient took included (but not limited to) depakote and levothyroxine, both of which required periodic lab monitoring to ensure drug therapy	G 536		

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effectiveness.

Review of a document dated and signed by RNCM G on 4/2/2021 titled "RN Re-Certification [comprehensive] Assessment" failed to evidence documented lab results and failed to evidence the registered nurse monitored for therapeutic blood levels of depakote and levothyroxine or obtained blood specimens for testing as per medication recommendations, and failed to evidence orders for therahoney (a topical wound ointment to treat wounds) for wound treatment to the medication profile.

Review of a document dated and signed by HHA H on 4/6/2021 titled "Daily [home health aide/attendant care] Visit Sheet for 4/02/2021" stated "... 3 pressure sores [open wound caused by unrelieved pressure] on bottom, one open. Nurse noted ...."

During a home visit observation on 4/13/2021 at 11:55 AM, a superficial open wound was observed on the right intergluteal cleft (butt crack). Family indicated they used therahoney on the wound. The alternate clinical manager was present for the home visit and indicated she would get an order for the therahoney.

18. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, other pertinent diagnosis included (but not limited to) iron deficiency anemia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021, which evidenced the patient received skilled nursing services for supervisory visits, HHA services for personal care, medications the patient took included (but not

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limited to) ferrous sulfate and vitamin D3, both of which required periodic lab monitoring to ensure drug therapy effectiveness.

Review of a document dated and signed by RNCM E on 3/5/2021 titled "RN Re-Certification Assessment" failed to evidence documented lab results and failed to evidence the registered nurse monitored for therapeutic blood levels of ferrous sulfate and vitamin D3 or obtained blood specimens for testing, failed to evidence an order for the Epsom salts and eucalyptus, nor was it listed on the medication profile.

During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA (home health aide) K were present. Observed patient's hands soaking in pans of water. When asked by the surveyor if there was anything added to the water, the patient indicated Epsom salts and eucalyptus (an herbal remedy/preparation) was routinely added. The alternate clinical manager stated she would get an order for the Epsom salts, and eucalyptus (but she failed to do so).

During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RN E, and HHA K were present. RN E asked HHA K what she added to the hand and foot soaks. HHA K indicated she added Epsom salts with eucalyptus and spearmint and stated "... about a handful ...." RN E indicated she would get an order. RNCM E failed to review and reconcile all the patient's current medications during the home visit.

19. Record review for patient #3 was completed on 4/12/2021 and again on 4/14/2021, start of care date 8/27/2019, primary diagnosis type 2

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diabetes with hyperglycemia (high blood sugar), other pertinent diagnoses included (but not limited to) essential tremor, chronic combined systolic and diastolic heart failure, and vitamin D deficiency, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 2/17/2021 - 4/17/2021, which evidenced (but not limited to) the patient received skilled nursing services (but not limited to) for weekly medication tray set up, was on a low sugar/simple carbohydrate (diabetic) diet, he was "relatively non-compliant" with his diet; and was prescribed (but not limited to) primidone (medication to treat tremors), spironolatactone (a diuretic medication), synjardy (a diabetes medication), and detemir (an injectable diabetes medication), all of which required periodic lab monitoring.

A recertification comprehensive assessment was completed on 2/12/2021. The comprehensive assessment failed to evidence documented lab results, failed to evidence the registered nurse monitored for therapeutic blood levels of primidone, spironolatactone, synjardy, and detemir, or obtained blood specimens for testing, and failed to evidence a licocaine topical patch on the medication profile.

Review of a drugs.com document dated 3/2/2021 titled "Drug Interaction Report" stated "... Applies to: insulin detemir, Synjardy ... Your blood glucose should be closely monitored ...."

Review of a document dated 3/30/2021 titled "Skilled Nurse Visit Note" evidenced the patient was alert and oriented, had no pain, vital signs were within normal limits, and evidenced the nurse applied a lidocaine patch (a medicated

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topical pain patch) to the patient's left shoulder. The record failed to evidence the nurse provided any teaching regarding the medication precautions, such as to remove the patch after 12 hours, or signs and symptoms to report to the nurse or physician.

Review of a document dated 4/1/2021 titled "Discharge Summary" stated "... Client found deceased in his bed by an unknown party on 3/31/2021 ...."

20. Record review for patient #4 was completed on 4/14/2021, start of care date 6/18/2020, primary diagnosis type 2 diabetes with hyperglycemia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/14/2021 - 6/12/2021, which evidenced (but not limited to) the patient received skilled nursing visits every 2 weeks to fill and organize medication delivery system (pill planner box), he was prescribed (but not limited to) potassium chloride and detemir (insulin), he was non-compliant with his diabetic diet, and in a section titled "60 Day Summary" stated "... The client has set a continuing goal for himself to reduce his A1C [a laboratory blood test to determine the patient's average blood sugar for the preceding 2 to 3 months].

A recertification comprehensive assessment dated 2/11/2021, completed by RNCM E failed to evidence documented lab results, failed to evidence the registered nurse monitored for therapeutic blood levels of potassium levels or hemoglobin A1C.

21. Record review for patient #5 was completed on 4/14/2021, start of care date 1/11/2016, primary diagnosis fibromyalgia, other (but not

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G 536	Continued From page 27 limited to) diagnoses of type 2 diabetes without complications, and magnesium deficiency. Review of a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/14/2021 - 6/12/2021, which evidenced (but not limited to) the patient received skilled nursing services every 2 weeks for medication tray set up, was very non-compliant with diabetes disease management, made poor food choices, was non-compliant with a diabetic diet, refused to check blood sugar levels (finger stick test in the home), pain and diabetes were not controlled, medications included (but not limited to) magnesium oxide, vitamin D3, and hydrocodone (for pain). A recertification comprehensive assessment was documented on 4/9/2021, from a skilled nurse visit made by RNCM E on 4/8/2021. The comprehensive assessment failed to evidence documented lab results, failed to evidence the registered nurse monitored for therapeutic blood levels of magnesium, vitamin D3 or hemoglobin A1C. 22. During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manager indicated she would expect to see an order for a lidocaine transdermal patch on the plan of care, anything added to water during a soak should be on the care plan, and there probably wasn't a drugs.com document (a web based drug interaction checker) in the chart for the comprehensive assessment completed for patient #1 on 4/2/2021 because "... this is so new for us ...." During this time, the administrator indicated the agency didn't have the staff to cover multiple weekly or even weekly visits for skilled care.	G 536		

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G 536	Continued From page 28 23. During an interview on 4/14/2021 at 12:25 PM, the alternate clinical manager indicated there were no lab results in patient records, and the agency did not perform lab draws. 17-14-1(a)(1)(B)	G 536		
G 544	Update of the comprehensive assessment CFR(s): 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- This Standard is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure a comprehensive re-assessment including OASIS (outcome and assessment information set) data was completed for 2 of 2 records reviewed for skilled patients whose health status declined (#1, 2). Findings include: 1. Review of an undated agency policy C-155, copyright Briggs Healthcare, Home Care Operational Guidelines titled "Client Reassessment/Update of Comprehensive Assessment Significant Change of Condition (SCIC)" 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 ... Assessment will include OASIS data collection for all Medicare and Medicaid skilled clients ... To identify decline or improvement in health status ... are	G 544		

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G 544	Continued From page 29 reassessed when significant changes occur in their condition ... [or] diagnosis ...." 2. A home visit observation was completed for patient #1 on 4/13/2021 at 11:55 AM. The alternate clinical director and HHA I was present. The patient's daughter (also a nurse) arrived during the visit, who indicated the patient developed symptoms of a respiratory infection on or about 3/8/2021, his symptoms worsened and he was seen in a walk-in clinic (3/11/2021), was prescribed antibiotics, she had him sleep in his recliner to help him breathe easier until about a week and a half ago, he developed a pressure sore due to spending so much time in the recliner, she used desitin (topical skin protectant) on his buttocks and TheraHoney wound gel (for use on wounds with no drainage to moderate drainage and should be paired with an occlusive absorbent dressing) on his wound for several weeks, and the wound was on his right intergluteal cleft (butt crack). Record review for patient this was completed on 4/14/2021, start of care date 7/15/2013, for certification periods 2/5/2021 - 4/5/2021, and 4/6/2021 - 6/4/2021, with primary diagnosis of Alzheimer's disease, unspecified. The record evidenced the agency was aware of the patient's first decline in health status on 3/11/2021, did not assess the patient until 3/23/2021, and failed to evidence the RN performed a comprehensive assessment including OASIS data on the patient based on the significant decline in health status on 3/23/2021. Additionally, the record evidenced the agency was aware of the patient's additional decline in health status (on 4/2/2021) with the development of a wound, and failed to ensure a comprehensive re-assessment with OASIS data was completed on 4/2/2021.	G 544		

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G 544	Continued From page 30 Review of a document dated and signed by the alternate clinical manager on 3/11/2021 titled "Care Coordination Note" stated "... spoke with Daughter of this client.about [sic] the client possibly having aspirational [sic] pneumonia. she [sic] is trying to get transportation to the walk in [sic] clinic as opposed to going to the hospital ... sitting him in a chair and using vicks [a mentholated topical cough suppressant ointment], cough syrup for two days now and thinks he needs an antibiotic ... I told her with the pneumonia he could get bad fast ... the daughter said she would let me know what happens ...." Review of a document dated and signed by the clinical manager on 3/12/2021 titled "Care Coordination Note" stated "... [daughter] took her father [patient] to a walk up clinic yesterday ... given a prescription for an oral antibiotic ... [daughter] to email the clinic paperwork to me today ...." Review of a document from walk-in clinic A dated 3/11/2021 evidenced the patient was diagnosed with bacterial lower respiratory infection, cough, fever, and was prescribed an antibiotic to treat the infection. Review of a document dated and signed 3/23/2021 by RNCM (registered nurse case manager) G titled "SN [skilled nurse] Daily Note" stated "... RNCM was notified by multiple reports (from the client's daughter, from HHA [home health aide], from other RNs) that the client's functional status has declined. He was reported to be weak, unable to get out of bed, unable to walk ... possible "aspiration pneumonia", has been to urgent care for antibiotics ... Daughter reports that client aspirated over the weekend while being fed ... Cannot walk more than a couple of steps. He was previously able to walk	G 544		

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G 544	Continued From page 31 with assistance ... Unstable and, deteriorating ... Current Plan of Care ... May need to be modified ...." Review of a document dated and signed by HHA H on 4/6/2021 titled "Daily [home health aide/attendant care] Visit Sheet for 4/02/2021" stated "... 3 pressure sores [open wound caused by unrelieved pressure] on bottom, one open. Nurse noted ...." Review of a document dated and signed by RNCM G on 4/2/2021 titled "RN Re-Certification Assessment" failed to evidence a comprehensive assessment was completed that included OASIS data due to the decline in the patient's health status. 3. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021. The document evidenced a section titled "60 Day Summary" which stated " ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ...." The plan of care failed to evidence orders for (but not limited to) skilled nursing frequency and duration of visits, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, constipation, dehydration interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown, an order for the homeopathic treatment of Epsom salts and eucalyptus (the use of natural substances as remedies, such as plants and minerals), and failed to evidence	G 544		

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pressure ulcer in the section titled "Other Pertinent Diagnoses". The record also failed to evidence any nursing visits were completed after 3/5/2021 to re-assess the patient's wound until the visit made with the surveyor on 4/14/2021.

Review of a document dated and signed by RNCM E on 3/5/2021 titled "RN Re-Certification Assessment" failed to evidence a comprehensive re-assessment including OASIS data was completed, and stated "... left heel pressure wound, 2cm round ... Ruptured blister. Dry, healing well, no signs/symptoms of infection ...." The RN failed to identify the correct location and stage of the wound, which was actually on the right foot.

During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA (home health aide) K were present. The patient was positioned sitting upright in bed with both heels elevated. The right heel evidenced intact skin with a circular hyperpigmented (darker than patient's normal skin color) area, approximately 3.0 - 4.0 cm in diameter. The left heel was observed intact with no evidence of skin breakdown. The patient indicated she had blister on her right heel from friction on the bed, but it was resolved, and she never had any breakdown on her left heel.

During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RNCM E, and HHA K were present. The patient indicated she had a problem with her right heel, not the left heel, it started about a month ago, her mom covered the wound with gauze and tape, she never had problems with skin breakdown prior to this wound, and she could only feel slight sensation in her feet, such

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as pain. RNCM E asked HHA K what she added to the hand and foot soaks. HHA K indicated she added Epsom salts with eucalyptus and spearmint and stated, "... about a handful ...." RNCM E indicated she would get an order. Observed RNCM E perform a head-to-toe physical assessment on the patient. HHA K was positioned on one side of the bed, and RNCM E was positioned on the other. After a portion of the assessment was completed, HHA K removed all the positional pillows and lowered the head of the bed so the patient could be turned onto her right side (to assess the backside of the body). RNCM E began to turn the patient without first moving her closer to her side of the bed, which would prevent the patient's face from hitting the siderail. HHA K and the patient stopped RNCM E and verbally directed her on proper turning technique. Also, during the assessment, RNCM E repeatedly left the room for several minutes to chart in the EMR (electronic medical record), and then return to continue her assessment and ask the patient additional questions. RNCM E indicated she completed the physical assessment at 10:29 AM. RNCM E failed to measure the hyperpigmented area on the patient's right heel, palpate, or check the area for blanching (indicates presence or absence of adequate blood flow to determine if a pressure injury or suspected deep tissue injury is present). RNCM E asked the patient when she was last weighed, to which the patient indicated it was a year ago when she was hospitalized for a UTI (urinary tract infection). When asked by RNCM E when her last bowel movement was, the patient stated "Monday [4/12/2021- two days ago]", and HHA K stated, "We're trying to keep her more regular." When asked by the surveyor if the RN provided any teaching, the patient stated "No." She also indicated she stayed in the same sitting position in bed all day on days she worked

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G 544	Continued From page 34 (patient does part time work on computer with the use of a pen in mouth to type) and family would reposition onto her side in the evenings. During this time, HHA K stated, "I don't think she's [patient] drinking enough." RNCM E instructed HHA K to encourage fluids. When asked by the surveyor if fluid intake was recorded/monitored, HHA K indicated it was not. At 10:52 AM, RNCM E discussed goals with the patient, indicated they were "keeping" the skin goal, instructed the patient to continue to keep her heels off of the bed, and hand and feet soaks would continue. RNCM E indicated this was not a skilled patient, the document used for the assessment was titled "RN Daily Note", and this patient received aide services only. RNCM E failed to complete a comprehensive re-assessment including OASIS data with onset of a new wound. Review of a document dated and signed by RN E on 4/14/2021 titled "SN Daily Note" stated "... System Review ... Integument [skin] ... No significant issues ... Care is considered custodial ...." 4. During an interview on 4/8/2021 at 3:02 PM, the alternate clinical manager indicated the RNCMs provided a "Daily Update Report" to the alternate clinical manager every morning by 9:00 AM, one of the "reportable" concerns was any patient experiencing a change in condition, if identified, the alternate clinical manager would assign an RNCM to perform the Comprehensive Assessment the same day and notify the patient's physician of the assessment findings. When asked if she had implemented the assignment of an RNCM to perform a comprehensive re-assessment for a change in condition, and if so, for what, she stated "Not yet."	G 544		

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G 544	Continued From page 35 5. During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manager indicated a stage 2 pressure injury would have the top layer of skin off, a fluid filled blister would be a stage 2 pressure injury, and anything added to water during a soak should be on the care plan. During this time, the administrator indicated the most recent nursing case manager meetings addressed client situations, new wounds, falls, clinical topics of relevance, admissions, and discharges; most recent meetings focused on plans of care, discussed the new wounds (for patients #1, 2), possible discharges for them (from the agency), the agency management made a decision to pull back from skilled care during this time, and then later decide how to move forward, there was no decision made at that time to discharge the wound patients, and the agency didn't have the staff to cover multiple weekly or even weekly visits for skilled care 17-14-1(a)(1)(B)	G 544		
G 546	Last 5 days of every 60 days unless: CFR(s): 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. This Element is not met as evidenced by: Based on record review and interview, the agency failed to ensure all patients' comprehensive re-assessments were completed during the last five days of the patient's certification period for 2 of 2 records reviewed for patients who required a recertification re-assessment (#4, 5). Findings include:	G 546		

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G 546	Continued From page 36 1. Review of an undated agency policy C-155, copyright Briggs Healthcare, Home Care Operational Guidelines titled "Client Reassessment/Update of Comprehensive Assessment Significant Change of Condition (SCIC)" stated "... Comprehensive Assessment will be updated and revised as often as the client's condition warrants ... Assessment will include OASIS [outcome and assessment information set] data collection for all Medicare and Medicaid skilled clients ... within last five (5) days of episode ... To identify decline or improvement in health status ... are reassessed when significant changes occur in their condition ... [or] diagnosis ... at least every fifty-six to sixty (56-60) days ...." 2. Record review for patient #4 was completed on 4/14/2021, start of care date 6/18/2020, certification period 4/14/2021 - 6/12/2021, evidenced a comprehensive re-assessment was required to be completed no earlier than 4/9/2021, but no later than 4/13/2021. The record failed to evidence a comprehensive re-assessment was completed, or completed within the required timeframe. Review of a document dated and signed by RNCM (Registered Nurse Case Manager) E on 4/8/2021 titled "Skilled Nurse Visit Note" evidenced a skilled nursing visit was completed on 4/8/2021, and the patient's medication pill box was set up by the nurse for 2 weeks. Review of a document dated 4/9/2021, author RNCM E (without a dated electronic signature) titled "RN Re-Certification Assessment" evidenced an assessment was completed by RN E on 4/9/2021, and failed to evidence inclusion of	G 546		

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G 546	Continued From page 37 OASIS data collection. 3. Record review for patient #5 was completed on 4/14/2021, start of care date 1/11/2016, certification period 4/14/2021 - 6/12/2021, evidenced a comprehensive re-assessment was required to be completed no earlier than 4/9/2021, but no later than 4/13/2021. The record failed to evidence a comprehensive re-assessment visit was completed, or completed within the required timeframe. Review of a document dated and signed by RNCM E on 4/8/2021 titled "Skilled Nurse Visit Note" evidenced a skilled nursing visit was completed on 4/8/2021, and the patient's medication pill box was set up by the nurse for 2 weeks. Review of a document dated 4/9/2021, author RNCM E (without a dated electronic signature) titled "RN Re-Certification Assessment" evidenced an assessment visit was completed by RN E on 4/9/2021, and failed to evidence inclusion of OASIS data collection. 4. During an interview on 4/9/2021 at 9:53AM, when asked the last time a nurse saw her, patient #5 stated "Yesterday [4/8/2021]." 5. During an interview on 4/9/2021 at 1:57 PM, RNCM E indicated she was in the office all day (4/9/2021), she did not perform any skilled nursing visits today (4/9/2021), she performed the re-assessments on patients #4 and #5 "... Yesterday ...." (4/8/2021), she couldn't open the "RN Re-Certification Assessment" documents until today (4/9/2021) for completion, and the EHR (electronic health record) only allowed the document to be opened during the last five days	G 546		

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G 546	Continued From page 38 of the certification period. She also indicated she didn't see a problem that she saw the patients on one day, and documented she saw them on a different day. 6. During an interview on 4/9/2021 at 3:45 PM, the alternate clinical manger indicated there was a 5-day timeframe for completing the comprehensive re-assessment, RNCM E should have used it, and performing a visit outside the required 5 days during the end of the certification period to fill a medication pill box was not a valid excuse. During this time, the administrator and clinical manager indicated they were unaware RNCM E falsified dates of assessments for patients #4 and #5. 7. During an interview on 4/14/2021 at 12:25 PM, the clinical manager indicated she addressed the falsification of visit dates with RNCM E, and RNCM E performed comprehensive re-assessments on patients #4 and 5 on 4/11/2021.	G 546		
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. 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	G 570		

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G 570	Continued From page 39 anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This Condition is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to meet the needs of the patient for 2 of 2 patients' observed with a change in condition (# 1, 2); failed to ensure all patients' plans of care included (but not limited to) all pertinent diagnoses, the frequency and duration of visits to be made, rehabilitation potential, all medications and treatments, patient and caregiver education and training to facilitate timely discharge, and patient-specific interventions and education (See Tag G574); failed to evidence treatments were administered only as ordered by a physician (See TagG580); failed to evidence physicians' verbal orders were accurately dated and timed (See Tag G584); failed to evidence the plans of care were reviewed as frequently as the patient's condition or needs required, but no less frequently than once every 60 days (See Tag G588); failed to evidence the physician was promptly notified of any changes in the patient's condition or needs that suggested the plan of care should be altered (See Tag G590); failed to evidence the revised plan of care reflected current information from the patient's updated comprehensive assessment (See Tag G592); and failed to evidence patients/caregivers received ongoing education and training provided by the agency regarding the care and services identified in the plans of care (See Tag G610). This practice had the potential to affect all agency patients. The cumulative effect of these systemic problems	G 570		

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G 570	Continued From page 40	G 570		

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.

Regarding G570, findings include:

1. Review of an undated agency policy C-120 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Admission Policy" stated "... Clients are accepted for treatment in the home on the basis of reasonable criteria and under the expectation that the client's medical, nursing, and social needs can be met adequately by Home Nursing Services in the client's place of residence ... will not admit client or continue to provide services ... Scope and complexity of needs cannot be met ... Skills and ... personnel are not adequate to meet client needs ...."

2. Record review for patient #1 was completed on 4/14/2021, start of care date 7/15/2013, for certification periods 2/5/2021 - 4/5/2021, and 4/6/2021 - 6/4/2021, with primary diagnosis of Alzheimer's disease, unspecified and orders for home health aide (HHA) services only. The plan of care also evidenced a section titled "60 Day Summary" (which provided a summary of patient findings from the previous certification period) that stated " ... formation of a stage 2 pressure sore on right buttock ... measures 0.5cm [centimeters] by 0.5cm ... the RN [registered nurse] case manager will need to make at least weekly visits to monitor the progress and assess if sore is getter better or worse with current treatment ...."

The record evidenced the agency was aware of the patient's first decline in health status on 3/11/2021 and failed to assess the patient until

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G 570	Continued From page 41 3/23/2021. Additionally, the record evidenced the agency was aware of the patient's additional decline in health status (on 4/2/2021) with the development of a wound. The agency failed to ensure they could meet the needs of the patient by: failing to obtain skilled nursing orders for observation and assessment to prevent further illness, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, and interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown. A home visit observation was completed for patient #1 on 4/13/2021 at 11:55 AM. The alternate clinical director and HHA I was present. A superficial open wound was observed on the right intergluteal cleft (butt crack), approximately 1.0 cm (centimeter) in diameter, 0.1 - 0.2 cm depth, with a pink, moist wound bed. The surrounding skin was not observable due to the presence of desitin ointment (zinc oxide topical skin protectant) on the skin. The patient's daughter (also a nurse) arrived during the visit, who indicated the patient developed symptoms of a respiratory infection on or about 3/8/2021, his symptoms worsened, and he was seen in a walk-in clinic (3/11/2021), was prescribed antibiotics, she had him sleep in his recliner to help him breathe easier. Additionally, she stated about a week and a half ago, he developed a pressure sore due to spending so much time in the recliner, he never had a pressure sore until the respiratory illness in March (2021). She used desitin on his buttocks and TheraHoney wound gel (for use on wounds with no drainage to moderate drainage and should be paired with an occlusive absorbent dressing) on his wound for several weeks, and the wound was on his right	G 570		

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G 570	Continued From page 42 buttock. Review of a document dated and signed by the alternate clinical manager on 3/11/2021 titled "Care Coordination Note" stated "... spoke with Daughter of this client.about [sic] the client possibly having aspirational [sic] pneumonia. she [sic] is trying to get transportation to the walk in [sic] clinic as opposed to going to the hospital ... sitting him in a chair and using vicks [a mentholated topical cough suppressant ointment], cough syrup for two days now and thinks he needs an antibiotic ... I told her with the pneumonia he could get bad fast ... the daughter said she would let me know what happens ...." Review of a document dated and signed by the clinical manager on 3/12/2021 titled "Care Coordination Note" stated "... [daughter] took her father [patient] to a walk up clinic yesterday ... given a prescription for an oral antibiotic ... [daughter] to email the clinic paperwork to me today ...." Review of a document from walk-in clinic A dated 3/11/2021 evidenced the patient was diagnosed with bacterial lower respiratory infection, cough, fever, and was prescribed an antibiotic to treat the infection. Review of a document dated and signed 3/23/2021 by RNCM (registered nurse case manager) G titled "SN [skilled nurse] Daily Note" stated "... RNCM was notified by multiple reports [from the client's daughter, from HHA [home health aide], from other RNs] that the client's functional status has declined. He was reported to be weak, unable to get out of bed, unable to walk ... possible "aspiration pneumonia", has been to urgent care for antibiotics ... Daughter	G 570		

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G 570	Continued From page 43 reports that client aspirated over the weekend while being fed ... Cannot walk more than a couple of steps. He was previously able to walk with assistance ... Unstable and, deteriorating ... Current Plan of Care ... May need to be modified ...." Review of a document dated and signed by HHA H on 4/6/2021 titled "Daily [home health aide/attendant care] Visit Sheet for 4/02/2021" stated "... 3 pressure sores [open wound caused by unrelieved pressure] on bottom, one open. Nurse noted ...." Review of a document dated and signed by RNCM G on 4/2/2021 titled "RN Re-Certification [comprehensive] Assessment" evidenced the patient was at risk for skin breakdown, the depth of the wound as 0.0 cm (depth was observed during home visit). 3. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021, which evidenced the patient received skilled nursing services for supervisory visits and HHA services for personal care. The document evidenced a section titled "60 Day Summary" which stated " ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ...."The agency failed to ensure they could meet the needs of the patient by: failing to obtain skilled nursing orders, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, and interventions for patient/family teaching regarding	G 570		

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wound care/prevention of new or worsening skin breakdown, and failed to ensure the RNCM had knowledge of how to properly turn patient as evidenced by:

Review of a document dated and signed by RNCM E on 3/5/2021 titled "RN Re-Certification Assessment" failed to evidence a comprehensive re-assessment including OASIS data was completed, and stated "... left heel pressure wound, 2cm round ... Ruptured blister. Dry, healing well, no signs/symptoms of infection ...."

During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA (home health aide) K were present. The patient was positioned sitting upright in bed with both heels elevated. The right heel evidenced intact skin with a circular hyperpigmented (darker than patient's normal skin color) area, approximately 3.0 - 4.0 cm in diameter. The left heel was observed intact with no evidence of skin breakdown. The patient indicated she had blister on her right heel from friction on the bed, but it was resolved, and she never had any breakdown on her left heel.

During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RNCM E, and HHA K were present. The patient indicated she had a problem with her right heel, not the left heel, it started about a month ago, her mom covered the wound with gauze and tape, she never had problems with skin breakdown prior to this wound, and she could only feel slight sensation in her feet, such as pain. Observed RNCM E perform a head-to-toe physical assessment on the patient. HHA K was positioned on one side of the bed, and RNCM E was positioned on the other. After a

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portion of the assessment was completed, HHA K removed all the positional pillows and lowered the head of the bed so the patient could be turned onto her right side (to assess the backside of the body). RNCM E began to turn the patient without first moving her closer to her side of the bed, which would prevent the patient's face from hitting the siderail. HHA K and the patient stopped RNCM E and verbally directed her on proper turning technique. Also, during the assessment, RNCM E repeatedly left the room for several minutes to chart in the EMR (electronic medical record), and then return to continue her assessment and ask the patient additional questions. RNCM E indicated she completed the physical assessment at 10:29 AM. RNCM E failed to measure the hyperpigmented area on the patient's right heel, palpate, or check the area for blanching (indicates presence or absence of adequate blood flow to determine if a pressure injury or suspected deep tissue injury is present). She also indicated she stayed in the same sitting position in bed all day on days she worked (patient does part time work on computer with the use of a pen in mouth to type) and family would reposition onto her side in the evenings.

Review of a document dated and signed by RN E on 4/14/2021 titled "SN Daily Note" stated "... System Review ... Integument [skin] ... No significant issues ... Care is considered custodial ...."

4. During an interview on 4/8/2021 at 3:02 PM, the alternate clinical manager indicated the RNCMs provided a "Daily Update Report" to the alternate clinical manager every morning by 9:00 AM, one of the "reportable" concerns was any patient experiencing a change in condition, if identified, the alternate clinical manager would

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G 570	Continued From page 46 assign an RNCM to perform the Comprehensive Assessment the same day and notify the patient's physician of the assessment findings. When asked if she had implemented the assignment of an RNCM to perform a comprehensive re-assessment for a change in condition, and if so, for what, she stated "Not yet."	G 570		
G 574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. This Element is not met as evidenced by:	G 574		

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G 574	Continued From page 47 Based on observation, record review and interview, the home health agency failed to ensure all patients' plans of care included (but not limited to) all pertinent diagnoses; failed to evidence the frequency and duration of visits to be made; failed to evidence rehabilitation potential; failed to evidence all medications and treatments; failed to evidence patient and caregiver education and training to facilitate timely discharge; and failed to evidence patient-specific interventions and education for 5 of 5 records reviewed (#1, 2, 3, 4, 5). Findings include: 1. Review of an undated agency policy C-850 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Plan of Care" stated (but not limited to) "... The Plan of Care is based on a comprehensive assessment and information provided by the client/family ... consistently reviewed to ensure that client needs are met ... assure the plan meets state/federal guidelines ... An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services ... shall be completed in full to include ... All pertinent diagnosis(es) ... Type, frequency, and duration of all visits/services ... Diagnostic tests, including laboratory ... Rehabilitation potential ... precautions ... Specific dietary or nutritional requirements or restrictions ... Medications, treatments ... Instructions to client/caregiver ... Other appropriate items ... All of the above items must always be addressed on the plan of care ... 2. Review of an undated agency policy C-100 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Services Provided" stated "... Services will be coordinated by the	G 574		

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G 574	Continued From page 48 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 ...." 3. Review of Job Description D-470 dated 06/2000 titled "Registered Nurse Case Manager" stated " ... obtains pertinent information concerning the nurse care to be provided to the client and develop the plan of care for the client ... contacts the clinical director with client information as necessary ...teaches the client and caregiver in the areas on the plan of care ...." 4. Review of the FDA web page reference https://www.accessdata.fda.gov/drugsatfda_docs/label/2008/012151s062lbl.pdf stated "... The recommended monitoring for potassium and creatinine is one week after initiation or increase in dose of Aldactone [spironolatactone], monthly for the first 3 months, then quarterly for a year, and then every 6 months ... Concomitant administration of potassium-sparing diuretics and ACE inhibitors or nonsteroidal anti-inflammatory drugs (NSAIDs), e.g., [aspirin], has been associated with severe hyperkalemia ... it is important to monitor serum potassium levels ... Patients who receive Aldactone should be advised to avoid potassium supplements and foods containing high levels of potassium, including salt substitutes ... Laboratory tests: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be done at appropriate intervals, particularly in the elderly ...." 5. Review of the pubmed.gov web page reference, https://pubmed.ncbi.nlm.nih.gov/17284506/	G 574		

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G 574	Continued From page 49 stated "... Laboratory evaluation of potassium and creatinine among ambulatory patients prescribed spironolactone: are we monitoring for hyperkalemia? ... Serum potassium and creatinine evaluation is recommended in patients prescribed spironolactone ...." 6. Review of the pubmed.gov web page reference, https://pubmed.ncbi.nlm.nih.gov/23110839/ stated "... Therapeutic drug monitoring of primidone and phenobarbital ... a first-line treatment of essential tremor ... Generally accepted therapeutic range for primidone is between 5 and 10 mg/L (23-46 mmol/L) ...." 7. Review of the FDA web page reference https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/208658s001lbl.pdf stated "... Geriatric patients: Higher incidence of adverse reactions related to volume depletion and reduced renal function. Assess renal function more frequently ... Obtain an eGFR at least annually in all patients taking SYNJARDY XR. In patients at increased risk for the development of renal impairment (e.g., the elderly), renal function should be assessed more frequently ...." 8. Review of dailymed web page reference https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=2b8d9730-686b-444b-9941-7b5877255924 stated "... Glucose monitoring is recommended for all patients with diabetes ...." 9. Review of drugs.com web page reference https://www.drugs.com/potassium_chloride.html stated "... To be sure potassium chloride is helping your condition, your blood may need to be tested often ...."	G 574		

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G 574	Continued From page 50 10. Review of drugs.com web page reference for depakote https://www.drugs.com/pro/depakote.html stated "... Serum liver tests should be performed prior to therapy and at frequent intervals thereafter ...." 11. Review of drugs.com web page reference for levothyroxine/Synthroid https://www.drugs.com/pro/synthroid.html stated "... Dosing must be individualized ... and dose adjustments made based on periodic assessment of the patient's clinical response and laboratory parameters ...." 12. Review of a U.S. National Library of Medicine web page reference for lidocaine pain patch https://medlineplus.gov/druginfo/meds/a603026.html stated "... never wear patches for more than 12 hours per day. Using too many patches or leaving patches on for too long may cause serious side effects ... If you wear too many patches or wear patches for too long, too much lidocaine may be absorbed into your blood. In that case, you may experience symptoms of an overdose ... If the victim has collapsed, had a seizure, has trouble breathing, or can't be awakened, immediately call emergency services at 911 ...." 13. Record review of patient #1 was completed on 4/12/2021 and again on 4/14/2021, start of care date 07/15/2013, primary diagnosis of Alzheimer's disease, unspecified, and other diagnoses (but not limited to) atrophy of thyroid, constipation, and pressure ulcer of right buttock, stage 2 (open or blister-like wound caused by unrelieved pressure or friction), and the patient received home health aide (HHA) services 2 to 5 hours per day, 5 days per week per family request, and skilled nursing for supervisory visits.	G 574		

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G 574	Continued From page 51 The record evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/6/21-6/4/21, which evidenced (but not limited to) the patient's prescribed medications included (but not limited to) depakote and levothyroxine (synthroid), both of which required periodic therapeutic drug level monitoring (lab draws), patient was at risk for aspiration (ingestion of food and/or fluids into the lungs), and the patient had a POA (power of attorney). The plan of care also evidenced a section titled "60 Day Summary" (which provided a summary of patient findings from the previous certification period) that stated " ... formation of a stage 2 pressure sore on right buttock ... measures 0.5cm [centimeters] by 0.5cm ... the RN [registered nurse] case manager will need to make at least weekly visits to monitor the progress and assess if sore is getter better or worse with current treatment ...." The plan of care failed to evidence orders for (but not limited to) orders for skilled nursing with frequency and duration of visits to monitor progress of the wound, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown, management of constipation, name and contact information for the patient's POA, or interventions to assure medications maintained therapeutic drug levels. 14. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, other pertinent diagnoses (but not limited to) included constipation, unspecified urinary incontinence, and fecal urgency (sudden, almost	G 574		

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G 574	Continued From page 52	G 574		

uncontrollable, need to defecate), and received HHA services 4 hours, 4 days weekly, and 8 hours, 1 day weekly. The record evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021, which evidenced a section titled "60 Day Summary" which stated " ... fecal and urinary incontinence ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ... RN will supervise patient ... through periodic planned and unplanned supervisory visits ...."

The plan of care failed to evidence the diagnosis of stage 2 pressure ulcer, orders for (but not limited to) orders for skilled nursing with frequency and duration of visits to monitor progress of the wound, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, constipation, interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown, an order for the homeopathic treatment of Epsom salts and eucalyptus (the use of natural substances as remedies, such as plants and minerals) or application of Vaseline as a skin barrier.

During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA K were present. The patient was positioned sitting upright in bed with both heels elevated. The right heel evidenced intact skin with a circular hyperpigmented (darker than patient's normal skin color) area, approximately 3.0 - 4.0 cm in diameter. The left heel was observed intact with no evidence of skin breakdown. The patient indicated she had blister

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G 574	Continued From page 53 on her right heel from friction on the bed, but it was resolved, and she never had any breakdown on her left heel. Observed patient's hands soaking in pans of water. When asked by the surveyor if there was anything added to the water, the patient indicated Epsom salts and eucalyptus was routinely added. During this time, HHA K indicated she used Vaseline as a skin barrier when she performed incontinence care per the patient's request. During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RN E, and HHA K were present. The patient indicated she had a problem with her right heel, not the left heel, it started about a month ago, her mom covered the wound with gauze and tape, she never had problems with skin breakdown prior to this wound, and she could only feel slight sensation in her feet, such as pain. RN E asked HHA K what she added to the hand and foot soaks. HHA K indicated she added Epsom salts with eucalyptus and spearmint and stated "... about a handful ...." RN E indicated she would get an order. Observed RN E perform a head-to-toe physical assessment on the patient. RN E indicated she completed the physical assessment at 10:29 AM. RN E failed to measure the hyperpigmented area on the patient's right heel, palpate, or check the area for blanching (indicates presence or absence of adequate blood flow to determine if a pressure injury or suspected deep tissue injury is present). When asked by RN E when her last bowel movement was, the patient stated "Monday [4/12/2021- two days ago]", and HHA K stated, "We're trying to keep her more regular." When asked by the surveyor if the RN provided any teaching, the patient stated "No." She also indicated she stayed in the same sitting position	G 574		

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G 574	Continued From page 54 in bed all day on days she worked but would reposition onto her side in the evenings. During this time, HHA K stated, "I don't think she's [patient] drinking enough." RN E instructed HHA K to encourage fluids. When asked by the surveyor if fluid intake was recorded/monitored, HHA K indicated it was not. At 10:52 AM, RN E discussed goals with the patient, indicated they were "keeping" the skin goal, instructed the patient to continue to keep her heels off the bed, and hand and feet soaks would continue. RN E indicated this was not a skilled patient, the document used for the assessment was titled "RN Daily Note", and this patient received aide services only. 15. Record review for patient #3 was completed on 4/12/2021 and again on 4/14/2021, start of care date 8/27/2019, primary diagnosis type 2 diabetes with hyperglycemia (high blood sugar), evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 2/17/2021 - 4/17/2021, which evidenced (but not limited to) the patient lived alone, received skilled nursing services (but not limited to) for weekly medication tray set up, was on a low sugar/simple carbohydrate (diabetic) diet, he was "relatively non-compliant" with his diet; and was prescribed (but not limited to) primidone (medication to treat tremors), spironolatactone (a diuretic medication), synjardy (a diabetes medication), and detemir (an injectable diabetes medication), all of which required periodic lab monitoring. The plan of care failed to evidence orders for (but not limited to) skilled nursing duration of visits, interventions for diabetes management and hyperglycemia, diabetic diet and non-compliance, interventions to monitor therapeutic drug levels, or interventions for patient/family teaching regarding disease	G 574		

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G 574	Continued From page 55	G 574		

management and diet; and failed to evidence lidocaine topical patch on the medication list.

Review of a drugs.com document dated 3/2/2021 titled "Drug Interaction Report" stated "... Applies to: insulin detemir, Synjardy ... Your blood glucose should be closely monitored ...."

Review of a document dated 3/30/2021 titled "Skilled Nurse Visit Note" evidenced the patient was alert and oriented, had no pain, vital signs were within normal limits, and evidenced the nurse applied a lidocaine patch (a medicated topical pain patch) to the patient's left shoulder. The document failed to evidence the nurse provided any teaching regarding the medication precautions, such as to remove the patch after 12 hours, or signs and symptoms to report to the nurse or physician; and failed to evidence any interventions such as patient education regarding diet, medication teaching, or teaching related to disease management.

Review of a document dated 4/1/2021 titled "Discharge Summary" stated "... Client found deceased in his bed by an unknown party on 3/31/2021 ...."

16. Record review for patient #4 was completed on 4/14/2021, start of care date 6/18/2020, primary diagnosis type 2 diabetes with hyperglycemia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/14/2021 - 6/12/2021, which evidenced (but not limited to) the patient was an 81 year old who lived alone, he received skilled nursing visits every 2 weeks to fill and organize medication delivery system (pill planner box), he was prescribed (but not limited to) potassium chloride and detemir (insulin), he

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G 574	Continued From page 56 was non-compliant with his diabetic diet, and in a section titled "60 Day Summary" stated "... The client has set a continuing goal for himself to reduce his A1C [a laboratory blood test to determine the patient's average blood sugar for the preceding 2 to 3 months]. The record failed to evidence orders for skilled nursing interventions such as lab monitoring for therapeutic blood potassium levels or hemoglobin A1C levels, failed to evidence results of a recent hemoglobin A1C level, and failed to evidence any interventions such as patient education regarding diet, medication teaching, or teaching related to disease management. 17. Record review for patient #5 was completed on 4/14/2021, start of care date 1/11/2016, primary diagnosis fibromyalgia, other (but not limited to) diagnoses of type 2 diabetes without complications, and magnesium deficiency. Review of a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/14/2021 - 6/12/2021, which evidenced (but not limited to) the patient was a 73 year old who lived alone, received skilled nursing services every 2 weeks for medication tray set up, was very non-compliant with diabetes disease management, made poor food choices, was non-compliant with a diabetic diet, refused to check her blood sugar, pain and diabetes were not controlled, medications included (but not limited to) magnesium oxide and hydrocodone (for pain). The record failed to evidence orders for skilled nursing interventions such as lab monitoring for therapeutic blood magnesium or hemoglobin A1C levels, medicinal and non-medicinal methods to mitigate pain, and failed to evidence interventions such as patient education regarding diet, medication teaching, or teaching related to disease management.	G 574		

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G 574	Continued From page 57 18. During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manager indicated she would expect to see an order for a lidocaine transdermal patch on the plan of care, sometimes patient education was found in the 60 Day Summary portion of the plan of care, a stage 2 pressure injury would have the top layer of skin off, a fluid filled blister would be a stage 2 pressure injury, and anything added to water during a soak should be on the care plan. 19. During an interview on 4/14/2021 at 12:25 PM, the alternate clinical manager indicated there were no lab results in patient records, and the agency did not perform lab draws. 17-13-1(a)(1)(B) 17-13-1(a)(1)(C) 17-13-1(a)(1)(D)(ii) 17-13-1(a)(1)(D)(iii) 17-13-1(a)(1)(D)(ix) 17-13-1(a)(1)(D)(xiii	G 574		
G 580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician. This Element is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure all services and treatments were provided/administered only as ordered by a physician for 3 of 5 records reviewed (#1, 2, 3). Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-635 titled "Physician Orders," stated "...	G 580		

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G 580	Continued From page 58 All medications, treatments, and services provided to clients must be ordered by a physician ...." 2. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines 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 ...." 3. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-340 titled "Home Health Aide Supervision," stated "Home Nursing Services shall provide Home Health Aide services ... when personal care services are indicated and ordered by the physician ...." 4. Review of a U.S. National Library of Medicine web page reference for lidocaine pain patch https://medlineplus.gov/druginfo/meds/a603026.html stated "... never wear patches for more than 12 hours per day. Using too many patches or leaving patches on for too long may cause serious side effects ... If you wear too many patches or wear patches for too long, too much lidocaine may be absorbed into your blood. In that case, you may experience symptoms of an overdose ... If the victim has collapsed, had a seizure, has trouble breathing, or can't be awakened, immediately call emergency services at 911 ...." 5. Record review of patient #1 was completed on 4/12/2021 and again on 4/14/2021, start of care date 07/15/2013, primary diagnosis of Alzheimer's	G 580		

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G 580	Continued From page 59 disease, unspecified, and other diagnoses (but not limited to) atrophy of thyroid, constipation, and pressure ulcer of right buttock, stage 2 (open or blister-like wound caused by unrelieved pressure or friction), and the patient received home health aide (HHA) services 2 to 5 hours per day, 5 days per week per family request, and skilled nursing services only for supervisory visits. The record evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/6/21-6/4/21, which evidenced (but not limited to) a section titled "60 Day Summary" (which provided a summary of patient findings from the previous certification period) that stated " ... formation of a stage 2 pressure sore on right buttock ... measures 0.5cm [centimeters] by 0.5cm ... the RN [registered nurse] case manager will need to make at least weekly visits to monitor the progress and assess if sore is getter better or worse with current treatment ...." The record evidenced a skilled nursing visit was made on 4/9/2021 for wound assessment but failed to evidence a physician's order for skilled nursing services for wound assessment and wound care treatment. Review of a document dated and signed on 4/9/2021 by RNCM (Registered nurse case manager) G on 4/9/2021 titled "SN [skilled nurse] Daily Note" evidenced the nurse performed a skilled nursing visit, and stated "... RNCM back ... to assess right buttock pressure wound from one week prior ... now measures 0.7 cm by 0.9 cm [worsened] ... right buttock is open and stageable as a stage 2 ... The left buttock is pinkened [sic], it blanches [positive blood flow], but there is no open area ... Wound measurements are being recorded on the ... Weekly Wound Measurements form ... Current Plan of Care ...	G 580		

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G 580	Continued From page 60 May need to be modified, will need increased frequencies ... Currently receiving RN visits weekly to assess wound progression ... Communicated with PCP [primary care physician] ... Via ... fax ... Update on wound status ...." The document failed to evidence the nurse requested skilled nursing orders (frequency, duration) for wound assessment/management or treatment orders. 6. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, other pertinent diagnoses (but not limited to) included constipation, unspecified urinary incontinence, and fecal urgency (sudden, almost uncontrollable, need to defecate), and received HHA services 4 hours, 4 days weekly, and 8 hours, 1 day weekly, and skilled nursing services only for supervisory visits The record evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021, which evidenced a section titled "60 Day Summary" which stated " ... fecal and urinary incontinence ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ... RN will supervise patient ... through periodic planned and unplanned supervisory visits ...." The record failed to evidence a physician's order for skilled nursing services for wound assessment and wound care treatment. The record evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021, failed to evidence the diagnosis of stage 2 pressure ulcer, and orders for (but not limited to) skilled nursing with frequency and	G 580		

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duration of visits to monitor progress of the wound, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, constipation, interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown, an order for the homeopathic treatment of Epsom salts and eucalyptus (the use of natural substances as remedies, such as plants and minerals) or application of Vaseline as a skin barrier.

During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA K were present. The patient was positioned sitting upright in bed with both heels elevated. The right heel evidenced intact skin with a circular hyperpigmented (darker than patient's normal skin color) area, approximately 3.0 - 4.0 cm in diameter. The left heel was observed intact with no evidence of skin breakdown. The patient indicated she had blister on her right heel from friction on the bed, but it was resolved, and she never had any breakdown on her left heel. Observed patient's hands soaking in pans of water. When asked by the surveyor if there was anything added to the water, the patient indicated Epsom salts and eucalyptus was routinely added. During this time, HHA K indicated she used Vaseline as a skin barrier when she performed incontinence care per the patient's request. Additionally, the patient indicated the nurse made a home visit last night (4/8/2021) to drop off paperwork and perform a skin assessment. The record failed to evidence documentation of a skilled nursing visit on 4/8/2021, a physician order for the visit, and upon survey exit, nothing further was submitted.

During a second home visit observation with the

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G 580	Continued From page 62 patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RN E, and HHA K were present. The patient indicated she had a problem with her right heel, not the left heel, it started about a month ago, her mom covered the wound with gauze and tape, she never had problems with skin breakdown prior to this wound, and she could only feel slight sensation in her feet, such as pain. RN E asked HHA K what she added to the hand and foot soaks. HHA K indicated she added Epsom salts with eucalyptus and spearmint, and stated "... about a handful ...." RN E indicated she would get an order. Observed RN E perform a head-to-toe physical assessment on the patient. RN E indicated she completed the physical assessment at 10:29 AM. RN E failed to measure the hyperpigmented area on the patient's right heel, palpate, or check the area for blanching (indicates presence or absence of adequate blood flow to determine if a pressure injury or suspected deep tissue injury is present). When asked by RN E when her last bowel movement was, the patient stated "Monday [4/12/2021- two days ago]", and HHA K stated "We're trying to keep her more regular." When asked by the surveyor if the RN provided any teaching, the patient stated "No She also indicated she stayed in the same sitting position in bed all day on days she worked (patient does part time work on computer with the use of a pen in mouth to type) and family would reposition onto her side in the evenings. During this time, HHA K stated "I don't think she's [patient] drinking enough." RN E instructed HHA K to encourage fluids. When asked by the surveyor if fluid intake was recorded/monitored, HHA K indicated it was not. At 10:52 AM, RN E discussed goals with the patient, indicated they were "keeping" the skin goal, instructed the patient to continue to keep her heels off of the bed, and hand and feet soaks	G 580		

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G 580	Continued From page 63	G 580		

would continue. RN E indicated this was not a skilled patient, the document used for the assessment was titled "RN Daily Note", and this patient received aide services only.

During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manager indicated if a skilled nursing visit was made last Thursday, she would expect it to be on the patient's schedule and see the completed note in the clinical record, and there should be orders for skilled nursing visits, and orders for the Epsom salts.

7. Record review for patient #3 was completed on 4/12/2021 and again on 4/14/2021, start of care date 8/27/2019, primary diagnosis type 2 diabetes with hyperglycemia (high blood sugar), evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 2/17/2021 - 4/17/2021, which evidenced (but not limited to) the patient lived alone, received skilled nursing services (but not limited to) for weekly medication tray set up, was prescribed (but not limited to) primidone (medication to treat tremors), spironolatactone (a diuretic medication), synjardy (a diabetes medication), and detemir (an injectable diabetes medication). The record failed to evidence orders for (but not limited to) a skilled nurse to apply a lidocaine topical patch to the patient's skin, or an order for the lidocaine patch to include location to apply the patch, directions or precautions for use.

Review of a document dated 3/30/2021 titled "Skilled Nurse Visit Note" evidenced the patient was alert and oriented, had no pain, vital signs were within normal limits, and evidenced the nurse applied a lidocaine patch (a medicated topical pain patch) to the patient's left shoulder. The document failed to evidence the nurse

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G 580	Continued From page 64 provided any teaching regarding the medication precautions, such as to remove the patch after 12 hours, or signs and symptoms to report to the nurse or physician; and failed to evidence any interventions such as patient education regarding diet, medication teaching, or teaching related to disease management. Review of a document dated 4/1/2021 titled "Discharge Summary" stated "... Client found deceased in his bed by an unknown party on 3/31/2021 ...." 8. During an interview on 4/12/2021 at 2:37 PM, When asked if any patient issues were identified, the administrator indicated there was discussion which regarded the wounds that came up (patients #1, 2), and possible discharges for those patients, the agency made a decision to pull back from skilled care during this time, and no decision made to discharge them yet (as of the date/time of the interview), and the agency didn't have adequate staff to cover multiple weekly, or even weekly visits. During this time, the alternate clinical manager indicated she would expect to see an order for a lidocaine transdermal patch on the plan of care, sometimes patient education was found in the 60 Day Summary portion of the plan of care, a stage 2 pressure injury would have the top layer of skin off, a fluid filled blister would be a stage 2 pressure injury, and anything added to water during a soak should be on the care plan. 17-13-1(a)	G 580		
G 590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) to any changes in the patient's	G 590		

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G 590	Continued From page 65 condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This Element is not met as evidenced by: Based on observation, record review and interview, the agency failed to promptly alert the physician to changes in the patient's condition that suggested the plan of care should have been altered for 2 of 2 records reviewed for patients who exhibited a change in condition (i.e. respiratory infection, new or worsening wound) which required medical intervention (#1, 2). Findings include: 1. Review of an undated agency policy C-850 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Plan of Care" stated "... The Plan of Care is based on a comprehensive assessment and information provided by the client/family ... consistently reviewed to ensure that client needs are met ... Professional staff shall promptly alert the physician to any changes that suggest the need to alter the plan of care ..." 2. Review of an undated agency policy C-635 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Physician Order" stated "... If the client or caregiver initiates changes that have been communicated to them by the physician, the nurse will write and date the order the day he/she is informed of the change, but shall indicate on the actual day the change was made ...." 3. Review of an undated agency policy C-100 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Services Provided" stated "... Services will be coordinated by the	G 590		

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G 590	Continued From page 66 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 ...." 4. Review of Job Description D-470 dated 06/2000 titled "Registered Nurse Case Manager" stated " ... Contacts the attending physician concerning any change in the condition of the client and receive the telephone orders from the physician ...." 5. Review of an undated Job Description titled "Home Nursing Services Job Description Licensed Practical Nurse [LPN]" stated "... Will receive report from prior agency employee and will recheck for any new or additional orders from the physician ... Will contact the Clinical Director [clinical manager] concerning any change in the condition of the client ...." 6. A home visit observation was completed for patient #1 on 4/13/2021 at 11:55 AM. The alternate clinical director and home health aide (HHA) I was present. A superficial open wound was observed on the right intergluteal cleft (butt crack), approximately 1.0 cm (centimeter) in diameter, 0.1 - 0.2 cm depth, with a pink, moist wound bed. The surrounding skin was not observable due to the presence of desitin ointment (zinc oxide topical skin protectant) on the skin. The patient's daughter (also a nurse) arrived during the visit, who indicated the patient developed symptoms of a respiratory infection on or about 3/8/2021, his symptoms worsened and he was seen in a walk-in clinic (3/11/2021), was prescribed antibiotics, she had him sleep in his recliner to help him breathe easier until about a week and a half ago, he developed a pressure	G 590		

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G 590	Continued From page 67	G 590		

sore due to spending so much time in the recliner, he never had a pressure sore until the respiratory illness in March (2021), she used desitin on his buttocks and TheraHoney wound gel (for use on wounds with no drainage to moderate drainage and should be paired with an occlusive absorbent dressing) on his wound for several weeks, and the wound was on his right buttock.

Record review for this patient was completed on 4/14/2021, start of care date 7/15/2013, for certification periods 2/5/2021 - 4/5/2021, and 4/6/2021 - 6/4/2021, with primary diagnosis of Alzheimer's disease, unspecified. The record evidenced the agency was aware of the patient's first decline in health status on 3/11/2021, failed to evidence the physician was promptly notified. failed to assess the patient until 3/23/2021, and again failed to promptly notify the physician in the change in condition. Additionally, the record evidenced the agency was aware of the patient's additional decline in health status (on 4/2/2021) with the development of a wound, and the record failed to evidence orders for skilled nursing wound care, assessment or management.

Review of a document dated and signed by the alternate clinical manager on 3/11/2021 titled "Care Coordination Note" stated "... spoke with Daughter of this client.about [sic] the client possibly having aspirational [sic] pneumonia. she [sic] is trying to get transportation to the walk in [sic] clinic as opposed to going to the hospital ... sitting him in a chair and using vicks [a mentholated topical cough suppressant ointment], cough syrup for two days now and thinks he needs an antibiotic ... I told her with the pneumonia he could get bad fast ... the daughter said she would let me know what happens ...."

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G 590	Continued From page 68 Review of a document dated and signed by the clinical manager on 3/12/2021 titled "Care Coordination Note" stated "... [daughter] took her father [patient] to a walk up clinic yesterday ... given a prescription for an oral antibiotic ... [daughter] to email the clinic paperwork to me today ...." The record failed to evidence the physician was notified until 4/2/2021. Review of a document from walk-in clinic A dated 3/11/2021 evidenced the patient was diagnosed with bacterial lower respiratory infection, cough, fever, and was prescribed an antibiotic to treat the infection. Review of a document dated and signed 3/23/2021 by RNCM (registered nurse case manager) G titled "SN [skilled nurse] Daily Note" stated "... RNCM was notified by multiple reports (from the client's daughter, from HHA [home health aide], from other RNs) that the client's functional status has declined. He was reported to be weak, unable to get out of bed, unable to walk ... possible "aspiration pneumonia", has been to urgent care for antibiotics ... Daughter reports that client aspirated over the weekend while being fed ... Any changes to medications: Yes ... Cannot walk more than a couple of steps. He was previously able to walk with assistance ... Unstable and, deteriorating ... Current Plan of Care ... May need to be modified ...." The document also failed to evidence the physician was notified for the medication changes or the patient aspirated. Review of a document dated and signed by RNCM G on 4/1/2021 titled "Physician Order" stated "... Client was prescribed [antibiotic] ... on 3/11/21 ... finished on 3/17/21 ... prescribed by	G 590		

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the walk-in-clinic ... also been taking [narcotic cough syrup] every 8 hours as needed per the report of his daughter ...."

Review of a document dated and signed by HHA H on 4/6/2021 titled "Daily [home health aide/attendant care] Visit Sheet for 4/02/2021" stated "... 3 pressure sores [open wound caused by unrelieved pressure] on bottom, one open. Nurse noted ...."

Review of a document dated and signed by RNCM G on 4/2/2021 titled "RN Re-Certification Assessment" evidenced the patient was at risk for skin breakdown, the depth of the wound as 0.0 cm, but indicated a pink, moist wound bed.

Review of an agency form titled "Home Nursing Services Coordination of Care with Other Providers" evidenced an entry dated 4/2/2021. The document evidenced the physician's nurse was notified on 4/2/2021 about the patient's illness (in March 2021) and new wound.

7. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021. The document evidenced a section titled "60 Day Summary" which stated " ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ...." The plan of care failed to evidence orders for (but not limited to) skilled nursing frequency and duration of visits, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, constipation, dehydration

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G 590	Continued From page 70 interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown, an order for the homeopathic treatment of Epsom salts and eucalyptus (the use of natural substances as remedies, such as plants and minerals), and failed to evidence pressure ulcer in the section titled "Other Pertinent Diagnoses". The record also failed to evidence any nursing visits were completed after 3/5/2021 to re-assess the patient's wound until the visit made with the surveyor on 4/14/2021. Review of a document dated and signed by RN E on 3/5/2021 titled "RN Re-Certification Assessment" stated "... left heel pressure wound, 2cm round ... Ruptured blister. Dry, healing well, no signs/symptoms of infection ...." The RN failed to identify the correct location and stage of the wound, which was actually on the right foot, and the document failed to evidence the physician was informed of the wound. During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA (home health aide) K were present. The patient was positioned sitting upright in bed with both heels elevated. The right heel evidenced intact skin with a circular hyperpigmented (darker than patient's normal skin color) area, approximately 3.0 - 4.0 cm in diameter. The left heel was observed intact with no evidence of skin breakdown. The patient indicated she had blister on her right heel from friction on the bed, but it was resolved, and she never had any breakdown on her left heel. Durinng this time, the patient indicated epsom salts were added to her hand and feet soaks, and HHA K indicated she applied vaseline to the patient's skin during incontinence care. The record failed to evidence orders for either	G 590		

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G 590	Continued From page 71 treatment. During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RN E, and HHA K were present. The patient indicated she had a problem with her right heel, not the left heel, it started about a month ago, her mom covered the wound with gauze and tape, she never had problems with skin breakdown prior to this wound, and she could only feel slight sensation in her feet, such as pain. RN E asked HHA K what she added to the hand and foot soaks. HHA K indicated she added Epsom salts with eucalyptus and spearmint, and stated "... about a handful ...." RN E indicated she would get an order. Observed RN E perform a head-to-toe physical assessment on the patient. HHA K was positioned on one side of the bed, and RN E was positioned on the other. After a portion of the assessment was completed, HHA K removed all of the positional pillows and lowered the head of the bed so the patient could be turned onto her right side (to assess the backside of the body). RN E began to turn the patient without first moving her closer to her side of the bed, which would prevent the patient's face from hitting the siderail. HHA K and the patient stopped RN E and verbally directed her on proper turning technique. Also during the assessment, RN E repeatedly left the room for several minutes to chart in the EMR (electronic medical record), and then return to continue her assessment and ask the patient additional questions. RN E indicated she completed the physical assessment at 10:29 AM. RN E failed to measure the hyperpigmented area on the patient's right heel, palpate, or check the area for blanching (indicates presence or absence of adequate blood flow to determine if a pressure injury or suspected deep tissue injury is present). RN E	G 590		

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G 590	Continued From page 72 asked the patient when she was last weighed, to which the patient indicated it was a year ago when she was hospitalized for a UTI (urinary tract infection). When asked by RN E when her last bowel movement was, the patient stated "Monday [4/12/2021- two days ago]", and HHA K stated "We're trying to keep her more regular." When asked by the surveyor if the RN provided any teaching, the patient stated "No." She also indicated she stayed in the same sitting position in bed all day on days she worked, but would reposition onto her side in the evenings. During this time, HHA K stated "I don't think she's [patient] drinking enough." RN E instructed HHA K to encourage fluids. When asked by the surveyor if fluid intake was recorded/monitored, HHA K indicated it was not. At 10:52 AM, RN E discussed goals with the patient, indicated they were "keeping" the skin goal, instructed the patient to continue to keep her heels off of the bed, and hand and feet soaks would continue. RN E indicated this was not a skilled patient, the document used for the assessment was titled "RN Daily Note", and this patient received aide services only. Review of a document dated and signed by RN E on 4/14/2021 titled "SN Daily Note" stated "... System Review ... Integument [skin] ... No significant issues ... Care is considered custodial ...." During an interview on 4/14/2021 at 12:10 PM when asked if she spoke to the physician about the patient after the visit today (4/14/2021) RNCM E stated "No, but I have order ready to go. Can't print until I get in office." The RNCM failed to promptly notify the physician, and instead wrote an order to send at a later time.	G 590		

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G 590	Continued From page 73 Review of the EMR (electronic medical record) on 4/14/2021 at 12:21 PM evidenced a new order dated 4/14/2021, given by physician D, taken by RNCM E, which stated "... New Order: FYI Client soaks hands and feet once a week in 1/2 gallon warm water and 1/2C [cup] Epsom salts ...." By the nurse's own admission, the physician wasn't notified for a verbal order to be received, and the order failed to evidence the Epson salts also included eucalyptus and spearmint, vaseline was used as an incontinence skin barrier, or the status of the wound. 5. During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manager indicated a stage 2 pressure injury would have the top layer of skin off, a fluid filled blister would be a stage 2 pressure injury, and anything added to water during a soak should be on the care plan. During this time, the administrator indicated the most recent nursing case manager meetings addressed client situations, new wounds, falls, clinical topics of relevance, admissions, and discharges; most recent meetings focused on plans of care, discussed the new wounds (for patients #1, 2), possible discharges for them (from the agency), the agency management made a decision to pull back from skilled care during this time, and then later decide how to move forward, there was no decision made at that time to discharge the wound patients, and the agency didn't have the staff to cover multiple weekly or even weekly visits for skilled care. 17-13-1(a)(2)	G 590		
G 610	Patients receive education and training CFR(s): 484.60(d)(5) Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing	G 610		

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G 610	Continued From page 74 education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge. This Element is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure all patients and/or caregivers received ongoing education and training regarding the needs of the patient as identified in the plans of care and failed to evidence patient and caregiver responses and comprehension of any training provided for 5 of 5 records reviewed (#1, 2, 3, 4, 5). Findings include: 1. Review of an undated agency policy C-400 copyright Briggs Healthcare titled "Client/Family Education" stated "... Clients and their families will be provided with information necessary to make decisions and to take responsibility for self-management activities related to their needs ... will target the clients [sic] ability to improve outcomes through promotion of healthy behavior and involvement in their care, treatment, and service decisions ... All client and/or caregiver education and instruction, as well as their perceived comprehension and demonstrated competency, as appropriate, will be documented in the client's record ...." 2. Review of an undated agency policy C-580 copyright Briggs Healthcare titled "Plan of Care" stated "... The Plan of Care shall be completed in full to include: ... Instructions to client/caregiver, as applicable ... All of the above items must always be addressed on the plan of care ...." 3. Review of an agency policy dated 06/2000	G 610		

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G 610	Continued From page 75 titled "Home Nursing Services Job Description Registered Nurse" stated "... Provides instruction to the client and the client's family on areas listed on the plan of care, documents what is taught, and lists the client and/or family's response ...." 4. Review of an undated agency policy titled "Home Nursing Services Job Description Licensed Practical Nurse [LPN]" stated "... Will teach the client and care giver [sic] in the areas on the plan of care, document what is taught and their response ...." 5. Record review of patient #1 was completed on 4/12/2021 and again on 4/14/2021, start of care date 07/15/2013, primary diagnosis of Alzheimer's disease, unspecified, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/6/21-6/4/21. The document evidenced a section titled "60 Day Summary" (which provided a summary of patient findings from the previous certification period) stated " ... He is at risk for aspiration [ingestion of food and/or fluids into the lungs] ... formation of a stage 2 pressure sore on right buttock ... measures 0.5cm [centimeters] by 0.5cm ... daughter applies desitin [topical skin protectant] barrier cream to the area with peri care [incontinence care to buttocks/groin area] ... daughter has been educated on the importance of getting patient off the recliner and into bed at night ... family has been educated on the importance of frequent position changes, and good perineal hygiene to prevent further alterations in skin integrity ... the RN [registered nurse] case manager will need to make at least weekly visits to monitor the progress and assess if sore is getter better or worse with current treatment . ..." The plan of care failed to evidence orders for (but not limited to) skilled	G 610		

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nursing interventions for family/caregiver education/teaching regarding wound care, prevention of new or worsening skin breakdown, signs and symptoms of aspiration (including frequency of the education).

Review of a document dated and signed by RN G on 4/9/2021 titled "SN [skilled nurse] Daily Note" stated " ... No significant issues, aspiration ... aspiration precautions ... RN case manager back to visit client to assess right buttock pressure wound from one week prior. The wound on the right buttock now measures 0.7cm by 0.9cm [worse] ... desitin is used with pericare per the daughter ...." The document evidenced the wound was worse (larger in size from previous assessment on 4/2/2021). The visit failed to evidence teaching related to aspiration precautions, special dietary considerations for patients at risk of aspiration, or signs and symptoms to report to the agency.

During a home visit observation on 4/13/2021 at 11:55 AM, a superficial open wound was observed on the right intergluteal cleft (butt crack), approximately 1.0 cm in diameter, with a pink, moist wound bed. The surrounding skin was not observable due to the presence of desitin ointment on the skin. Family indicated she used therahoney (a topical wound ointment to treat wounds) on the wound, had been using it for 2 - 4 weeks, and no cover dressing was applied. While HHA I fed the patient lunch, he coughed while eating/swallowing (sign of aspiration). Family stated the patient had not had a swallow study to rule out aspiration.

6. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia,

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G 610	Continued From page 77 evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021. The document evidenced a section titled "60 Day Summary" which stated " ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ...." The plan of care failed to evidence (but not limited to) interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown, an order for the homeopathic treatment of Epsom salts and eucalyptus (the use of natural substances as remedies, such as plants and minerals), fluid intake, proper techniques of turning/rolling patient, dehydration, and constipation all with specifics on frequency education was to be completed. Review of a document dated and signed by RN E on 3/5/2021 titled "RN Re-Certification Assessment" stated "... left heel pressure wound, 2cm round ... Ruptured blister. Dry, healing well, no signs/symptoms of infection ...." The RN failed to identify the correct location and stage of the wound, which was on the right foot, and failed to evidence any teaching was provided to the patient or family. During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA (home health aide) K were present. The patient was positioned sitting upright in bed with both heels elevated. The right heel evidenced intact skin with a circular hyperpigmented (darker than patient's normal skin color) area, approximately 3.0 - 4.0 cm in diameter. The left heel was observed intact with no evidence of skin breakdown. The patient indicated she had blister on her right heel from	G 610		

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friction on the bed, but it was resolved, and she never had any breakdown on her left heel. Observed patient's hands soaking in pans of water. When asked by the surveyor if there was anything added to the water, the patient indicated Epsom salts and eucalyptus was routinely added.

During an interview on 4/9/2021 at 1:57 PM, RN E indicated she didn't remember the last time she saw patient #2. After the surveyor informed RN E that patient #2 indicated she was seen by RN E last night (4/8/2021), RN E agreed she saw the patient last night and assessed her skin.

During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RN E, and HHA K were present. The patient indicated she had a problem with her right heel, not the left heel, it started about a month ago, her mom covered the wound with gauze and tape, she never had problems with skin breakdown prior to this wound, and she could only feel slight sensation in her feet, such as pain. RN E asked HHA K what she added to the hand and foot soaks. HHA K indicated she added Epsom salts with eucalyptus and spearmint and stated "... about a handful ...." RN E indicated she would get an order. Observed RN E perform a head-to-toe physical assessment on the patient. HHA K was positioned on one side of the bed, and RN E was positioned on the other. After a portion of the assessment was completed, HHA K removed all of the positional pillows and lowered the head of the bed so the patient could be turned onto her right side (to assess the backside of the body). RN E began to turn the patient without first moving her closer to her side of the bed, which would prevent the patient's face from hitting the siderail. HHA K and the patient stopped RN E and verbally directed her on proper

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turning technique. Also, during the assessment, RN E repeatedly left the room for several minutes to chart in the EMR (electronic medical record), and then return to continue her assessment and ask the patient additional questions. RN E indicated she completed the physical assessment at 10:29 AM. RN E failed to measure the hyperpigmented area on the patient's right heel, palpate, or check the area for blanching (indicates presence or absence of adequate blood flow to determine if a pressure injury or suspected deep tissue injury is present). RN E asked the patient when she was last weighed, to which the patient indicated it was a year ago when she was hospitalized for a UTI (urinary tract infection). When asked by RN E when her last bowel movement was, the patient stated "Monday [4/12/2021- two days ago]", and HHA K stated, "We're trying to keep her more regular." When asked by the surveyor if the RN provided any teaching, the patient stated "No." She also indicated she stayed in the same sitting position in bed all day on days she worked (patient does part time work on computer with the use of a pen in mouth to type) and family would reposition onto her side in the evenings. During this time, HHA K stated, "I don't think she's [patient] drinking enough." RN E instructed HHA K to encourage fluids. When asked by the surveyor if fluid intake was recorded/monitored, HHA K indicated it was not. At 10:52 AM, RN E discussed goals with the patient, indicated they were "keeping" the skin goal, instructed the patient to continue to keep her heels off the bed, and hand and feet soaks would continue. RN E indicated this was not a skilled patient, the document used for the assessment was titled "RN Daily Note", and this patient received aide services only. RNCM E failed to provide education to family/HHA K regarding signs/symptoms of constipation that

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should be reported to the nurse, such as (but not limited to) no bowel movement for 3 days, or abdominal distention/pain; failed to provide education to family/HHA K regarding signs/symptoms of dehydration, such as (but not limited to) dry mucous membranes, strong smelling, dark colored, decrease urine output; and failed to educate the patient on when to call the nurse for intervention.

7. Record review for patient #3 was completed on 4/12/2021 and again on 4/14/2021, start of care date 8/27/2019, primary diagnosis type 2 diabetes with hyperglycemia (high blood sugar), evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 2/17/2021 - 4/17/2021, which evidenced (but not limited to) the patient lived alone, received skilled nursing services (but not limited to) for weekly medication tray set up, was on a low sugar/simple carbohydrate (diabetic) diet, he was "relatively non-compliant" with his diet; and was prescribed (but not limited to) primidone (medication to treat tremors), spironolatactone (a diuretic medication), synjardy (a diabetes medication), and detemir (an injectable diabetes medication). The plan of care failed to evidence orders for (but not limited to) skilled nursing duration of visits, interventions for diabetes management and hyperglycemia, diabetic diet and non-compliance, interventions to monitor therapeutic drug levels, or interventions for patient/family teaching regarding disease management and diet; and failed to evidence lidocaine topical patch on the medication list.

Review of a document dated 3/30/2021 titled "Skilled Nurse Visit Note" evidenced the patient was alert and oriented, had no pain, vital signs were within normal limits, and evidenced the

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G 610	Continued From page 81 nurse applied a lidocaine patch (a medicated topical pain patch) to the patient's left shoulder. The document failed to evidence the nurse provided any teaching regarding the medication precautions, such as to remove the patch after 12 hours, or signs and symptoms to report to the nurse or physician; and failed to evidence any interventions such as patient education regarding diet, medication teaching, or teaching related to disease management. Review of a document dated 4/1/2021 titled "Discharge Summary" stated "... Client found deceased in his bed by an unknown party on 3/31/2021 ...." 8. Record review for patient #4 was completed on 4/14/2021, start of care date 6/18/2020, primary diagnosis type 2 diabetes with hyperglycemia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/14/2021 - 6/12/2021, which evidenced (but not limited to) the patient was an 81 year old who lived alone, he received skilled nursing visits every 2 weeks to fill and organize medication delivery system (pill planner box), he was prescribed (but not limited to) potassium chloride and detemir (insulin), he was non-compliant with his diabetic diet, and in a section titled "60 Day Summary" stated "... The client has set a continuing goal for himself to reduce his A1C [a laboratory blood test to determine the patient's average blood sugar for the preceding 2 to 3 months]. The record failed to evidence orders for skilled nursing interventions such as lab monitoring for therapeutic blood potassium levels or hemoglobin A1C levels, failed to evidence results of a recent hemoglobin A1C level, and failed to evidence any interventions such as patient education regarding diet,	G 610		

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G 610	Continued From page 82 medication teaching, or teaching related to disease management. 9. Record review for patient #5 was completed on 4/14/2021, start of care date 1/11/2016, primary diagnosis fibromyalgia, other (but not limited to) diagnoses of type 2 diabetes without complications, and magnesium deficiency. Review of a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/14/2021 - 6/12/2021, which evidenced (but not limited to) the patient was a 73 year old who lived alone, received skilled nursing services every 2 weeks for medication tray set up, was very non-compliant with diabetes disease management, made poor food choices, was non-compliant with a diabetic diet, refused to check her blood sugar, pain and diabetes were not controlled, medications included (but not limited to) magnesium oxide and hydrocodone (for pain). The record failed to evidence orders for skilled nursing interventions such as lab monitoring for therapeutic blood magnesium or hemoglobin A1C levels, medicinal and non-medicinal methods to mitigate pain, and failed to evidence interventions such as patient education regarding diet, medication teaching, or teaching related to disease management. 10. During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manager indicated sometimes patient education was found in the 60 Day Summary portion of the plan of care, During this time, the administrator indicated the most recent nursing case manager meetings addressed client situations, new wounds, falls, clinical topics of relevance, admissions, and discharges; most recent meetings focused on plans of care, discussed the new wounds (for patients #1, 2), and possible discharges for them,	G 610		

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G 610	Continued From page 83 the agency management made a decision to pull back from skilled care during this time, and then decide how to move forward, there was no decision made at that time to discharge the wound patients, and the agency didn't have the staff to cover multiple weekly or even weekly visits for skilled care. 17-14-1(a)(1)(G)	G 610		
G 726	Nursing services supervised by RN CFR(s): 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). This Element is not met as evidenced by: Based on record review and interview, the RNCM (registered nurse case manager) failed to monitor and ensure the care/treatment provided by the LPN (licensed practical nurse) included only care/treatment identified on the patient's plan of care for 1 of 1 record reviewed with skilled services provided by an LPN (#3). Findings include: Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines 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 ...." Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-635 titled "Physician Orders," stated "... All medications, treatments, and services	G 726		

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G 726	Continued From page 84 provided to clients must be ordered by a physician ...." Record review for patient #3 was completed on 4/12/2021 and again on 4/14/2021, start of care date 8/27/2019, primary diagnosis type 2 diabetes with hyperglycemia (high blood sugar), evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 2/17/2021 - 4/17/2021, which evidenced (but not limited to) the patient lived alone, received skilled nursing services (but not limited to) for weekly medication tray set up, was prescribed (but not limited to) primidone (medication to treat tremors), spironolatactone (a diuretic medication), synjardy (a diabetes medication), and detemir (an injectable diabetes medication). The record failed to evidence orders for (but not limited to) a skilled nurse to apply a licocaine topical patch (a medicated topical pain patch) to the patient's skin, or an order for the lidocaine patch to include anatomical location to apply the patch, directions, or precautions for use. Review of a document dated 2/23/2021 and signed by LPN J on 3/7/2021 titled "Skilled Nurse Visit Note" stated "... Lidocaine patch applied to L [left] shoulder per patient request ...." Review of a document dated 3/9/2021 and signed by LPN J on 4/1/2021 titled "Skilled Nurse Visit Note" stated "... Lidocaine patch to L shoulder was applied ...." Review of a document dated and signed by RNCM E on 3/9/2021 titled "Supervisory Visits of Home Health Care Staff" evidenced RNCM E performed a supervisory visit at the patient's home, LPN J was present for the visit, and LPN J	G 726		

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G 726	Continued From page 85 followed the care plan. LPN J applied the lidocaine patch to the patient's left shoulder during her visit on 3/9/2021. The document failed to address the lidocaine patch, and lack of orders to administer. Review of a document dated 3/16/2021 and signed by LPN J on 4/1/2021 titled "Skilled Nurse Visit Note" stated "... He [patient] complained about Synergy [sic - synjardy] causing loose BMs [bowel movements]. Report to RN ...." The record failed to evidence RNCM E followed up with the patient's concern, or if the concern was resolved. Review of a document dated 3/23/2021 and signed by LPN J on 4/9/2021 titled "Skilled Nurse Visit Note" stated "... Applied lidocaine patch to L shoulder ...." Review of a document dated 3/30/2021 titled "Skilled Nurse Visit Note" evidenced the patient was alert and oriented, had no pain, vital signs were within normal limits, and evidenced the nurse applied a lidocaine patch to the patient's left shoulder. During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manager indicated she would expect to see an order for the lidocaine patch. 17-14-1(a)(1)(J)	G 726		
G 798	Home health aide assignments and duties CFR(s): 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by	G 798		

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G 798	Continued From page 86 that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). This Standard is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure the home health aide (HHA) care plan was individualized with specific, not generic, tasks to be completed for 2 of 2 records reviewed that were assigned home health aides (#1, 2). Findings include: 1. Review of an undated agency policy C-780, copyright Briggs Healthcare, Home Care Operational Guidelines titled "Home Health Aide: Assignment" stated "... The assignment of tasks will be identified in the home health aide assignment sheet ... Any change in the assignment must be approved by the professional managing the client's care ... All changes in the assignment ... will be documented on the care plan ... Changes must reflect physician orders ...." 2. Review of an undated agency policy, copyright Briggs Healthcare, Home Care Operational Guidelines titled "Home Health Aide: Documentation" stated "... Home health aides will document care/services provided ... should be in accordance with direction provided in the Home Health Aide Assignment Sheet ...." 3. Review of an undated agency policy C-220, copyright Briggs Healthcare, Home Care Operational Guidelines titled "Home Health Aide Services" stated "... The Aide will follow the care plan and will not initiate new services or discontinue services without contacting a Registered Nurse ... All services provided by the	G 798		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 798	Continued From page 87 Home Health Aide shall be documented in the clinical record ...." 4. Record review for patient #1 was completed on 4/14/2021, start of care date 7/15/2013, with primary diagnosis of Alzheimer's disease, unspecified. Review of documents titled "Home Health Certification/Recertification Plan of Care Order" for certification periods 2/5/2021 - 4/5/2021, and 4/6/2021 - 6/4/2021 evidenced (but not limited to) the patient received HHA services 2-5 hours per day, 5 days per week, and visit frequency/duration could be changed per family request. The document for certification period 4/6/2021 - 6/4/2021 evidenced (but not limited to) the patient was at risk for aspiration (ingestion of food and/or fluids into the lungs), and he had a pressure injury on his right buttock. Review of a document signed and dated 2/3/2021 and again on 4/5/2021 by RNCM (registered nurse case manager) G titled "Plan of Care Service Plan [home health aide care plan] ...." evidenced (but not limited to) the aide was to shower the patient or give a partial bath if patient refused shower, shampoo hair, apply lotion to skin, clip toenails and fingernails, brush teeth, the client wears disposable briefs, assess temperature, and offer water mixed with cranberry juice- offer this frequently, at least 5 glasses per day. The document failed to evidence which part(s) of the body to apply lotion to, how often to clip toenails and fingernails, document how many glasses of juice the patient drank (to monitor compliance with HHA orders), how often to check his briefs for incontinence, skin care for incontinence (such as application of Desitin barrier ointment), precautions/care for the patient's wound, or to notify the RNCM when the patient refuses tasks assigned on the aide care	G 798		

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G 798	Continued From page 88	G 798		

plan.

A home visit observation was completed on 4/13/2021 at 11:55 AM. The alternate clinical director and HHA I was present. A superficial open wound was observed on the right intergluteal cleft (butt crack), approximately 1.0 cm (centimeter) in diameter, 0.1 - 0.2 cm depth, with a pink, moist wound bed. The surrounding skin was not observable due to the presence of desitin ointment (zinc oxide topical skin protectant) on the skin. The patient's daughter (also a nurse) arrived during the visit, who indicated the patient developed symptoms of a respiratory infection on or about 3/8/2021, his symptoms worsened and he was seen in a walk-in clinic (3/11/2021), was prescribed antibiotics, she had him sleep in his recliner to help him breathe easier until about a week and a half ago, he developed a pressure sore due to spending so much time in the recliner, he never had a pressure sore until the respiratory illness in March (2021), they used desitin on his buttocks and TheraHoney wound gel (for use on wounds with no drainage to moderate drainage and should be paired with an occlusive absorbent dressing) on his wound for several weeks, and the wound was on his right buttock.

During an interview on 4/12/2021 2:37 PM, the alternate clinical manager indicated the patient used Desitin barrier cream for incontinence care.

5. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021. The document evidenced (but not limited to) the

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G 798	Continued From page 89 patient received HHA services for 4 hours, 4 days per week, and 8 hours 1 day per week, soak hands and feet 1 time per week, a section titled "60 Day Summary" which stated " ... [skin] will remain intact through diligent positioning, frequent incontinence and skin care, encouragement to drink fluids ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ...." Review of a document received on 4/9/2021 at 11:54 from the alternate clinical manager signed and dated most recently by RNCM E on 3/5/2021 titled "Plan of Care Service Plan ...." evidenced (but not limited to) partial bed bath as needed/requested, soak the patient's hands on Fridays, soak feet on Fridays if the patient was up (out of bed), assist with elimination, and turn the patient every two hours. The document failed to evidence for the aide to document fluid intake (to monitor compliance with HHA orders to encourage fluids), how often to check her briefs for incontinence, skin care for incontinence (such as application of vaseline), precautions/care for the patient's wound such as floating the heels to relieve pressure), or the addition of epsom salts with eucalyptus and spearmint (including how much) to the water used for hand and foot soaks. During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA K were present. HHA K indicated she used vaseline on the patient's buttocks, and she added epsom salts to the water used for hand and foot soaking, per the patient's request. The aide care plan failed to evidence application of vaseline. During an interview on 4/12/2021 at 2:37 PM,	G 798		

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G 798	Continued From page 90 when asked if anything was added to the water when the aide soaked a patient's hands or feet, the alternate clinical manager indicated it should have been on the aide care plan. During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RN E, and HHA K were present. RN E asked HHA K what she added to the hand and foot soaks. HHA K indicated she added Epsom salts with eucalyptus and spearmint and stated "... about a handful ...." RN E indicated she would get an order. When asked by RN E when her last bowel movement was, the patient stated "Monday [4/12/2021- two days ago]", and HHA K stated, "We're trying to keep her more regular." She also indicated she stayed in the same sitting position in bed all day on days she worked (patient does part time work on computer with the use of a pen in mouth to type) and family would reposition onto her side in the evenings. During this time, HHA K stated, "I don't think she's [patient] drinking enough." RN E instructed HHA K to encourage fluids. When asked by the surveyor if fluid intake was recorded/monitored, HHA K indicated it was not. At 10:52 AM, RN E discussed goals with the patient, indicated they were "keeping" the skin goal, instructed the patient to continue to keep her heels off the bed, and hand and feet soaks would continue. RN E indicated this was not a skilled patient, the document used for the assessment was titled "RN Daily Note", and this patient received aide services only. 17-13-2(a)	G 798		
G 800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are:	G 800		

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G 800	Continued From page 91 (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. This Element is not met as evidenced by: Based on record review and interview, the home health aide (HHA) failed to follow the plan of care and practiced outside of the home health aide scope of practice for 2 of 2 records reviewed that were assigned home health aides (#1, 2). Findings include: 1. Review of an undated agency policy C-708, copyright Briggs Healthcare, Home Care Operational Guidelines titled "Medication Administration" stated "... Home Health aides may apply topical ointments, creams and shampoos, if included as part of assigned duties ...." 2. Review of an undated agency policy C-705 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Medication Management" stated "... Home Nursing Services has a medication management system that supports client safety and improves quality of care treatment and services ... Comprehensive client assessment ... include [sic] review of all medications ... (prescribed, samples, over the counter, herbal remedies, PRN [as needed] medications) and records this in the client record ... orders will be obtained for the use of herbal drugs or preparations ...." 3. Review of an undated agency policy C-780, copyright Briggs Healthcare, Home Care Operational Guidelines titled "Home Health Aide: Assignment" stated "... The assignment of tasks	G 800		

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G 800	Continued From page 92 will be identified in the home health aide assignment sheet ... Any change in the assignment must be approved by the professional managing the client's care ... All changes in the assignment ... will be documented on the care plan ... Changes must reflect physician orders ...." 4. Review of an undated agency policy, copyright Briggs Healthcare, Home Care Operational Guidelines titled "Home Health Aide: Documentation" stated "... Home health aides will document care/services provided ... should be in accordance with direction provided in the Home Health Aide Assignment Sheet ...." 5. Review of an undated agency policy C-220, copyright Briggs Healthcare, Home Care Operational Guidelines titled "Home Health Aide Services" stated "... The Aide will follow the care plan and will not initiate new services or discontinue services without contacting a Registered Nurse ... All services provided by the Home Health Aide shall be documented in the clinical record ...." 6. Record review for patient #1 was completed on 4/14/2021, start of care date 7/15/2013, with primary diagnosis of Alzheimer's disease, unspecified. Review of documents titled "Home Health Certification/Recertification Plan of Care Order" for certification periods 2/5/2021 - 4/5/2021, and 4/6/2021 - 6/4/2021 evidenced (but not limited to) the patient received HHA services 2-5 hours per day, 5 days per week, and visit frequency/duration could be changed per family request. The document for certification period 4/6/2021 - 6/4/2021 evidenced (but not limited to) the patient was at risk for aspiration (ingestion of food and/or fluids into the lungs), and he had a pressure injury on his right buttock.	G 800		

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G 800	Continued From page 93 Review of a document signed and dated 2/3/2021 and again on 4/5/2021 by RNCM (registered nurse case manager) G titled "Plan of Care Service Plan [home health aide care plan] ...." evidenced (but not limited to) the aide was to shower the patient or give a partial bath if patient refused shower, shampoo hair, apply lotion to skin, clip toenails and fingernails, brush teeth, the client wears disposable briefs, assess temperature, and offer water mixed with cranberry juice- offer this frequently, at least 5 glasses per day. A home visit observation was completed on 4/13/2021 at 11:55 AM. The alternate clinical director and HHA I was present. A superficial open wound was observed on the right intergluteal cleft (butt crack), approximately 1.0 cm (centimeter) in diameter, 0.1 - 0.2 cm depth, with a pink, moist wound bed. The surrounding skin was not observable due to the presence of desitin ointment (zinc oxide topical skin protectant) on the skin. The patient's daughter (also a nurse) arrived during the visit, who indicated the patient developed symptoms of a respiratory infection on or about 3/8/2021, his symptoms worsened and he was seen in a walk-in clinic (3/11/2021), was prescribed antibiotics, she had him sleep in his recliner to help him breathe easier until about a week and a half ago, he developed a pressure sore due to spending so much time in the recliner, he never had a pressure sore until the respiratory illness in March (2021), they used desitin on his buttocks (which was not ordered on the aide care plan). During an interview on 4/12/2021 2:37 PM, the alternate clinical manager indicated the patient used Desitin barrier cream for incontinence care.	G 800		

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G 800	Continued From page 94 7. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021. The document evidenced (but not limited to) the patient received HHA services for 4 hours, 4 days per week, and 8 hours 1 day per week, soak hands and feet 1 time per week, a section titled "60 Day Summary" which stated " ... [skin] will remain intact through diligent positioning, frequent incontinence and skin care, encouragement to drink fluids ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ...." Review of a document received on 4/9/2021 at 11:54 from the alternate clinical manager signed and dated most recently by RNCM E on 3/5/2021 titled "Plan of Care Service Plan ...." evidenced (but not limited to) partial bed bath as needed/requested, soak the patient's hands on Fridays, soak feet on Fridays if the patient was up (out of bed), assist with elimination, and turn the patient every two hours. During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA K were present. HHA K indicated she used Vaseline on the patient's buttocks, and she added epsom salts to the water used for hand and foot soaking, per the patient's request. The aide care plan failed to evidence order to apply Vaseline. During an interview on 4/12/2021 at 2:37 PM, when asked if anything was added to the water	G 800		

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G 800	Continued From page 95 when the aide soaked a patient's hands or feet, the alternate clinical manager indicated it should have been on the aide care plan. During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RN E, and HHA K were present. RN E asked HHA K what she added to the hand and foot soaks. HHA K indicated she added Epsom salts with eucalyptus and spearmint and stated "... about a handful ...." RN E indicated she would get an order. When asked by RN E when her last bowel movement was, the patient stated "Monday [4/12/2021- two days ago]", and HHA K stated, "We're trying to keep her more regular." During this time, the patient indicated she stayed in the same sitting position in bed all day on days she worked but would reposition onto her side in the evenings. During this time, HHA K stated, "I don't think she's [patient] drinking enough." RN E instructed HHA K to encourage fluids. When asked by the surveyor if fluid intake was recorded/monitored, HHA K indicated it was not. At 10:52 AM, RN E discussed goals with the patient, indicated they were "keeping" the skin goal, instructed the patient to continue to keep her heels off of the bed, and hand and feet soaks would continue. RN E indicated this was not a skilled patient, the document used for the assessment was titled "RN Daily Note", and this patient received aide services only.	G 800		
G 940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and	G 940		

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G 940	Continued From page 96 outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. This Condition is not met as evidenced by: Based on observation, record review and interview, the Governing Body minutes failed to evidence information regarding policy review, updates, and approvals (G942); the administrator failed to be responsible for the day to day functions of the agency (G948); the clinical manager (CM) failed to coordinate patient care for the agency (G962); the CM failed assure patient needs were continuously assessed (G966); the CM failed to assure patient plans of care were implemented, and updated to ensure the needs of the patient were being met (G968); and the agency failed to report a branch location to the state survey agency (G972). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.105 Organization and administration of services.	G 940		
G 942	Governing body CFR(s): 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans,	G 942		

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G 942	Continued From page 97 and its quality assessment and performance improvement program. This Standard is not met as evidenced by: Based on record review, the Governing Body failed to periodically review and approve the agency's operational policies and review and approve updated/new policies. Findings include: 1. Review of a copyright Briggs Healthcare policy B-100 dated 2021 titled "Governing Body" stated "... The Governing Body shall assume full legal authority and responsibility for the operation of Home Nursing Services ... The duties and responsibilities of the Governing Body shall include ... Adopt and periodically review and approve the administrative and personnel policies, client care policies and procedures ... as required by state licensure regulations ...." 2. Review of a document titled "Home Nursing Services Job Description Administrator" was dated 3/2021. 3. Review of a document titled "Home Nursing Services Job Description Clinical Director" was dated 3/2021. 4. Review of a document titled "Home Nursing Services Job Description Clinical Services Coordinator" was dated 3/2021. 5. Review of a document dated 01/12/2021 titled "Written Consent to Resolutions of the Board of Directors of Home Nursing Services, Inc." failed to evidence agency policies were reviewed and approved. 6. Review of a document dated 01/22/2021 titled	G 942		

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G 942	Continued From page 98 "Written Consent to Resolutions of the Board of Directors of Home Nursing Services, Inc." failed to evidence agency policies were reviewed and approved. 7. Review of a document dated 2/19/2021 titled "Written Consent to Resolutions of the Board of Directors of Home Nursing Services, Inc." failed to evidence agency policies were reviewed and approved. 8. Review of a document dated 3/18/2021 titled "Written Consent to Resolutions of the Board of Directors of Home Nursing Services, Inc." stated "... the Governing Body will meet quarterly ... to review and approve the agency's operational policies and updated new policies, if any ....", and failed to evidence agency policies were reviewed and approved. 9. Review of a Department of Health and Human Services Centers for Medicare & Medicaid Services document titled "Statement of Deficiencies And Plan of Correction" evidenced a completion date of 3/19/2021 under the deficiency cited G942, and stated "... How the deficiency will be or has been corrected? The Governing Body will meet to review and approve the agency ' s operational policies and review and approve updated/new policies. How the deficiency will be prevented from recurring? · The Governing Body will meet quarterly to review and approve the agency ' s operational policies and review and approve updated/new policies ...." 10. Upon survey exit on 4/14/2021 at 1:24 PM, nothing further was submitted for review. 17-12-1(b)	G 942		
G 948	Responsible for all day-to-day operations	G 948		

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G 948	Continued From page 99 CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This Element is not met as evidenced by: Based on record review and interview, the administrator failed to be responsible for all day-to-day operations of the agency; failed to have systems in place to monitor ongoing staff performance to ensure comprehensive assessments were being conducted timely, that patient's needs were being met, and documented as the actual date the assessment was completed for 2 of 2 records reviewed (#4, 5) which required recertification re-assessments; and failed to ensure agency had adequate nursing staff to meet all patients' needs for 2 of 2 records reviewed which required skilled nursing care (#1, 2). This practice had the potential to affect all agency patients. Findings include: 1. Review of an undated copyright Briggs Corporation, Home Care Operational Guidelines policy C-870 titled "Clinical Records/Medical Record Retention" stated "... Clinical records are legal documents containing comprehensive, accurate ... information regarding the client's health ... treatments and services rendered by the Registered Professional Nurses ... The individual must date ... and sign the entry ... to authenticate an entry in the clinical record ... documentation for each service or care provided must be completed on the day the service is rendered ...." 2. Review of an undated copyright Briggs Corporation, Home Care Operational Guidelines policy titled "Documentation of Changes to the Medical Record" stated, "... Medical records are	G 948		

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G 948	Continued From page 100 legal documents that support the delivery of client services. Any changes or revisions ... must follow accepted legal requirements ... If it is necessary to make an addition to a previous entry, this must be done using an addendum to the record. The entry will be marked as an addendum and must include the date it is written and the visit date that the entry relates to ...." 3. Review of an undated copyright Briggs Corporation, Home Care Operational Guidelines policy C-120 titled "Admission Policy" stated "... Clients are accepted for treatment ... under the expectation that the client's medical, nursing, and social needs can be met adequately by Home Nursing Services ... Home Nursing Services services must be appropriate and available to meet the specific needs ... of the client ...." 4. Review of an undated agency policy C-155, copyright Briggs Healthcare, Home Care Operational Guidelines titled "Client Reassessment/Update of Comprehensive Assessment Significant Change of Condition (SCIC)" stated "... Comprehensive Assessment will be updated and revised as often as the client's condition warrants ... Assessment will include OASIS [outcome and assessment information set] data collection for all Medicare and Medicaid skilled clients ... within last five (5) days of episode ... To identify decline or improvement in health status ... are reassessed when significant changes occur in their condition ... [or] diagnosis ... at least every fifty-six to sixty (56-60) days ...." 5. Review of an undated agency document titled "Home Nursing Services Job Description Administrator" stated "... Essential job functions ... Plans, organizes, and directs the day-to-day	G 948		

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G 948	Continued From page 101 operations ... Ensures compliance with federal/state regulations governing home health care services ... Coordinates the QAPI [quality assurance, performance improvement] program ... Assists in implementation of recommendations and plans for evaluating results ...." 6. Review of a document dated 01/22/2021 titled "Written Consent to Resolutions of the Board of Directors of Home Nursing Services, Inc." stated "... approved the following changes in agency operations ... Agency will discharge and transfer all clients receiving LPN [licensed practical nurse] or RN [registered nurse] services except for medication set-ups ... clients to be discharged include clients who receive skilled care including, but not limited to clients with catheters [a tube inserted into the bladder to drain urine], and clients with wounds in need of skilled care ...." 7. Review of a Department of Health and Human Services Centers for Medicare & Medicaid Services document titled "Statement of Deficiencies And Plan of Correction" evidenced a completion date of 3/26/2021 under the deficiency cited G948, and stated "... The Administrator will meet daily with the Clinical Director and/or Assistant Clinical Director to review daily operations of the clinical staff, including the status of comprehensive assessments, plans of care, physician orders and missed visit reports. · The Administrator will conduct weekly staff meetings that will include reports by the Clinical Director of [sic] Assistant Clinical Director on referrals, admissions, discharges, utilization, incidents and other general management issues. · The Administrator will attend biweekly meetings of RN Case Managers to monitor and ensure that clinical issues are being discussed and resolved ... The	G 948		

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G 948	Continued From page 102 Governing Body will review the Administrator ' s performance on a quarterly basis ...." 8. Review of an undated agency policy C-120 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Admission Policy" stated "... Clients are accepted for treatment in the home on the basis of reasonable criteria and under the expectation that the client's medical, nursing, and social needs can be met adequately by Home Nursing Services in the client's place of residence ... will not admit client or continue to provide services ... Scope and complexity of needs cannot be met ... Skills and ... personnel are not adequate to meet client needs ...." 9. Record review for patient #1 was completed on 4/14/2021, start of care date 7/15/2013, for certification periods 2/5/2021 - 4/5/2021, and 4/6/2021 - 6/4/2021, with primary diagnosis of Alzheimer's disease, unspecified and orders for home health aide (HHA) services only. The plan of care also evidenced a section titled "60 Day Summary" (which provided a summary of patient findings from the previous certification period) that stated " ... formation of a stage 2 pressure sore on right buttock ... measures 0.5cm [centimeters] by 0.5cm ... the RN [registered nurse] case manager will need to make at least weekly visits to monitor the progress and assess if sore is getter better or worse with current treatment ...." The record evidenced the agency was aware of the patient's first decline in health status on 3/11/2021 and failed to assess the patient until 3/23/2021. Additionally, the record evidenced the agency was aware of the patient's additional decline in health status (on 4/2/2021) with the development of a wound. The agency failed to	G 948		

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G 948	Continued From page 103	G 948		

ensure they could meet the needs of the patient by: failing to obtain skilled nursing orders for observation and assessment to prevent further illness, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, and interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown.

A home visit observation was completed for patient #1 on 4/13/2021 at 11:55 AM. The alternate clinical director and HHA I was present. A superficial open wound was observed on the right intergluteal cleft (butt crack), approximately 1.0 cm (centimeter) in diameter, 0.1 - 0.2 cm depth, with a pink, moist wound bed. The surrounding skin was not observable due to the presence of desitin ointment (zinc oxide topical skin protectant) on the skin. The patient's daughter (also a nurse) arrived during the visit, who indicated the patient developed symptoms of a respiratory infection on or about 3/8/2021, his symptoms worsened, and he was seen in a walk-in clinic (3/11/2021), was prescribed antibiotics, she had him sleep in his recliner to help him breathe easier. Additionally, she stated about a week and a half ago, he developed a pressure sore due to spending so much time in the recliner, he never had a pressure sore until the respiratory illness in March (2021). She used desitin on his buttocks and TheraHoney wound gel (for use on wounds with no drainage to moderate drainage and should be paired with an occlusive absorbent dressing) on his wound for several weeks, and the wound was on his right buttock.

Review of a document dated and signed by the alternate clinical manager on 3/11/2021 titled

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G 948	Continued From page 104 "Care Coordination Note" stated "... spoke with Daughter of this client.about [sic] the client possibly having aspirational [sic] pneumonia. she [sic] is trying to get transportation to the walk in [sic] clinic as opposed to going to the hospital ... sitting him in a chair and using vicks [a mentholated topical cough suppressant ointment], cough syrup for two days now and thinks he needs an antibiotic ... I told her with the pneumonia he could get bad fast ... the daughter said she would let me know what happens ...." Review of a document dated and signed by the clinical manager on 3/12/2021 titled "Care Coordination Note" stated "... [daughter] took her father [patient] to a walk up clinic yesterday ... given a prescription for an oral antibiotic ... [daughter] to email the clinic paperwork to me today ...." Review of a document from walk-in clinic A dated 3/11/2021 evidenced the patient was diagnosed with bacterial lower respiratory infection, cough, fever, and was prescribed an antibiotic to treat the infection. Review of a document dated and signed 3/23/2021 by RNCM (registered nurse case manager) G titled "SN [skilled nurse] Daily Note" stated "... RNCM was notified by multiple reports [from the client's daughter, from HHA [home health aide], from other RNs] that the client's functional status has declined. He was reported to be weak, unable to get out of bed, unable to walk ... possible "aspiration pneumonia", has been to urgent care for antibiotics ... Daughter reports that client aspirated over the weekend while being fed ... Cannot walk more than a couple of steps. He was previously able to walk with assistance ... Unstable and, deteriorating ...	G 948		

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G 948	Continued From page 105 Current Plan of Care ... May need to be modified ...." Review of a document dated and signed by HHA H on 4/6/2021 titled "Daily [home health aide/attendant care] Visit Sheet for 4/02/2021" stated "... 3 pressure sores [open wound caused by unrelieved pressure] on bottom, one open. Nurse noted ...." Review of a document dated and signed by RNCM G on 4/2/2021 titled "RN Re-Certification [comprehensive] Assessment" evidenced the patient was at risk for skin breakdown, the depth of the wound as 0.0 cm (depth was observed during home visit). 10. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021, which evidenced the patient received skilled nursing services for supervisory visits and HHA services for personal care. The document evidenced a section titled "60 Day Summary" which stated " ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ...."The agency failed to ensure they could meet the needs of the patient by: failing to obtain skilled nursing orders, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, and interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown, and failed to ensure the RNCM had knowledge of how to properly turn patient as evidenced by:	G 948		

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G 948	Continued From page 106 Review of a document dated and signed by RNCM E on 3/5/2021 titled "RN Re-Certification Assessment" failed to evidence a comprehensive re-assessment including OASIS data was completed, and stated "... left heel pressure wound, 2cm round ... Ruptured blister. Dry, healing well, no signs/symptoms of infection ...." During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA (home health aide) K were present. The patient was positioned sitting upright in bed with both heels elevated. The right heel evidenced intact skin with a circular hyperpigmented (darker than patient's normal skin color) area, approximately 3.0 - 4.0 cm in diameter. The left heel was observed intact with no evidence of skin breakdown. The patient indicated she had blister on her right heel from friction on the bed, but it was resolved, and she never had any breakdown on her left heel. During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RNCM E, and HHA K were present. The patient indicated she had a problem with her right heel, not the left heel, it started about a month ago, her mom covered the wound with gauze and tape, she never had problems with skin breakdown prior to this wound, and she could only feel slight sensation in her feet, such as pain. Observed RNCM E perform a head-to-toe physical assessment on the patient. HHA K was positioned on one side of the bed, and RNCM E was positioned on the other. After a portion of the assessment was completed, HHA K removed all the positional pillows and lowered the head of the bed so the patient could be turned onto her right side (to assess the backside of the	G 948		

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G 948	Continued From page 107 body). RNCM E began to turn the patient without first moving her closer to her side of the bed, which would prevent the patient's face from hitting the siderail. HHA K and the patient stopped RNCM E and verbally directed her on proper turning technique. Also, during the assessment, RNCM E repeatedly left the room for several minutes to chart in the EMR (electronic medical record), and then return to continue her assessment and ask the patient additional questions. RNCM E indicated she completed the physical assessment at 10:29 AM. RNCM E failed to measure the hyperpigmented area on the patient's right heel, palpate, or check the area for blanching (indicates presence or absence of adequate blood flow to determine if a pressure injury or suspected deep tissue injury is present). She also indicated she stayed in the same sitting position in bed all day on days she worked (patient does part time work on computer with the use of a pen in mouth to type) and family would reposition onto her side in the evenings. Review of a document dated and signed by RN E on 4/14/2021 titled "SN Daily Note" stated "... System Review ... Integument [skin] ... No significant issues ... Care is considered custodial ...." 11. Record review for patient #4 was completed on 4/14/2021, start of care date 6/18/2020, certification period 4/14/2021 - 6/12/2021, evidenced a comprehensive re-assessment was required to be completed no earlier than 4/9/2021, but no later than 4/13/2021. The record failed to evidence a comprehensive re-assessment was completed or completed within the required timeframe. Review of a document dated and signed by	G 948		

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G 948	Continued From page 108 RNCM (Registered Nurse Case Manager) E on 4/8/2021 titled "Skilled Nurse Visit Note" evidenced a skilled nursing visit was completed on 4/8/2021, and the patient's medication pill box was set up by the nurse for 2 weeks. Review of a document dated 4/9/2021, author RNCM E (without a dated electronic signature) titled "RN Re-Certification Assessment" evidenced an assessment was completed by RN E on 4/9/2021. RNCM E did not complete a nursing visit on 4/9/2021. 12. Record review for patient #5 was completed on 4/14/2021, start of care date 1/11/2016, certification period 4/14/2021 - 6/12/2021, evidenced a comprehensive re-assessment was required to be completed no earlier than 4/9/2021, but no later than 4/13/2021. The record failed to evidence a comprehensive re-assessment visit was completed or completed within the required timeframe. Review of a document dated and signed by RNCM E on 4/8/2021 titled "Skilled Nurse Visit Note" evidenced a skilled nursing visit was completed on 4/8/2021, and the patient's medication pill box was set up by the nurse for 2 weeks. Review of a document dated 4/9/2021, author RNCM E (without a dated electronic signature) titled "RN Re-Certification Assessment" evidenced an assessment visit was completed by RN E on 4/9/2021. RNCM E did not complete a nursing visit on 4/9/2021. During an interview on 4/9/2021 at 9:53 AM, when asked the last time a nurse saw her, patient #5 stated "Yesterday [4/8/2021]."	G 948		

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G 948	Continued From page 109 13. During an interview on 4/8/2021 at 3:02 PM, when asked about the content of daily meetings with the clinical manager and/or alternate clinical manager, the administrator indicated he had more frequent conversations with the clinical manager and/or alternate clinical manager several times per day, he had a better opportunity to hear the clinical side, and he saw "red flags" a little easier. When asked to describe the weekly staff meetings he conducted, the administrator indicated the meetings were an organizational meeting at director level with members of personal services agency B leaders, they brought up general issues and strategized, so they were on the same page. During this time, when asked to describe biweekly meetings with RN Case Managers, the administrator referred the question to the alternate clinical manager who indicated they were educational meetings for the administrator to see what was "going on". When asked if there was still a hold on skilled admits except disease management and med set ups, the administrator stated "Yes ....", and indicated a change in condition would trigger a new admit. When asked when his last evaluation was completed by the governing body, the administrator stated "I don't know. It was on the schedule to have one soon, I know that." When asked what the agency's current QAPI indicators were, the administrator stated "Infections." When asked if there were any other QAPI indicators, the administrator stated "Yes, but I don't know what they are ... I believe we had discussions on COVID-19." 14. During an interview on 4/9/2021 at 1:57 PM, RNCM E indicated she was in the office all day (4/9/2021), she did not perform any skilled nursing visits today (4/9/2021), she performed the	G 948		

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G 948	Continued From page 110 re-assessments on patients #4 and #5 "... Yesterday ...." (4/8/2021), she couldn't open the "RN Re-Certification Assessment" documents until today (4/9/2021) for completion, and the EHR (electronic health record) only allowed the document to be opened during the last five days of the certification period. She also indicated she didn't see a problem that she saw the patients on one day, and documented she saw them on a different day. 15. During an interview on 4/9/2021 at 3:45 PM, the alternate clinical manger indicated there was a 5-day timeframe for completing the comprehensive re-assessment, RNCM E should have used it, and performing a visit outside the required 5 days during the end of the certification period to fill a medication pill box was not a valid excuse. During this time, the administrator and clinical manager indicated they were unaware RNCM E falsified dates of assessments for patients #4 and #5. 16. During an interview on 4/12/2021 at 2:37 PM, when asked about topics discussed during case manager meetings, the administrator indicated most recent meetings have focused on plans of care. When asked if any patient issues were identified, the administrator indicated there was discussion which regarded the wounds that came up (patients #1, 2), and possible discharges for those patients, the agency decided to pull back from skilled care during this time, and no decision made to discharge them yet (as of the date/time of the interview), and the agency didn't have adequate staff to cover multiple weekly, or even weekly visits. 17-12-1(b)(3) 17-12-1(c)(1)	G 948		

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G 962	Continued From page 111	G 962		
G 962	Coordinate patient care CFR(s): 484.105(c)(2) Coordinating patient care, This Element is not met as evidenced by: Based on observation, record review and interview, the clinical manager failed to ensure the registered nurse case manager coordinated with physicians for 2 of 2 records reviewed with patients who had a change in condition (#1, 2), and for 1 of 1 records reviewed where the nurse administered a medication without a physician's order (#3). Findings include: 1. Review of an undated agency policy C-635 copyright Briggs Corporation, Home Care Operational Guidelines titled "Physician Orders" stated "... All medications, treatments and services provided to clients must be ordered by a physician ... To document verification that orders for services have been obtained from the physician ... To assure accurate and complete orders are obtained and verified ... To document that orders taken by the designated Home Nursing Services nurses are communicated to the Clinical Director ... Physician will be contacted when any of the following occurs ... Condition changes ... Any change in client condition or ... services ... including non-compliance of the client ...." 2. Review of an undated agency policy C-360 copyright Briggs Corporation, Home Care Operational Guidelines titled "Coordination of Client Services" stated "... ensure services are coordinated ... ensure appropriate, quality care is being provided to clients ... To provide the attending physician with an ongoing assessment	G 962		

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G 962	Continued From page 112 of the client and identify the client's response to services provided ...." 3. A home visit observation was completed for patient #1 on 4/13/2021 at 11:55 AM. The alternate clinical director and HHA (home health aide) I was present. A superficial open wound was observed on the right intergluteal cleft (butt crack), approximately 1.0 cm (centimeter) in diameter, 0.1 - 0.2 cm depth, with a pink, moist wound bed. The surrounding skin was not observable due to the presence of desitin ointment (zinc oxide topical skin protectant) on the skin. Family (also a nurse) arrived during the visit, who indicated the patient developed symptoms of a respiratory infection on or about 3/8/2021, his symptoms worsened and he was seen in a walk-in clinic (3/11/2021), was prescribed antibiotics and robitussin (guaifenesin) with codeine, she had him sleep in his recliner to help him breathe easier until about a week and a half ago, he developed a pressure sore due to spending so much time in the recliner, he never had a pressure sore until the respiratory illness in March (2021), she used desitin on his buttocks and TheraHoney wound gel (for use on wounds with no drainage to moderate drainage and should be paired with an occlusive absorbent dressing) on his wound for several weeks, and the wound was on his right buttock. The patient was observed as he was fed by HHA I, and the patient exhibited signs of aspiration by coughing/choking while swallowing food. Family indicated he had not had a swallow study (a study performed to rule out aspiration, or the ingestion of food/fluids into the lungs). During this time, the alternate clinical manager indicated she was unaware of the use of TheraHoney on the patient's buttocks, and she would get an order from the physician.	G 962		

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G 962	Continued From page 113 Record review for patient #1 was completed on 4/14/2021, start of care date 7/15/2013, for certification periods 2/5/2021 - 4/5/2021, and 4/6/2021 - 6/4/2021, with primary diagnosis of Alzheimer's disease, unspecified. The record evidenced the agency was aware of the patient's first decline in health status on 3/11/2021, failed to assess the patient until 3/23/2021, and failed to coordinate significant findings and changes indicated below with the patient's physician. Review of a document dated and signed by the alternate clinical manager on 3/11/2021 titled "Care Coordination Note" stated "... spoke with Daughter of this client.about [sic] the client possibly having aspirational [sic] pneumonia. she [sic] is trying to get transportation to the walk in [sic] clinic as opposed to going to the hospital ... sitting him in a chair and using vicks [a mentholated topical cough suppressant ointment], cough syrup for two days now and thinks he needs an antibiotic ... I told her with the pneumonia he could get bad fast ... the daughter said she would let me know what happens ...." Review of a document dated and signed by the clinical manager on 3/12/2021 titled "Care Coordination Note" stated "... [daughter] took her father [patient] to a walk up clinic yesterday ... given a prescription for an oral antibiotic ... [daughter] to email the clinic paperwork to me today ...." Review of a document from walk-in clinic A dated 3/11/2021 evidenced the patient was diagnosed with bacterial lower respiratory infection, cough, fever, and was prescribed an antibiotic to treat the infection.	G 962		

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G 962	Continued From page 114 Review of a document dated 3/12/2021 and signed by the clinical manager on 3/25/2021 titled "Care Coordination Note" stated "... I phoned [family] ... for an update on how he [patient] is doing today ... She took [patient] to a walk up clinic yesterday ... given a prescription for an oral antibiotic ...." The record failed to evidence the physician was contacted for care coordination and report of the patient's status. Review of a document dated and signed 3/23/2021 by RNCM (registered nurse case manager) G titled "SN [skilled nurse] Daily Note" stated "... RNCM was notified by multiple reports (from the client's daughter, from HHA [home health aide], from other RNs) that the client's functional status has declined. He was reported to be weak, unable to get out of bed, unable to walk ... possible "aspiration pneumonia", has been to urgent care for antibiotics ... Daughter reports that client aspirated over the weekend while being fed ... Cannot walk more than a couple of steps. He was previously able to walk with assistance ... Unstable and, deteriorating ... Current Plan of Care ... May need to be modified ...." The document failed to evidence the physician was notified for care coordination and report of the patient's current status. Review of a document dated and signed by HHA H on 4/6/2021 titled "Daily [home health aide/attendant care] Visit Sheet for 4/02/2021" stated "... 3 pressure sores [open wound caused by unrelieved pressure] on bottom, one open. Nurse noted ...." Review of a document dated and signed by RNCM G on 4/2/2021 titled "RN Re-Certification Assessment" evidenced the patient had a new wound on right buttock, was at risk for skin	G 962		

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breakdown, was at risk for aspiration, and was a high fall risk. The document failed to evidence care coordination with the physician for report of current status.

Review of a document dated 4/2/2021 titled "Care Coordination Note" stated "... The [physician] is aware of the recent upper respiratory illness ... from March ... provided update that the client completed [antibiotics] and is currently on guaifenesin with codeine ... developed a pressure sore ... [physician] ... is on spring break until 4/12/2021 ...." The clinical manager failed to ensure the registered nurse obtained physician's orders for the recertification period which included (but not limited to) skilled nursing orders and wound care treatment orders.

4. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021. The document evidenced a section titled "60 Day Summary" which stated " ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ...." The record failed to evidence any nursing visits were completed after 3/5/2021 to re-assess the patient's wound until the visit made with the surveyor on 4/14/2021, and failed to coordinate changes below with the physician.

Review of a document dated and signed by RN E on 3/5/2021 titled "RN Re-Certification Assessment" stated "... left heel pressure wound, 2cm round ... Ruptured blister. Dry, healing well, no signs/symptoms of infection ...." The RN failed to identify the correct location and stage of the

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G 962	Continued From page 116	G 962		

wound, which was actually on the right foot, and failed to evidence the registered nurse obtained physician's orders for the recertification period which included (but not limited to) skilled nursing orders and wound care treatment orders.

During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA (home health aide) K were present. The patient was positioned sitting upright in bed with both heels elevated. The right heel evidenced intact skin with a circular hyperpigmented (darker than patient's normal skin color) area, approximately 3.0 - 4.0 cm in diameter. The left heel was observed intact with no evidence of skin breakdown. The patient indicated she had blister on her right heel from friction on the bed, but it was resolved, and she never had any breakdown on her left heel.

During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RN E, and HHA K were present. The patient indicated she had a problem with her right heel, not the left heel, it started about a month ago, her mom covered the wound with gauze and tape, she never had problems with skin breakdown prior to this wound, and she could only feel slight sensation in her feet, such as pain. RN E asked HHA K what she added to the hand and foot soaks. HHA K indicated she added Epsom salts with eucalyptus and spearmint and stated "... about a handful ...." RN E indicated she would get an order. Observed RN E perform a head-to-toe physical assessment on the patient. HHA K was positioned on one side of the bed, and RN E was positioned on the other. After a portion of the assessment was completed, HHA K removed all of the positional pillows and lowered the head of the bed so the patient could

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be turned onto her right side (to assess the backside of the body). RN E began to turn the patient without first moving her closer to her side of the bed, which would prevent the patient's face from hitting the siderail. HHA K and the patient stopped RN E and verbally directed her on proper turning technique. Also, during the assessment, RN E repeatedly left the room for several minutes to chart in the EMR (electronic medical record), and then return to continue her assessment and ask the patient additional questions. RN E indicated she completed the physical assessment at 10:29 AM. RN E failed to measure the hyperpigmented area on the patient's right heel, palpate, or check the area for blanching (indicates presence or absence of adequate blood flow to determine if a pressure injury or suspected deep tissue injury is present). RN E asked the patient when she was last weighed, to which the patient indicated it was a year ago when she was hospitalized for a UTI (urinary tract infection). When asked by RN E when her last bowel movement was, the patient stated "Monday [4/12/2021- two days ago]", and HHA K stated, "We're trying to keep her more regular." When asked by the surveyor if the RN provided any teaching, the patient stated "No." She also indicated she stayed in the same sitting position in bed all day on days she worked but would reposition onto her side in the evenings. During this time, HHA K stated, "I don't think she's [patient] drinking enough." RN E instructed HHA K to encourage fluids. When asked by the surveyor if fluid intake was recorded/monitored, HHA K indicated it was not. At 10:52 AM, RN E discussed goals with the patient, indicated they were "keeping" the skin goal, instructed the patient to continue to keep her heels off the bed, and hand and feet soaks would continue. RN E indicated this was not a skilled patient, the

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G 962	Continued From page 118 document used for the assessment was titled "RN Daily Note", and this patient received aide services only. Review of a document dated and signed by RN E on 4/14/2021 titled "SN Daily Note" stated "... System Review ... Integument [skin] ... No significant issues ... Has the change been documented and sent to the physician for approval: ... No ... Continue with current plan ... Care is considered custodial ...." The document failed to evidence the physician was notified for an update to the status of the patient's wound. 5. Record review for patient #3 was completed on 4/12/2021 and again on 4/14/2021, start of care date 8/27/2019, primary diagnosis type 2 diabetes with hyperglycemia (high blood sugar), evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 2/17/2021 - 4/17/2021, which evidenced (but not limited to) the patient lived alone, received skilled nursing services (but not limited to) for weekly medication tray set up, was on a low sugar/simple carbohydrate (diabetic) diet, he was "relatively non-compliant" with his diet; and was prescribed (but not limited to) primidone (medication to treat tremors), spironatactone (a diuretic medication), syngardy (a diabetes medication), and detemir (an injectable diabetes medication), all of which required periodic lab monitoring. The record failed to evidence a communication with the physician for a physician's order for the lidocaine topical patch (a medicated pain patch) or if lab testing was required. Review of a document dated 3/30/2021 titled "Skilled Nurse Visit Note" evidenced the patient was alert and oriented, had no pain, vital signs	G 962		

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G 962	Continued From page 119 were within normal limits, and evidenced the nurse applied a lidocaine patch to the patient's left shoulder. The document failed to evidence the physician was notified for an order clarification for the lidocaine patch.	G 962		
G 966	Assure patient needs are continually assessed CFR(s): 484.105(c)(4) Assuring that patient needs are continually assessed, and This Element is not met as evidenced by: Based on record review and interview, the clinical director failed to ensure the registered nurse (RN) continually assessed and accurately described the patient's current health status, which led to new or worsening wounds for 2 of 2 patients' records reviewed with wounds (#1, 2). Findings include: 1. Review of an undated agency policy C-120 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Admission Policy" stated "... Clients are accepted for treatment in the home on the basis of reasonable criteria and under the expectation that the client's medical, nursing, and social needs can be met adequately by Home Nursing Services in the client's place of residence ... will not admit client or continue to provide services ... Scope and complexity of needs cannot be met ... Skills and ... personnel are not adequate to meet client needs ...." 2. Review of an undated agency policy C-155 copyright Briggs Healthcare titled "Client 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	G 966		

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G 966	Continued From page 120 identify decline or improvement ... are reassessed when significant changes occur in their condition ... [or] diagnosis ...." 3. Review of agency policy dated 6/2000 titled "Home Nursing Services Job Description: Registered Nurse" stated "... Becomes familiar with the diagnostic services available for home health care and follows the directions of the Clinical Director in utilizing these services to meet the needs of the client ... Documents fully and accurately to record a complete, total picture of the client's status and progress, and gives a complete synopsis of the care provided by the skilled registered nurse ...." 4. Record review for patient #1 was completed on 4/14/2021, start of care date 7/15/2013, for certification periods 2/5/2021 - 4/5/2021, and 4/6/2021 - 6/4/2021, with primary diagnosis of Alzheimer's disease, unspecified and orders for home health aide (HHA) services only. The plan of care also evidenced a section titled "60 Day Summary" (which provided a summary of patient findings from the previous certification period) that stated " ... formation of a stage 2 pressure sore on right buttock ... measures 0.5cm [centimeters] by 0.5cm ... the RN [registered nurse] case manager will need to make at least weekly visits to monitor the progress and assess if sore is getter better or worse with current treatment ...." The record evidenced the agency was aware of the patient's first decline in health status on 3/11/2021 and failed to assess the patient until 3/23/2021. Additionally, the record evidenced the agency was aware of the patient's additional decline in health status (on 4/2/2021) with the development of a wound. The agency failed to	G 966		

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G 966	Continued From page 121 ensure they could meet the needs of the patient by: failing to obtain skilled nursing orders for observation and assessment to prevent further illness, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, and interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown. A home visit observation was completed for patient #1 on 4/13/2021 at 11:55 AM. The alternate clinical director and HHA I was present. A superficial open wound was observed on the right intergluteal cleft (butt crack), approximately 1.0 cm (centimeter) in diameter, 0.1 - 0.2 cm depth, with a pink, moist wound bed. The surrounding skin was not observable due to the presence of desitin ointment (zinc oxide topical skin protectant) on the skin. The patient's daughter (also a nurse) arrived during the visit, who indicated the patient developed symptoms of a respiratory infection on or about 3/8/2021, his symptoms worsened, and he was seen in a walk-in clinic (3/11/2021), was prescribed antibiotics, she had him sleep in his recliner to help him breathe easier. Additionally, she stated about a week and a half ago, he developed a pressure sore due to spending so much time in the recliner, he never had a pressure sore until the respiratory illness in March (2021). She used desitin on his buttocks and TheraHoney wound gel (for use on wounds with no drainage to moderate drainage and should be paired with an occlusive absorbent dressing) on his wound for several weeks, and the wound was on his right buttock. Review of a document dated and signed by the alternate clinical manager on 3/11/2021 titled	G 966		

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G 966	Continued From page 122 "Care Coordination Note" stated "... spoke with Daughter of this client.about [sic] the client possibly having aspirational [sic] pneumonia. she [sic] is trying to get transportation to the walk in [sic] clinic as opposed to going to the hospital ... sitting him in a chair and using vicks [a mentholated topical cough suppressant ointment], cough syrup for two days now and thinks he needs an antibiotic ... I told her with the pneumonia he could get bad fast ... the daughter said she would let me know what happens ...." Review of a document dated and signed by the clinical manager on 3/12/2021 titled "Care Coordination Note" stated "... [daughter] took her father [patient] to a walk up clinic yesterday ... given a prescription for an oral antibiotic ... [daughter] to email the clinic paperwork to me today ...." Review of a document from walk-in clinic A dated 3/11/2021 evidenced the patient was diagnosed with bacterial lower respiratory infection, cough, fever, and was prescribed an antibiotic to treat the infection. Review of a document dated and signed 3/23/2021 by RNCM (registered nurse case manager) G titled "SN [skilled nurse] Daily Note" stated "... RNCM was notified by multiple reports [from the client's daughter, from HHA [home health aide], from other RNs] that the client's functional status has declined. He was reported to be weak, unable to get out of bed, unable to walk ... possible "aspiration pneumonia", has been to urgent care for antibiotics ... Daughter reports that client aspirated over the weekend while being fed ... Cannot walk more than a couple of steps. He was previously able to walk with assistance ... Unstable and, deteriorating ...	G 966		

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G 966	Continued From page 123 Current Plan of Care ... May need to be modified ...." Review of a document dated and signed by HHA H on 4/6/2021 titled "Daily [home health aide/attendant care] Visit Sheet for 4/02/2021" stated "... 3 pressure sores [open wound caused by unrelieved pressure] on bottom, one open. Nurse noted ...." Review of a document dated and signed by RNCM G on 4/2/2021 titled "RN Re-Certification [comprehensive] Assessment" evidenced the patient was at risk for skin breakdown, the depth of the wound as 0.0 cm (depth was observed during home visit). 5. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021, which evidenced the patient received skilled nursing services for supervisory visits and HHA services for personal care. The document evidenced a section titled "60 Day Summary" which stated " ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ...."The agency failed to ensure they could meet the needs of the patient by: failing to obtain skilled nursing orders, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, and interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown, and failed to ensure the RNCM had knowledge of how to properly turn patient as evidenced by:	G 966		

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G 966	Continued From page 124 Review of a document dated and signed by RNCM E on 3/5/2021 titled "RN Re-Certification Assessment" failed to evidence a comprehensive re-assessment including OASIS data was completed, and stated "... left heel pressure wound, 2cm round ... Ruptured blister. Dry, healing well, no signs/symptoms of infection ...." During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA (home health aide) K were present. The patient was positioned sitting upright in bed with both heels elevated. The right heel evidenced intact skin with a circular hyperpigmented (darker than patient's normal skin color) area, approximately 3.0 - 4.0 cm in diameter. The left heel was observed intact with no evidence of skin breakdown. The patient indicated she had blister on her right heel from friction on the bed, but it was resolved, and she never had any breakdown on her left heel. During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RNCM E, and HHA K were present. The patient indicated she had a problem with her right heel, not the left heel, it started about a month ago, her mom covered the wound with gauze and tape, she never had problems with skin breakdown prior to this wound, and she could only feel slight sensation in her feet, such as pain. Observed RNCM E perform a head-to-toe physical assessment on the patient. HHA K was positioned on one side of the bed, and RNCM E was positioned on the other. After a portion of the assessment was completed, HHA K removed all the positional pillows and lowered the head of the bed so the patient could be turned onto her right side (to assess the backside of the	G 966		

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G 966	Continued From page 125 body). RNCM E began to turn the patient without first moving her closer to her side of the bed, which would prevent the patient's face from hitting the siderail. HHA K and the patient stopped RNCM E and verbally directed her on proper turning technique. Also, during the assessment, RNCM E repeatedly left the room for several minutes to chart in the EMR (electronic medical record), and then return to continue her assessment and ask the patient additional questions. RNCM E indicated she completed the physical assessment at 10:29 AM. RNCM E failed to measure the hyperpigmented area on the patient's right heel, palpate, or check the area for blanching (indicates presence or absence of adequate blood flow to determine if a pressure injury or suspected deep tissue injury is present). The patient also indicated she stayed in the same sitting position in bed all day on days caregiver worked but would reposition onto her side in the evenings. Review of a document dated and signed by RN E on 4/14/2021 titled "SN Daily Note" stated "... System Review ... Integument [skin] ... No significant issues ... Care is considered custodial ...." 6. During an interview on 4/8/2021 at 3:02 PM, the alternate clinical manager indicated the RNCMs provided a "Daily Update Report" to the alternate clinical manager every morning by 9:00 AM, one of the "reportable" concerns was any patient experiencing a change in condition, if identified, the alternate clinical manager would assign an RNCM to perform the Comprehensive Assessment the same day and notify the patient's physician of the assessment findings. When asked if she had implemented the assignment of an RNCM to perform a comprehensive	G 966		

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G 966	Continued From page 126 re-assessment for a change in condition, and if so, for what, she stated "Not yet." 7. During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manager indicated a stage 2 pressure injury would have the top layer of skin off, a fluid filled blister would be a stage 2 pressure injury, and anything added to water during a soak should be on the care plan. During this time, the administrator indicated the most recent nursing case manager meetings addressed client situations, new wounds, falls, clinical topics of relevance, admissions, and discharges; most recent meetings focused on plans of care, discussed the new wounds (for patients #1, 2), possible discharges for them (from the agency), the agency management made a decision to pull back from skilled care during this time, and then later decide how to move forward, there was no decision made at that time to discharge the wound patients, and the agency didn't have the staff to cover multiple weekly or even weekly visits for skilled care.	G 966		
G 968	Assure implementation of plan of care CFR(s): 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. This Element is not met as evidenced by: Based on observation, record review, and interview, the clinical manager failed to ensure all patients' records identified with wounds included skilled nursing interventions such as wound care/treatments, patient/family education for wound care/treatment, or interventions to mitigate worsening skin breakdown on the plans of care for 2 of 2 records reviewed with wounds (#1, 2); and failed to ensure all patients' records identified who received skilled nursing services for medication set up included skilled nursing	G 968		

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G 968	Continued From page 127	G 968		

interventions such as monitoring effectiveness and compliance with medication regimen, monitoring therapeutic drug levels as indicated, and patient/family education for disease process management and specialized diets for 3 of 3 records reviewed with skilled nursing medication set up (#3, 4, 5).

Findings include:

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 procedures ... medications, treatments, and procedures . ..."

2. 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 ... to identify need to modify the plan of care . ..."

3. Review of an undated copyrighted Briggs Healthcare policy C-400 titled "Client/Family Education" stated " ... the education and training for clients and families will target the clients ability to improve outcomes through promotion of healthy and involvement in their care, treatment and service decisions ...."

4. Review of an undated copyrighted Briggs Healthcare policy titled "Assessment/Staging of Pressure Ulcers" stated " ... in assessing the pressure ulcer, the following parameters should be addressed consistently. Site, stage of ulcer (include length, width, and depth) ... Stage 2:

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G 968	Continued From page 128 May also present as an intact or open/ruptured serum filled blister . ..." 5. Review of Job Description D-470 dated 06/2000 titled "Registered Nurse Case Manager" stated " ... obtains pertinent information concerning the nurse care to be provided to the client and develop the plan of care for the client ... contacts the clinical director with client information as necessary ...teaches the client and caregiver in the areas on the plan of care ...." 6. Review of an undated agency policy C-705 copyright Briggs Healthcare, Home Care Operational Guidelines titled "Medication Management" stated "... Home Nursing Services has a medication management system that supports client safety and improves quality of care treatment and services ... Comprehensive client assessment ... include [sic] review of all medications ... (prescribed, samples, over the counter, herbal remedies, PRN [as needed] medications) and records this in the client record ... Information that must be available in the record ... relevant laboratory values and regularly scheduled lab testing ... The primary pharmacy will also be identified and the phone number recorded ... on the medication profile ... orders will be obtained for the use of herbal drugs or preparations ... When Home Nursing Services staff are administering medications ... Clinician will verify that the medication is ... correct ... based on the order ... Client response to medications will be assessed on each home visit ... Laboratory values will be evaluated ...." 7. Review of the FDA web page reference https://www.accessdata.fda.gov/drugsatfda_docs/label/2008/012151s062lbl.pdf stated "... The recommended monitoring for potassium and	G 968		

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G 968	Continued From page 129 creatinine is one week after initiation or increase in dose of Aldactone [spironolatactone], monthly for the first 3 months, then quarterly for a year, and then every 6 months ... Concomitant administration of potassium-sparing diuretics and ACE inhibitors or nonsteroidal anti-inflammatory drugs (NSAIDs), e.g., [aspirin], has been associated with severe hyperkalemia ... it is important to monitor serum potassium levels ... Patients who receive Aldactone should be advised to avoid potassium supplements and foods containing high levels of potassium, including salt substitutes ... Laboratory tests: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be done at appropriate intervals, particularly in the elderly ...." 8. Review of the pubmed.gov web page reference, https://pubmed.ncbi.nlm.nih.gov/17284506/ stated "... Laboratory evaluation of potassium and creatinine among ambulatory patients prescribed spironolactone: are we monitoring for hyperkalemia? ... Serum potassium and creatinine evaluation is recommended in patients prescribed spironolactone ...." 9. Review of the pubmed.gov web page reference, https://pubmed.ncbi.nlm.nih.gov/23110839/ stated "... Therapeutic drug monitoring of primidone and phenobarbital ... a first-line treatment of essential tremor ... Generally accepted therapeutic range for primidone is between 5 and 10 mg/L (23-46 mmol/L) ...." 10. Review of the FDA web page reference https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/208658s001lbl.pdf stated "... Geriatric	G 968		

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G 968	Continued From page 130 patients: Higher incidence of adverse reactions related to volume depletion and reduced renal function. Assess renal function more frequently ... Obtain an eGFR at least annually in all patients taking SYNJARDY XR. In patients at increased risk for the development of renal impairment (e.g., the elderly), renal function should be assessed more frequently ...." 11. Review of dailymed web page reference https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=2b8d9730-686b-444b-9941-7b5877255924 stated "... Glucose monitoring is recommended for all patients with diabetes ...." 12. Review of drugs.com web page reference https://www.drugs.com/potassium_chloride.html stated "... To be sure potassium chloride is helping your condition, your blood may need to be tested often ...." 13. Review of drugs.com web page reference for depakote https://www.drugs.com/pro/depakote.html stated "... Serum liver tests should be performed prior to therapy and at frequent intervals thereafter ...." 14. Review of drugs.com web page reference for levothyroxine/Synthroid https://www.drugs.com/pro/synthroid.html stated "... Dosing must be individualized ... and dose adjustments made based on periodic assessment of the patient's clinical response and laboratory parameters ...." 15. Review of a U.S. National Library of Medicine web page reference for lidocaine pain patch https://medlineplus.gov/druginfo/meds/a603026.html stated "... never wear patches for more than 12 hours per day. Using too many patches or	G 968		

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G 968	Continued From page 131 leaving patches on for too long may cause serious side effects ... If you wear too many patches or wear patches for too long, too much lidocaine may be absorbed into your blood. In that case, you may experience symptoms of an overdose ... If the victim has collapsed, had a seizure, has trouble breathing, or can't be awakened, immediately call emergency services at 911 ...." 16. Record review of patient #1 was completed on 4/12/2021 and again on 4/14/2021, start of care date 07/15/2013, primary diagnosis of Alzheimer's disease, unspecified, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/6/21-6/4/21. The document evidenced a section titled "60 Day Summary" (which provided a summary of patient findings from the previous certification period) stated " ... formation of a stage 2 pressure sore on right buttock ... measures 0.5cm [centimeters] by 0.5cm ... daughter applies desitin [topical skin protectant] barrier cream to the area with peri care [incontinence care to buttocks/groin area] ... daughter has been educated on the importance of getting patient off the recliner and into bed at night ... family has been educated on the importance of frequent position changes, and good perineal hygiene to prevent further alterations in skin integrity ... the RN [registered nurse] case manager will need to make at least weekly visits to monitor the progress and assess if sore is getter better or worse with current treatment ..." The record failed to evidence orders for (but not limited to) skilled nursing frequency and duration of visits, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, or interventions for patient/family teaching regarding	G 968		

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G 968	Continued From page 132 wound care/prevention of new or worsening skin breakdown. Review of a document dated and signed by RN G on 4/2/2021 titled "Care Coordination Note" stated " ... pressure sore on right inner buttock, measuring 0.5cm by 0.5cm ... the family is applying desitin moisture barrier cream with pericare ... information would be sent to primary care physician who is out of office until 4/12/21 per primary care physician phone RN ...." The document failed to evidence the RN obtained orders for wound care. Review of a document dated and signed by HHA H on 4/6/2021 titled "Daily [home health aide/attendant care] Visit Sheet for 4/02/2021" stated "... 3 pressure sores [open wound caused by unrelieved pressure] on bottom, one open. Nurse noted ...." Review of a document dated and signed by RN G on 4/9/2021 titled "SN [skilled nurse] Daily Note" stated " ... RN case manager back to visit client to assess right buttock pressure wound from one week prior. The wound on the right buttock now measures 0.7cm by 0.9cm ... desitin is used with pericare per the daughter ...." The document evidenced the wound was worse (larger in size from previous assessment on 4/2/2021). During a home visit observation on 4/13/2021 at 11:55 AM, a superficial open wound was observed on the right intergluteal cleft (butt crack), approximately 1.0 cm in diameter, with a pink, moist wound bed. The surrounding skin was not observable due to the presence of desitin ointment on the skin. Family indicated she used therahoney (a topical wound ointment to treat wounds) on the wound, had been using it for 2 - 4	G 968		

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G 968	Continued From page 133	G 968		

weeks, and no cover dressing was applied. The record failed to evidence orders for the use of therahoney on the wound. The alternate clinical manager was present for the home visit and indicated she would get an order for the therahoney.

17. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021. The document evidenced a section titled "60 Day Summary" which stated " ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ...." The plan of care failed to evidence orders for (but not limited to) skilled nursing frequency and duration of visits, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, constipation, dehydration interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown, an order for the homeopathic treatment of Epsom salts and eucalyptus (the use of natural substances as remedies, such as plants and minerals), and failed to evidence pressure ulcer in the section titled "Other Pertinent Diagnoses".

Review of a document dated and signed by RN E on 3/5/2021 titled "RN Re-Certification Assessment" stated "... left heel pressure wound, 2cm round ... Ruptured blister. Dry, healing well, no signs/symptoms of infection ...." The RN failed to identify the correct location and stage of the wound, which was actually on the right foot.

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G 968	Continued From page 134 During a home visit observation with the patient on 4/9/21 at 9:53 AM, the alternate clinical manager and HHA (home health aide) K were present. The patient was positioned sitting upright in bed with both heels elevated. The right heel evidenced intact skin with a circular hyperpigmented (darker than patient's normal skin color) area, approximately 3.0 - 4.0 cm in diameter. The left heel was observed intact with no evidence of skin breakdown. The patient indicated she had blister on her right heel from friction on the bed, but it was resolved, and she never had any breakdown on her left heel. Observed patient's hands soaking in pans of water. When asked by the surveyor if there was anything added to the water, the patient indicated Epsom salts and eucalyptus was routinely added. When asked by the surveyor when was the last time she had a nursing visit, the patient stated, "Last night." During an interview on 4/9/2021 at 1:57 PM, RN E indicated she didn't remember the last time she saw patient #2. After the surveyor informed RN E that patient #2 indicated she was seen by RN E last night (4/8/2021), RN E agreed she saw the patient last night and assessed her skin. During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RN E, and HHA K were present. The patient indicated she had a problem with her right heel, not the left heel, it started about a month ago, her mom covered the wound with gauze and tape, she never had problems with skin breakdown prior to this wound, and she could only feel slight sensation in her feet, such as pain. RN E asked HHA K what she added to the hand and foot soaks. HHA K indicated she added Epsom salts with eucalyptus and	G 968		

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G 968	Continued From page 135	G 968		

spearmint, and stated "... about a handful ...." RN E indicated she would get an order. Observed RN E perform a head-to-toe physical assessment on the patient. HHA K was positioned on one side of the bed, and RN E was positioned on the other. After a portion of the assessment was completed, HHA K removed all of the positional pillows and lowered the head of the bed so the patient could be turned onto her right side (to assess the backside of the body). RN E began to turn the patient without first moving her closer to her side of the bed, which would prevent the patient's face from hitting the siderail. HHA K and the patient stopped RN E and verbally directed her on proper turning technique. Also during the assessment, RN E repeatedly left the room for several minutes to chart in the EMR (electronic medical record), and then return to continue her assessment and ask the patient additional questions. RN E indicated she completed the physical assessment at 10:29 AM. RN E failed to measure the hyperpigmented area on the patient's right heel, palpate, or check the area for blanching (indicates presence or absence of adequate blood flow to determine if a pressure injury or suspected deep tissue injury is present). RN E asked the patient when she was last weighed, to which the patient indicated it was a year ago when she was hospitalized for a UTI (urinary tract infection). When asked by RN E when her last bowel movement was, the patient stated "Monday [4/12/2021- two days ago]", and HHA K stated, "We're trying to keep her more regular." When asked by the surveyor if the RN provided any teaching, the patient stated "No." She also indicated she stayed in the same sitting position in bed all day on days she worked but would reposition onto her side in the evenings. During this time, HHA K stated, "I don't think she's [patient] drinking enough." RN E instructed HHA

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G 968	Continued From page 136 K to encourage fluids. When asked by the surveyor if fluid intake was recorded/monitored, HHA K indicated it was not. At 10:52 AM, RN E discussed goals with the patient, indicated they were "keeping" the skin goal, instructed the patient to continue to keep her heels off the bed, and hand and feet soaks would continue. RN E indicated this was not a skilled patient, the document used for the assessment was titled "RN Daily Note", and this patient received aide services only. 18. Record review for patient #3 was completed on 4/12/2021 and again on 4/14/2021, start of care date 8/27/2019, primary diagnosis type 2 diabetes with hyperglycemia (high blood sugar), evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 2/17/2021 - 4/17/2021, which evidenced (but not limited to) the patient lived alone, received skilled nursing services (but not limited to) for weekly medication tray set up, was on a low sugar/simple carbohydrate (diabetic) diet, he was "relatively non-compliant" with his diet; and was prescribed (but not limited to) primidone (medication to treat tremors), spironatactone (a diuretic medication), syngardy (a diabetes medication), and detemir (an injectable diabetes medication), all of which required periodic lab monitoring. The record failed to evidence orders for (but not limited to) skilled nursing duration of visits, interventions for diabetes management and hyperglycemia, diabetic diet and non-compliance, interventions to monitor therapeutic drug levels, or interventions for patient/family teaching regarding disease management and diet; and failed to evidence licocaine topical patch on the medication list. Review of a drugs.com document dated 3/2/2021	G 968		

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G 968	Continued From page 137 titled "Drug Interaction Report" stated "... Applies to: insulin detemir, Synjardy ... Your blood glucose should be closely monitored ...." Review of a document dated 3/30/2021 titled "Skilled Nurse Visit Note" evidenced the patient was alert and oriented, had no pain, vital signs were within normal limits, and evidenced the nurse applied a lidocaine patch (a medicated topical pain patch) to the patient's left shoulder. The document failed to evidence the nurse provided any teaching regarding the medication precautions, such as to remove the patch after 12 hours, or signs and symptoms to report to the nurse or physician; and failed to evidence any interventions such as patient education regarding diet, medication teaching, or teaching related to disease management. Review of a document dated 4/1/2021 titled "Discharge Summary" stated "... Client found deceased in his bed by an unknown party on 3/31/2021 ...." 19. Record review for patient #4 was completed on 4/14/2021, start of care date 6/18/2020, primary diagnosis type 2 diabetes with hyperglycemia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/14/2021 - 6/12/2021, which evidenced (but not limited to) the patient was an 81 year old who lived alone, he received skilled nursing visits every 2 weeks to fill and organize medication delivery system (pill planner box), he was prescribed (but not limited to) potassium chloride and detemir (insulin), he was non-compliant with his diabetic diet, and in a section titled "60 Day Summary" stated "... The client has set a continuing goal for himself to reduce his A1C [a laboratory blood test to	G 968		

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G 968	Continued From page 138 determine the patient's average blood sugar for the preceding 2 to 3 months]. The record failed to evidence orders for skilled nursing interventions such as lab monitoring for therapeutic blood potassium levels or hemoglobin A1C levels, failed to evidence results of a recent hemoglobin A1C level, and failed to evidence any interventions such as patient education regarding diet, medication teaching, or teaching related to disease management. 20. Record review for patient #5 was completed on 4/14/2021, start of care date 1/11/2016, primary diagnosis fibromyalgia, other (but not limited to) diagnoses of type 2 diabetes without complications, and magnesium deficiency. Review of a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 4/14/2021 - 6/12/2021, which evidenced (but not limited to) the patient was a 73 year old who lived alone, received skilled nursing services every 2 weeks for medication tray set up, was very non-compliant with diabetes disease management, made poor food choices, was non-compliant with a diabetic diet, refused to check her blood sugar, pain and diabetes were not controlled, medications included (but not limited to) magnesium oxide and hydrocodone (for pain). The record failed to evidence orders for skilled nursing interventions such as lab monitoring for therapeutic blood magnesium or hemoglobin A1C levels, medicinal and non-medicinal methods to mitigate pain, and failed to evidence interventions such as patient education regarding diet, medication teaching, or teaching related to disease management. 21. During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manager indicated she would expect to see an order for a lidocaine	G 968		

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G 968	Continued From page 139 transdermal patch on the plan of care, sometimes patient education was found in the 60 Day Summary portion of the plan of care, a stage 2 pressure injury would have the top layer of skin off, a fluid filled blister would be a stage 2 pressure injury, and anything added to water during a soak should be on the care plan. During this time, the administrator indicated the most recent nursing case manager meetings addressed client situations, new wounds, falls, clinical topics of relevance, admissions, and discharges; most recent meetings focused on plans of care, discussed the new wounds (for patients #1, 2), and possible discharges for them, the agency management made a decision to pull back from skilled care during this time, and then decide how to move forward, there was no decision made at that time to discharge the wound patients, and the agency didn't have the staff to cover multiple weekly or even weekly visits for skilled care. 22. During an interview on 4/14/2021 at 12:25 PM, the alternate clinical manager indicated there were no lab results in patient records, and the agency did not perform lab draws. 17-14-1(a)(1)(c)	G 968		
G 972	Report all branch locations to SA CFR(s): 484.105(d)(1) The parent HHA is responsible for reporting all branch locations of the HHA to the state survey agency at the time of the HHA's request for initial certification, at each survey, and at the time the parent proposes to add or delete a branch. This Element is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to report a branch location to the state survey agency for 1	G 972		

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G 972	Continued From page 140 of 1 branch locations observed. Findings include: 1. Review of a Department of Health and Human Services Centers for Medicare & Medicaid Services document titled "Statement of Deficiencies And Plan of Correction" evidenced a completion date of 3/26/2021 under the deficiency cited G0972, and stated "... The agency does not maintain branch locations, and instead operates convenience sites at the offices of its sister company ... [personal services agency B, with same owners as Home Nursing Services] ... a Personal Services Agency ... The Agency has entered into a Memorandum of Understanding with [personal services agency B] providing for occasional use of [personal services agency B] Auburn and Bluffton offices for convenience purposes ... All hiring and onboarding of Agency employees are conducted by Agency employees or within the provisions of the Memorandum of Understanding ... How the deficiency will be prevented from recurring? ... [personal services agency B] branches will not be used as drop sites for the Agency ... [personal services agency B] branches will not be used by Agency ' s RN Case Managers for EHR documentation ...." 2. During an interview on 4/8/2021 at 10:55 AM, the administrator indicated the agency did not have any branch locations. 3. During an interview on 4/8/2021 at 1:55 PM, the administrator indicated he couldn't find the Memorandum of Understanding with personal services agency B, he was sure sure he pulled it from a previous survey for submission, and it wasn't relevant because that shouldn't have been	G 972		

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G 972	Continued From page 141 on the plan of corrections, and it was supposed to have been taken off. Upon survey exit, the administrator failed to submit the Memorandum of Understanding with personal services agency B. 4. During an observation and interview on 4/9/2021 at 8:45 AM at personal services agency B, personal services agency B's human resource coordinator C indicated personal services agency B was a paperwork drop off site for personal services agency B and Home Nursing Services, and indicated Home Nursing Services staff also came to the Bluffton office to pick up time off requests or mileage reports. 5. During an interview on 4/9/2021 at 3:45 PM, the administrator indicated it was an ongoing learning process for agency employees, it was a lot work for both agencies (personal services agency B and Home Nursing Services), it was rough to get proper PPE (personal protective equipment) to employees who lived far from the agency, the agency might have been too strict on themselves on the plan of correction (survey dated 01/12/2021 and correction date 3/26/2021), and he was under the impression that the agency was allowed to open its own drop location site without prior permission from IDOH or CMS. He also indicated agency staff picked up job related paperwork at personal services agency B, he would like to reconsider using the branches (offices for personal services agency B in Bluffton and Auburn), and the agency management had a hard time getting staff to drive outside their county of residence (to Home Nursing Services).	G 972		
G1012	Required items in clinical record CFR(s): 484.110(a)(1) The patient's current comprehensive	G1012		

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G1012	Continued From page 142 assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician orders; This Element is not met as evidenced by: Based on record review and interview, the agency failed to ensure all patients' records contained completed current comprehensive re-assessments for 2 of 2 patients who required a comprehensive re-assessment (#4, 5), and all patients' records contained all physician orders for treatment/services provided for 3 of 5 records reviewed (#1, 2, 3). Findings include: 1. Review of an undated agency policy C-155, copyright Briggs Healthcare, Home Care Operational Guidelines titled "Client Reassessment/Update of Comprehensive Assessment Significant Change of Condition (SCIC)" stated "... Comprehensive Assessment will be updated and revised as often as the client's condition warrants ... Assessment will include OASIS [outcome and assessment information set] data collection for all Medicare and Medicaid skilled clients ... within last five (5) days of episode ... To identify decline or improvement in health status ... are reassessed when significant changes occur in their condition ... [or] diagnosis ... at least every fifty-six to sixty (56-60) days ...." 2. Review of an undated copyright Briggs Corporation, Home Care Operational Guidelines policy C-870 titled "Clinical Records/Medical Record Retention" stated "... Clinical records are legal documents containing comprehensive, accurate ... information regarding the client's health ... treatments and services rendered by the Registered Professional Nurses ... The individual	G1012		

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G1012	Continued From page 143 must date ... and sign the entry ... to authenticate an entry in the clinical record ... documentation for each service or care provided must be completed on the day the service is rendered ...." 3. Review of an undated copyright Briggs Corporation, Home Care Operational Guidelines policy titled "Documentation of Changes to the Medical Record" stated, "... Medical records are legal documents that support the delivery of client services. Any changes or revisions ... must follow accepted legal requirements ... If it is necessary to make an addition to a previous entry, this must be done using an addendum to the record. The entry will be marked as an addendum and must include the date it is written and the visit date that the entry relates to ...." 4. Review of an undated copyright Briggs Corporation, Home Care Operational Guidelines policy C-701 titled "Medication Set Up Policy" stated "... The medication list is current and updated with physician orders as changes occur ... This includes over the counter medications ...." 5. Review of an undated copyright Briggs Corporation, Home Care Operational Guidelines policy C-635 titled "Physician Orders" stated "... All medications, treatments and services provided to clients must be ordered by a physician ... All signed physician orders shall be maintained in the clinical record ...." 6. A home visit observation was completed for patient #1 on 4/13/2021 at 11:55 AM. The alternate clinical director and HHA I was present. A superficial open wound was observed on the right intergluteal cleft (butt crack), approximately 1.0 cm (centimeter) in diameter, 0.1 - 0.2 cm depth, with a pink, moist wound bed. The	G1012		

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G1012	Continued From page 144	G1012		

surrounding skin was not observable due to the presence of desitin ointment (zinc oxide topical skin protectant) on the skin. The patient's daughter (also a nurse) arrived during the visit, who indicated the patient developed symptoms of a respiratory infection on or about 3/8/2021, his symptoms worsened and he was seen in a walk-in clinic (3/11/2021), was prescribed antibiotics, she had him sleep in his recliner to help him breathe easier until about a week and a half ago, he developed a pressure sore due to spending so much time in the recliner, he never had a pressure sore until the respiratory illness in March (2021), she used desitin on his buttocks and TheraHoney wound gel (for use on wounds with no drainage to moderate drainage and should be paired with an occlusive absorbent dressing) on his wound for several weeks, and the wound was on his right buttock. The record failed to evidence orders for therahoney, desitin, antibiotics used for respiratory infection, or wound treatment.

Record review for patient #1 was completed on 4/14/2021, start of care date 7/15/2013, for certification periods 2/5/2021 - 4/5/2021, and 4/6/2021 - 6/4/2021, with primary diagnosis of Alzheimer's disease, unspecified. The record evidenced the agency was aware of the patient's first decline in health status on 3/11/2021, and failed to assess the patient until 3/23/2021. Additionally, the record evidenced the agency was aware of the patient's additional decline in health status (on 4/2/2021) with the development of a wound, and the record failed to evidence orders for skilled nursing visits for wound care, assessment or management, or orders for Therahoney.

Review of a document dated and signed by the

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G1012	Continued From page 145	G1012		

alternate clinical manager on 3/11/2021 titled "Care Coordination Note" stated "... spoke with Daughter of this client.about [sic] the client possibly having aspirational [sic] pneumonia. she [sic] is trying to get transportation to the walk in [sic] clinic as opposed to going to the hospital ... sitting him in a chair and using vicks [a mentholated topical cough suppressant ointment], cough syrup for two days now and thinks he needs an antibiotic ... I told her with the pneumonia he could get bad fast ... the daughter said she would let me know what happens ...." The record failed to evidence orders for Vicks or cough syrup.

Review of a document dated and signed by the clinical manager on 3/12/2021 titled "Care Coordination Note" stated "... [daughter] took her father [patient] to a walk up clinic yesterday ... given a prescription for an oral antibiotic ... [daughter] to email the clinic paperwork to me today ...."

Review of a document from walk-in clinic A dated 3/11/2021 evidenced the patient was diagnosed with bacterial lower respiratory infection, cough, fever, and was prescribed an antibiotic to treat the infection. The record failed to evidence an order for the antibiotic.

Review of a document dated and signed 3/23/2021 by RNCM (registered nurse case manager) G titled "SN [skilled nurse] Daily Note" stated "... RNCM was notified by multiple reports (from the client's daughter, from HHA [home health aide], from other RNs) that the client's functional status has declined. He was reported to be weak, unable to get out of bed, unable to walk ... possible "aspiration pneumonia", has been to urgent care for antibiotics ... Daughter

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G1012	Continued From page 146 reports that client aspirated over the weekend while being fed ... Cannot walk more than a couple of steps. He was previously able to walk with assistance ... Unstable and, deteriorating ... Current Plan of Care ... May need to be modified ...." Review of a document dated and signed by HHA H on 4/6/2021 titled "Daily [home health aide/attendant care] Visit Sheet for 4/02/2021" stated "... 3 pressure sores [open wound caused by unrelieved pressure] on bottom, one open. Nurse noted ...." Review of a document dated and signed by RNCM G on 4/2/2021 titled "RN Re-Certification Assessment" which failed to evidence OASIS data incorporated, due to the change in condition. 7. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, primary diagnosis quadriplegia, evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/10/2021 - 5/8/2021. The document evidenced a section titled "60 Day Summary" which stated " ... [patient] currently has a 2cm round ruptured blister on left heel this is dry [sic], free from signs/symptoms of infection and healing well ...." The record failed to evidence orders for (but not limited to) skilled nursing frequency and duration of visits, interventions for wound assessment/treatment, interventions to mitigate new or worsening skin breakdown, constipation, dehydration interventions for patient/family teaching regarding wound care/prevention of new or worsening skin breakdown, an order for the homeopathic treatment of Epsom salts and eucalyptus (the use of natural substances as remedies, such as	G1012		

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G1012	Continued From page 147 plants and minerals), and failed to evidence pressure ulcer in the section titled "Other Pertinent Diagnoses". During a second home visit observation with the patient on 4/14/21 at 10:00 AM, the alternate clinical manager, RN E, and HHA K were present. The patient indicated she had a problem with her right heel, not the left heel, it started about a month ago, her mom covered the wound with gauze and tape, she never had problems with skin breakdown prior to this wound, and she could only feel slight sensation in her feet, such as pain. RN E asked HHA K what she added to the hand and foot soaks. HHA K indicated she added Epsom salts with eucalyptus and spearmint, and stated "... about a handful ...." RN E indicated she would get an order. Observed RN E perform a head-to-toe physical assessment on the patient. HHA K was positioned on one side of the bed, and RN E was positioned on the other. After a portion of the assessment was completed, HHA K removed all of the positional pillows and lowered the head of the bed so the patient could be turned onto her right side (to assess the backside of the body). RN E began to turn the patient without first moving her closer to her side of the bed, which would prevent the patient's face from hitting the siderail. HHA K and the patient stopped RN E and verbally directed her on proper turning technique. Also, during the assessment, RN E repeatedly left the room for several minutes to chart in the EMR (electronic medical record), and then return to continue her assessment and ask the patient additional questions. RN E indicated she completed the physical assessment at 10:29 AM. RN E failed to measure the hyperpigmented area on the patient's right heel, palpate, or check the area for blanching (indicates presence or absence of adequate	G1012		

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blood flow to determine if a pressure injury or suspected deep tissue injury is present). RN E asked the patient when she was last weighed, to which the patient indicated it was a year ago when she was hospitalized for a UTI (urinary tract infection). When asked by RN E when her last bowel movement was, the patient stated "Monday [4/12/2021- two days ago]", and HHA K stated, "We're trying to keep her more regular." When asked by the surveyor if the RN provided any teaching, the patient stated "No." She also indicated she stayed in the same sitting position in bed all day on days she worked but would reposition onto her side in the evenings. During this time, HHA K stated, "I don't think she's [patient] drinking enough." RN E instructed HHA K to encourage fluids. When asked by the surveyor if fluid intake was recorded/monitored, HHA K indicated it was not. At 10:52 AM, RN E discussed goals with the patient, indicated they were "keeping" the skin goal, instructed the patient to continue to keep her heels off of the bed, and hand and feet soaks would continue. RN E indicated this was not a skilled patient, the document used for the assessment was titled "RN Daily Note", and this patient received aide services only.

Review of a document dated and signed by RN E on 4/14/2021 titled "SN Daily Note" stated "... System Review ... Integument [skin] ... No significant issues ... Care is considered custodial ...."

During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manager indicated a stage 2 pressure injury would have the top layer of skin off, a fluid filled blister would be a stage 2 pressure injury, and anything added to water during a soak should be on the care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G1012	Continued From page 149 8. Record review for patient #3 was completed on 4/12/2021 and again on 4/14/2021, start of care date 8/27/2019, primary diagnosis type 2 diabetes with hyperglycemia (high blood sugar), evidenced a document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 2/17/2021 - 4/17/2021, which evidenced (but not limited to) the patient lived alone, received skilled nursing services (but not limited to) for weekly medication tray set up, was on a low sugar/simple carbohydrate (diabetic) diet, he was "relatively non-compliant" with his diet; and was prescribed (but not limited to) primidone (medication to treat tremors), Spironolactone (a diuretic medication), synjardy (a diabetes medication), and detemir (an injectable diabetes medication), all of which required periodic lab monitoring. The record failed to evidence a physician's order for a licocaine topical patch (a medicated pain patch). Review of a document dated 3/30/2021 titled "Skilled Nurse Visit Note" evidenced the patient was alert and oriented, had no pain, vital signs were within normal limits, and evidenced the nurse applied a lidocaine patch to the patient's left shoulder. The document failed to evidence the physician was notified for an order clarification for the lidocaine patch. 9. Record review for patient #4 was completed on 4/14/2021, start of care date 6/18/2020, certification period 4/14/2021 - 6/12/2021, evidenced a comprehensive re-assessment was required to be completed no earlier than 4/9/2021, but no later than 4/13/2021. The record failed to evidence a comprehensive re-assessment was completed or completed within the required timeframe.	G1012		

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	157211	A. BUILDING _____ B. WING _____	R-C 04/14/2021

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G1012	Continued From page 150 Review of a document dated and signed by RNCM (Registered Nurse Case Manager) E on 4/8/2021 titled "Skilled Nurse Visit Note" evidenced a skilled nursing visit was completed on 4/8/2021, and the patient's medication pill box was set up by the nurse for 2 weeks. Review of a document dated 4/9/2021, author RNCM E (without a dated electronic signature) titled "RN Re-Certification Assessment" evidenced an assessment was completed by RN E on 4/9/2021. RNCM E did not perform a skilled nursing visit with comprehensive re-assessment on 4/9/2021. During an interview on 4/9/2021 at 11:35 AM, when asked the last time a nurse saw him, patient #5 indicated the nurse visited every 2 weeks, declined to indicate the last time the nurse saw him, and stated "I'm not going to say." 10. Record review for patient #5 was completed on 4/14/2021, start of care date 1/11/2016, certification period 4/14/2021 - 6/12/2021, evidenced a comprehensive re-assessment was required to be completed no earlier than 4/9/2021, but no later than 4/13/2021. The record failed to evidence a comprehensive re-assessment visit was completed or completed within the required timeframe. Review of a document dated and signed by RNCM E on 4/8/2021 titled "Skilled Nurse Visit Note" evidenced a skilled nursing visit was completed on 4/8/2021, and the patient's medication pill box was set up by the nurse for 2 weeks. Review of a document dated 4/9/2021, author	G1012		

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G1012	Continued From page 151 RNCM E (without a dated electronic signature) titled "RN Re-Certification Assessment" evidenced an assessment visit was completed by RN E on 4/9/2021. RNCM E did not perform a skilled nursing visit with comprehensive re-assessment on 4/9/2021. During an interview on 4/9/2021 at 9:53 AM, when asked the last time a nurse saw her, patient #5 stated "Yesterday [4/8/2021]." 11. During an interview on 4/9/2021 at 1:57 PM, RNCM E indicated she was in the office all day (4/9/2021), she did not perform any skilled nursing visits today (4/9/2021), she performed nursing visits on patients #4 and #5 "... Yesterday ...." (4/8/2021), she couldn't open the "RN Re-Certification Assessment" documents until today (4/9/2021) for completion, and the EHR (electronic health record) only allowed the document to be opened during the last five days of the certification period. She also indicated she didn't see a problem that she saw the patients on one day, and documented she saw them on a different day. 12. During an interview on 4/9/2021 at 3:45 PM, the alternate clinical manger indicated there was a 5-day timeframe for completing the comprehensive re-assessment, RNCM E should have used it, and performing a visit outside the required 5 days during the end of the certification period to fill a medication pill box was not a valid excuse. During this time, the administrator and clinical manager indicated they were unaware RNCM E falsified dates of assessments for patients #4 and #5. 13. During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manger indicated she would	G1012		

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G1012	Continued From page 152 expect to see a physician's order for a (lidocaine) transdermal patch. 14. During an interview on 4/14/2021 at 12:25 PM, the clinical manager indicated she addressed the falsification of visit dates with RNCM E, and RNCM E performed comprehensive re-assessments on patients #4 and 5 on 4/11/2021. 17-15-1(a)(3) 17-15-1(a)(4) 17-15-1(a)(7)	G1012		
G1024	Authentication CFR(s): 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. This Standard is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure all clinical record entries were complete, and appropriately authenticated, dated, and timed for 3 of 5 records reviewed (#2, 4, 5). This practice had the potential to affect all agency patients. Findings include: 1. Review of an undated copyright Briggs Corporation, Home Care Operational Guidelines policy C-870 titled "Clinical Records/Medical Record Retention" stated "... Clinical records are legal documents containing comprehensive, accurate ... information regarding the client's health ... treatments and services rendered by the	G1024		

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G1024	Continued From page 153 Registered Professional Nurses ... The individual must date ... and sign the entry ... to authenticate an entry in the clinical record ... documentation for each service or care provided must be completed on the day the service is rendered ...." 2. Review of an undated copyright Briggs Corporation, Home Care Operational Guidelines policy titled "Documentation of Changes to the Medical Record" stated, "... Medical records are legal documents that support the delivery of client services. Any changes or revisions ... must follow accepted legal requirements ... If it is necessary to make an addition to a previous entry, this must be done using an addendum to the record. The entry will be marked as an addendum and must include the date it is written and the visit date that the entry relates to ...." 3. Review of an undated agency policy C-155, copyright Briggs Healthcare, Home Care Operational Guidelines titled "Client Reassessment/Update of Comprehensive Assessment Significant Change of Condition (SCIC)" stated "... Comprehensive Assessment will be updated and revised as often as the client's condition warrants ... Assessment will include OASIS [outcome and assessment information set] data collection for all Medicare and Medicaid skilled clients ... within last five (5) days of episode ... To identify decline or improvement in health status ... are reassessed when significant changes occur in their condition ... [or] diagnosis ... at least every fifty-six to sixty (56-60) days ...." 4. Review of a Department of Health and Human Services Centers for Medicare & Medicaid Services document titled "Statement of Deficiencies And Plan of Correction" evidenced a	G1024		

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G1024	Continued From page 154	G1024		

completion date of 3/26/2021 under the deficiency cited G1024, which stated "... The Clinical Director or Assistant Clinical Director will hold in-person training session to re-instruct all staff on the Agency ' s Authentication policy including the following requirements: ... All entries must be legible, clear, complete, and appropriately authenticated, dated and timed ... Authentication must include a signature and a title, or a secured computer entry by a unique identifier of a primary author who has reviewed and approved the entry ...."

5. Record review for patient #2 was completed on 4/12/21 and again on 4/14/2021, start of care date 8/30/2011, with primary diagnosis quadriplegia, failed to evidence a skilled nursing visit note for 4/8/2021.

During a home visit observation with patient #2 on 4/9/2021 at 9:53 AM, the patient indicated RNCM E came to her house last night (4/8/2021), brought paperwork for her home folder, checked her skin (skilled nursing assessment), and that was all.

During an interview on 4/9/2021 at 1:57 PM, RN E indicated she didn't remember the last time she saw patient #2. After the surveyor informed RNCM E that patient #2 indicated she was seen by RNCM E last night (4/8/2021), RN E agreed she saw the patient last night and assessed her skin.

During an interview on 4/12/2021 at 2:37 PM, the alternate clinical manger indicated if a nurse made a visit last Thursday (4/8/2021), she would expect to see the documentation in the clinical record, it should be entered at the time of the visit, RNCM E saw patient #2 on 4/8/2021, and

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G1024	Continued From page 155 the record failed to evidence a skilled nurse visit note. 6. Record review for patient #4 was completed on 4/14/2021, start of care date 6/18/2020, certification period 4/14/2021 - 6/12/2021, evidenced a comprehensive re-assessment was required to be completed no earlier than 4/9/2021, but no later than 4/13/2021. The record failed to evidence a comprehensive re-assessment was completed or completed within the required timeframe. Review of a document dated and signed by RNCM (Registered Nurse Case Manager) E on 4/8/2021 titled "Skilled Nurse Visit Note" evidenced a skilled nursing visit was completed on 4/8/2021, and the patient's medication pill box was set up by the nurse for 2 weeks. Review of a document dated 4/9/2021, author RNCM E (without a dated electronic signature) titled "RN Re-Certification Assessment" evidenced an assessment was documented by RN E on 4/9/2021. RNCM E failed to perform a skilled nursing visit with comprehensive re-assessment on 4/9/2021. During an interview on 4/9/2021 at 11:35 AM, when asked the last time a nurse saw him, patient #5 indicated the nurse visited every 2 weeks, declined to indicate the last time the nurse saw him, and stated "I'm not going to say." 7. Record review for patient #5 was completed on 4/14/2021, start of care date 1/11/2016, certification period 4/14/2021 - 6/12/2021, evidenced a comprehensive re-assessment was required to be completed no earlier than 4/9/2021, but no later than 4/13/2021. The record	G1024		

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G1024	Continued From page 156 failed to evidence a comprehensive re-assessment visit was completed or completed within the required timeframe. Review of a document dated and signed by RNCM E on 4/8/2021 titled "Skilled Nurse Visit Note" evidenced a skilled nursing visit was completed on 4/8/2021, and the patient's medication pill box was set up by the nurse for 2 weeks. Review of a document dated 4/9/2021, author RNCM E (without a dated electronic signature) titled "RN Re-Certification Assessment" evidenced an assessment visit was documented by RN E on 4/9/2021. RNCM E failed to perform a skilled nursing visit with comprehensive re-assessment on 4/9/2021. During an interview on 4/9/2021 at 9:53 AM, when asked the last time a nurse saw her, patient #5 stated "Yesterday [4/8/2021]." 8. During an interview on 4/9/2021 at 1:57 PM, RNCM E indicated she was in the office all day (4/9/2021), she did not perform any skilled nursing visits today (4/9/2021), she performed the re-assessments on patients #4 and #5 "... Yesterday ...." (4/8/2021), she couldn't open the "RN Re-Certification Assessment" documents until today (4/9/2021) for completion, and the EHR (electronic health record) only allowed the document to be opened during the last five days of the certification period. She also indicated she didn't see a problem that she saw the patients on one day, and documented she saw them on a different day. 9. During an interview on 4/9/2021 at 3:45 PM, the alternate clinical manger indicated there was	G1024		

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G1024	Continued From page 157 a 5-day timeframe for completing the comprehensive re-assessment, RNCM E should have used it, and performing a visit outside the required 5 days during the end of the certification period to fill a medication pill box was not a valid excuse. During this time, the administrator and clinical manager indicated they were unaware RNCM E falsified dates of assessments for patients #4 and #5. 10. During an interview on 4/14/2021 at 12:25 PM, the clinical manager indicated she addressed the falsification of visit dates with RNCM E, and RNCM E performed new comprehensive re-assessments on patients #4 and 5 on 4/11/2021. 17-15-1(a)(7)	G1024		