STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157005	A. BUILDING 00 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT JOSEPH VNA HOME CARE	3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00	This was a fully extended federal and state survey with 2 complaints. Complaints: IN00284807 - substantiated with findings IN00216770 - substantiated with findings Survey dates: February 9, 10, 11, 22, 23, 24, 25, 26; and March 1, 2 (2021). Facility number: IN005248 Provider number: 157005 Current census: 229 This deficiency report reflects State Findings cited in accordance with 410 IAC Article 17. Refer to State Form for additional State Findings. Saint Joseph VNA Home Health Care is precluded from providing its own home health training and competency evaluation for a period of two years beginning 2/2/2021 - 2/2/2023 due to being found out of compliance with the Conditions of Participation 42 CFR 484.55 Comprehensive Assessment of Patients, Saint Joseph VNA Home Health Care is precluded from providing its own home health training and competency evaluation for a period of two years beginning 2/2/2021 - 2/2/2023 due to being found out of compliance with the Conditions of Participation 42 CFR 484.55 Comprehensive Assessment of Patients, 484.60 Care planning, coordination, and quality of care and 484.105 Organization and administration of services. and 484.105 Organization and	G 0000		

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

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

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	administration of services. 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.			
G 0510 Bldg. 00	484.55 Comprehensive Assessment of Patients 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. Based on observation, record review and interview, the home health agency failed to ensure all comprehensive assessments accurately reflected the patients' current health status (G528); and failed to ensure the comprehensive re-assessments were completed as often as the patients' condition warranted (G544). This practice had the potential to affect all agency patients. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.55 Comprehensive Assessment of Patients. 17-14-1(a)(1)(B)	G 0510	**CONDITION LEVEL G 510 Comprehensive Assessment of Patients CFR(s)484.55** Refer to: ·G528 Health, psychosocial, functional, cognition CFR(s)484.55(c)(1) ·G544 Update of the Comprehensive assessment CFR(s)484.55(d) N 520 410 IAC 17-13-1(a) N 541 17-14-1(a)(1)(B) **G528 Health, psychosocial, functional, cognition CFR(s)484.55(c)(1)**	05/13/2021

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			Plan: ·All Therapist staff (Physical Therapy, Occupational Therapy and Speech Therapy) staff received education by the Administrator regarding performing a complete comprehensive assessment that provides the agency with a total picture of the patient's current health status during verbal staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Additional education was conducted by the Administrator or designee by May 13, 2021 for the clinical (Therapist and Nursing) staff including the following: ·Review of agency Initial Assessment, Admission for Services and Care Management and the Plan of Care, and Physical Therapist Policies. ·Elements of comprehensive assessment and timepoints, and specific assessment areas including full body physical, psychosocial and cognitive assessment and assessment of skin integrity, wounds, cardiac status and vital signs, and follow up with the physician and RN regarding any finding that requires additional follow up. ·Performing a complete comprehensive assessment in accordance with the Agency Initial Assessment, Admission for	

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			Services and Care Management and the Plan of Care, and Physical Therapist Policies. ·Education will be provided through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The Clinical Manager or designee will review all active patient records to ensure comprehensive assessments are complete and updated to reflect the patient's current health status. **·Specific action taken for clinical records #7, #13 and #14:** ·Agency action to mitigate and resolve noted deficiencies in individual client records was limited in some cases due to discharge of patient prior to or shortly after survey exit interview as well as due to agency was not provided with chart/patient identifiers or information regarding identified deficits at time of survey exit. ·Clinical record #7: ·A full and comprehensive assessment was performed with patient on 3/14/2021 and documented in a Resumption of Care OASIS on this same date. Record review by agency leadership confirms assessment included assessment of all body systems and the patient's health,	

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			psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment. ·Subsequent comprehensive assessments were completed on 3/22/2021 (Recertification OASIS documented) and at Discharge on 5/08/2021. The patient's plan of care was also updated in conjunction with the recertification assessment performed on 3/22/2021. ·Clinical record #13 ·A full and comprehensive assessment was performed with patient on 2/24/2021 and documented in a Skilled Nursing Evaluation note. Record review by agency leadership confirms assessment included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment. ·A subsequent comprehensive assessment was also completed on 3/17/2021 in conjunction with patient's agency discharge ·Clinical record #14: ·Agency was unaware of assessment deficits in chart #14 until after receipt of the survey findings on April 28, 2021. ·Patient was discharged from services on 3/23/2021.	

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			Person Responsible: Administrator **Date of Completion:** May 13, 2021 **Compliance:** ·Beginning May 14, 2021, 100% of admissions, resumption of care, and recertifications will be audited weekly to ensure compliance with this standard. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the admissions, resumption of care, and recertifications for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks, then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and reported quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	

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G 0528 Bldg. 00	484.55(c)(1) Health, psychosocial, functional, cognition The patient's current health, psychosocial, functional, and cognitive status; Based on observation, record review and interview, the agency failed to ensure the physical therapist (PT) performed a complete comprehensive assessment that provided the agency with a total picture of the patient's current health status for 3 of 3 records reviewed with physical therapy as the only skilled service. (#7, 13, 14) The findings include: 1. Review of an agency policy, with an approval/review date of 4/2020, titled "Initial Assessment and Admission for Services" stated "... For-therapy-only [sic] cases, the therapist is the primary case manager ... staff begins the initial or comprehensive assessment ... discipline specific SOC/ROC [start of care/resumption of care] electronic assessments ... admitting staff provides appropriate care including ... observation	G 0528	Refer to: ·G528 Health, psychosocial, functional, cognition CFR(s)484.55(c)(1) ·G544 Update of the Comprehensive assessment CFR(s)484.55(d) N 520 410 IAC 17-13-1(a) N 541 17-14-1(a)(1)(B) **G528 Health, psychosocial, functional, cognition CFR(s)484.55(c)(1)** **Plan:**	05/13/2021

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	and assessment, dressing changes, teaching and other services ... The clinician completes patient system assessment during the initial visit...." 2. Review of an agency policy with an approval/review date of 4/2020, titled "Care Management and the Plan of Care" stated "... During visits and other patient contacts, the clinician regularly reevaluates the client's medical condition ... assesses the patient using the appropriate comprehensive assessment form ... the therapist requests a physician order for 1 or more nursing visit(s) if the patient ... has care needs which are not within the therapist's scope of practice ...." 3. Review of an agency job description dated 05/08/2019, titled "Physical Therapist" stated "... Accurately assesses clients at admission and other required time points ... Reports changes in client condition as appropriate and in a timely manner ...." 4. A home visit of patient #7 was observed on 2/23/2021 at 1:50 PM , start of care date 1/22/2021, for certification period 1/22/2021 - 3/22/2021. The patient received physical and occupational therapy services, and skilled nursing services was ordered on 2/18/2021. The patient's primary diagnosis was COVID-19, and other diagnoses included (but not limited to) pneumonia due to COVID-19, acute respiratory failure with hypoxia (deprivation of oxygen), acute on chronic systolic (congestive) heart failure, obstructive sleep apnea, type 2 diabetes with diabetic chronic kidney disease, non-ST elevation (NSTEMI) myocardial infarction (heart attack), constipation, long term (current) use of aspirin, and long term (current) use of anticoagulants.		·All Therapist staff (Physical Therapy, Occupational Therapy and Speech Therapy) staff received education by the Administrator regarding performing a complete comprehensive assessment that provides the agency with a total picture of the patient's current health status during verbal staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Additional education was conducted by the Administrator or designee by May 13, 2021 for the clinical (Therapist and Nursing) staff including the following: ·Review of agency Initial Assessment, Admission for Services and Care Management and the Plan of Care, and Physical Therapist Policies. ·Elements of comprehensive assessment and timepoints, and specific assessment areas including full body physical, psychosocial and cognitive assessment and assessment of skin integrity, wounds, cardiac status and vital signs, and follow up with the physician and RN regarding any finding that requires additional follow up. ·Performing a complete comprehensive assessment in accordance with the Agency Initial Assessment, Admission for Services and Care Management and the Plan of Care, and Physical Therapist Policies.	

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	During the home visit, The patient presented sitting upright in his recliner with both legs elevated 90 degrees to his body, and feet rested on a firm, ridged pillow, which caused visible pitting into both posterior ankles. His abdomen was significantly distended. He was not wearing socks, and had no footwear visible in his immediate area. Both lower legs were extremely swollen, dark red, shiny, and had multiple small open areas. His left great toe presented with a black necrotic (dead body tissue) area approximately 1.0cm (centimeters) in diameter. His right 2nd toe was swollen, with a large blister present. He had a large SDTI (suspected deep tissue injury) on his right heel. The nurse assessed his buttocks/backside which revealed an open stage 2 pressure injury on his (left side) gluteal cleft (groove between the buttocks) just below his tailbone. The wound center was yellow, and the surrounding skin was dark purple. He did not have a pressure relieving cushion on his chair. He was wearing an incontinence brief, which was soiled. His skin on his bottom was moist and hyperpigmented (darker than normal color for patient). He indicated he had an old hospital bed that did not work (the head of the bed no longer elevated) so he was sleeping in his recliner since hospital discharge, as he had chest pain and difficulty breathing while in a supine (lying on back) position, his CPAP (Continuous Positive Airway Pressure machine that forces air into lungs, generally worn during sleep) was broken and he was waiting on a new one, his legs were like this since hospital discharge and getting worse, he had severe pain to the touch of the right heel and with any movement of both feet/lower legs, he had very limited ROM (range of motion) of both lower legs and feet due to swelling and severe pain, he had no footwear that fit him, and a nurse came out to see him for the first time last		·Education will be provided through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The Clinical Manager or designee will review all active patient records to ensure comprehensive assessments are complete and updated to reflect the patient's current health status. **·Specific action taken for clinical records #7, #13 and #14:** ·Agency action to mitigate and resolve noted deficiencies in individual client records was limited in some cases due to discharge of patient prior to or shortly after survey exit interview as well as due to agency was not provided with chart/patient identifiers or information regarding identified deficits at time of survey exit. ·Clinical record #7: ·A full and comprehensive assessment was performed with patient on 3/14/2021 and documented in a Resumption of Care OASIS on this same date. Record review by agency leadership confirms assessment included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction	

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	week (he also indicated he thought a nurse was coming from day one). He also indicated he had a heart attack while in the hospital, and he had ongoing chest pain and poor endurance, and he only changed his brief once daily, because it was "too hard to do more than that." Record review completed on 2/24/2021, and again on 3/2/2021, evidenced a document dated 1/22/2021, by PT [physical therapist] II titled "Visit Note Report" which stated "... Visit Type: ... PT OASIS [Outcome and Assessment Information Set] Admission" indicated the patient had no pain, a standard mattress was appropriate at that time, had minimal to no risk for skin breakdown. Additionally, the document stated "... Was integumentary [skin] assessed? No ... Not applicable ... Was cardiovascular system assessed? No ... Not applicable ... Respiratory assessment findings ... WNL [within normal limits] ... Was genitourinary system assessed? No ... Not applicable ... Gastrointestinal assessment ... Not assessed due to not applicable ... [patient statement] 'I have no pain' ... Patient does not need ... HHA [home health aide] ... or SN [skilled nurse] ... Was Endocrine [conditions such as, but not limited to diabetes, thyroid issues]/Hematopoietic [system of organs and tissues involved in the production of cellular blood components] assessed? No ... Not applicable ... Head and neck assessment findings ... Not assessed due to not applicable ... sleeps in recliner ...." The document failed to evidence a complete comprehensive assessment was completed to evidence the patient's current health status, the therapist failed to request a physician order to add skilled nursing for the patient's complex medical condition upon admission, the patient was subsequently seen in the emergency department on 2/17/2021 for swelling, draining,		with this assessment. ·Subsequent comprehensive assessments were completed on 3/22/2021 (Recertification OASIS documented) and at Discharge on 5/08/2021. The patient's plan of care was also updated in conjunction with the recertification assessment performed on 3/22/2021. ·Clinical record #13 ·A full and comprehensive assessment was performed with patient on 2/24/2021 and documented in a Skilled Nursing Evaluation note. Record review by agency leadership confirms assessment included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment. ·A subsequent comprehensive assessment was also completed on 3/17/2021 in conjunction with patient's agency discharge ·Clinical record #14: ·Agency was unaware of assessment deficits in chart #14 until after receipt of the survey findings on April 28, 2021. ·Patient was discharged from services on 3/23/2021. **Person Responsible:** Administrator	

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	and intractable pain in both legs, and was prescribed antibiotics. He was seen in the emergency room again on 2/24/2021 and was admitted. He remained hospitalized upon survey exit. During an interview on 2/24/2021 at 11:27 AM, family stated they called 911 about "10 minutes ago [2/24/2021]" for chest pain, and stated "... [chest pain] It's been off and on since he got home from the hospital ...." She also indicated he got up this morning, he wasn't feeling good, he (patient) "... took like 6 nitros [nitroglycerin for chest pain] no relief." She also indicated he was coughing quite a bit after the nurse left yesterday (2/23/2021), and he didn't have a good night. When asked if the patient complained of pain since he came home from the hospital prior to the initiation of home health services (start of care), she stated "Yes. His feet, he never feels good. So much pain." During an interview on 2/24/2021 at 2:25 PM, the administrator/clinical manager indicated she thought PT's weren't taught how to listen to heart and lung sounds in therapy school, the PT clinical manager indicated she'd always been told not to listen to lung sounds, it wasn't in the PT scope of practice, PTs were supposed to check skin, respiratory status but not heart and lung sounds, and if there were cardiac issues, they referred nursing. When queried why a nurse wasn't referred upon start of care to complete a comprehensive assessment (patient's primary diagnosis was COVID-19, and additional pertinent respiratory and cardiac diagnoses), the administrator/clinical manager stated "I can't answer that. I don't know." 5. A home visit of patient #13 was observed on		**Date of Completion:** May 13, 2021 **Compliance:** ·Beginning May 14, 2021, 100% of admissions, resumption of care, and recertifications will be audited weekly to ensure compliance with this standard. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the admissions, resumption of care, and recertifications for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks, then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and reported quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	

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	2/25/2021 at 1:50 PM , start of care date 1/22/2021, and primary diagnosis of displ intertroch fx L femur, subs for clos fx w routn heal (left hip fracture which required surgical intervention). The patient received physical and occupational therapy services, and skilled nursing and home health aide services were ordered on 2/22/2021. Review of a document dated 2/18/2021 by PT X titled "Visit Note Report" stated "... Visit Type: ... PT OASIS Admission" indicated there were no structural barriers in the patient's home, but stairs to enter the home, and stairs within the home were observed, the integumentary system was not assessed- "not applicable", the cardiovascular system was assessed, the respiratory system was not assessed- "not assessed due to not applicable", the genitourinary system was not assessed- "not applicable", the gastrointestinal system was not assessed- "not applicable", the head and neck was not assessed- "not assessed due to not applicable", and the immunologic assessment was not completed- "not assessed due to not applicable". The document failed to evidence a complete comprehensive assessment was completed to evidence the patient's current health status. 6. Record review for patient #14 was completed on 3/2/2021, start of care date 1/28/2021, primary diagnosis sepsis (a serious infection that causes your immune system to attack your body) due to E coli (bacteria). Review of a document dated and signed 1/28/2021, by PT Y titled "Visit Note Report" stated "... Visit Type: ... PT OASIS Admission" stated "... Was integumentary assessed? No ... not appropriate at time of evaluation ....", indicated pain in spine, and need for OT (occupational therapy), skilled nursing and home health aide services. The document failed to			

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	evidence a complete comprehensive assessment was completed to evidence the patient's current health status. Review of a document dated and signed 1/30/2021 by RN [registered nurse] U titled "Visit Note Report ... RN Add-On Evaluation" indicated no skin issues were identified, the patient had no pain, and no further nursing visits were necessary. Review of a document dated and signed 2/1/2021 by OT [occupational therapist] F titled "Visit Note Report ... OT Add-On Evaluation" stated "... Was integumentary [skin] assessed? No ....", and indicated the patient had left hip/groin pain. Review of a document dated and signed 2/2/2021, by PT Z titled "Visit Note Report ... PT Subsequent Visit" stated "... Pain on bed sore on bottom ....", and failed to evidence the patient's skin was assessed. Review of a document dated and signed 2/4/2021, by PT Z titled "Visit Note Report ... PT Subsequent Visit" stated "... Pain ... left buttocks pressure sore ... checked patient's buttocks while in bathroom and noted there looked like a stage II pressure sore [a partial thickness wound caused by pressure]; called MD [medical doctor] and gor [sic] order for SN to eval ...." 7. During an interview on 2/22/2021 at 1:24 PM, when asked why the PTs weren't doing complete physical assessments including (but not limited to) skin, cardiovascular, and respiratory assessments, PT clinical manager A indicated they probably weren't doing it if there was a nurse involved, if no nurse was involved then they would always do the assessments, and she			

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	always did a full assessment for the initial evaluation, but not necessarily every visit thereafter. During this interview, she also stated "PT don't do heart/lungs sounds." 8. During an interview on 3/2/2021 at 2:30 PM, the administrator/clinical manager agreed the comprehensive assessments were not complete, and indicated the agency immediately addressed the concern regarding incomplete comprehensive assessments as soon as it was brought to her attention on 2/24/2021.			
G 0544 Bldg. 00	484.55(d) Update of the comprehensive assessment 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- Based on observation, record review and interview, the agency failed to ensure a comprehensive re-assessment (including the administration of the OASIS) was completed for all agency patients as frequently as the patients' condition warranted for 3 of 3 clinical records reviewed with a significant change in condition. (#1, 7, 14) The findings include: 1. Review of an agency policy, with an approval/review date of 4/2020, titled "Care Management and the Plan of Care" stated "... During visits and other patient contacts, the clinician regularly reevaluates the client's medical condition ... assesses the patient using the	G 0544	**CONDITION LEVEL G 510 Comprehensive Assessment of Patients CFR(s)484.55** Refer to: ·G528 Health, psychosocial, functional, cognition CFR(s)484.55(c)(1) ·G544 Update of the Comprehensive assessment CFR(s)484.55(d) N 520 410 IAC 17-13-1(a) N 541 17-14-1(a)(1)(B) **G528 Health, psychosocial, functional, cognition CFR(s)484.55(c)(1)** **Plan:** ·All Therapist staff (Physical	05/27/2021

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	appropriate comprehensive assessment form ... The case manager/nurse/therapist: ... Reassesses the patient condition ... As appropriate ... Contacts the attending physician whenever the patient has ... Condition changes ... Completes comprehensive assessments including ... Follow-up when a significant change in condition occurs ...." 2. Review of an agency job description dated 05/08/2019, titled "Physical Therapist" stated "... Accurately assesses clients at admission and other required time points ... Reports changes in client condition as appropriate and in a timely manner ...." 3. Review of an agency job description dated (revised) 3/17/2019, titled "Primary Care Nurse (PCN)" stated "... The RN [registered nurse] is accountable for the client assessment ...." 4. Record review for patient #1 was completed on 2/10/2021, and again on 3/2/2021, start of care date 4/7/2020, primary diagnosis encounter for attention to cystostomy (suprapubic catheter- an opening in the lower abdomen where a tube is inserted directly into the bladder for drainage of urine). Review of a document titled "Home Health Certification and Plan of Care" for certification period 12/3/2020 - 1/31/2021, indicated skilled nursing services (effective 12/13/2020) once every 2 weeks for two weeks, then once every 4 weeks for 4 weeks, and 2 PRN (as needed) visits for bleeding, cardiac, catheter issues, diabetic, falls, pain, respiratory, or skin breakdown. The document failed to evidence the patient had current skin breakdown. Review of a document dated and signed by RN P on 12/30/2020, titled "Visit Note Report ... SN		Therapy, Occupational Therapy and Speech Therapy) staff received education by the Administrator regarding performing a complete comprehensive assessment that provides the agency with a total picture of the patient's current health status during verbal staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Additional education was conducted by the Administrator or designee by May 13, 2021 for the clinical (Therapist and Nursing) staff including the following: ·Review of agency Initial Assessment, Admission for Services and Care Management and the Plan of Care, and Physical Therapist Policies. ·Elements of comprehensive assessment and timepoints, and specific assessment areas including full body physical, psychosocial and cognitive assessment and assessment of skin integrity, wounds, cardiac status and vital signs, and follow up with the physician and RN regarding any finding that requires additional follow up. ·Performing a complete comprehensive assessment in accordance with the Agency Initial Assessment, Admission for Services and Care Management and the Plan of Care, and Physical Therapist Policies. ·Education will be provided	

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	[skilled nurse] Subsequent Visit" evidenced no skin breakdown/open area(s), and a request was made for PT (physical therapy) to evaluate. Review of a document dated and signed by PT AA on 1/5/2021, titled "Visit Note Report ... PT Add-On Evaluation" stated "... Integumentary assessment findings: Stage 2 pressure sores along both lateral borders of sacrum [lower back] and dry skin causing itchiness all around that area ....", and evidenced the RN was notified. Review of a document dated and signed 1/6/2021, by the administrator/clinical manager titled "Physician Order" stated "... SN visit for wound/skin assessment ...." Review of a document dated and signed by LPN [licensed practical nurse] K on 1/7/2021, titled "Visit Note Report ... SN [skilled nurse] Subsequent Visit" stated "... Patient has an open area to L [left] upper buttock. It has been draining serous [a clear to pale yellow watery fluid that is found in the body] fluid. Right buttock has no open area or drainage. Buttocks are purple in color as patient does not move off of them ... This area is not listed in skin areas yet as this writer has no wound care orders as of yet. Approximately 3 cm [centimeters] x .05cm [sic] x 0.1cm. Patient unable to stand for long ... poor hydration ... tried to call physician [for orders] ...." The record failed to ensure a comprehensive re-assessment (including the administration of the OASIS) was completed on or after 1/6/2021 by a registered nurse. During an interview on 2/10/2021 at 12:40 PM, the administrator/clinical manager agreed the visit on 1/7/2021, made by a LPN should have been an RN comprehensive re-assessment visit due to the new skin breakdown.		through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The Clinical Manager or designee will review all active patient records to ensure comprehensive assessments are complete and updated to reflect the patient's current health status. **·Specific action taken for clinical records #7, #13 and #14:** ·Agency action to mitigate and resolve noted deficiencies in individual client records was limited in some cases due to discharge of patient prior to or shortly after survey exit interview as well as due to agency was not provided with chart/patient identifiers or information regarding identified deficits at time of survey exit. ·Clinical record #7: ·A full and comprehensive assessment was performed with patient on 3/14/2021 and documented in a Resumption of Care OASIS on this same date. Record review by agency leadership confirms assessment included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment.	

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	5. A home visit of patient #7 was observed on 2/23/2021 at 1:50 PM, start of care date 1/22/2021, for certification period 1/22/2021 - 3/22/2021. The patient received physical and occupational therapy services, and skilled nursing services was ordered on 2/18/2021. The patient's primary diagnosis was COVID-19, and other diagnoses included (but not limited to) pneumonia due to COVID-19, acute respiratory failure with hypoxia (deprivation of oxygen), acute on chronic systolic (congestive) heart failure, obstructive sleep apnea, type 2 diabetes with diabetic chronic kidney disease, non-ST elevation (NSTEMI) myocardial infarction (heart attack), constipation, long term (current) use of aspirin, and long term (current) use of anticoagulants. During the home visit, The patient presented sitting upright in his recliner with both legs elevated 90 degrees to his body, and feet rested on a firm, ridged pillow, which caused visible pitting into both posterior ankles. His abdomen was significantly distended. He was not wearing socks, and had no footwear visible in his immediate area. Both lower legs were extremely swollen, dark red, shiny, and had multiple small open areas. His left great toe presented with a black necrotic (dead body tissue) area approximately 1.0cm (centimeters) in diameter. His right 2nd toe was swollen, with a large blister present. He had a large SDTI (suspected deep tissue injury) on his right heel. The nurse assessed his buttocks/backside which revealed an open stage 2 pressure injury on his (left side) gluteal cleft (groove between the buttocks) just below his tailbone. The wound center was yellow, and the surrounding skin was dark purple. He did not have a pressure relieving cushion on his chair. He was wearing an incontinence brief, which was		·Subsequent comprehensive assessments were completed on 3/22/2021 (Recertification OASIS documented) and at Discharge on 5/08/2021. The patient's plan of care was also updated in conjunction with the recertification assessment performed on 3/22/2021. ·Clinical record #13 ·A full and comprehensive assessment was performed with patient on 2/24/2021 and documented in a Skilled Nursing Evaluation note. Record review by agency leadership confirms assessment included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment. ·A subsequent comprehensive assessment was also completed on 3/17/2021 in conjunction with patient's agency discharge ·Clinical record #14: ·Agency was unaware of assessment deficits in chart #14 until after receipt of the survey findings on April 28, 2021. ·Patient was discharged from services on 3/23/2021. **Person Responsible:** Administrator **Date of Completion:** May 13, 2021 **Compliance:**	

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	soiled. His skin on his bottom was moist and hyperpigmented (darker than normal color for patient). He indicated he had an old hospital bed that did not work (the head of the bed no longer elevated) so he was sleeping in his recliner since hospital discharge, as he had chest pain and difficulty breathing while in a supine (lying on back) position, his CPAP (Continuous Positive Airway Pressure machine that forces air into lungs, generally worn during sleep) was broken and he was waiting on a new one, his legs were like this since hospital discharge and getting worse, he had severe pain to the touch of the right heel and with any movement of both feet/lower legs, he had very limited ROM (range of motion) of both lower legs and feet due to swelling and severe pain, he had no footwear that fit him, and a nurse came out to see him for the first time last week (he also indicated he thought a nurse was coming from day one). He also indicated he had a heart attack while in the hospital, and he had ongoing chest pain and poor endurance, and he only changed his brief once daily, because it was "too hard to do more than that." Record review completed on 2/24/2021, and again on 3/2/2021, evidenced a document dated 1/22/2021, by PT X titled "Visit Note Report" which stated "... Visit Type: ... PT OASIS [Outcome and Assessment Information Set] Admission" indicated the patient had no pain, a standard mattress was appropriate at that time, had minimal to no risk for skin breakdown. Additionally, the document stated "... Was integumentary [skin] assessed? No ... Not applicable ...." The document evidenced the patient had no pain, and failed to evidence any lower extremity edema, skin breakdown or open skin area(s). The patient was subsequently seen in the emergency department on 2/17/2021 for		·Beginning May 14, 2021, 100% of admissions, resumption of care, and recertifications will be audited weekly to ensure compliance with this standard. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the admissions, resumption of care, and recertifications for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks, then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and reported quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	

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	swelling, draining, and intractable pain in both legs, and was prescribed antibiotics. He was seen in the emergency room again on 2/24/2021, and was admitted with complaint of shortness of breath, chest pain. He remained hospitalized upon survey exit dated 03/02/2021. Review of a document dated and signed 2/12/2021, by PT BB titled "Visit Note Report ... PT Subsequent Visit" indicated the patient had weeping edema to both lower extremities. Review of a document dated and signed 2/16/2021, by OT CC titled "Visit Note Report ... OT Subsequent Visit" indicated the patient had pain to right foot, 2nd and 3rd toes, burning, and stabbing. Review of a document dated and signed 2/18/2021, by OT CC titled "Visit Note Report ... OT Subsequent Visit" evidenced the patient was seen in the emergency department on 2/17/2021 for complaint of pain and legs seeping, and was sent home on oral antibiotics for "infection in legs" per patient report, and a referral for skilled nursing was requested. Review of a document dated and signed 2/20/2021, by RN J titled "Visit Note Report ... RN Add-On Evaluation" evidenced the patient had lower extremity edema, open seeping wounds to both lower legs, open wound to left buttock (Pressure ulcer), abnormal heart sounds, abnormal breath sounds, poor appetite, and poor hydration. The record failed to evidence a comprehensive re-assessment (including the administration of the OASIS) was completed for the patient's change in condition. During an interview on 2/24/2021 at 11:27 AM,			

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	family stated they called 911 about "10 minutes ago [2/24/2021]" for chest pain, and stated "... [chest pain] It's been off and on since he got home from the hospital ...." She also indicated he got up this morning, he wasn't feeling good, he (patient) "... took like 6 nitros [nitroglycerin for chest pain] no relief." She also indicated he was coughing quite a bit after the nurse left yesterday (2/23/2021), and he didn't have a good night. When asked if the patient complained of pain since he came home from the hospital prior to the initiation of home health services (start of care), she stated "Yes. His feet, he never feels good. So much pain." During an interview on 2/24/2021 at 2:25 PM, the administrator/clinical manager indicated an add-on evaluation did not include OASIS elements. When asked why a nurse wasn't referred upon start of care to complete a comprehensive assessment, (patient's primary diagnosis was COVID-19, and additional pertinent respiratory and cardiac diagnoses), the administrator/clinical manager stated "I can't answer that. I don't know." 6. Record review for patient #14 was completed on 3/2/2021, start of care date 1/28/2021, primary diagnosis sepsis (a serious infection that causes your immune system to attack your body) due to E coli (bacteria). Review of a document dated and signed 1/28/2021 by PT Y titled "Visit Note Report" stated "... Visit Type: ... PT OASIS Admission" stated "... Was integumentary assessed? No ... not appropriate at time of evaluation ....", indicated pain in spine, and need for OT (occupational therapy), skilled nursing and home health aide services. The document failed to evidence a complete comprehensive assessment was completed to evidence the patient's current health status.			

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Review of a document dated and signed 1/30/2021, by RN U titled "Visit Note Report ... RN Add-On Evaluation" indicated no skin issues were identified, the patient had no pain, and no further nursing visits were necessary.

Review of a document dated and signed 2/1/2021, by OT F titled "Visit Note Report ... OT Add-On Evaluation" stated "... Was integumentary [skin] assessed? No ....", and indicated the patient had left hip/groin pain.

Review of a document dated and signed 2/2/2021, by PT Z titled "Visit Note Report ... PT Subsequent Visit" stated "... Pain on bed sore on bottom ....", and failed to evidence the patient's skin was assessed.

Review of a document dated and signed 2/4/2021, by PT Z titled "Visit Note Report ... PT Subsequent Visit" stated "... Pain ... left buttocks pressure sore ... checked patient's buttocks while in bathroom and noted there looked like a stage II pressure sore [a partial thickness wound caused by pressure]; called MD and gor [sic] order for SN to eval ...."

Review of a document dated and signed by RN J on 2/6/2021 titled "Visit Note Report ... RN Add-On Evaluation" evidenced the patient had poor hydration, was a high nutritional risk, and had a stage 2 pressure injury to the left buttock. The record failed to evidence a comprehensive re-assessment (including the administration of the OASIS) was completed for the patient's change in condition.

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

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G 0570 Bldg. 00	484.60 Care planning, coordination, quality of care Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice.			
	Based on observation, record review and interview, the home health agency failed to ensure it conformed with physician orders (G578); failed to ensure all changes in the patients condition was promptly relayed to the primary care physician (G590); failed to coordinate care amongst the different disciplines/entities that provided care to the agency's patients (G606); failed to ensure that all patients received written visit schedules (G614); failed to ensure that all patients had current/updated written medication schedule/instructions prepared by agency staff in the home (G616); and failed to ensure that all patients received a current/updated written plan of care (G618). This practice had the potential to affect all agency patients.	G 0570	17-14-1(a)(1)(H) 17-12-2(g) 17-12-2(h) G578 Conformance with physician orders G570 Care planning, coordination, and quality of care CFR(s) 484.6 17-14-1(a)(1)(H) 17-12-2(g) 17-12-2(h) **G578 Conformance with physician orders**	05/27/2021

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	The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care for the Condition of Participation 42 CFR 484.60 Care planning, coordination, and quality of care. 17-14-1(a)(1)(H) 17-12-2(g) 17-12-2(h)		**Plan:** ·All clinical staff received education by the Administrator regarding the need to ensure all care, treatment and services are provided in accordance current physician orders during staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Follow up in-service education was conducted by the Administrator or designee by May 13, 2021 for all clinical staff. This education included: ·Review of agency Care Management and the Plan of Care and Physician Orders policies. ·Review of physician order requirements, as well as the need to ensure documentation of medication reconciliation, PT/INR results and missed visits with physician notification in accordance with Agency Care Management and the Plan of Care and Physician Orders policies. ·Additional in-service education and corrective action will be conducted by the Administrator or designee by May 27, 2021 as described in the "specific action for clinical records" section that follows. ·Education will be provided through mandatory in-service education and attendance will be tracked with sign-in sheets.	

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			Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The Clinical Manager or designee will review all active patient records to ensure current physician orders area present for all care, treatment and services provided. **·Specific action taken for clinical records #1, #3, #6, #7, #8, #9, #10, #11, #14 and #16:** ·Agency action to mitigate and resolve noted deficiencies in individual client records was limited in some cases due to discharge of patient prior to or shortly after survey exit interview as well as due to agency was not provided with chart/patient identifiers or information regarding identified deficits at time of survey exit. ·Clinical record #1 ·Agency reviewed clinical record and verified noncompliance with physician orders as cited by surveyor. ·Corrective action and 1:1 education related to compliance with physician orders to be completed by Administrator or designee with nursing staff involved in patient care by May 27, 2021. ·Patient was discharged from agency services on 3/10/2021 ·Clinical record #3	

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			·Agency reviewed clinical record and verified noncompliance with medication reconciliation. ·Corrective action and 1:1 education to occur with Physical Therapist who performed 2/15/21 visit post-hospitalization regarding medication reconciliation. ·Education and corrective action to be completed by Administrator or designee by May 27, 2021. ·Agency process implemented to require medication reconciliation following hospital observation stays. ·Education was provided to all clinical staff by Administrator or designee by May 13, 2021. ·Clinical record #6 ·Agency reviewed clinical record and verified noncompliance with physician orders as cited by surveyor. ·Physician notification was made by agency RN and documented in clinical record on 2/23/2021 regarding agency failure to perform ordered wound care in compliance with order issued to patient on 2/18/2021 and faxed to agency on 2/22/2021. ·RN obtained and documented order from physician on 2/23/2021 approving wound care to be performed without the adaptic dressing to wound bed	

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			until the ordered adaptic dressing supplies arrived to patient home. ·Corrective action and 1:1 education related to compliance with physician orders to be completed with nursing staff involved in patient care. ·Education and corrective action to be completed by Administrator or designee by May 27, 2021. ·Clinical record #7 ·Agency reviewed clinical record: ·Confirmed deficient documentation as noted by surveyor. Physical therapist failed to document assessment of dressing integrity to bilateral lower extremities. ·Unable to verify noncompliance with physician's order for "PT to do dressing change elastic bandage to BLE if legs are soaked from weeping edema.." as clinical record lacks information regarding status of dressings on the 2/19/2021 visit cited. ·Education to be provided to physical therapist regarding compliance with physician's orders and appropriate assessment and documentation. ·Education to be completed by Administrator or designee by May 27, 2021. ·Patient was discharged	

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			from agency services on 5/08/2021 ·Clinical record #8 ·Agency reviewed clinical record and confirmed deficient documentation and noncompliance with physician orders as noted by surveyor. ·Agency RN failed to document that teaching was provided to patient and caregiver at the Start of Care visit for performance of wound care. ·Ordered intervention for wound care on the 485-Plan of Treatment indicates caregiver to perform dressing changes when "SN not available". On 6/13/2016 and 6/20/2016 skilled nursing notes indicate dressing change was not performed by skilled nursing due to the caregiver having already performed wound care. ·No evidence in chart of physician notification or request to update to wound care order to allow for caregiver to perform wound care on days that skilled nurse performed home visits. ·Agency reviewed clinical record and was unable to confirm noncompliance with physician orders for wound care as cited by surveyor regarding the issue below. ·On 6/20/16 visit note, RN responded to question "are wound care orders being followed" was answered "no" by RN.	

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			Question is located in the Supervisory functions section of skilled nursing visit note and refers to wound care that is performed by a supervised colleague such as an LPN/LVN or home health aide. ·Home health aide was not involved in or performed any wound care for this client. ·Education was provided to all clinical staff on compliance with physician orders as described in plan above. ·All clinical nursing staff involved in care of this patient are no longer employed by the agency preventing any 1:1 education or counselling from occurring. ·Patient was discharged from agency services on 6/20/2016 ·Clinical record #9 ·Agency reviewed chart and was unable to verify noncompliance as cited by surveyor but did identify charting issue which created appearance of noncompliance. ·Recert visit was performed late on 9/22/20. Physician was notified of delayed recert and order for 1 skilled nursing visit in week of 9/20/2020 to perform recertification was obtained and entered in clinical record on 9/21/2020. ·485-Plan of Treatment created by 9/22/20 recertification visit contains	

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			documentation of the ordered visit frequency subsequent to that visit with additional SNV in week of 9/20/2020 (for total of 2 SNV's completed week of 9/20/2020). ·Agency to provide education to all clinical staff regarding writing visit frequencies with adequate specificity including use of language to clarify when visits are being added to a Medicare week versus reflecting visits in same week already performed (Example: 1 Skilled Nursing visit week of 9/20/2020 for recertification" and "POC effective 9/22/2020: 1 additional visit week of 9/20 then ....". ·Education to be completed by Administrator or designee by May 27, 2021. ·Patient was discharged from agency services on 10/14/2020 ·Clinical record #10 ·Agency reviewed clinical record and was unable to verify noncompliance with ordered visit frequency as cited by surveyor. ·Skilled Nursing frequency at start of episode was 1wk1, 2wk8 per signed 485-plan of treatment. ·Order obtained and documented in clinical record on 2/26/2020 changed skilled nursing frequency to "Effective 2/23/2020: 2wk1, 1wk5". ·Surveyor noted only	

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			1 skilled nursing visit was performed in week of 3/08/2020. This is correct and in compliance with the with physician order dated 2/26/2020. ·Agency reviewed clinical record and verified noncompliance with frequency and ordered dates of PT/INR testing. ·Clinical manager involved in care coordination and oversight of this patient is no longer employed by agency preventing counselling and/or corrective action. ·Corrective action and 1:1 education related to compliance with physician orders to be completed with nursing staff involved in patient care. ·Education and corrective action to be completed by Administrator or designee by May 27, 2021. ·Patient was discharged from agency services on 3/19/2020 ·Clinical record #11 ·Agency reviewed chart and was unable to verify noncompliance as cited by surveyor. ·Documentation supports compliance with PT visit frequency of 1wk1, 2wk3 as evidenced by completed home visits or appropriately documented missed visits and documentation of timely physician notification of missed	

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			visits matching this frequency. ·One missed visit was noted in record. PTA visit on 8/16/2016 was attempted but refused by the patient. A missed visit note was appropriately entered in the medical record which documented the reason as "patient refusal". This note was faxed to the ordering physician as notification on 8/17/2016. ·Patient was discharged from agency services on 9/16/2016 ·Clinical record #14: ·Agency was unaware of assessment deficits in chart #14 until following receipt of the survey findings on April 28, 2021. ·Patient was discharged from services on 3/23/2021. ·Agency has reviewed the clinical record and confirmed the finding as indicated by surveyor of a missed visit note entered by home health aide on 2/12/2021 with reason for missed visits stated as "scheduling conflict". ·Agency observed that ordered home health aide frequency was met by completion of in-home visits or documentation of missed visits with appropriate physician notification of missed visits. ·Agency provided education to all clinical staff regarding precise documentation of reasons for missed visit including avoidance of selecting	

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			"scheduling conflict" from EMR "missed visit reason" options without providing additional detail sufficient to demonstrate that visit was not missed due to agency or clinician reasons but only if patient or caregiver reported a scheduling conflict and declined/refused attempts to reschedule. ·Education was completed by Administrator or designee on May 18, 2021. ·Patient was discharged from agency services on 3/23/2021 ·Clinical record #16 ·Agency reviewed clinical record and confirmed the findings as indicated by surveyor. ·A home health aide visit in week 2 was missed but no appropriate missed visit note was entered and no physician notification of the missed visit is evidenced in the clinical record. ·Agency to provide 1:1 education with the home health aide ·Education to be completed by Administrator or designee by May 27, 2021. ·Clinical manager will ensure appropriate documentation and physician/provider notification of all missed visits is evident in all charts. ·Skilled nursing visit frequency on 485-Plan of	

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			Treatment listed as "2wk1, 1wk3…." however plotted/planned visit frequency was noted to be "1wk4". Agency leadership reviewed clinical record and identified a charting error was made when visit frequency was manually written on 485 resulting in ordered frequency exceeding that plotted and assigned to clinician. ·Agency to provide 1:1 education to skilled nurse related to compliance with physician orders including reviewing ordered frequency and reporting and correcting errors appropriately. ·Education to be completed by Administrator or designee by May 27, 2021. **Person Responsible:** Administrator **Date of Completion:** May 27, 2021 **Compliance:** ·Beginning May 14, 2021, 100% of admissions, resumptions of care, and recertifications and discharges will be audited weekly to ensure compliance with this standard. Audits will be completed	

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			until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the admissions, resumption of care, and recertifications and discharges for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	
G 0578 Bldg. 00	484.60(b) Conformance with physician orders Standard: Conformance with physician or allowed practitioner orders. Based on observation, record review and interview, the agency failed to conform with physician orders for 10 of 15 records reviewed (#1, 3, 6, 7, 8, 9, 10, 11, 14, 16). The findings include:	G 0578	17-14-1(a)(1)(B)**CONDITION LEVEL G570 Care planning, coordination, and quality of care CFR(s)484.60**	05/27/2021

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	1. Review of an agency policy, with an approval/review date of 4/2020, titled "Care Management and the Plan of Care" stated "... The agency case manager (registered nurse or managing therapist) ... works with the attending physician to develop the plan of care ... notify the physician to obtain updated orders ... provides the patient with the services according to the ... plan of care ... plan of care specifies the care and services necessary ... all medications and treatments ...." 2. Review of an agency policy, with an approval/review date of 4/2020, titled "Physician Orders" stated "... Physician orders are required for services provided to agency patients ... orders are followed when administering medications or providing care treatment or services ... review all orders for accuracy prior to providing care, treatment or services ...." 3. Record review for patient #1 was completed on 2/10/2021, and again on 3/2/2021, start of care date 4/7/2020, primary diagnosis encounter for attention to cystostomy (suprapubic catheter- an opening in the lower abdomen where a tube is inserted directly into the bladder for drainage of urine). Review of a document titled "Home Health Certification and Plan of Care" for certification period 12/3/2020 - 1/31/2021, indicated skilled nursing services (effective 12/13/2020) once every 2 weeks for two weeks, then once every 4 weeks for 4 weeks, and 2 PRN (as needed) visits for bleeding, cardiac, catheter issues, diabetic, falls, pain, respiratory, or skin breakdown. The record evidenced the patient developed open wound(s) on 1/5/2021, an order for wound care was received on 1/7/2021, no wound care was performed during a nursing visit on 1/11/2021, and was eventually		Refer to: ·G578 Conformance with physician orders ·G590 promptly alert relevant physician of changes CFR(s)484.60(c)(1) ·G606 Integrate all services CFR(s)484.60(d)(3) ·G614 Visit schedule CFR(s)484.60(e)(1) ·G616 Patient medication schedule/instructions CFR(s)484.60(e)(2) ·G618 Treatments and therapy services CFR(s)484.60(e)(3) 17-14-1(a)(1)(H) 17-12-2(g) 17-12-2(h) **G578 Conformance with physician orders** **Plan:** ·All clinical staff received education by the Administrator regarding the need to ensure all care, treatment and services are provided in accordance current physician orders during staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Follow up in-service education was conducted by the Administrator or designee by May 13, 2021 for all clinical staff. This education included:	

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	performed on 1/13/2021, 6 days after the order was received. Review of a document dated 1/5/2021, titled "Client Coordination Note Report" stated "... Stage 2 pressure sores each side of sacrum ...." Review of a document dated 1/7/2021, titled "Physician Order" stated "... SN to perform/teach wound care to client/caregiver. Cleanse left buttock wound with normal saline or wound cleanser, cover with duoderm bordered dressing on M/W/PRN [Monday/Wednesday/As Needed], all other days by client/caregiver ...." During an interview on 2/10/2021 at 12:40 PM, the administrator/clinical manager indicated it was clear the nurse did not review the record/order prior to her visit on 1/11/2021, as the order was received on 1/7/2021 (before the 1/11/2021 nursing visit). Review of a document dated 1/11/2021, titled "Visit Note Report ... SN Subsequent Visit" stated "... Wound care not provided: awaiting orders ...." Review of a document dated 1/13/2021, titled "Visit Note Report ... SN Subsequent Visit" stated "... supplies arrived today and area was cleaned and dressed per orders ...." 4. Record review for patient #3 was completed on 2/22/2021, and again on 3/2/2021, start of care date 10/10/2020, primary diagnosis urinary tract infection (UTI),site not specified, and other pertinent (but not limited to) diagnoses of cerebral palsy, morbid (severe) obesity, epilepsy, history of falling, and pacemaker. Review of a document titled "Home Health Certification and Plan of Care" for certification period 2/7/2021- 4/7/2021,		·Review of agency Care Management and the Plan of Care and Physician Orders policies. ·Review of physician order requirements, as well as the need to ensure documentation of medication reconciliation, PT/INR results and missed visits with physician notification in accordance with Agency Care Management and the Plan of Care and Physician Orders policies. ·Additional in-service education and corrective action will be conducted by the Administrator or designee by May 27, 2021 as described in the "specific action for clinical records" section that follows. ·Education will be provided through mandatory in-service education and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The Clinical Manager or designee will review all active patient records to ensure current physician orders area present for all care, treatment and services provided. **·Specific action taken for clinical records #1, #3, #6, #7, #8, #9, #10, #11, #14 and #16:** ·Agency action to mitigate and resolve noted deficiencies in individual client records was limited in some cases due to	

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	indicated the patient received skilled nursing, PT services, and home health aide. The record evidenced the patient was hospitalized in observation status from 2/11/2021 - 2/14/2021. The record failed to evidence home health aide visits were made, and failed to evidence the patient's medications conformed with updated physician orders. Review of a document dated 2/14/2021, titled "Discharge Summary" from hospital M indicated medications including (but not limited to) Centrum Silver Men's oral tablet daily after breakfast, Docusate sodium (colace) 100mg (milligrams) twice daily after breakfast and dinner, and furosemide 40mg, 0.5 tab (20mg) daily after breakfast. Review of a document dated 2/15/2021 titled "Visit Note Report ... PT [physical therapy] Subsequent Visit" indicated no medication changes were identified. During an interview on 2/22/2021 at 1:24 PM, the administrator/clinical manager indicated no home health aide visits had been made as ordered. During an interview on 3/2/2021 at 2:30 PM, the administrator/clinical manager indicated she didn't see a medication reconciliation was completed after the patient returned home from the hospital on 2/14/2021, and agreed the medications listed in the EMR (electronic medical record) were not updated to match the medication changes on the hospital discharge documents. The EMR failed to evidence the Centrum Silver Men's oral tablet , indicated the docusate sodium Colace was twice a day "as needed" (last updated 2/2/2021, and the furosemide was 80mg, 0.5 tab (40mg) twice daily (last updated 2/2/2021).		discharge of patient prior to or shortly after survey exit interview as well as due to agency was not provided with chart/patient identifiers or information regarding identified deficits at time of survey exit. ·Clinical record #1 ·Agency reviewed clinical record and verified noncompliance with physician orders as cited by surveyor. ·Corrective action and 1:1 education related to compliance with physician orders to be completed by Administrator or designee with nursing staff involved in patient care by May 27, 2021. ·Patient was discharged from agency services on 3/10/2021 ·Clinical record #3 ·Agency reviewed clinical record and verified noncompliance with medication reconciliation. ·Corrective action and 1:1 education to occur with Physical Therapist who performed 2/15/21 visit post-hospitalization regarding medication reconciliation. ·Education and corrective action to be completed by Administrator or designee by May 27, 2021. ·Agency process implemented to require medication	

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	5. During a home visit on 2/23/2021 at 10:00 AM with patient #6, review of the patient's home folder evidenced a document from wound clinic A dated 2/18/2021, titled "Physician Orders". The document indicated wound care orders to the left leg included (but not limited to) the placement of adaptic (vaseline impregnated gauze) to the wound bed (to prevent the foam dressing from sticking the the wound bed), and zinc (protective barrier cream) to red areas (on the surrounding skin). During observation of wound care, the nurse failed to apply adaptic to the wound bed, and failed to apply zinc to the red areas. After wound care was completed, the nurse reviewed the EMR, indicated she made an error, she didn't apply the adaptic prior to the application of foam, the agency got the order yesterday (2/22/2021), she didn't have any adaptic in her bag, she would notify the wound clinic, and would come back later (same day) to redo dressing. The patient indicated he did not want the dressing changed due to pain during the procedure, and would wait until the next time it was due to be changed. Review of a document dated 2/20/2021, titled "Visit Note Report ... SN Subsequent Visit" failed to evidence the nurse applied adaptic to the wound bed prior to the application of the foam, and failed to apply zinc to the red areas. During an interview on 2/24/2021 at 11:18 AM, the administrator/clinical manager agreed the current wound care order dated 2/18/2021, was in the home folder (readily accessible to nurses prior to providing wound care), and the agency failed to conform with physician orders on nursing visits completed 2/20/2021 and 2/23/2021. 6. A home visit of patient #7 was observed on		reconciliation following hospital observation stays. ·Education was provided to all clinical staff by Administrator or designee by May 13, 2021. ·Clinical record #6 ·Agency reviewed clinical record and verified noncompliance with physician orders as cited by surveyor. ·Physician notification was made by agency RN and documented in clinical record on 2/23/2021 regarding agency failure to perform ordered wound care in compliance with order issued to patient on 2/18/2021 and faxed to agency on 2/22/2021. ·RN obtained and documented order from physician on 2/23/2021 approving wound care to be performed without the adaptic dressing to wound bed until the ordered adaptic dressing supplies arrived to patient home. ·Corrective action and 1:1 education related to compliance with physician orders to be completed with nursing staff involved in patient care. ·Education and corrective action to be completed by Administrator or designee by May 27, 2021. ·Clinical record #7 ·Agency reviewed clinical record: ·Confirmed deficient	

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	2/23/2021 at 1:50 PM , start of care date 1/22/2021, for certification period 1/22/2021 - 3/22/2021. The patient received physical and occupational therapy services, and skilled nursing services was ordered on 2/18/2021, for wounds. The patient's primary diagnosis was COVID-19, and other diagnoses included (but not limited to) pneumonia due to COVID-19, acute respiratory failure with hypoxia (deprivation of oxygen), acute on chronic systolic (congestive) heart failure, obstructive sleep apnea, type 2 diabetes with diabetic chronic kidney disease, non-ST elevation (NSTEMI) myocardial infarction (heart attack), constipation, long term (current) use of aspirin, and long term (current) use of anticoagulants. Record review completed on 2/24/2021, and again on 3/2/2021, evidenced a document dated 1/22/2021, by PT X titled "Visit Note Report" which stated "... Visit Type: ... PT OASIS [Outcome and Assessment Information Set] Admission" evidenced the patient had no pain, and failed to evidence any lower extremity edema, skin breakdown or open skin area(s). The patient was subsequently seen in the emergency department on 2/17/2021, for swelling, draining, and intractable pain in both legs, and was prescribed antibiotics. He was seen in the emergency room again on 2/24/2021, and was admitted with complaint of shortness of breath, and chest pain. He remained hospitalized upon survey exit on 03/02/2021. Review of a document signed and dated 2/19/2021, by PT BB titled "Physician Order" stated "... PT to do dressing change elastic bandage as needed B [both] LE [lower extremities] if legs are soaked from weeping edema ...." Review of a document dated and signed		documentation as noted by surveyor. Physical therapist failed to document assessment of dressing integrity to bilateral lower extremities. ·Unable to verify noncompliance with physician's order for "PT to do dressing change elastic bandage to BLE if legs are soaked from weeping edema.." as clinical record lacks information regarding status of dressings on the 2/19/2021 visit cited. ·Education to be provided to physical therapist regarding compliance with physician's orders and appropriate assessment and documentation. ·Education to be completed by Administrator or designee by May 27, 2021. ·Patient was discharged from agency services on 5/08/2021 ·Clinical record #8 ·Agency reviewed clinical record and confirmed deficient documentation and noncompliance with physician orders as noted by surveyor. ·Agency RN failed to document that teaching was provided to patient and caregiver at the Start of Care visit for performance of wound care. ·Ordered intervention for wound care on the 485-Plan of Treatment indicates caregiver to	

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	2/19/2021, by PT BB titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had weeping edema to both lower extremities, failed to evidence the integrity of the dressings/bandages, and failed to evidence the bandages were changed as ordered by the physician. 7. Record review for patient #8 was completed on 2/24/2021, and again on 3/2/2021, start of care date 6/11/2016, primary diagnosis quadriplegia (paralyzed from the neck down), unspecified, and other pertinent (but not limited to) diagnoses pressure ulcer left buttock, rheumatoid arthritis, depression, anxiety, tobacco use, and diabetes. Review of a document titled "Home Health Certification and Plan of Care" for certification period 6/11/2016 - 8/9/2016, indicated (but not limited to) skilled nursing orders for wound care 3 times per week, foley catheter changes, patient/caregiver teaching related to wound care and management of health conditions, and caregiver to provide wound care on non-nursing visit days. Review of a document dated 6/11/2016, titled ""Visit Note Report ... RN OASIS Admission" failed to evidence the nurse taught the caregiver proper wound care procedures as ordered by the physician so the caregiver could perform the treatment on non-nursing visit days. Review of a document dated 6/13/2016 titled ""Visit Note Report ... SN Subsequent Visit" failed to evidence wound care was performed as ordered on the plan of care. Review of a document dated 6/20/2016 titled ""Visit Note Report ... SN Subsequent Visit - As Needed" stated "... Are wound care orders being followed? No ....", and failed to evidence wound		perform dressing changes when "SN not available". On 6/13/2016 and 6/20/2016 skilled nursing notes indicate dressing change was not performed by skilled nursing due to the caregiver having already performed wound care. ·No evidence in chart of physician notification or request to update to wound care order to allow for caregiver to perform wound care on days that skilled nurse performed home visits. ·Agency reviewed clinical record and was unable to confirm noncompliance with physician orders for wound care as cited by surveyor regarding the issue below. ·On 6/20/16 visit note, RN responded to question "are wound care orders being followed" was answered "no" by RN. Question is located in the Supervisory functions section of skilled nursing visit note and refers to wound care that is performed by a supervised colleague such as an LPN/LVN or home health aide. ·Home health aide was not involved in or performed any wound care for this client. ·Education was provided to all clinical staff on compliance with physician orders as described in plan above. ·All clinical nursing staff involved in care of this patient are no longer employed by the	

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	care was performed as ordered on the plan of care. 8. Record review for patient #9 was completed on 3/2/2021, start of care date 7/23/2020, evidenced a document titled "Home Health Certification and Plan of Care" for dates 9/21/2020 - 11/19/2020, with primary diagnosis encounter for attention to cysts, other pertinent diagnoses including (but not limited to) laceration without foreign body of left upper arm, diabetes, heart failure, and indicated skilled nursing visits 1 time week of 9/20/2020, 2 times week of 9/27/2020, then every 2 weeks for 2 weeks, then once every 5 weeks, and 2 extra visits for unplanned needs. Review of the record evidenced 2 nursing visits were completed the week of 9/20/2020. 9. Record review for patient #10 was completed on 3/2/2021, start of care date 10/8/2019, evidenced a document titled "Home Health Certification and Plan of Care" for dates 2/5/2020 - 4/4/2020, with primary diagnosis disruption of external operation (surgical) wound, other (but not limited to) pertinent diagnoses hypertension (high blood pressure), chronic pain, depression, anxiety, and long term (current) use of anticoagulants. The document evidenced orders for skilled nursing twice weekly beginning week of 2/9/2020. Only 1 visit was made week of 3/8/2020. Additionally, the document indicated skilled nurse to perform PT/INR via finger stick (a blood test to monitor therapeutic anticoagulant drug levels) every Monday. Review of a document dated 2/3/2020 (Monday) titled "Visit Note Report ... RN Recert with Skill" evidenced a PT/INR was completed. Review of a document dated 2/6/2020 (Thursday) titled "Visit Note Report ... RN Subsequent Visit"		agency preventing any 1:1 education or counselling from occurring. ·Patient was discharged from agency services on 6/20/2016 ·Clinical record #9 ·Agency reviewed chart and was unable to verify noncompliance as cited by surveyor but did identify charting issue which created appearance of noncompliance. ·Recert visit was performed late on 9/22/20. Physician was notified of delayed recert and order for 1 skilled nursing visit in week of 9/20/2020 to perform recertification was obtained and entered in clinical record on 9/21/2020. ·485-Plan of Treatment created by 9/22/20 recertification visit contains documentation of the ordered visit frequency subsequent to that visit with additional SNV in week of 9/20/2020 (for total of 2 SNV's completed week of 9/20/2020). ·Agency to provide education to all clinical staff regarding writing visit frequencies with adequate specificity including use of language to clarify when visits are being added to a Medicare week versus reflecting visits in same week already performed (Example: 1 Skilled Nursing visit week of 9/20/2020 for recertification" and "POC effective	

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	evidenced a PT/INR was completed (no order). Review of a document dated 2/10/2020 (Monday) titled "Visit Note Report ... RN Subsequent Visit" evidenced a PT/INR was completed. No nursing visit was made on 2/17/2020 (Monday-No PT/INR completed). Review of a document dated 2/18/2020 (Tuesday) titled "Visit Note Report ... RN Subsequent Visit" evidenced a PT/INR was completed (no order). Review of a document dated 2/21/2020 signed by the certifying physician on 3/2/2020 titled "Physician Order" stated "... Recheck INR on 2/27/2020 ...." (Record failed to evidence INR was checked on 2/27/2020.) Review of a document dated 2/26/2020 (not signed by a physician) titled "Physician Order" stated "... Check INR weekly ... patient prefers ... Fridays, per nursing ...." Review of a document dated 2/28/2020 (Friday) titled "Visit Note Report ... RN Subsequent Visit" Record evidenced a PT/INR was completed with critical result of 7.0 (2.0-3.0 is desired therapeutic range, and result of 7.0 could cause spontaneous bleeding/hemorrhage), and patient had lab drawn at infusion clinic. 10. Record review for patient #11 was completed on 3/2/2021, start of care date 7/14/2016, evidenced a document titled "Home Health Certification and Plan of Care" for dates 7/14/2016 - 9/11/2016, with primary diagnosis encounter for fitting and adjustment of urinary device, other pertinent diagnoses including (but not limited to) enlarged prostate, and urine retention. The		9/22/2020: 1 additional visit week of 9/20 then ....". ·Education to be completed by Administrator or designee by May 27, 2021. ·Patient was discharged from agency services on 10/14/2020 ·Clinical record #10 ·Agency reviewed clinical record and was unable to verify noncompliance with ordered visit frequency as cited by surveyor. ·Skilled Nursing frequency at start of episode was 1wk1, 2wk8 per signed 485-plan of treatment. ·Order obtained and documented in clinical record on 2/26/2020 changed skilled nursing frequency to "Effective 2/23/2020: 2wk1, 1wk5". ·Surveyor noted only 1 skilled nursing visit was performed in week of 3/08/2020. This is correct and in compliance with the with physician order dated 2/26/2020. ·Agency reviewed clinical record and verified noncompliance with frequency and ordered dates of PT/INR testing. ·Clinical manager involved in care coordination and oversight of this patient is no longer employed by agency preventing counselling and/or corrective action. ·Corrective action and	

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	document evidenced skilled nursing monthly for urinary catheter changes, with 3 extra visits as needed for catheter complications. Review of a document effective date 7/31/2016, signed by the physician 8/10/2016 titled "Physician Verbal Order" indicated PT visit frequency once per week for 1 week, then twice weekly for 3 weeks. The record failed to evidence 2 PT visits were made during the week of 8/14/2016 as ordered by the physician. 11. Record review for patient #14 was completed on 3/2/2021, start of care date 1/28/2021, evidenced a document titled "Home Health Certification and Plan of Care" for dates 1/28/2021 - 3/28/2021, with primary diagnosis sepsis (a serious infection that causes your immune system to attack your body) due to E coli (bacteria), evidenced (but not limited to) home health aide (beginning week of 1/31/2021) once weekly for 4 weeks. Review of a document dated Friday, 2/12/2021 titled "Client Coordination Note Report" evidenced a home health aide visit was missed do to a "scheduling conflict", and no other aide visit was made that week. 12. Record review for patient #16 was completed on 3/2/2021, start of care date 1/7/2016, evidenced a document titled "Home Health Certification and Plan of Care" for dates 2/9/2021 - 4/9/2021, with primary neuromuscular dysfunction of bladder, evidenced (but not limited to) skilled nursing visits 2 times the first week, then once weekly for 3 weeks, and home health aide visits once the first week, then twice weekly for 8 weeks. The record evidenced only 1 skilled nursing visit was made the first week, and only 1 home health aide visit		1:1 education related to compliance with physician orders to be completed with nursing staff involved in patient care. ·Education and corrective action to be completed by Administrator or designee by May 27, 2021. ·Patient was discharged from agency services on 3/19/2020 ·Clinical record #11 ·Agency reviewed chart and was unable to verify noncompliance as cited by surveyor. ·Documentation supports compliance with PT visit frequency of 1wk1, 2wk3 as evidenced by completed home visits or appropriately documented missed visits and documentation of timely physician notification of missed visits matching this frequency. ·One missed visit was noted in record. PTA visit on 8/16/2016 was attempted but refused by the patient. A missed visit note was appropriately entered in the medical record which documented the reason as "patient refusal". This note was faxed to the ordering physician as notification on 8/17/2016. ·Patient was discharged from agency services on 9/16/2016 ·Clinical record #14: ·Agency was unaware of	

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	was made on the second week. 17-14-1(a)(1)(H)		assessment deficits in chart #14 until following receipt of the survey findings on April 28, 2021. ·Patient was discharged from services on 3/23/2021. ·Agency has reviewed the clinical record and confirmed the finding as indicated by surveyor of a missed visit note entered by home health aide on 2/12/2021 with reason for missed visits stated as "scheduling conflict". ·Agency observed that ordered home health aide frequency was met by completion of in-home visits or documentation of missed visits with appropriate physician notification of missed visits. ·Agency provided education to all clinical staff regarding precise documentation of reasons for missed visit including avoidance of selecting "scheduling conflict" from EMR "missed visit reason" options without providing additional detail sufficient to demonstrate that visit was not missed due to agency or clinician reasons but only if patient or caregiver reported a scheduling conflict and declined/refused attempts to reschedule. ·Education was completed by Administrator or designee on May 18, 2021. ·Patient was discharged from agency services on 3/23/2021	

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			·Clinical record #16 ·Agency reviewed clinical record and confirmed the findings as indicated by surveyor. ·A home health aide visit in week 2 was missed but no appropriate missed visit note was entered and no physician notification of the missed visit is evidenced in the clinical record. ·Agency to provide 1:1 education with the home health aide ·Education to be completed by Administrator or designee by May 27, 2021. ·Clinical manager will ensure appropriate documentation and physician/provider notification of all missed visits is evident in all charts. ·Skilled nursing visit frequency on 485-Plan of Treatment listed as "2wk1, 1wk3…." however plotted/planned visit frequency was noted to be "1wk4". Agency leadership reviewed clinical record and identified a charting error was made when visit frequency was manually written on 485 resulting in ordered frequency exceeding that plotted and assigned to clinician. ·Agency to provide 1:1 education to skilled nurse related to compliance with physician orders including reviewing ordered frequency and	

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			reporting and correcting errors appropriately. ·Education to be completed by Administrator or designee by May 27, 2021. **Person Responsible:** Administrator **Date of Completion:** May 27, 2021 **Compliance:** ·Beginning May 14, 2021, 100% of admissions, resumptions of care, and recertifications and discharges will be audited weekly to ensure compliance with this standard. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the admissions, resumption of care, and recertifications and discharges for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until	

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			compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	
G 0590 Bldg. 00	484.60(c)(1) Promptly alert relevant physician of changes The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on observation, record review and interview, the agency failed to ensure the physician was notified of changes in the patient's condition for 6 of 15 records reviewed (#3, 7, 8, 9). Findings include: 1. Review of an agency policy approval/reviewed date 4/2020 titled "Care Management and the Plan of Care" stated "... Agency staff maintain liaison among disciplines to ensure that coordinated care is provided and supports the objectives in the plan of care ... regularly coordinates patient care activities with the physician and/or other members of the health care team and documents communications ... also shares and receives patient information with other providers of care,	G 0590	17-14-1(a)(1)(B)**CONDITION LEVEL G570 Care planning, coordination, and quality of care CFR(s)484.60** Refer to: ·G578 Conformance with physician orders ·G590 promptly alert relevant physician of changes CFR(s)484.60(c)(1) ·G606 Integrate all services CFR(s)484.60(d)(3) ·G614 Visit schedule CFR(s)484.60(e)(1)	05/27/2021

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	treatment or services ...." 2. Record review for patient #3 was completed on 2/22/2021 and again on 3/2/2021, start of care date 10/10/2020, primary diagnosis urinary tract infection (UTI), site not specified, and other pertinent (but not limited to) diagnoses of cerebral palsy, morbid (severe) obesity, epilepsy, history of falling, and pacemaker. Review of a document titled "Home Health Certification and Plan of Care" for certification period 2/7/2021- 4/7/2021 indicated the patient received skilled nursing and PT services, and home health aide. The record evidenced the patient was hospitalized in observation status 2/11/2021 - 2/14/2021. Review of a document dated 2/14/2021 titled "Discharge Summary" from hospital M indicated medications including (but not limited to) Centrum Silver Men's oral tablet daily after breakfast, Docusate sodium (colace) 100mg (milligrams) twice daily after breakfast and dinner, and furosemide 40mg, 0.5 tab (20mg) daily after breakfast. Review of a document dated 2/15/2021 titled "Visit Note Report ... PT [physical therapy] Subsequent Visit" indicated no medication changes were identified (there were medication changes), and the record failed to evidence the physician was notified for post-hospitalization medication reconciliation for the new/changed medications. During an interview on 3/2/2021 at 2:30 PM, the administrator/clinical manager indicated she didn't see a medication reconciliation was completed after the patient returned home from the hospital on 2/14/2021, and agreed the medications listed in the EMR (electronic medical record) were not updated to match the medication changes on the		·G616 Patient medication schedule/instructions CFR(s)484.60(e)(2) ·G618 Treatments and therapy services CFR(s)484.60(e)(3) 17-14-1(a)(1)(H) 17-12-2(g) 17-12-2(h) **G578 Conformance with physician orders** **Plan:** ·All clinical staff received education by the Administrator regarding the need to ensure all care, treatment and services are provided in accordance current physician orders during staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Follow up in-service education was conducted by the Administrator or designee by May 13, 2021 for all clinical staff. This education included: ·Review of agency Care Management and the Plan of Care and Physician Orders policies. ·Review of physician order requirements, as well as the need to ensure documentation of medication reconciliation, PT/INR results and missed visits with physician notification in accordance with Agency Care Management and the Plan of Care	

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	hospital discharge documents. 3. A home visit of patient #7 was observed on 2/23/2021 at 1:50 PM, start of care date 1/22/2021, for certification period 1/22/2021 - 3/22/2021. The patient received physical and occupational therapy services, and skilled nursing services was ordered on 2/18/2021, for wounds. The patient's primary diagnosis was COVID-19, and other diagnoses, which included (but was not limited to), pneumonia due to COVID-19, acute respiratory failure with hypoxia (deprivation of oxygen), acute on chronic systolic (congestive) heart failure, obstructive sleep apnea, type 2 diabetes with diabetic chronic kidney disease, non-ST elevation (NSTEMI) myocardial infarction (heart attack), constipation, long term (current) use of aspirin, and long term (current) use of anticoagulants. Record review completed on 2/24/2021, and again on 3/2/2021, evidenced a document dated 1/22/2021, by PT X titled "Visit Note Report" which stated "... Visit Type: ... PT OASIS [Outcome and Assessment Information Set] Admission" evidenced the patient had no pain, and failed to evidence any lower extremity edema, skin breakdown or open skin area(s). Review of a document dated 2/4/2021, titled "Visit Note Report ... PT Subsequent Visit" evidenced medication changes were identified during the visit, failed to evidence what medications(s) were changed, and evidenced no care coordination with a nurse/clinical manager or physician occurred, and stated "... care coordination ... NO ...." Review of a document dated 2/6/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced		and Physician Orders policies. ·Additional in-service education and corrective action will be conducted by the Administrator or designee by May 27, 2021 as described in the "specific action for clinical records" section that follows. ·Education will be provided through mandatory in-service education and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The Clinical Manager or designee will review all active patient records to ensure current physician orders area present for all care, treatment and services provided. **·Specific action taken for clinical records #1, #3, #6, #7, #8, #9, #10, #11, #14 and #16:** ·Agency action to mitigate and resolve noted deficiencies in individual client records was limited in some cases due to discharge of patient prior to or shortly after survey exit interview as well as due to agency was not provided with chart/patient identifiers or information regarding identified deficits at time of survey exit. ·Clinical record #1 ·Agency reviewed clinical record and verified noncompliance with physician orders as cited by	

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	medication changes were identified during the visit, failed to evidence what medications(s) were changed, and evidenced no care coordination with a nurse/clinical manager or physician occurred, and stated "... care coordination ... NO ...." Review of a document dated 2/8/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had bilateral lower extremity edema (swelling), and evidenced no care coordination with a nurse/clinical manager or physician occurred, and stated "... care coordination ... NO ...." Review of a document dated 2/11/2021 titled "Visit Note Report ... OT Add-On Evaluation" evidenced the patient complained of fatigue and shortness of breath with exertion, mild foot pain (no complaint of pain prior to this visit per record review), the patient stated "... Feels like skin is stretching [describing his pain] ....", red areas were assessed on skin (patient explained it was an allergic reaction to lotion), and evidenced no care coordination with a nurse/clinical manager or physician occurred. to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/12/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had weeping edema to both lower extremities, medication changes were identified during the visit, a medication reconciliation was performed, failed to evidence what medications(s) were changed, and evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...."		surveyor. ·Corrective action and 1:1 education related to compliance with physician orders to be completed by Administrator or designee with nursing staff involved in patient care by May 27, 2021. ·Patient was discharged from agency services on 3/10/2021 ·Clinical record #3 ·Agency reviewed clinical record and verified noncompliance with medication reconciliation. ·Corrective action and 1:1 education to occur with Physical Therapist who performed 2/15/21 visit post-hospitalization regarding medication reconciliation. ·Education and corrective action to be completed by Administrator or designee by May 27, 2021. ·Agency process implemented to require medication reconciliation following hospital observation stays. ·Education was provided to all clinical staff by Administrator or designee by May 13, 2021. ·Clinical record #6 ·Agency reviewed clinical record and verified noncompliance with physician orders as cited by surveyor.	

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	Review of a document dated 2/16/2021 titled "Visit Note Report ... OT Subsequent Visit" evidenced the patient's pain was described as "burning ... stabbing", rated from 5-7 (on a pain scale 0-10, with 0 being no pain, and 10 being the most severe), pain was located to the right foot, 2nd and 3rd toes, patient was weak and unsteady, and evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/18/2021 titled "Visit Note Report ... OT Subsequent Visit" evidenced the patient was seen in the emergency department on 2/17/2021 for complaint of intractable pain in legs (10/10), legs seeping, and was given antibiotics for infection in legs per patient report. Review of a document dated 2/18/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient was seen in the emergency department on 2/17/2021 (via ambulance) for bilateral lower extremity weeping edema, blisters on right foot 2nd toe, and had a new antibiotic. The document stated "... The dressing was soaked totally and needed to be replaced, PT recommended to request daughter to replace soaked dressing when she gets home ...." The document evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/19/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had weeping edema to both lower extremities, failed to evidence the integrity of the dressings/bandages, evidenced the patient had pain 8/10 on pain scale, and pain to touch. The document evidenced no care coordination with a		·Physician notification was made by agency RN and documented in clinical record on 2/23/2021 regarding agency failure to perform ordered wound care in compliance with order issued to patient on 2/18/2021 and faxed to agency on 2/22/2021. ·RN obtained and documented order from physician on 2/23/2021 approving wound care to be performed without the adaptic dressing to wound bed until the ordered adaptic dressing supplies arrived to patient home. ·Corrective action and 1:1 education related to compliance with physician orders to be completed with nursing staff involved in patient care. ·Education and corrective action to be completed by Administrator or designee by May 27, 2021. ·Clinical record #7 ·Agency reviewed clinical record: ·Confirmed deficient documentation as noted by surveyor. Physical therapist failed to document assessment of dressing integrity to bilateral lower extremities. ·Unable to verify noncompliance with physician's order for "PT to do dressing change elastic bandage to BLE if legs are soaked from weeping edema.." as clinical record lacks	

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	nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." During an interview on 2/24/2021 at 11:27 AM family stated they called 911 about "10 minutes ago [2/24/2021]" for chest pain, and stated "... [chest pain] It's been off and on since he got home from the hospital ...." She also indicated he got up this morning, he wasn't feeling good, he (patient) "... took like 6 nitros [nitroglycerin for chest pain] no relief." She also indicated he was coughing quite a bit after the nurse left yesterday (2/23/2021), and he didn't have a good night. When asked if the patient complained of pain since he came home from the hospital prior to the initiation of home health services (start of care), she stated "Yes. His feet, he never feels good. So much pain." The patient was subsequently seen in the emergency department on 2/17/2021 for swelling, draining, and intractable pain in both legs, and was prescribed antibiotics. He was seen in the emergency room again on 2/24/2021 and was admitted with complaint of shortness of breath, heart failure, and chest pain. He remained hospitalized upon survey exit. 4. Record review for patient #8 was completed on 2/24/2021 and again on 3/2/2021, start of care date 6/11/2016, primary diagnosis quadriplegia (paralyzed from the neck down), unspecified, and other pertinent (but not limited to) diagnoses of, pressure ulcer left buttock, rheumatoid arthritis, depression, anxiety, tobacco use, and diabetes. Review of the document titled "Home Health Certification and Plan of Care" for certification period 6/11/2016 - 8/9/2016, indicated (but was not limited to) skilled nursing orders for wound care 3 times per week, foley catheter changes, patient/caregiver teaching related to wound care,		information regarding status of dressings on the 2/19/2021 visit cited. ·Education to be provided to physical therapist regarding compliance with physician's orders and appropriate assessment and documentation. ·Education to be completed by Administrator or designee by May 27, 2021. ·Patient was discharged from agency services on 5/08/2021 ·Clinical record #8 ·Agency reviewed clinical record and confirmed deficient documentation and noncompliance with physician orders as noted by surveyor. ·Agency RN failed to document that teaching was provided to patient and caregiver at the Start of Care visit for performance of wound care. ·Ordered intervention for wound care on the 485-Plan of Treatment indicates caregiver to perform dressing changes when "SN not available". On 6/13/2016 and 6/20/2016 skilled nursing notes indicate dressing change was not performed by skilled nursing due to the caregiver having already performed wound care. ·No evidence in chart of physician notification or request to update to wound care order to allow for caregiver to	

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	management of health conditions, and caregiver was to provide wound care on non-nursing visit days. Review of a document dated 6/13/2016, titled ""Visit Note Report ... SN Subsequent Visit" stated "... Usual blood sugar readings: "200 to 300 Am fasting. Some times [sic] over 500 late in the day...." and evidenced the wound on the right upper buttock was worse, a new wound on the left posterior lower buttock, a new wound on the sacrum, a stool sample was obtained, and evidenced no care coordination with the physician occurred to report high blood sugar readings and worsening/new wounds. This document stated "... care coordination ... not applicable ...." Review of a document dated on 6/20/2016, titled "Visit Note Report ... SN Subsequent Visit - As Needed" evidenced the visit was for patient complaint of occluded urinary catheter, urine was dark amber colored, and stated "... Upon arrival after milking foley urine flowed free ...." The document failed to evidence coordination with the physician for signs of UTI (urinary tract infection) such as dark colored urine and occluded catheter, and stated "... care coordination ... NO ...." 5. Record review for patient #9 was completed on 3/2/2021, start of care date 7/23/2020, evidenced a document titled "Home Health Certification and Plan of Care" for dates 9/21/2020 - 11/19/2020, with primary diagnosis encounter for attention to cystsostomy (urinary drainage tube), other pertinent diagnoses including (but not limited to), laceration without foreign body of left upper arm, diabetes, heart failure, and indicated the patient received skilled nursing services. Review of a document titled "Home Health Certification and		perform wound care on days that skilled nurse performed home visits. ·Agency reviewed clinical record and was unable to confirm noncompliance with physician orders for wound care as cited by surveyor regarding the issue below. ·On 6/20/16 visit note, RN responded to question "are wound care orders being followed" was answered "no" by RN. Question is located in the Supervisory functions section of skilled nursing visit note and refers to wound care that is performed by a supervised colleague such as an LPN/LVN or home health aide. ·Home health aide was not involved in or performed any wound care for this client. ·Education was provided to all clinical staff on compliance with physician orders as described in plan above. ·All clinical nursing staff involved in care of this patient are no longer employed by the agency preventing any 1:1 education or counselling from occurring. ·Patient was discharged from agency services on 6/20/2016 ·Clinical record #9 ·Agency reviewed chart and was unable to verify noncompliance as cited by surveyor but did identify charting	

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	Plan of Care" for certification period 9/21/2020 - 11/19/2020 failed to evidence the presence of a cardiac pacemaker. Review of a document dated 9/22/2020 titled "Visit Note Report ... RN Recert with Skill" stated "... Cardiovascular assessment ... WNL [within normal limits] ... indwelling/suprapubic catheter ... leaking from penis ... mental status ... WNL ... alert ... oriented to person ... oriented to place ... forgetful ..." The document failed to evidence presence of a cardiac pacemaker. Review of a document dated 9/25/2020 titled "Visit Note Report ... SN Subsequent Visit" stated "... Cardiovascular assessment ... pacemaker ... Indicate type of pacemaker and rate ... unknown ....", evidenced purulent (indicative of infection) drainage from arm wound, and evidenced no care coordination with a nurse/clinical manager or physician occurred for care coordination regarding the patient's pacemaker and purulent drainage, and stated "... care coordination ... NO ...." Review of a document dated 9/29/2020 titled "Visit Note Report ... SN Subsequent Visit" evidenced urine was dark amber color, the patient was confused, and evidenced no care coordination with a nurse/clinical manager or physician occurred for care coordination regarding the patient's signs and symptoms of UTI (dark amber color urine, confusion), and stated "... care coordination ... NO ...." Review of a document dated 10/2/2020, titled "Client Coordination Note Report" stated "... Son expressed concerned [sic] that patient has come down with a UTI due to increased confusion and hallucinations ...."		issue which created appearance of noncompliance. ·Recert visit was performed late on 9/22/20. Physician was notified of delayed recert and order for 1 skilled nursing visit in week of 9/20/2020 to perform recertification was obtained and entered in clinical record on 9/21/2020. ·485-Plan of Treatment created by 9/22/20 recertification visit contains documentation of the ordered visit frequency subsequent to that visit with additional SNV in week of 9/20/2020 (for total of 2 SNV's completed week of 9/20/2020). ·Agency to provide education to all clinical staff regarding writing visit frequencies with adequate specificity including use of language to clarify when visits are being added to a Medicare week versus reflecting visits in same week already performed (Example: 1 Skilled Nursing visit week of 9/20/2020 for recertification" and "POC effective 9/22/2020: 1 additional visit week of 9/20 then ....". ·Education to be completed by Administrator or designee by May 27, 2021. ·Patient was discharged from agency services on 10/14/2020 ·Clinical record #10 ·Agency reviewed clinical	

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	Review of a document dated 10/2/2020 titled "Visit Note Report ... SN Subsequent Visit" stated "... Cardiovascular assessment ... edema ... lower right ... lower left ... cough ... son [name] wants to get a UA [urinalysis lab test] to rule out a UTI ...." Review of an additional document dated 10/2/2020, titled "Client Coordination Note Report" stated "... Went back to patient home and obtained a urine sample. Dropped sample off ...." Review of a document dated 10/14/2020, titled "Visit Note Report ... SN Subsequent Visit" stated "... Cardiovascular assessment ... edema ... lower right ... lower left ... cough ... confused ....", and evidenced no care coordination with a nurse/clinical manager or physician occurred for care coordination regarding the patient's edema, cough, confusion, or urinalysis follow up, and stated "... care coordination ... NO ...." Review of a document received on 3/1/2021, (not part of patient's agency clinical record) dated and signed by physician N on 10/20/2020, titled "Physician New Clinic Note" stated "... I [physician N] reviewed patient's urine culture from 2 days ago showing a Pseudomonas infection that is resistant to oral antibiotics ... I will send him down to the emergency room where he will likely benefit from an admission and treatment for urosepsis ...." During an interview on 3/1/2021 at 11:04 AM, the patient's family indicated the reason the patient was discharged in October (2020), was due to hospitalization for a bad infection, he required IV [intravenous] antibiotics, then went to a skilled nursing facility for rehab, and when he got out, they (home health agency) wouldn't see him again		record and was unable to verify noncompliance with ordered visit frequency as cited by surveyor. ·Skilled Nursing frequency at start of episode was 1wk1, 2wk8 per signed 485-plan of treatment. ·Order obtained and documented in clinical record on 2/26/2020 changed skilled nursing frequency to "Effective 2/23/2020: 2wk1, 1wk5". ·Surveyor noted only 1 skilled nursing visit was performed in week of 3/08/2020. This is correct and in compliance with the with physician order dated 2/26/2020. ·Agency reviewed clinical record and verified noncompliance with frequency and ordered dates of PT/INR testing. ·Clinical manager involved in care coordination and oversight of this patient is no longer employed by agency preventing counselling and/or corrective action. ·Corrective action and 1:1 education related to compliance with physician orders to be completed with nursing staff involved in patient care. ·Education and corrective action to be completed by Administrator or designee by May 27, 2021. ·Patient was discharged from agency services on	

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	because of their caseload. He also indicated the patient had recurrent UTIs, and whenever he got a UTI, he got very confused. Finally, he indicated the patient had a pacemaker, and stated "Yes, left side ....", indicated it paced at 70 bpm (beats per minute), it was inserted about a year ago or two, about 8 years left on a 10 year battery, it was checked every 6 months, and he took him to an outpatient facility for the checks. During an interview on 3/2/2021 at 2:30 PM, the administrator/clinical manager indicated the agency didn't usually call for lab results, the lab faxed them to the agency if they were critical, the agency has identified a problem with UTIs, and lack of care coordination. RN B indicated she didn't see follow up for UA [urinalysis] results or for pacemaker in the patient's record. 17-13-1(a)(2)		3/19/2020 ·Clinical record #11 ·Agency reviewed chart and was unable to verify noncompliance as cited by surveyor. ·Documentation supports compliance with PT visit frequency of 1wk1, 2wk3 as evidenced by completed home visits or appropriately documented missed visits and documentation of timely physician notification of missed visits matching this frequency. ·One missed visit was noted in record. PTA visit on 8/16/2016 was attempted but refused by the patient. A missed visit note was appropriately entered in the medical record which documented the reason as "patient refusal". This note was faxed to the ordering physician as notification on 8/17/2016. ·Patient was discharged from agency services on 9/16/2016 ·Clinical record #14: ·Agency was unaware of assessment deficits in chart #14 until following receipt of the survey findings on April 28, 2021. ·Patient was discharged from services on 3/23/2021. ·Agency has reviewed the clinical record and confirmed the finding as indicated by surveyor of a missed visit note entered by home health aide on 2/12/2021 with reason for missed visits	

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			stated as "scheduling conflict". ·Agency observed that ordered home health aide frequency was met by completion of in-home visits or documentation of missed visits with appropriate physician notification of missed visits. ·Agency provided education to all clinical staff regarding precise documentation of reasons for missed visit including avoidance of selecting "scheduling conflict" from EMR "missed visit reason" options without providing additional detail sufficient to demonstrate that visit was not missed due to agency or clinician reasons but only if patient or caregiver reported a scheduling conflict and declined/refused attempts to reschedule. ·Education was completed by Administrator or designee on May 18, 2021. ·Patient was discharged from agency services on 3/23/2021 ·Clinical record #16 ·Agency reviewed clinical record and confirmed the findings as indicated by surveyor. ·A home health aide visit in week 2 was missed but no appropriate missed visit note was entered and no physician notification of the missed visit is evidenced in the clinical record. ·Agency to provide	

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			1:1 education with the home health aide ·Education to be completed by Administrator or designee by May 27, 2021. ·Clinical manager will ensure appropriate documentation and physician/provider notification of all missed visits is evident in all charts. ·Skilled nursing visit frequency on 485-Plan of Treatment listed as "2wk1, 1wk3…." however plotted/planned visit frequency was noted to be "1wk4". Agency leadership reviewed clinical record and identified a charting error was made when visit frequency was manually written on 485 resulting in ordered frequency exceeding that plotted and assigned to clinician. ·Agency to provide 1:1 education to skilled nurse related to compliance with physician orders including reviewing ordered frequency and reporting and correcting errors appropriately. ·Education to be completed by Administrator or designee by May 27, 2021. **Person Responsible:**	

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			Administrator **Date of Completion:** May 27, 2021 **Compliance:** ·Beginning May 14, 2021, 100% of admissions, resumptions of care, and recertifications and discharges will be audited weekly to ensure compliance with this standard. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the admissions, resumption of care, and recertifications and discharges for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	

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G 0606 Bldg. 00	484.60(d)(3) Integrate all services Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on observation, record review and interview, the home health agency failed to coordinate care amongst the different disciplines/entities that provided care to the agency's patients for 6 of 15 records reviewed (#1, 3, 6, 7, 8, 9). The findings include: 1. Review of an agency policy, with an approval/reviewed date of 4/2020 titled "Care Management and the Plan of Care" stated "... Agency staff maintain liaison among disciplines to ensure that coordinated care is provided and supports the objectives in the plan of care ... regularly coordinates patient care activities with the physician and/or other members of the health care team and documents communications ... also shares and receives patient information with other providers of care, treatment or services ...." 2. Record review for patient #1 was completed on 2/10/2021 and again on 3/2/2021, start of care date 4/7/2020, primary diagnosis encounter for attention to cystostomy (suprapubic catheter- an opening in the lower abdomen where a tube is	G 0606	N 484 410 IAC 17-12-2(g) 17-13-1(a)(2) **G606 Integrate all services CFR(s)484.60(d)(3)** **Plan:** ·All clinical staff received education by the Administrator regarding the requirement for coordination and communication between all disciplines providing care to assure identification of patient needs and factors that could affect patient safety and treatment effectiveness in accordance with the Care Management and the Plan of Care policy during verbal staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Follow up in-service education was conducted by the Administrator or designee by May 13, 2021 for the clinical and home health aide staff. This training included, but was not limited to: ·Review of the agency Care	05/27/2021

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	inserted directly into the bladder for drainage of urine). Review of a document titled "Home Health Certification and Plan of Care" for certification period 12/3/2020 - 1/31/2021 indicated skilled nursing services (effective 12/13/2020) once every 2 weeks for two weeks, then once every 4 weeks for 4 weeks, and 2 PRN (as needed) visits for bleeding, cardiac, catheter issues, diabetic, falls, pain, respiratory, or skin breakdown. The clinical record evidenced the patient developed open wound(s) on 1/5/2021, an order for wound care was received on 1/7/2021, and no wound care was performed during a nursing visit on 1/11/2021. Review of a document dated 1/5/2021, titled "Client Coordination Note Report" evidenced new wounds were identified, and stated "... Stage 2 pressure sores each side of sacrum ...." Review of a document dated and signed by the administrator/clinical manager 1/7/2021, titled "Physician Order" stated "... SN [skilled nurse] to perform/teach wound care to client/caregiver. Cleanse left buttock wound with normal saline or wound cleanser, cover with duoderm bordered dressing on M/W/PRN [Monday/ Wednesday/as needed] , all other days by client/caregiver ...." Review of a document signed and dated 1/11/2021 by LPN [licensed practical nurse] K titled "Visit Note Report ... SN Subsequent Visit" stated "... Wound care not provided: awaiting orders ...." During an interview on 2/10/2021 at 12:40 PM, the administrator/clinical manager indicated it was clear the nurse did not review the record/order prior to her visit, and stated "Yeah, there's no coordination from RN [registered nurse] to LPN		Management and the Plan of Care policies. ·The case conferencing documentation process and the requirement for regular communication between all disciplines providing care, LPN communication to the RN, and reporting/communicating changes in patient status and symptoms. ·LPNs will be instructed to document coordination with the RN case manager following each visit. The RN case manager and Clinical Manager will ensure that follow up visits to address reported changes in patient status will be completed by an RN. LPNs will be supervised in accordance with Agency policy. ·Follow up in-service education will be provided to all clinical staff by the Administrator or designee by May 27, 2021. This training will include, but not be limited to: ·Integration of services, coordination of care with other members of interdisciplinary clinical team and with external entities, including physicians, who are providing services to the patient. ·Appropriate coordination of care and communication related to delegation to and supervision of LPN's, Therapy Assistants, and home health aides. ·Reporting of adverse patient events and appropriate follow up. ·Methods and performance of	

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	for wound orders." RN B (Performance Improvement/PI Manager and Educator) and administrator/clinical manager agreed there was an issue with interdisciplinary communication. PT [physical therapist] A (Clinical Manager) also indicated it was a problem. 3. Record review for patient #3 was completed on 2/22/2021 and again on 3/2/2021, start of care date 10/10/2020, primary diagnosis urinary tract infection (UTI),site not specified, and other pertinent (but not limited to) diagnoses of cerebral palsy, morbid (severe) obesity, epilepsy, history of falling, and pacemaker. Review of a document titled "Home Health Certification and Plan of Care" for certification period 2/7/2021- 4/7/2021, indicated the patient received skilled nursing, PT services, and home health aide. The clinical record evidenced the patient was hospitalized in observation status 2/11/2021 - 2/14/2021. Review of a document dated 2/9/2021, titled "Visit Note Report ... SN Subsequent Visit" evidenced the nurse performed an aide supervisory visit, but there were no aide visits made. Review of a document dated 2/14/2021, titled "Discharge Summary" from hospital M, indicated medications including (but not limited to) Centrum Silver Men's oral tablet daily after breakfast, Docusate sodium (colace) 100mg (milligrams) twice daily after breakfast and dinner, and furosemide 40mg, 0.5 tab (20mg) daily after breakfast were prescribed. Review of a document dated 2/15/2021, titled "Visit Note Report ... PT Subsequent Visit" indicated no medication changes were identified,		formal and informal care coordination with interdisciplinary team members and outside entities who provide services to patients, and documentation of care coordination activities. ·Additional in-service education and corrective action will be conducted by the Administrator or designee by May 27, 2021 as described in the "specific action for clinical records" section that follows. ·Education will be provided through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The Clinical Manager or designee will review all active patient records to ensure evidence of documentation of communication from interdisciplinary team members to the RN Case Manager and other team members regarding changes in patient status. ·The Clinical Manager will conduct regular case conferences and case review with primary clinicians on a regular basis, ensuring input from all active disciplines is gathered, to ensure there is evidence of communication from interdisciplinary team members to the RN Case Manager and other team members regarding changes	

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	the patient sustained a fall on 2/14/2021, and failed to evidence care coordination with an RN/Clinical Supervisor for post-hospitalization medication reconciliation or report of fall. During an interview on 2/22/2021 at 1:24 PM, the administrator/clinical manager indicated no home health aide visits had been made as ordered, and RN B indicated there wasn't follow up with a nurse for the fall. During an interview on 3/2/2021 at 2:30 PM, the administrator/clinical manager indicated she didn't see a medication reconciliation was completed after the patient returned home from the hospital on 2/14/2021, and agreed the medications listed in the EMR (electronic medical record) were not updated to match the medication changes on the hospital discharge documents. 4. Record review for patient #6 was completed on 2/26/2021 and again on 3/2/2021, start of care date 1/31/2021, for certification period 1/31/2021 - 3/31/2021, which evidenced the patient received skilled nursing services for NPWT (negative pressure wound therapy), and was seen by wound clinic A every Thursday. During a home visit on 2/23/2021 at 10:00 AM, review of the patient's home folder evidenced a document from wound clinic A dated 2/18/2021, titled "Physician Orders". The document evidenced wound care orders to the left leg which included (but was not limited to), the placement of adaptic (vaseline impregnated gauze) to the wound bed (to prevent the foam dressing from sticking the the wound bed), and zinc (protective barrier cream) to red areas (on the surrounding skin). During observation of wound care, the nurse failed to apply adaptic to the wound bed,		in patient status and to ensure appropriate and timely coordination of care with outside health entities who provide service to agency patents. **·Specific action taken for clinical records #1, #3, #6, #7, #8 and #9:** ·Agency action to mitigate and resolve noted deficiencies in individual client records was limited in some cases due to discharge of patient prior to or shortly after survey exit interview as well as due to agency was not provided with chart/patient identifiers or information regarding identified deficits at time of survey exit. ·Clinical record #1 ·Agency reviewed clinical record and was able to verify noncompliance with coordination between RN and LPN as cited by surveyor. ·Education to be completed by Administrator or designee by May 27, 2021. ·Counselling and 1:1 education related to coordination between RN and LPN to be completed with nursing staff involved in patient care. ·Education to all clinical staff on coordination of services and communication between clinicians including delegation to LPN's to be provided. ·Patient was discharged from agency services on	

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	and failed to apply zinc to the red areas. After wound care was completed, the nurse reviewed the EMR, indicated she made an error, she didn't apply the adaptic prior to the application of foam, and the agency got the order yesterday (2/22/2021). Review of a document dated 2/20/2021, titled "Visit Note Report ... SN Subsequent Visit" failed to evidence the nurse applied adaptic to the wound bed prior to the application of the foam, and failed to apply zinc to the red areas as indicated in the physician order. During an interview on 2/24/2021 at 11:18 AM, the administrator/clinical manager agreed the current wound care order dated 2/18/2021, was in the home folder (readily accessible to nurses prior to providing wound care), and the agency failed to coordinate wound care treatment orders for skilled nurse visits 2/20/2021 and 2/23/2021. 5. A home visit of patient #7 was observed on 2/23/2021 at 1:50 PM, start of care date 1/22/2021, for certification period 1/22/2021 - 3/22/2021. The patient received physical and occupational therapy services, and skilled nursing services was ordered on 2/18/2021, for wounds. The patient's primary diagnosis was COVID-19, and other diagnoses, which included (but was not limited to), pneumonia due to COVID-19, acute respiratory failure with hypoxia (deprivation of oxygen), acute on chronic systolic (congestive) heart failure, obstructive sleep apnea, type 2 diabetes with diabetic chronic kidney disease, non-ST elevation (NSTEMI) myocardial infarction (heart attack), constipation, long term (current) use of aspirin, and long term (current) use of anticoagulants.		3/10/2021 ·Clinical record #3 ·Agency reviewed clinical record and was able to verify noncompliance with integration and coordination of services as cited by surveyor. ·Education to be completed by Administrator or designee by May 27, 2021. ·1:1 education and counselling related to integration of services and appropriate supervision of home health aide services and staff to be completed with nursing staff involved in patient care. ·Corrective action and 1:1 education with Physical Therapist who performed 2/15/21 visit post-hospitalization regarding appropriate reporting and follow-up actions in response to adverse events such as falls. ·Education to all clinical staff to be provided including: ·Coordination and integration of services and delegation to and supervision of home health aide staff to be provided. ·Reporting of adverse patient events and appropriate follow up. ·Education to Clinical Manager regarding appropriate action and documentation required if unable to provide services as requested and/or ordered.	

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	Record review completed on 2/24/2021, and again on 3/2/2021, evidenced a document dated 1/22/2021, by PT X titled "Visit Note Report" which stated "... Visit Type: ... PT OASIS [Outcome and Assessment Information Set] Admission" evidenced the patient had no pain, and failed to evidence any lower extremity edema, skin breakdown or open skin area(s). Review of a document dated 2/4/2021, titled "Visit Note Report ... PT Subsequent Visit" evidenced medication changes were identified during the visit, failed to evidence what medications(s) were changed, and evidenced no care coordination with a nurse/clinical manager or physician occurred, and stated "... care coordination ... NO ...." Review of a document dated 2/6/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced medication changes were identified during the visit, failed to evidence what medications(s) were changed, and evidenced no care coordination with a nurse/clinical manager or physician occurred, and stated "... care coordination ... NO ...." Review of a document dated 2/8/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had bilateral lower extremity edema (swelling), and evidenced no care coordination with a nurse/clinical manager or physician occurred, and stated "... care coordination ... NO ...." Review of a document dated 2/11/2021 titled "Visit Note Report ... OT Add-On Evaluation" evidenced the patient complained of fatigue and shortness of breath with exertion, mild foot pain (no complaint of pain prior to this visit per record review), the		·Agency implemented process to require reassessment and medication reconciliation by appropriately licensed clinical staff with appropriate care coordination following hospital observation stays. ·Education was provided to all clinical staff by Administrator or designee by May 13, 2021. ·Clinical manager to formally notify the ordering physician by May 27, 2021 of agency failure to provide home health aide services as ordered on 485-Plan of Treatment and document this notification in the clinical record. ·Clinical manager to enter late entry documentation (labeled as such appropriately) describing the communication to patient and caregiver regarding unavailability of aide services and appropriate offer to transfer care to another provider. ·Clinical record #6 ·Agency reviewed clinical record and was able to verify noncompliance with integration and coordination of services as cited by surveyor. ·Education to be provided to all clinical staff by Administrator or designee by May 27, 2021. ·Coordination and integration of services including with other members of interdisciplinary clinical team and	

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	patient stated "... Feels like skin is stretching [describing his pain] ....", red areas were assessed on skin (patient explained it was an allergic reaction to lotion), and evidenced no care coordination with a nurse/clinical manager or physician occurred. to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/12/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had weeping edema to both lower extremities, medication changes were identified during the visit, a medication reconciliation was performed, failed to evidence what medications(s) were changed, and evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/16/2021 titled "Visit Note Report ... OT Subsequent Visit" evidenced the patient's pain was described as "burning ... stabbing", rated from 5-7 (on a pain scale 0-10, with 0 being no pain, and 10 being the most severe), pain was located to the right foot, 2nd and 3rd toes, patient was weak and unsteady, and evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/18/2021 titled "Visit Note Report ... OT Subsequent Visit" evidenced the patient was seen in the emergency department on 2/17/2021 for complaint of intractable pain in legs (10/10), legs seeping, and was given antibiotics for infection in legs per patient report. Coordination did occur this visit with RN clinical manager to request a nurse.		with external entities, including physicians, who are providing services to the patient. ·Clinical record #7 ·A full and comprehensive assessment was performed with patient on 3/14/2021 and documented in a Resumption of Care OASIS on this same date. Record review by agency leadership confirms assessment included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment. ·Subsequent comprehensive assessments were completed on 3/22/2021 (Recertification OASIS documented) and at Discharge on 5/08/2021. The patient's plan of care was also updated in conjunction with the recertification assessment performed on 3/22/2021. ·Interdisciplinary case conferences were completed with input/participation from all active, treating disciplines to review patient's condition and plan of care on 4/06/2021 and 5/06/2021. ·Education to be provided to all clinical staff by the Administrator or designee by May 27th, 2021 to include: ·Formal and informal care coordination with interdisciplinary team members	

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	Review of a document dated 2/18/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient was seen in the emergency department on 2/17/2021 (via ambulance) for bilateral lower extremity weeping edema, blisters on right foot 2nd toe, and had a new antibiotic. The document stated "... The dressing was soaked totally and needed to be replaced, PT recommended to request daughter to replace soaked dressing when she gets home ...." The document evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/19/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had weeping edema to both lower extremities, failed to evidence the integrity of the dressings/bandages, evidenced the patient had pain 8/10 on pain scale, and pain to touch. The document evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." During an interview on 2/24/2021 at 11:27 AM family stated they called 911 about "10 minutes ago [2/24/2021]" for chest pain, and stated "... [chest pain] It's been off and on since he got home from the hospital ...." She also indicated he got up this morning, he wasn't feeling good, he (patient) "... took like 6 nitros [nitroglycerin for chest pain] no relief." She also indicated he was coughing quite a bit after the nurse left yesterday (2/23/2021), and he didn't have a good night. When asked if the patient complained of pain since he came home from the hospital prior to the initiation of home health services (start of care), she stated "Yes. His feet, he never feels good. So		and outside entities, and documentation of care coordination activities. ·The Clinical Manager will conduct regular case conferences and case review with primary clinicians on a regular basis to ensure adequate care coordination with the interdisciplinary team members and outside entities, and to ensure documentation of care coordination activities completed during case conferences. ·Patient was discharged from agency services on 5/08/2021 ·Clinical record #8 ·Agency reviewed clinical record and was able to verify noncompliance with care coordination as cited by surveyor. ·Education to be completed by Administrator or designee by May 27, 2021. ·Education to all clinical staff on performance and documentation of coordination of services to be provided as described above. ·1:1 education clinical nursing staff involved in care of this patient not possible as all involved nurses no longer employed by the agency. ·Patient was discharged from agency services on 6/20/2016 ·Clinical record #9 ·Education to be completed by Administrator or	

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	much pain." The patient was subsequently seen in the emergency department on 2/17/2021 for swelling, draining, and intractable pain in both legs, and was prescribed antibiotics. He was seen in the emergency room again on 2/24/2021 and was admitted with complaint of shortness of breath, heart failure, and chest pain. He remained hospitalized upon survey exit. 6. Record review for patient #8 was completed on 2/24/2021 and again on 3/2/2021, start of care date 6/11/2016, primary diagnosis quadriplegia (paralyzed from the neck down), unspecified, and other pertinent (but not limited to) diagnoses of, pressure ulcer left buttock, rheumatoid arthritis, depression, anxiety, tobacco use, and diabetes. Review of the document titled "Home Health Certification and Plan of Care" for certification period 6/11/2016 - 8/9/2016, indicated (but was not limited to) skilled nursing orders for wound care 3 times per week, foley catheter changes, patient/caregiver teaching related to wound care, management of health conditions, and caregiver was to provide wound care on non-nursing visit days. Review of a document dated 6/13/2016, titled ""Visit Note Report ... SN Subsequent Visit" stated "... Usual blood sugar readings: "200 to 300 Am fasting. Some times [sic] over 500 late in the day...." and evidenced the wound on the right upper buttock was worse, a new wound on the left posterior lower buttock, a new wound on the sacrum, a stool sample was obtained, and evidenced no care coordination with a nurse/clinical manager or physician occurred to report high blood sugar readings and worsening/new wounds. This document stated "... care coordination ... not applicable ...."		designee by May 27, 2021. ·Education to all clinical staff on performance and documentation of coordination of services to be provided as described above. ·The Clinical Manager will conduct regular case conferences and case review with primary clinicians on a regular basis to ensure adequate care coordination with the interdisciplinary team members and outside entities, and to ensure documentation of care coordination activities completed during case conferences. ·Process for reporting and monitoring lab results to be implemented as described above. ·Patient was discharged from agency services on 10/14/2020 **Person Responsible:** Administrator **Date of Completion:** May 27, 2021 **Compliance:** ·Beginning May 14, 2021, 100% of admissions, resumptions of care, and recertifications will be audited weekly to ensure compliance with this standard. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the admissions, resumption of care, and recertifications for 3 months or	

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	Review of a document dated on 6/20/2016, titled "Visit Note Report ... SN Subsequent Visit - As Needed" evidenced the visit was for patient complaint of occluded urinary catheter, urine was dark amber colored, and stated "... Upon arrival after milking foley urine flowed free ...." The document failed to evidence coordination with a nurse/clinical manager or physician for signs of UTI (urinary tract infection) such as dark colored urine and occluded catheter, and stated "... care coordination ... NO ...." 7. Record review for patient #9 was completed on 3/2/2021, start of care date 7/23/2020, evidenced a document titled "Home Health Certification and Plan of Care" for dates 9/21/2020 - 11/19/2020, with primary diagnosis encounter for attention to cystsostomy (urinary drainage tube), other pertinent diagnoses including (but not limited to), laceration without foreign body of left upper arm, diabetes, heart failure, and indicated the patient received skilled nursing services. Review of a document titled "Home Health Certification and Plan of Care" for certification period 9/21/2020 - 11/19/2020 failed to evidence the presence of a cardiac pacemaker. Review of a document dated 9/22/2020 titled "Visit Note Report ... RN Recert with Skill" stated "... Cardiovascular assessment ... WNL [within normal limits] ... indwelling/suprapubic catheter ... leaking from penis ... mental status ... WNL ... alert ... oriented to person ... oriented to place ... forgetful ..." The document failed to evidence presence of a cardiac pacemaker. Review of a document dated 9/25/2020 titled "Visit Note Report ... SN Subsequent Visit" stated "... Cardiovascular assessment ... pacemaker ... Indicate type of pacemaker and rate ... unknown		until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	...", evidenced purulent (indicative of infection) drainage from arm wound, and evidenced no care coordination with a nurse/clinical manager or physician occurred for care coordination regarding the patient's pacemaker and purulent drainage, and stated "... care coordination ... NO ...." Review of a document dated 9/29/2020 titled "Visit Note Report ... SN Subsequent Visit" evidenced urine was dark amber color, the patient was confused, and evidenced no care coordination with a nurse/clinical manager or physician occurred for care coordination regarding the patient's signs and symptoms of UTI (dark amber color urine, confusion), and stated "... care coordination ... NO ...." Review of a document dated 10/2/2020, titled "Client Coordination Note Report" stated "... Son expressed concerned [sic] that patient has come down with a UTI due to increased confusion and hallucinations ...." Review of a document dated 10/2/2020 titled "Visit Note Report ... SN Subsequent Visit" stated "... Cardiovascular assessment ... edema ... lower right ... lower left ... cough ... son [name] wants to get a UA [urinalysis lab test] to rule out a UTI ...." Review of an additional document dated 10/2/2020, titled "Client Coordination Note Report" stated "... Went back to patient home and obtained a urine sample. Dropped sample off ...." Review of a document dated 10/14/2020, titled "Visit Note Report ... SN Subsequent Visit" stated "... Cardiovascular assessment ... edema ... lower right ... lower left ... cough ... confused ....", and evidenced no care coordination with a			

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	157005	A. BUILDING 00 B. WING	03/02/2021

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SAINT JOSEPH VNA HOME CARE	3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545

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	nurse/clinical manager or physician occurred for care coordination regarding the patient's edema, cough, confusion, or urinalysis follow up, and stated "... care coordination ... NO ...." Review of a document received on 3/1/2021, (not part of patient's agency clinical record) dated and signed by physician N on 10/20/2020, titled "Physician New Clinic Note" stated "... I [physician N] reviewed patient's urine culture from 2 days ago showing a Pseudomonas infection that is resistant to oral antibiotics ... I will send him down to the emergency room where he will likely benefit from an admission and treatment for urosepsis ...." During an interview on 3/1/2021 at 11:04 AM, the patient's family indicated the reason the patient was discharged in October (2020), was due to hospitalization for a bad infection, he required IV [intravenous] antibiotics, then went to a skilled nursing facility for rehab, and when he got out, they (home health agency) wouldn't see him again because of their caseload. He also indicated the patient had recurrent UTIs, and whenever he got a UTI, he got very confused. Finally, he indicated the patient had a pacemaker, and stated "Yes, left side ....", indicated it paced at 70 bpm (beats per minute), it was inserted about a year ago or two, about 8 years left on a 10 year battery, it was checked every 6 months, and he took him to an outpatient facility for the checks. During an interview on 3/2/2021 at 2:30 PM, the administrator/clinical manager indicated the agency didn't usually call for lab results, the lab faxed them to the agency if they were critical, the agency has identified a problem with UTIs, and lack of care coordination. RN B indicated she didn't see follow up for UA [urinalysis] results or			

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	for pacemaker in the patient's record. 17-12-2(g) 17-12-2(h)			
G 0614 Bldg. 00	484.60(e)(1) Visit schedule Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review and interview, the agency failed to ensure that all patients received written visit schedules, which included the frequency of visits by all agency staff assigned to the patients for 5 of 7 home visits observed (#1, 5, 6, 7, 13). The findings include: 1. Review of an agency policy, with an approval/review date of 4/2020, titled "2.1 Patient Rights and Responsibilities" stated "... the patient is informed both verbally and in writing of all rights including: ... the types (disciplines) of the caregivers who will furnish the care and the frequency of the visits ...." 2. A home visit of patient #1 was observed on 2/11/2021 at 10:00 AM, start of care date 4/7/2020, and primary diagnosis of encounter for attention to cystostomy (suprapubic catheter - an opening in the lower abdomen where a tube is inserted directly into the bladder for urine drainage). The patient received skilled nursing services. Agency staff, patient and family were unable to locate the patient's home folder. The patient indicated he knew when staff was coming by when they called him the night before, and he didn't have a schedule.	G 0614	17-12-2(g) 17-12-2(h)**G614 Visit schedule CFR(s)484.60(e)(1)** **Plan:** ·All clinical staff received education by the Administrator regarding the requirement to ensure all patients receive a written visit schedule to be left in their home upon admission and updated with any changes, which includes the frequency of visits by all agency staff and the Patient Rights and Responsibilities policy in their admission booklet left in the home, during verbal staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Follow up inservice education will be conducted by the Administrator or designee by May 13, 2021 for the Clinical Managers and clinical staff. This training will include, but not be limited to the following: ·Review of the agency Patient Rights and Responsibilities policy. ·The process for providing	05/27/2021

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	3. A home visit of patient #5 was observed on 2/23/2021 at 12:30 PM, start of care date 1/26/2021, and primary diagnosis of hypertensive heart disease with heart failure (a heart condition caused by high blood pressure). The patient's home folder failed to evidence a written visit schedule. The patient received skilled nursing and physical therapy services. 4. A home visit of patient #6 was observed on 2/23/2021 at 10:00 AM, start of care date 1/31/2021, and primary diagnosis of cellulitis (an infection of the skin and deep underlying tissues) of left lower limb. The patient received skilled nursing services. The patient's home folder failed to evidence a written visit schedule. 5. A home visit of patient #7 was observed on 2/23/2021 at 1:50 PM , start of care date 1/22/2021, and primary diagnosis of COVID-19. The patient received physical and occupational therapy services, and skilled nursing services was ordered on 2/18/2021 . The patient's home folder failed to evidence a written visit schedule. When asked if he knew when agency staff was scheduled to visit, the patient stated "... Yeah, whenever they feel like coming ...." He indicated he didn't like that he never knew when the physical therapist was going to come, and stated "... he switched his schedule and never showed ...." He also indicated he thought a nurse was supposed to be coming since he got home from the hospital, and stated "... [he] finally saw a nurse last week [week of 2/14/2021] for the first time." 6. A home visit of patient #13 was observed on 2/25/2021 at 1:50 PM , start of care date 1/22/2021, and primary diagnosis of displ intertroch fx L femur, subs for clos fx w routn heal (left hip fracture which required surgical intervention). The		and updating the written visit schedule for patients by all professional disciplines and home health aide staff in the home. ·The process for documentation in the clinical record that required written patient information is provided on admission in accordance with 484,60(e). ·Education will be provided through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The RN/Therapy Case Managers initiated a home visit validation process for active patients and new admissions to ensure that all required patient information in accordance with 484.60(e) is present in each patient's home on 5/10/21. **Person Responsible:** Clinical Manager **Date of Completion:** May 13, 2021 **Compliance:** ·Beginning the week of May 10, 2021, three (3) home supervisory visits will be made weekly to validate compliance with the standard. The supervisory visits will be performed by the Clinical Manager or designee. Weekly home visit validations will continue until 100% compliance is reached	

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	patient received physical and occupational therapy services, skilled nursing and home health aide services were ordered on 2/22/2021. The patient's home folder failed to evidence a written visit schedule.		for 4 consecutive weeks. ·Once met, three (3) home visit validations will be performed by the Clinical Manager or designee monthly until 100% compliance for 3 consecutive months. ·Once the threshold is met, three (3) home visit validations will be performed by the Clinical Manager or designee completed quarterly. ·If the threshold is not reached, the Administrator will ensure additional training for individual staff and continue weekly supervisory visits until the threshold is met. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	
G 0616 Bldg. 00	484.60(e)(2) Patient medication schedule/instructions Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review and interview, the agency failed to ensure that all patients had current/updated written medication schedule/instructions prepared by agency staff in the home for 5 of 7 home visits observed (#1, 5, 6, 7, 13,).	G 0616	17-14-1(a)(1)(B)CONDITION LEVEL G570 Care planning, coordination, and quality of care CFR(s)484.60 Refer to:	05/27/2021

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	Findings include: 1. Review of an agency policy approval/review date 4/2020 titled "2.1 Patient Rights and Responsibilities" stated "... the patient is informed both verbally and in writing of all rights including: ... treatment [i.e. medications] or services...." 2. A home visit of patient #1 was observed on 2/11/2021 at 10:00 AM, start of care date 4/7/2020, and primary diagnosis of encounter for attention to cystostomy (suprapubic catheter - an opening in the lower abdomen where a tube is inserted directly into the bladder for urine drainage). The patient received skilled nursing services. Agency staff, patient and family unable to locate the patient's home folder. The patient indicated he didn't know what medications he took. There failed to be evidence of a medication schedule provided by the home health agency in the patient's home. Record review for patient #1 that was completed on 2/1/2021, evidenced a document dated 1/7/2021, titled "Client Coordination Note Report", which stated "... Medication reconciliation not done today as daughter was not in home and patient doesn't [sic] k ow [sic] where list or meds are ...." 3. A home visit of patient #5 was observed on 2/23/2021 at 12:30 PM, start of care date 1/26/2021, and primary diagnosis of hypertensive heart disease with heart failure (a heart condition caused by high blood pressure). The patient received skilled nursing and physical therapy services. The patient's home folder failed to evidence a medication schedule/instructions prepared by agency staff. The patient indicated she used the list the hospital gave her upon		·G578 Conformance with physician orders ·G590 promptly alert relevant physician of changes CFR(s)484.60(c)(1) ·G606 Integrate all services CFR(s)484.60(d)(3) ·G614 Visit schedule CFR(s)484.60(e)(1) ·G616 Patient medication schedule/instructions CFR(s)484.60(e)(2) ·G618 Treatments and therapy services CFR(s)484.60(e)(3) 17-14-1(a)(1)(H) 17-12-2(g) 17-12-2(h) G578 Conformance with physician orders Plan: **G616 Patient medication schedule/instructions CFR(s)484.60(e)(2)** **Plan:** ·All clinical staff received education by the Administrator regarding the requirement to ensure all patients received a current medication schedule/instructions left in their home, including: medication name, dosage and frequency and	

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	discharge for reference. 4. A home visit of patient #6 was observed on 2/23/2021 at 10:00 AM, start of care date 1/31/2021, and primary diagnosis of cellulitis (an infection of the skin and deep underlying tissues) of left lower limb. The patient received skilled nursing services. The patient's home folder failed to evidence a medication schedule/instructions prepared by agency staff. 5. A home visit of patient #7 was observed on 2/23/2021 at 1:50 PM , start of care date 1/22/2021, and primary diagnosis of COVID-19. The patient received physical and occupational therapy services, and skilled nursing services was ordered on 2/18/2021 . The patient's home folder failed to evidence a medication schedule/instructions prepared by agency staff. 6. A home visit of patient #13 was observed on 2/25/2021 at 1:50 PM , start of care date 1/22/2021, and primary diagnosis of displ intertroch fx L femur, subs for clos fx w routn heal (left hip fracture which required surgical intervention). The patient received physical and occupational therapy services, skilled nursing and home health aide services were ordered on 2/22/2021. The patient's home folder failed to evidence a medication schedule/instructions prepared by agency staff.		which medications will be administered by Agency personnel and personnel acting on behalf of the Agency. Medication record to be updated in the home on every visit per visiting clinician. Also, the Patient Rights and Responsibilities policy during verbal staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Follow up inservice education will be conducted by the Administrator or designee by May 13, 2021 for the Clinical Managers and clinical staff. This training will include, but not be limited to the following: ·Review of the agency Patient Rights and Responsibilities policy. ·The process for providing and updating the medication list and schedule for patients by the RN/Therapy case manager to include medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by Agency personnel and personnel acting on behalf of the Agency. This medication list will be left in the patient's home and updated with each agency visit. ·The process for conducting medication reconciliation during each RN/Therapy case manager visit to ensure the medication	

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			profile, physician orders and medication list/schedule provided to the patient is current in their home, complete and reflects any changes, and the patient received instructions regarding new/changed medications. ·The process for RN review and reconciliation of medications, performed by RN Clinical Manager, on all Therapy only cases at the time of SOC/ROC/SCIC/Recertification. ·The process for documentation in the clinical record that required written patient information is provided on admission in accordance with 484,60(e). ·Education will be provided through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The RN/Therapy Case Managers initiated a home visit validation process for active patients and new admissions to ensure that all required patient information in accordance with 484.60(e) is present in each patient's home, including current medication lists/schedules on 5/10/21. **Person Responsible:** Clinical Manager	

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			Date of Completion: May 13, 2021 **Compliance:** ·Beginning the week of May 10, 2021, three (3) home supervisory visits will be made weekly to validate compliance with the standard. The supervisory visits will be performed by the Clinical Manager or designee. Weekly home visit validations will continue until 100% compliance is reached for 4 consecutive weeks. ·Once met, three (3) home visit validations will be performed by the Clinical Manager or designee monthly until 100% compliance for 3 consecutive months. ·Once the threshold is met, three (3) home visit validations will be performed by the Clinical Manager or designee completed quarterly. ·If the threshold is not reached, the Administrator will ensure additional training for individual staff and continue weekly supervisory visits until the threshold is met. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	

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G 0618 Bldg. 00	484.60(e)(3) Treatments and therapy services Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation, record review and interview, the agency failed to ensure that all patients received a current/updated written plan of care for 5 of 7 home visits observed (#1, 5, 6, 7, 13,). The findings include: 1. Review of an agency policy, with an approval/review date of 4/2020, titled "2.1 Patient Rights and Responsibilities" stated "... the patient is informed both verbally and in writing of all rights including: ... the right to participate in planning care or treatment and in planning changes ... update the patient, representative caregivers ... when a change is being made ...." 2. Review of an agency policy, with an approval/review date of 4/2020, titled "Care Management and the Plan of Care" stated "... The clinician works closely with the client/caregiver, who participates in development and carrying out the plan of care and changes to the plan of care ...." 3. A home visit of patient #1 was observed on 2/11/2021 at 10:00 AM, start of care date 4/7/2020, and primary diagnosis of encounter for attention to cystostomy (suprapubic catheter - an opening in the lower abdomen where a tube is inserted directly into the bladder for urine drainage). The patient received skilled nursing services. Agency staff, patient and family were unable to locate the patient's home folder. The patient failed to have written information provided by the home health	G 0618	17-14-1(a)(1)(B)CONDITION LEVEL G570 Care planning, coordination, and quality of care CFR(s)484.60 Refer to: ·G578 Conformance with physician orders ·G590 promptly alert relevant physician of changes CFR(s)484.60(c)(1) ·G606 Integrate all services CFR(s)484.60(d)(3) ·G614 Visit schedule CFR(s)484.60(e)(1) ·G616 Patient medication schedule/instructions CFR(s)484.60(e)(2) ·G618 Treatments and therapy services CFR(s)484.60(e)(3) 17-14-1(a)(1)(H) 17-12-2(g) 17-12-2(h) G578 Conformance with physician orders Plan: .	05/27/2021

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	agency of any treatments they were to administer 4. A home visit of patient #5 was observed on 2/23/2021 at 12:30 PM, start of care date 1/26/2021, and primary diagnosis of hypertensive heart disease with heart failure (a heart condition caused by high blood pressure). The patient received skilled nursing and physical therapy services. The patient's home folder failed to evidence a current/updated plan of care which would include any treatments the agency was to administer. 5. A home visit of patient #6 was observed on 2/23/2021 at 10:00 AM, start of care date 1/31/2021, and primary diagnosis of cellulitis (an infection of the skin and deep underlying tissues) of left lower limb. The patient received skilled nursing services. The patient's home folder failed to evidence a a current/updated plan of care which would include any treatments the home health agency was to administer. 6. A home visit of patient #7 was observed on 2/23/2021 at 1:50 PM , start of care date 1/22/2021, and primary diagnosis of COVID-19. The patient received physical and occupational therapy services, and skilled nursing services was ordered on 2/18/2021 . The patient's home folder failed to evidence a current/updated plan of care, which would include any treatments the home health agency was to administer. . 7. A home visit of patient #13 was observed on 2/25/2021 at 1:50 PM , start of care date 1/22/2021, and primary diagnosis of displ intertroch fx L femur, subs for clos fx w routn heal (left hip fracture which required surgical intervention). The patient received physical and occupational therapy services, and skilled nursing and home		**G618 Treatments and therapy services CFR(s)484.60(e)(3)** **Plan:** ·All clinical staff received education by the Administrator regarding the requirement to ensure all patients received a written/updated plan of care including treatments to be administered by Agency personnel and personnel acting on behalf of the Agency, including therapy service during verbal staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. This plan of care will be left in the patient's home and updated upon change of plan of care/doctor's orders. ·Follow up inservice education will be conducted by the Administrator or designee by May 13, 2021 for the Clinical Managers and clinical staff. This training will include, but not be limited to the following: ·Review of the Patient Rights and Responsibilities and Care Management and Plan of Care policies. ·The process for providing and updating the written care plan to be left in the patient's home for patients by the RN/Therapy case manager to include treatments to be administered by Agency personnel and personnel acting on	

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	health aide services were ordered on 2/22/2021. The patient's home folder failed to evidence a a current/updated plan of care, which would include any treatments the home health agency was to administer. 8. During an interview on 2/12/2021 at 4:48 PM, OT [occupational therapist] F indicated the plans of care were mailed to the patients. 9. During an interview on 2/12/2021 at 5:41 PM, RN [registered nurse] G indicated he didn't know if a current/updated copy of the plan of care was in the patients' home folders. 10. During an interview on 3/2/2021 at 2:30 PM, the administrator indicated there was no proof the patients received their mailed plans of care, and agreed they were not evidenced in the home folders observed during home visits.		behalf of the Agency, including therapy services. The written care plan left in the patient's home will be updated according to change in care or based on physician orders. ·The process for documentation in the clinical record that required written patient information is provided on admission in accordance with 484,60(e). ·Education will be provided through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The RN/Therapy Case Managers initiated a home visit validation process for active patients and new admissions to ensure that all required patient information in accordance with 484.60(e) is present in each patient's home, including current medication lists/schedules on 5/10/21. **Person Responsible:** Clinical Manager **Date of Completion:** May 13, 2021 **Compliance:** ·Beginning the week of May 10, 2021, three (3) home supervisory visits will be made	

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			weekly to validate compliance with the standard of the plan of care is in the home and updated appropriately. The supervisory visits will be performed by the Clinical Manager or designee. Weekly home visit validations will continue until 100% compliance is reached for 4 consecutive weeks. ·Once met, three (3) home visit validations will be performed by the Clinical Manager or designee monthly until 100% compliance for 3 consecutive months. ·Once the threshold is met, three (3) home visit validations will be performed by the Clinical Manager or designee completed quarterly. ·If the threshold is not reached, the Administrator will ensure additional training for individual staff and continue weekly supervisory visits until the threshold is met. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings. ·Specific action taken for clinical records #1, #3, #6, #7, #8, #9, #10, #11, #14 and #16: ·Agency action to mitigate and resolve noted deficiencies in	

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			individual client records was limited in some cases due to discharge of patient prior to or shortly after survey exit interview as well as due to agency was not provided with chart/patient identifiers or information regarding identified deficits at time of survey exit. ·Clinical record #1 ·Agency reviewed clinical record and verified noncompliance with physician orders as cited by surveyor. ·Corrective action and 1:1 education related to compliance with physician orders to be completed by Administrator or designee with nursing staff involved in patient care by May 27, 2021. ·Patient was discharged from agency services on 3/10/2021 ·Clinical record #3 ·Agency reviewed clinical record and verified noncompliance with medication reconciliation. ·Corrective action and 1:1 education to occur with Physical Therapist who performed 2/15/21 visit post-hospitalization regarding medication reconciliation. ·Education and corrective action to be completed by Administrator or designee by May 27, 2021.	

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			·Agency process implemented to require medication reconciliation following hospital observation stays. ·Education was provided to all clinical staff by Administrator or designee by May 13, 2021. ·Clinical record #6 ·Agency reviewed clinical record and verified noncompliance with physician orders as cited by surveyor. ·Physician notification was made by agency RN and documented in clinical record on 2/23/2021 regarding agency failure to perform ordered wound care in compliance with order issued to patient on 2/18/2021 and faxed to agency on 2/22/2021. ·RN obtained and documented order from physician on 2/23/2021 approving wound care to be performed without the adaptic dressing to wound bed until the ordered adaptic dressing supplies arrived to patient home. ·Corrective action and 1:1 education related to compliance with physician orders to be completed with nursing staff involved in patient care. ·Education and corrective action to be completed by Administrator or designee by May 27, 2021. ·Clinical record #7 ·Agency reviewed clinical	

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			record: ·Confirmed deficient documentation as noted by surveyor. Physical therapist failed to document assessment of dressing integrity to bilateral lower extremities. ·Unable to verify noncompliance with physician's order for "PT to do dressing change elastic bandage to BLE if legs are soaked from weeping edema.." as clinical record lacks information regarding status of dressings on the 2/19/2021 visit cited. ·Education to be provided to physical therapist regarding compliance with physician's orders and appropriate assessment and documentation. ·Education to be completed by Administrator or designee by May 27, 2021. ·Patient was discharged from agency services on 5/08/2021 ·Clinical record #8 ·Agency reviewed clinical record and confirmed deficient documentation and noncompliance with physician orders as noted by surveyor. ·Agency RN failed to document that teaching was provided to patient and caregiver at the Start of Care visit for performance of wound care. ·Ordered intervention	

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			for wound care on the 485-Plan of Treatment indicates caregiver to perform dressing changes when "SN not available". On 6/13/2016 and 6/20/2016 skilled nursing notes indicate dressing change was not performed by skilled nursing due to the caregiver having already performed wound care. ·No evidence in chart of physician notification or request to update to wound care order to allow for caregiver to perform wound care on days that skilled nurse performed home visits. ·Agency reviewed clinical record and was unable to confirm noncompliance with physician orders for wound care as cited by surveyor regarding the issue below. ·On 6/20/16 visit note, RN responded to question "are wound care orders being followed" was answered "no" by RN. Question is located in the Supervisory functions section of skilled nursing visit note and refers to wound care that is performed by a supervised colleague such as an LPN/LVN or home health aide. ·Home health aide was not involved in or performed any wound care for this client. ·Education was provided to all clinical staff on compliance with physician orders as described in plan above. ·All clinical nursing	

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			staff involved in care of this patient are no longer employed by the agency preventing any 1:1 education or counselling from occurring. ·Patient was discharged from agency services on 6/20/2016 ·Clinical record #9 ·Agency reviewed chart and was unable to verify noncompliance as cited by surveyor but did identify charting issue which created appearance of noncompliance. ·Recert visit was performed late on 9/22/20. Physician was notified of delayed recert and order for 1 skilled nursing visit in week of 9/20/2020 to perform recertification was obtained and entered in clinical record on 9/21/2020. ·485-Plan of Treatment created by 9/22/20 recertification visit contains documentation of the ordered visit frequency subsequent to that visit with additional SNV in week of 9/20/2020 (for total of 2 SNV's completed week of 9/20/2020). ·Agency to provide education to all clinical staff regarding writing visit frequencies with adequate specificity including use of language to clarify when visits are being added to a Medicare week versus reflecting visits in same week already performed (Example: 1 Skilled	

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			Nursing visit week of 9/20/2020 for recertification" and "POC effective 9/22/2020: 1 additional visit week of 9/20 then ....". ·Education to be completed by Administrator or designee by May 27, 2021. ·Patient was discharged from agency services on 10/14/2020 ·Clinical record #10 ·Agency reviewed clinical record and was unable to verify noncompliance with ordered visit frequency as cited by surveyor. ·Skilled Nursing frequency at start of episode was 1wk1, 2wk8 per signed 485-plan of treatment. ·Order obtained and documented in clinical record on 2/26/2020 changed skilled nursing frequency to "Effective 2/23/2020: 2wk1, 1wk5". ·Surveyor noted only 1 skilled nursing visit was performed in week of 3/08/2020. This is correct and in compliance with the with physician order dated 2/26/2020. ·Agency reviewed clinical record and verified noncompliance with frequency and ordered dates of PT/INR testing. ·Clinical manager involved in care coordination and oversight of this patient is no longer employed by agency preventing counselling and/or	

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			corrective action. ·Corrective action and 1:1 education related to compliance with physician orders to be completed with nursing staff involved in patient care. ·Education and corrective action to be completed by Administrator or designee by May 27, 2021. ·Patient was discharged from agency services on 3/19/2020 ·Clinical record #11 ·Agency reviewed chart and was unable to verify noncompliance as cited by surveyor. ·Documentation supports compliance with PT visit frequency of 1wk1, 2wk3 as evidenced by completed home visits or appropriately documented missed visits and documentation of timely physician notification of missed visits matching this frequency. ·One missed visit was noted in record. PTA visit on 8/16/2016 was attempted but refused by the patient. A missed visit note was appropriately entered in the medical record which documented the reason as "patient refusal". This note was faxed to the ordering physician as notification on 8/17/2016. ·Patient was discharged from agency services on 9/16/2016	

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			·Clinical record #14: ·Agency was unaware of assessment deficits in chart #14 until following receipt of the survey findings on April 28, 2021. ·Patient was discharged from services on 3/23/2021. ·Agency has reviewed the clinical record and confirmed the finding as indicated by surveyor of a missed visit note entered by home health aide on 2/12/2021 with reason for missed visits stated as "scheduling conflict". ·Agency observed that ordered home health aide frequency was met by completion of in-home visits or documentation of missed visits with appropriate physician notification of missed visits. ·Agency provided education to all clinical staff regarding precise documentation of reasons for missed visit including avoidance of selecting "scheduling conflict" from EMR "missed visit reason" options without providing additional detail sufficient to demonstrate that visit was not missed due to agency or clinician reasons but only if patient or caregiver reported a scheduling conflict and declined/refused attempts to reschedule. ·Education was completed by Administrator or designee on May 18, 2021. ·Patient was discharged	

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			from agency services on 3/23/2021 ·Clinical record #16 ·Agency reviewed clinical record and confirmed the findings as indicated by surveyor. ·A home health aide visit in week 2 was missed but no appropriate missed visit note was entered and no physician notification of the missed visit is evidenced in the clinical record. ·Agency to provide 1:1 education with the home health aide ·Education to be completed by Administrator or designee by May 27, 2021. ·Clinical manager will ensure appropriate documentation and physician/provider notification of all missed visits is evident in all charts. ·Skilled nursing visit frequency on 485-Plan of Treatment listed as "2wk1, 1wk3…." however plotted/planned visit frequency was noted to be "1wk4". Agency leadership reviewed clinical record and identified a charting error was made when visit frequency was manually written on 485 resulting in ordered frequency exceeding that plotted and assigned to clinician. ·Agency to provide 1:1 education to skilled nurse related to compliance with	

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			physician orders including reviewing ordered frequency and reporting and correcting errors appropriately. ·Education to be completed by Administrator or designee by May 27, 2021. Person Responsible: Administrator Date of Completion: May 27, 2021 Compliance: ·Beginning May 14, 2021, 100% of admissions, resumptions of care, and recertifications and discharges will be audited weekly to ensure compliance with this standard. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the admissions, resumption of care, and recertifications and discharges for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly	

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			audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	
G 0682 Bldg. 00	484.70(a) Infection Prevention Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review and interview, the skilled nurse failed to follow standard precautions (a group of infection practices that apply to all patients regardless of suspected or confirmed infection status at the time health care is delivered, and are based on the principle that all blood, body fluids, secretions, excretions, may contain transmissible infectious agents) for 1 of 3 home visits observed with patients who required wound care. (#1) The findings include: 1. Review of an undated agency policy titled "Hand Hygiene" stated "... To prevent transfer of	G 0682	N 470 410 IAC 17-12-1(m)**STANDARD: G682 Infection Prevention CFR(s)484.70(a)** **Plan:** ·All direct care and clinical staff received education by the Administrator regarding the requirement to adhere to infection prevention policies, including the Hand Hygiene policy during verbal staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Follow up in-service education	05/13/2021

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	germs and transmission of infections to patients and caregivers ... Indications for staff performing hand hygiene are: ... Before and after each procedure ... After contact with any contaminated materials ... Before [accessing] patient's clean supplies ... All employees are responsible for implementing hand hygiene procedures ... {hand hygiene] After removing gloves ... After contact with blood, body fluids, ... non-intact skin and wound dressings ... Moving from contaminated patient body site to clean site during patient care ...." 2. Review of a reference CDC (Centers for Disease Control and Prevention) web-based site (https://www.cdc.gov/hai/ca_uti/uti.html) titled "Catheter-associated Urinary Tract Infections (CAUTI)" stated "... A urinary tract infection (UTI) ... is ... the most common type of healthcare-associated infection ...." 3. A home visit of patient #1 was observed on 2/11/2021 at 10:00 AM, start of care date 4/7/2020, and primary diagnosis of encounter for attention to cystostomy (suprapubic catheter - an opening in the lower abdomen where a tube is inserted directly into the bladder for urine drainage). LPN [licensed practical nurse] HH removed a soiled dressing from the patient's right buttock, and performed wound care. After wound care was completed, LPN HH failed to remove his contaminated gloves, perform hand hygiene, and don new gloves before moving to the patient's suprapubic catheter site (to perform a dressing change and care of the site. The clinical manager was present during the home visit and indicated standard precautions were not followed.		was conducted by the Administrator or designee by May 13, 2021 for all direct care and clinical staff. This training included, but was not limited to the following: ·OSHA standard precautions, current CDC guidance and the Agency Hand Hygiene policy to prevent the transmission of infections and communicable diseases, with a particular focus on hand hygiene and glove changing procedures, to ensure such precautions are maintained during all care, services and treatments provided. ·The Agency requirement for Hand Hygiene competency to be initiated for all direct care and clinical staff during orientation and observed by Clinical Managers during home supervisory visits. ·Agency to perform a baseline training/competency assessment of all staff during re-education. ·Education will be provided through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The Agency maintains an infection control program to prevent and control infectious and communicable disease as identified by the Centers for Disease Control and Prevention	

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			("CDC") and to reduce the risk of transmission of microbes from both recognized and unrecognized sources of infection. The infection control program also supports compliance with the Indiana Occupational Safety and Health Administration guidelines. The Agency Administrator is responsible for ensuring compliance with the Agency infection control program. **Person Responsible:** Clinical Manager **Date of Completion:** May 13, 2021 **Compliance:** ·Beginning the week of May 10, 2021, three (3) home supervisory visits will be made weekly to validate compliance with the standard. The supervisory visits will be performed by the Clinical Manager or designee and will include hand hygiene validation from representatives of all disciplines. Weekly home visit validations will continue until 100% of all direct care and clinical staff members have been observed and passed competency assessment requirements. ·Once met, three (3) home visit validations will be performed by the Clinical Manager or designee monthly until 100% compliance for 3 consecutive months. ·Once the threshold is met, three (3) home visit validations will be performed by the Clinical	

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			Manager or designee completed quarterly. ·If the threshold is not reached, the Administrator will ensure additional training for individual staff and continue weekly supervisory visits until the threshold is met. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	
G 0940 Bldg. 00	484.105 Organization and administration of services Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Based on record review and interview, the agency failed to ensure the responsibilities of the governing body, administrator and clinical manager were not delegated to another organization or other person(s) on an on-going basis (See G942); the administrator failed to be	G 0940	**Governance** 17-12-1(a)(1) 17-12-1(a)(2)	05/27/2021

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SAINT JOSEPH VNA HOME CARE	3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	appointed by and reported directly to the Governing Body (See G946); the administrator failed to be responsible for the day to day functions of the agency (See G948); the clinical manager failed ensure coordination of referrals (See G964); failed to maintain overall responsibility for the services it provided under arrangement, and failed to maintain overall responsibility for the manner in which they were furnished; and failed to maintain overall responsibility for the services it provided (G978). Additionally: 1. IDOH [Indiana Department Of Health] has no reciprocal agreements with surrounding states for the home health program. 2. Review of an agency document for scheduled home visits on 2/12/2021 titled "Worker Schedule Report" evidenced agency staff was scheduled to see patients in Michigan, and stated "... Assigned Branch: MIH [Saint Joseph VNA] ... Assigned Branch MUH [Muskegon, Michigan- home care agency D] ...." 3. Review of an IDOH document titled "Facility Census-Home Health" stated "... Skilled Patients ... MIH 229 + MUH 16 ... Total 245 ... Total # [number] of active patients ... MIH 229 + MUH 16." 4. During an interview on 2/9/2021 at 1:42 PM, the administrator stated "We see patients in Michigan. They're our patients ... 'MIH' is Mishawaka, and 'MUH' is Muskegon." She indicated MUH was not a branch of the agency, and both agencies were owned by corporation E. 5. During an interview on 2/9/2021 at 11:05 AM,		17-12-1(b) 17-12-1(b)(1) 17-12-1(b)(3) 17-12-1(c)(1) 17-12-2(d) 17-12-2(e) N 449 17-12-1(c)(1) **G940 Organization and administration of services CFR(s):484.105** **Plan:** ·Saint Joseph VNA will cease to provide staffing to support patients in Michigan effective May 28 2021 or date of discharge of the last patient under service, whichever comes first. ·In order to permit a 30-day transition of patients a written agreement was executed between Mishawaka and Saint Joseph VNA (Agency) to permit clinical staffing to be performed under arrangements for at the direction of the Agency and the Agency Administrator effective May 1, 2021. ·All staff received education on March 17-18, 2021 by the Administrator that patients from Michigan will not be managed	

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	the administrator/clinical manager indicated the agency saw patients in Michigan, and stated "... It's our staff, our patients. Our clinicians have both state's licenses." 6. During an interview on 2/9/2021 at 2:10 PM, the administrator indicated she was told by the colleague relations partner (Human Resource-HR) the agency was contracted with home care agency D, and as requested by the surveyor, she indicated she would submit a copy of the contract. 7. During an interview on 2/9/2021 at 2:17 PM, the surveyor received an admission packet from administrative assistant W (with home care agency D's information), who indicated it was the admission packet agency clinicians provided to Michigan patients. 8. During an interview on 2/9/2021 at 2:57 PM, the colleague relations partner, person C (St. Joseph VNA Home Care's human resource employee) indicated St. Joseph VNA Home Care had no contracts on premises, it had no access, and any contracts were "... up at corporate." 9. During an interview on 2/9/2021 at 3:34 PM, colleague relations partner, person C indicated she spoke with the executive director over home care agency D, and stated "Because we're both under [corporation E], our parent company, it's just considered just a transfer of labor between the agencies, and our clinicians seeing patients also have Michigan licenses. [Person H] was the former compliance officer with 'corporate', and she was involved with both states to make sure it was all okay, and that's why 50% [of our staff] have dual licenses prior to implementing [services to Michigan patients] in 2018, [because] that's what		through the Saint Joseph VNA Home Care office. ·Education attendance was tracked with sign-in sheets. Individual meetings were provided for the clinicians that did not participate in the in-service. ·Referring providers and facilities will be sent written notification of the transition plan during the week of May 16, 2021 **Compliance:** ·No new Michigan patients will be brought on service for care under arrangements. Ceased acceptance of new referrals on May 6th, 2021. Last admission was performed on April 26, 2021 ·All patients from Michigan are either discharged if course of care is complete or transitioned to a Michigan provider. **Person Responsible:** Administrator	

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	state wanted." 10. During an interview on 2/9/2021 at 2:49 PM, the administrator stated "... They [home care agency D] pay us for the [agency staffing] labor." When asked if there was a written contract, she stated "... not needed because we are same organization per [colleague relations partner, person C]." She also indicated home care agency D's patients were included in the agency's quality assurance/performance improvement (QAPI) program. When queried if home care agency D asked about the Michigan patients, she stated "No." When queried how the agency handled complaints made by Michigan patients, she indicated the agency gave the Michigan Board of Health contact information. When queried if a Michigan surveyor showed up at home care agency D, and visited one of the patients St. Joseph VNA Home Care staff cared for in Michigan, would it be correct to say home care agency D wouldn't know anything about the patient, colleague relations partner stated "Correct." Also, she indicated agency staff who saw patients in Michigan were not dually employed by home care agency D St. Joseph VNA Home Care. When queried how the agency ensured staff followed Michigan regulations, she stated "That is a good question." 11. During an interview on 2/12/2021 at 4:48 PM, OT F indicated she saw patients in Michigan for at least two years, agency (Saint Joseph VNA) staff admitted the patients, if patients had a complaint or needed to speak with a clinician, home care agency D patients called St. Joseph VNA Home Care cell numbers, and stated "We give them our name and number they can call, but the [home] folder has [home care agency D] numbers." She also indicated she never had an			

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	on-site supervisory visit (in Michigan) to evaluate her performance or to evaluate the patients' satisfaction with home care agency D patients, she reported to PT [physical therapist] A, case conferences were conducted with agency staff, home care agency D's office was located in Muskegon, she hadn't spoken with anyone at home care agency D for over two years, and the patients' home folders were specific to the state they lived in. 12. During an interview on 2/12/2021 at 5:41 PM, RN G indicated he saw patients in Michigan for "... probably not quite a year ....", agency staff with Michigan nursing licenses admitted the patients, if patients had a complaint or needed to speak with a clinician, home care agency D patients would call the toll free (corporate) number. He also indicated he never had an on-site supervisory visit (for Michigan patients he provided services to) to evaluate his performance or to evaluate the patients' satisfaction with home care agency D patients, he reported to RN (Clinical Manager) D, and case conferences were conducted with agency staff every morning via Zoom conference. He stated "Our main office is Livonia [Michigan]. There could very well be another satellite, not sure. Calls go through [agency] office." 13. During an interview on 2/26/2021 at 2:26 PM, person J (Corporate CEO [chief executive officer], President, Governing Body Member) indicated the agency does provide staff for home care agency D patients, the staff were dually licensed in both states, and that made them eligible to see home care agency D's patients. The cumulative effect of this systemic problem resulted in the agency being out of compliance			

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	with the Condition of Participation 42 CFR 484.105 Organization and administration of services. 17-12-1(a)(1) 17-12-1(a)(2) 17-12-1(b) 17-12-1(b)(1) 17-12-1(b)(3) 17-12-1(c)(1) 17-12-2(d) 17-12-2(e)			
G 0942 Bldg. 00	484.105(a) Governing body 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, and its quality assessment and performance improvement program. Based on record review and interview, the governing body failed to ensure the agency's overall management and oversight was not delegated to another person or organization, agency lines of authority for the delegation of responsibility were clearly identifiable and readily available, and provision of home health services was only provided for patients in the state of Indiana under the agency's license issued by IDOH [Indiana Department of Health]. The findings include: 1. Review of an agency policy with an approval/revised date of 02/2019, titled "Governance: Home Health Board of Directors" stated "The Homecare Board of Directors is the	G 0942	N 444 17-12-1(c)(1) **G942 Governing Body CFR(s) 484.105(a)** **Plan:** ·Members of Governing Body will receive refresher training regarding roles and responsibilities regarding Home Health Agency organization and administration of services will be provided to the Governing Body by May 14th,	05/14/2021

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	Governing Body with full responsibility for THAH [Trinity Health at Home, corporate owner of agency] agencies ... Appointment of a qualified CEO [chief executive officer], Homecare Director/Administrator and alternate for each agency, delegating to that individual, the responsibility for the quality of services provided by that Agency ... Communication directly with the agency Administrator/Director as needed ...Meeting quarterly and, as necessary, recording minutes in which all decisions regarding home healthcare are documented ... An administrator or director has direct access to the board with no intermediaries." 2. Review of an undated agency document received on 2/11/2021, titled "Trinity Health at Home (THAH) Board of Directors" evidenced person J as the CEO [chief executive officer], President, GB [governing body] Member, and failed to evidence person G (VP [vice president] Operational Excellence/Regional Executive Director) or person I (COO- Chief Operating Officer) as members of the governing board for Saint Joseph VNA Home Care located in Indiana. 3. Review of an agency document received on 2/9/2021, titled "Saint Joseph VNA Home Care Colleague List" failed to evidence person G or person I were agency employees. 4. Review of an agency document received on 2/09/2021, titled "Saint Joseph VNA Home Care Organizational Chart" evidenced the administrator reported to the governing body and person G. 5. Review of another agency document received on 2/10/2021, titled "Saint Joseph VNA Home Care Organizational Chart" evidenced the administrator reported directly to person G, who reported to		2021 and reviewed at a board meeting schedule for May 25, 2021. ·Evidence of refresher training will be noted in Governing Body meeting minutes. ·This training will be incorporated into the agency Governing Body orientation and annual education plan May 25, 2021. ·Administrator position description updated on April 30, 2021 to reflect reporting relationship to the Governing Body. ·Organization chart updated on May 4, 2021 to reflect Administrator reports directly to the Governing Body. ·Administrator and alternate administrator were oriented to position descriptions and reporting relationship, responsibilities on May 6, 2021. ·The Administrator and alternate administrator validated understanding of roles and responsibilities in line with federal and state regulations as evidenced by signed job description and attestation of training. ·Administrator and alternate administrator were provided a Governing Body contact in addition to the CEO who is also a Governing Body member. ·Administrator and alternate administrator were provided a list	

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	person I, who reported to person J. These persons the administrator reported to failed to be evidenced as a governing body member, owner or officer of the agency located in Indiana. 6. Review of an agency job description dated 10/01/2018, titled Administrator, Regional Administrator indicated the administrator reports to the Executive Director/Regional Executive Director, not the governing body. 7. During an interview on 2/26/2021 at 2:26 PM, person J of the governing body indicated the agency does staff Michigan patients, the staff were dually licensed in both states, and that made them eligible to see Michigan patients. 17-12-1(b)		of all Governing Body members. ·Administrator will communicate with the Governing Body on a quarterly basis or as needed. **Compliance:** ·A Performance review will be conducted by a representative of the Governing Body in 90 days and then annually to assure the Administrator is performing responsibilities in accordance with the standard and that the current organizational structure and reporting/oversight processes implemented for the plan of correction are effective. The performance evaluation will be filed in the Administrator's personnel record. ·The Governing Body will review the Agency Organizational Chart annually. ·The Administrator will assess the performance of the services described in the Written Agreement and status of oversight activities related to patients and report upon those to the Governing Body during each regularly scheduled meeting. **Person Responsible:** CEO/Governing Body Designee **Date of Completion:** May 14, 2021.	

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G 0946 Bldg. 00	484.105(b)(1)(i) Administrator appointed by governing body (i) Be appointed by and report to the governing body; Based on record review and interview, the administrator failed to be appointed by and reported directly to the Governing Body (GB). The findings include: Review of an agency policy with an approval/revised date of 02/2019, titled "Governance: Home Health Board of Directors" stated "The Homecare Board of Directors is the Governing Body with full responsibility for THAH [Trinity Health at Home, corporate owner of agency] agencies ... Appointment of a qualified CEO [chief executive officer], Homecare Director/Administrator and alternate for each agency, delegating to that individual, the responsibility for the quality of services provided by that Agency ... Communication directly with the agency Administrator/Director as needed ...Meeting quarterly and, as necessary, recording minutes in which all decisions regarding home healthcare are documented ... An administrator or director has direct access to the board with no intermediaries." Review of an undated agency document received on 2/09/2021, titled "Saint Joseph VNA Home Care Organizational Chart" evidenced the administrator reported to the governing body and person G. Review of another agency document dated	G 0946	N 442 17-12-1(b)**G946 Administrator Appointed by governing body: CFR(s) 484.105(b)(1)i)** **Plan:** ·Administrator position description updated on April 30, 2021 to reflect reporting relationship to the Governing Body. ·The Governing Body reaffirmed the appointed of the Administrator and Alternate Administrator/Designee on May 6, 2021 as evidenced by the resolution signed by the Governing Body Secretary. ·Organization chart updated on May 4, 2021 to reflect Administrator reports directly to the Governing Body. ·Administrator and alternate administrator were oriented to position descriptions and reporting relationship, responsibilities, as well as the relationship between corporate support services and the	05/28/2021

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	2/8/2021, received on 2/10/2021, titled "Saint Joseph VNA Home Care Organizational Chart" evidenced the administrator reported directly to person G (VP [vice president] Operational Excellence/Regional Executive Director), who failed to be evidenced as a governing board member or officer of the agency at the Indiana Department of Health. Review of an undated agency document received on 2/11/2021, titled "Trinity Health at Home (THAH) Board of Directors" evidenced person J as the CEO, President, GB Member, and failed to evidence person G as a member of the GB/Board of Directors. Review of an agency document received on 2/9/2021, titled "Saint Joseph VNA Home Care Colleague List" failed to evidence person G was an agency employee. Review of an agency job description dated 10/1/2018, titled "Administrator (Agency Administrator, Regional Administrator)" evidenced the administrator reported to person G (not the governing body). Review of an unsigned document dated 12/2/2020, titled "Trinity Continuing Care Board of Directors Meeting" stated "Consent Agenda ... Recommendations for Appointment of Alternate Administrators ... It is requested that this Board of Directors appoint [interim administrator D] as the alternate administrator ...." The document failed to evidence who the request was made by, or the request was approved by the governing body. During an interview on 2/10/2021 at 2:49 PM, the administrator indicated she reported to person G (not the governing body), and she didn't know		Administrator on May 6, 2021. This training reiterated the responsibility of the Administrator/Designee for all day to day operations for the Agency, including but not limited to human resources, IT, contracts. ·The Administrator and alternate administrator validated understanding of roles and responsibilities in line with federal and state regulations as evidenced by signed job description and attestation of training on May 6, 2021. ·Administrator and alternate administrator were provided a Governing Body contact in addition to the CEO who is a Governing Body member. ·Administrator will communicate with the Governing Body on a quarterly basis or as needed. ·Position description updated April 30, 2021 to reflect Clinical Manager reports to the Administrator. ·Written agreement executed between Mercy Health VNS (Muskegon, MI) and Saint Joseph VNA (Agency) to permit clinical staffing to be performed under arrangements during 60 patient transition period at the direction of the Agency and the Agency Administrator effective May 1, 2021. **Compliance:**	

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	who the members of the governing body were. During an interview on 2/25/2021 at 3:00 PM, the administrator indicated she was initially hired by the VP Operational Excellence/Regional Executive Director (person G) on 7/27/2020 as the interim administrator and clinical manager. She indicated the agency's former administrator did her initial interview, but person G made the final decision and hired the agency's administrator and clinical manager(s). Additionally, she accepted role as the agency administrator on or about 2/17/2021. During this time, meeting minutes were requested that evidenced governing body appointment and approval of her role as interim administrator and subsequently full time administrator. No additional documentation was submitted upon survey exit. 17-12-1(b)(1)		·A Performance review will be conducted by a representative of the Governing Body in 30 days and then annually to assure the Administrator is performing responsibilities in accordance with the standard and that the current organizational structure and reporting/oversight processes implemented for the plan of correction are effective. ·The Administrator will assess the performance of the services described in the Written Agreement and status of oversight activities related to patients and report upon those to the Governing Body during each regularly scheduled meeting. ·The Governing Body will review the Agency Organizational Chart with any personnel changes and annually and the status of the plan of correction during each regularly scheduled meeting. **Person Responsible: CEO/Governing Body Designee** **Date of Completion:** May 28, 2021.	
G 0948 Bldg. 00	484.105(b)(1)(ii) Responsible for all day-to-day operations (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the administrator failed to be responsible for the day	G 0948	17-12-1(b)(1)**G948 Responsible**	05/09/2021

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	to day functions of the agency. The findings include: 1. Review of an agency policy with an approval/revised date of 02/2019, titled "Governance: Home Health Board of Directors" stated "The Homecare Board of Directors is the Governing Body with full responsibility for THAH [Trinity Health at Home, corporate owner of agency] agencies ... Appointment of a qualified CEO [chief executive officer], Homecare Director/Administrator and alternate for each agency, delegating to that individual, the responsibility for the quality of services provided by that Agency ...." 2. Review of an agency document dated 2/8/2021, received on 2/10/2021, titled "Saint Joseph VNA Home Care Organizational Chart" evidenced the administrator reported directly to person G (VP Operational Excellence/Regional Executive Director). 3. Review of an agency document received on 2/9/2021, titled "Saint Joseph VNA Home Care Colleague List" failed to evidence person G was an agency employee of Saint Joseph VNA Home Care. 4. Review of an agency job description dated 10/1/2018, titled "Administrator (Agency Administrator, Regional Administrator)" evidenced the administrator reported to the Executive Director/Regional Executive Director (not the governing body), and stated "... Directs the homecare/hospice agency ongoing functions in compliance with policy and legal requirements including maintenance of appropriate records, supervision of office personnel ... Hires, orients,		**for all day-to-day operations: CFR(s) 484.105(b)(1)(ii)** **Plan:** ·Administrator position description updated on April 30, 2021 to reflect reporting relationship to the Governing Body. ·The Governing Body appointed the Administrator and Alternate Administrator/Designee on May 6, 2021 as evidenced in Governing Body minutes ·Organization chart updated on May 4, 2021 to reflect Administrator reports directly to the Governing Body. ·Administrator and alternate administrator were oriented to position descriptions and reporting relationship, responsibilities, as well as the relationship between corporate support services and the Administrator on May 6, 2021. This training reiterated the responsibility of the Administrator/Designee for all day to day operations for the Agency, including but not limited to human resources, IT, contracts. ·The Administrator and alternate administrator validated understanding of roles and responsibilities in line with federal and state regulations as evidenced by signed job description and attestation of training on May 6, 2021.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and leads qualified management and administrative personnel ... Responsible for implementing Regional Executive Director directives ...." 5. Review of an agency job description dated 1/2017, titled "Clinical Manager" stated "...Reports to: Executive Director ...." The job description failed to evidence the clinical manager reported to the administrator. 6. During an interview on 2/9/2021 at 1:23 PM, the administrator indicated she had no control over authorizing the surveyor access to the agency's electronic health records (EHR), it was controlled and authorized by "corporate", company policies had to be released by corporate person L (Regional Compliance, Survey Accreditation Manager), she had no control over the decision that the agency saw Michigan patients (decision was made by corporate), 7. During an interview on 2/9/2021 at 2:57 PM, the administrator stated "... Corporate makes final say on all management hires." During this time, the Colleague Relations Partner (agency human resource person) indicated no contracts were located at the agency, they were at corporate level, the agency had no access to them, and access had to be requested. 8. During an interview on 2/10/2021 at 2:49 PM, the administrator indicated corporate had the final decision who was hired for agency management positions. 9. During an interview on 2/22/2021 at 11:47 AM, the administrator indicated the agency kept no hard copies of personnel files on site at the agency, they were maintained at the corporate		·Administrator and alternate administrator were provided a Governing Body contact in addition to the CEO who is a Governing Body member. ·Administrator and alternate administrator were provided a list of all Governing Body members. ·Administrator will communicate with the Governing Body on a quarterly basis or as needed. ·Position description updated to reflect Clinical Manager reports to the Administrator. ·Written agreement executed between Mercy Health VNS (Muskegon, MI) and Saint Joseph VNA (Agency) to permit clinical staffing to be performed under arrangements at the direction of the Agency and the Agency Administrator effective May 1, 2021. **Compliance:** ·A Performance review will be conducted by the Governing Body in 30 days and then annually to assure the Administrator is performing responsibilities in accordance with the standard and that the current organizational structure and reporting/oversight processes implemented for the plan of correction are effective. ·The Administrator will assess the performance of the services described in the Written	

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	157005	A. BUILDING 00 B. WING	03/02/2021

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	location in Michigan, and she was going to follow up with corporate to find out how the surveyor could get full access to the personnel records. 10. During an interview on 2/22/2021 at 12:09 PM, Colleague Relations Partner, person C indicated she followed up with the corporate Senior Accreditation Manager (not an agency employee), who was concerned about releasing/printing entire personnel record, she wanted to know what regulation required this, indicated the surveyor could look at the electronic files with the assistance of the Colleague Relations Partner, but she would not allow any part of the personnel records to be printed without proof of need. 11. During an interview on 3/2/2021 at 10:24 AM, Colleague Relations Partner, person C indicated she reported to the (corporate) Colleague and Labor Relations Manager (not the administrator). 17-12-1(b)(3) 17-12-1(c)(1)		Agreement and status of oversight activities related to patients and report upon those to the Governing Body during each regularly scheduled meeting. ·The Governing Body will review the Agency Organizational Chart with any personnel changes and annually and the status of the plan of correction during each regularly scheduled meeting. **Person Responsible: CEO/Governing Body Designee** **Date of Completion:** May 28, 2021.	
G 0964 Bldg. 00	484.105(c)(3) Coordinate referrals; Coordinating referrals, Based on record review and interview, the clinical manager failed to coordinate agency referrals. The findings include: Review of an undated agency policy titled " Care Management and the Plan of Care" stated "... The nurse/therapist assigned to admit the client: ... Within 1 day of the referral, calls the prospective patient to discuss needs ...." Review of an undated agency policy titled "Physician Orders" stated "... Orders to initiate	G 0964	17-12-1(b)(3) N 444 17-12-1(c)(1)**G964** **Coordinate Referrals: CFR(s) 484.105** **Plan:** ·Clinical manager position description updated on April 30, 2021 to reflect reporting relationship directly to the Administrator. ·Organization chart updated on May 4th, 2021 to reflect Clinical	05/05/2021

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	billable insurance services: ... a telephone referral from the physician office for home care evaluation is taken by an office representative who enters a referral information note ... A faxed referral that is not signed by the physician is sufficient to make the first visit if it contains an indication written by the home care coordinator/discharge planner ...." During an interview on 2/9/2021 at 11:05 AM, the administrator indicated hospital referrals were faxed to corporate intake for processing, not the agency, then the agency received the referral if it was approved by corporate.		Manager reports directly to the Administrator. ·Clinical Manager and alternate Clinical Manager were oriented to position descriptions and reporting relationship, responsibilities on May 5, 2021. ·Retraining was provided to Administrator and Clinical Manager regarding referral coordination on May 6, 2021. Despite centralized referral entry, this training reiterated the responsibility of local leadership to not only properly coordinate referrals, but also finalize all referral acceptance/denial decisions. ·The Clinical Manager and alternate Clinical Manager validated understanding of roles and responsibilities in line with federal and state regulations as evidenced by signed job description and attestation of training on May 5, 2021. **Compliance:** ·A Performance review will be conducted by the Administrator in 30 days and then annually to assure the Clinical Manager is performing responsibilities regarding coordination of referrals in accordance with the standard and processes implemented for the plan of correction is effective. **Person Responsible:** Administrator **Date of Completion**: May 28, 2021.	

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G 0978 Bldg. 00	484.105(e)(2)(i-iv) Must have a written agreement An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. The agency, organization, or individual providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid; (iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program. Based on record review and interview, the agency failed to maintain overall responsibility for the services it provided under arrangement with home care agency D (a home care agency in Muskegon, Michigan with same corporate ownership as agency), and failed to maintain overall responsibility for the manner in which they were furnished. The findings include: IDOH [Indiana Department of Health] has no reciprocal agreements with surrounding states for the home health program. Review of an agency document for scheduled home visits on 2/12/2021, titled "Worker Schedule Report" evidenced agency staff was scheduled to see patients for home care agency D, and stated	G 0978	**Date of Completion**: May 28, 2021 N 478 410 IAC 17-12-2(d) 17-12-2(d) **G978 Must Have a Written Agreement: CFR(s): 484.105(e)(2)(i-iv)** **Plan:** ·Saint Joseph VNA will cease to provide staffing to support patients in Michigan effective June 30, 2021 or date of discharge of final patient under care. ·In order to permit a30-day transition of patients a written agreement was executed between Mercy Health VNS (Muskegon, MI) and Saint Joseph VNA (Agency) to permit clinical staffing	05/28/2021

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	"... Assigned Branch: MIH [Saint Joseph VNA] ... Assigned Branch MUH [home care agency D] ...." Record review failed to evidence any written agreement between Saint Joseph VNA Home Care and agency D. During an interview on 2/9/2021 at 11:05 AM, the administrator/clinical manager indicated the agency saw patients in Michigan, and stated "... It's our staff, our patients. Our clinicians have both state's licenses." During an interview on 2/9/2021 at 2:10 PM, the administrator indicated she was told by the colleague relations partner, person C (Human Resource-HR) the agency was contracted with home care agency D, and as requested by the surveyor, she indicated she would submit a copy of the contract. During an interview on 2/9/2021 at 2:57 PM, the colleague relations partner, person C indicated the agency had no contracts on premises, the agency had no access, and any contracts were "... up at corporate." During an interview on 2/9/2021 at 2:49 PM, the administrator stated "... They [home care agency D] pay us for the [agency staffing] labor." When asked if there was a written contract, she stated "... not needed because we are same organization per [colleague relations partner, person C]." During an interview on 2/26/2021 at 2:26 PM, person J (Corporate CEO, President, Governing Body Member) indicated the agency did staff home care agency D's patients, the staff were dually licensed in both states, and that made them eligible to see those patients.		to be performed under arrangements for at the direction of the Agency and the Agency Administrator effective May 1, 2021. ·All staff received education on March 17-18, 2021 by the Administrator that patients from Michigan will not be managed through the Saint Joseph VNA Home Care office. ·Education attendance was tracked with sign-in sheets. Individual meetings were provided for the clinicians that did not participate in the in-service. ·Referring providers and facilities will be sent written notification of the transition plan during the week of May 10, 2021. **Compliance:** ·No new Michigan patients will be brought on service for care under arrangements. Ceased acceptance of new referrals on May 6th, 2021. Last admission was performed on April 26, 2021 ·All patients from Michigan are either discharged if course of care is complete or transitioned to a Michigan provider. **Person Responsible:** Administrator **Date of Completion:** May 28, 2021.	

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	17-12-2(d)			
N 0000 Bldg. 00	This was a fully extended federal and state survey with 2 complaints. Complaints: IN00284807 - substantiated with findings IN00216770 - substantiated with findings Survey dates: February 9, 10, 11, 22, 23, 24, 25, 26; and March 1, 2 (2021). Facility number: IN005248 Provider number: 157005 Current census: 229 Refer to Federal Form for additional State Findings.	N 0000		
N 0442 Bldg. 00	410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency. Based on record review and interview, the	N 0442	N 442 17-12-1(b)**G946**	05/27/2021

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	governing body failed to ensure the agency's overall management and oversight was not delegated to another person or organization, agency lines of authority for the delegation of responsibility were clearly identifiable and readily available, and provision of home health services was only provided for patients in the state of Indiana under the agency's license issued by IDOH [Indiana Department of Health]. The findings include: Review of an agency policy with an approval/revised date of 02/2019, titled "Governance: Home Health Board of Directors" stated "The Homecare Board of Directors is the Governing Body with full responsibility for THAH [Trinity Health at Home, corporate owner of agency] agencies ... Appointment of a qualified CEO [chief executive officer], Homecare Director/Administrator and alternate for each agency, delegating to that individual, the responsibility for the quality of services provided by that Agency ... Communication directly with the agency Administrator/Director as needed ...Meeting quarterly and, as necessary, recording minutes in which all decisions regarding home healthcare are documented ... An administrator or director has direct access to the board with no intermediaries." Review of an undated agency document received on 2/11/2021, titled "Trinity Health at Home (THAH) Board of Directors" evidenced person J as the CEO [chief executive officer], President, GB [governing body] Member, and failed to evidence person G (VP [vice president] Operational Excellence/Regional Executive Director) or person I (COO- Chief Operating Officer) as members of the governing board for Saint Joseph VNA Home		**Administrator Appointed by governing body: CFR(s) 484.105(b)(1)i)** **Plan:** ·Administrator position description updated on April 30, 2021 to reflect reporting relationship to the Governing Body. ·The Governing Body reaffirmed the appointed of the Administrator and Alternate Administrator/Designee on May 6, 2021 as evidenced by the resolution signed by the Governing Body Secretary. ·Organization chart updated on May 4, 2021 to reflect Administrator reports directly to the Governing Body. ·Administrator and alternate administrator were oriented to position descriptions and reporting relationship, responsibilities, as well as the relationship between corporate support services and the Administrator on May 6, 2021. This training reiterated the responsibility of the Administrator/Designee for all day to day operations for the Agency, including but not limited to human resources, IT, contracts. ·The Administrator and alternate administrator validated understanding of roles and responsibilities in line with federal and state regulations as evidenced by signed job description and attestation of training on May 6,	

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	Care located in Indiana. Review of an agency document received on 2/9/2021, titled "Saint Joseph VNA Home Care Colleague List" failed to evidence person G or person I were agency employees. Review of an agency document received on 2/09/2021, titled "Saint Joseph VNA Home Care Organizational Chart" evidenced the administrator reported to the governing body and person G. Review of another agency document received on 2/10/2021, titled "Saint Joseph VNA Home Care Organizational Chart" evidenced the administrator reported directly to person G, who reported to person I, who reported to person J. These persons the administrator reported to failed to be evidenced as a governing body member, owner or officer of the agency located in Indiana. Review of an agency job description dated 10/01/2018, titled Administrator, Regional Administrator indicated the administrator reports to the Executive Director/Regional Executive Director, not the governing body. Review of an unsigned document dated 12/2/2020, titled "Trinity Continuing Care Board of Directors Meeting" stated "Consent Agenda ... Recommendations for Appointment of Alternate Administrators ... It is requested that this Board of Directors appoint [interim administrator D] as the alternate administrator ...." The document failed to evidence who the request was made by, or the request was approved by the governing body.Review of an unsigned document dated 12/2/2020, titled "Trinity Continuing Care Board of Directors Meeting" stated "Consent Agenda ... Recommendations for Appointment of Alternate		2021. ·Administrator and alternate administrator were provided a Governing Body contact in addition to the CEO who is a Governing Body member. ·Administrator will communicate with the Governing Body on a quarterly basis or as needed. ·Position description updated April 30, 2021 to reflect Clinical Manager reports to the Administrator. ·Written agreement executed between Mercy Health VNS (Muskegon, MI) and Saint Joseph VNA (Agency) to permit clinical staffing to be performed under arrangements during 60 patient transition period at the direction of the Agency and the Agency Administrator effective May 1, 2021. **Compliance:** ·A Performance review will be conducted by a representative of the Governing Body in 30 days and then annually to assure the Administrator is performing responsibilities in accordance with the standard and that the current organizational structure and reporting/oversight processes implemented for the plan of correction are effective. ·The Administrator will assess the performance of the services described in the Written Agreement and status of oversight activities related to patients and	

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	Administrators ... It is requested that this Board of Directors appoint [interim administrator D] as the alternate administrator ...." The document failed to evidence who the request was made by, or the request was approved by the governing body. During an interview on 2/26/2021 at 2:26 PM, person J of the governing body indicated the agency does staff Michigan patients, the staff were dually licensed in both states, and that made them eligible to see Michigan patients. During an interview on 2/10/2021 at 2:49 PM, the administrator indicated she reported to person G (not the governing body), and she didn't know who the members of the governing body were. During an interview on 2/25/2021 at 3:00 PM, the administrator indicated she was initially hired by the VP Operational Excellence/Regional Executive Director (person G) on 7/27/2020 as the interim administrator and clinical manager. She indicated the agency's former administrator did her initial interview, but person G made the final decision and hired the agency's administrator and clinical manager(s). Additionally, she accepted role as the agency administrator on or about 2/17/2021. During this time, meeting minutes were requested that evidenced governing body appointment and approval of her role as interim administrator and subsequently full time administrator. No additional documentation was submitted upon survey exit.		report upon those to the Governing Body during each regularly scheduled meeting. ·The Governing Body will review the Agency Organizational Chart with any personnel changes and annually and the status of the plan of correction during each regularly scheduled meeting. **Person Responsible: CEO/Governing Body Designee** **Date of Completion:** May 27, 2021	
N 0444 Bldg. 00	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency			

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	in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on record review and interview, the administrator failed to be responsible for the day to day functions of the agency. The findings include: 1. Review of an agency policy with an approval/revised date of 02/2019, titled "Governance: Home Health Board of Directors" stated "The Homecare Board of Directors is the Governing Body with full responsibility for THAH [Trinity Health at Home, corporate owner of agency] agencies ... Appointment of a qualified CEO [chief executive officer], Homecare Director/Administrator and alternate for each agency, delegating to that individual, the responsibility for the quality of services provided by that Agency ...." 2. Review of an agency document dated 2/8/2021, received on 2/10/2021, titled "Saint Joseph VNA Home Care Organizational Chart" evidenced the administrator reported directly to person G (VP Operational Excellence/Regional Executive Director). 3. Review of an agency document received on 2/9/2021, titled "Saint Joseph VNA Home Care Colleague List" failed to evidence person G was an agency employee of Saint Joseph VNA Home Care.	N 0444	N 444 17-12-1(c)(1) **G942 Governing Body CFR(s) 484.105(a)** **Plan:** ·Members of Governing Body will receive refresher training regarding roles and responsibilities regarding Home Health Agency organization and administration of services will be provided to the Governing Body by May 14th, 2021 and reviewed at a board meeting schedule for May 25, 2021. ·Evidence of refresher training will be noted in Governing Body meeting minutes. ·This training will be incorporated into the agency Governing Body orientation and annual education plan May 25, 2021. ·Administrator position description updated on April 30, 2021 to reflect reporting relationship to the Governing Body. ·Organization chart updated on May 4, 2021 to reflect Administrator reports directly to the Governing Body. ·Administrator and alternate administrator were oriented to	05/14/2021

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	4. Review of an agency job description dated 10/1/2018, titled "Administrator (Agency Administrator, Regional Administrator)" evidenced the administrator reported to the Executive Director/Regional Executive Director (not the governing body), and stated "... Directs the homecare/hospice agency ongoing functions in compliance with policy and legal requirements including maintenance of appropriate records, supervision of office personnel ... Hires, orients, and leads qualified management and administrative personnel ... Responsible for implementing Regional Executive Director directives ...." 5. Review of an agency job description dated 1/2017, titled "Clinical Manager" stated "...Reports to: Executive Director ...." The job description failed to evidence the clinical manager reported to the administrator. 6. During an interview on 2/9/2021 at 1:23 PM, the administrator indicated she had no control over authorizing the surveyor access to the agency's electronic health records (EHR), it was controlled and authorized by "corporate", company policies had to be released by corporate person L (Regional Compliance, Survey Accreditation Manager), she had no control over the decision that the agency saw Michigan patients (decision was made by corporate), 7. During an interview on 2/9/2021 at 2:57 PM, the administrator stated "... Corporate makes final say on all management hires." During this time, the Colleague Relations Partner (agency human resource person) indicated no contracts were located at the agency, they were at corporate level, the agency had no access to them, and access had to be requested.		position descriptions and reporting relationship, responsibilities on May 6, 2021. ·The Administrator and alternate administrator validated understanding of roles and responsibilities in line with federal and state regulations as evidenced by signed job description and attestation of training. ·Administrator and alternate administrator were provided a Governing Body contact in addition to the CEO who is also a Governing Body member. ·Administrator and alternate administrator were provided a list of all Governing Body members. ·Administrator will communicate with the Governing Body on a quarterly basis or as needed. **Compliance:** ·A Performance review will be conducted by a representative of the Governing Body in 90 days and then annually to assure the Administrator is performing responsibilities in accordance with the standard and that the current organizational structure and reporting/oversight processes implemented for the plan of correction are effective. The performance evaluation will be filed in the Administrator's personnel record. ·The Governing Body will review the Agency Organizational Chart annually. ·The Administrator will assess	

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	8. During an interview on 2/10/2021 at 2:49 PM, the administrator indicated corporate had the final decision who was hired for agency management positions. 9. During an interview on 2/22/2021 at 11:47 AM, the administrator indicated the agency kept no hard copies of personnel files on site at the agency, they were maintained at the corporate location in Michigan, and she was going to follow up with corporate to find out how the surveyor could get full access to the personnel records. 10. During an interview on 2/22/2021 at 12:09 PM, Colleague Relations Partner, person C indicated she followed up with the corporate Senior Accreditation Manager (not an agency employee), who was concerned about releasing/printing entire personnel record, she wanted to know what regulation required this, indicated the surveyor could look at the electronic files with the assistance of the Colleague Relations Partner, but she would not allow any part of the personnel records to be printed without proof of need. 11. During an interview on 3/2/2021 at 10:24 AM, Colleague Relations Partner, person C indicated she reported to the (corporate) Colleague and Labor Relations Manager (not the administrator).		the performance of the services described in the Written Agreement and status of oversight activities related to patients and report upon those to the Governing Body during each regularly scheduled meeting. **Person Responsible:** CEO/Governing Body Designee **Date of Completion:** May 14, 2021	
N 0445 Bldg. 00	410 IAC 17-12-1(c)(2) Home health agency administration/management Rule 12 Sec. 1(c)(2) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (2) Maintain ongoing liaison among the governing body and the staff.			

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	157005	A. BUILDING 00 B. WING	03/02/2021

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	Based on interview, the administrator/clinical manager failed to identify the members of the governing body, and failed to ensure agency staff was aware of the lines of authority in 3 of 4 home health agency staff interviewed. (employee B, F, G) Findings include: 1. During an interview on 2/9/2021 at 11:05 AM, the administrator/clinical manager indicated person J was the alternate administrator, and she did not know who the members of the governing body were. At 1:35 PM (on 2/9/2021), she then indicated Employee B was the alternate administrator, not person J. 2. During an interview on 2/12/2021 at 4:48 PM, OT [occupational therapist] F indicated employee A was the alternate administrator. 3. During an interview on 2/12/2021 at 5:41 PM, RN G indicated he didn't know who the administrator was, but would have to say employee D (administrator), and he didn't know who the alternate administrator was.	N 0445	N 444, 445 17-12-1(c)(1) **G942 Governing Body CFR(s) 484.105(a)** **Plan:** ·Members of Governing Body will receive refresher training regarding roles and responsibilities regarding Home Health Agency organization and administration of services will be provided to the Governing Body by May 14th, 2021 and reviewed at the next regularly scheduled board meeting schedule for June 24, 2021. ·Evidence of refresher training will be noted in Governing Body meeting minutes. ·This training will be incorporated into the agency Governing Body orientation and annual training June 24, 2021. ·Administrator position description updated on April 30, 2021 to reflect reporting relationship to the Governing Body. ·Organization chart updated on May 4, 2021 to reflect Administrator reports directly to the Governing Body. ·Administrator and alternate administrator were oriented to position descriptions and reporting relationship, responsibilities on May 6, 2021. ·The Administrator and alternate administrator validated understanding of roles and responsibilities in line with federal	05/14/2021

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			and state regulations as evidenced by signed job description and attestation of training. ·Administrator and alternate administrator were provided a Governing Body contact in addition to the CEO who is also a Governing Body member. ·Administrator and alternate administrator were provided a list of all Governing Body members. ·Administrator will communicate with the Governing Body on a quarterly basis or as needed. **Compliance:** ·A Performance review will be conducted by a representative of the Governing Body in 90 days and then annually to assure the Administrator is performing responsibilities in accordance with the standard and that the current organizational structure and reporting/oversight processes implemented for the plan of correction are effective. The performance evaluation will be filed in the Administrator's personnel record. ·The Governing Body will review the Agency Organizational Chart annually. ·The Administrator will assess the performance of the services described in the Written Agreement and status of oversight activities related to patients and report upon those to the Governing Body during each regularly scheduled meeting.	

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N 0449 Bldg. 00	410 IAC 17-12-1(c)(6) Home health agency administration/management Rule 12 Sec. 1(c)(6) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (6) Ensure that the home health agency meets all rules and regulations for licensure. Based on record review and interview, the home health agency failed to ensure they met all rules and regulations for licensure in the state of Indiana. The findings include: 1. IDOH [Indiana Department Of Health] has no reciprocal agreements with surrounding states for the home health program. 2. Review of an agency document for scheduled home visits on 2/12/2021 titled "Worker Schedule Report" evidenced agency staff was scheduled to see patients in Michigan, and stated "... Assigned Branch: MIH [Saint Joseph VNA] ... Assigned Branch MUH [Muskegon, Michigan- home care agency D] ...." 3. Review of an IDOH document titled "Facility Census-Home Health" stated "... Skilled Patients ... MIH 229 + MUH 16 ... Total 245 ... Total # [number] of active patients ... MIH 229 + MUH	N 0449	**Person Responsible:** CEO/Governing Body Designee **Date of Completion:** May 14, 2021 17-12-1(a)(1) 17-12-1(a)(2) 17-12-1(b) 17-12-1(b)(1) 17-12-1(b)(3) 17-12-1(c)(1) 17-12-2(d) 17-12-2(e) N 449 17-12-1(c)(1) **G940 Organization and administration of services CFR(s):484.105** **Plan:**	06/27/2021

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	16." 4. During an interview on 2/9/2021 at 1:42 PM, the administrator stated "We see patients in Michigan. They're our patients ... 'MIH' is Mishawaka, and 'MUH' is Muskegon." She indicated MUH was not a branch of the agency, and both agencies were owned by corporation E. 5. During an interview on 2/9/2021 at 11:05 AM, the administrator/clinical manager indicated the agency saw patients in Michigan, and stated "... It's our staff, our patients. Our clinicians have both state's licenses." 6. During an interview on 2/9/2021 at 2:10 PM, the administrator indicated she was told by the colleague relations partner (Human Resource-HR) the agency was contracted with home care agency D, and as requested by the surveyor, she indicated she would submit a copy of the contract. 7. During an interview on 2/9/2021 at 2:17 PM, the surveyor received an admission packet from administrative assistant W (with home care agency D's information), who indicated it was the admission packet agency clinicians provided to Michigan patients. 8. During an interview on 2/9/2021 at 2:57 PM, the colleague relations partner, person C (St. Joseph VNA Home Care's human resource employee) indicated St. Joseph VNA Home Care had no contracts on premises, it had no access, and any contracts were "... up at corporate." 9. During an interview on 2/9/2021 at 3:34 PM, colleague relations partner, person C indicated she spoke with the executive director over home		·Saint Joseph VNA will cease to provide staffing to support patients in Michigan effective May 28 2021 or date of discharge of the last patient under service, whichever comes first. ·In order to permit a 30-day transition of patients a written agreement was executed between Mishawaka and Saint Joseph VNA (Agency) to permit clinical staffing to be performed under arrangements for at the direction of the Agency and the Agency Administrator effective May 1, 2021. ·All staff received education on March 17-18, 2021 by the Administrator that patients from Michigan will not be managed through the Saint Joseph VNA Home Care office. ·Education attendance was tracked with sign-in sheets. Individual meetings were provided for the clinicians that did not participate in the in-service. ·Referring providers and facilities will be sent written notification of the transition plan during the week of May 10, 2021 **Compliance:** ·No new Michigan patients will be brought on service for care under arrangements. Ceased acceptance of new referrals on May 6th, 2021. Last admission	

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	care agency D, and stated "Because we're both under [corporation E], our parent company, it's just considered just a transfer of labor between the agencies, and our clinicians seeing patients also have Michigan licenses. [Person H] was the former compliance officer with 'corporate', and she was involved with both states to make sure it was all okay, and that's why 50% [of our staff] have dual licenses prior to implementing [services to Michigan patients] in 2018, [because] that's what state wanted." 10. During an interview on 2/9/2021 at 2:49 PM, the administrator stated "... They [home care agency D] pay us for the [agency staffing] labor." When asked if there was a written contract, she stated "... not needed because we are same organization per [colleague relations partner, person C]." She also indicated home care agency D's patients were included in the agency's quality assurance/performance improvement (QAPI) program. When queried if home care agency D asked about the Michigan patients, she stated "No." When queried how the agency handled complaints made by Michigan patients, she indicated the agency gave the Michigan Board of Health contact information. When queried if a Michigan surveyor showed up at home care agency D, and visited one of the patients St. Joseph VNA Home Care staff cared for in Michigan, would it be correct to say home care agency D wouldn't know anything about the patient, colleague relations partner stated "Correct." Also, she indicated agency staff who saw patients in Michigan were not dually employed by home care agency D St. Joseph VNA Home Care. When queried how the agency ensured staff followed Michigan regulations, she stated "That is a good question."		was performed on April 26, 2021 ·All patients from Michigan are either discharged if course of care is complete or transitioned to a Michigan provider. **Person Responsible:** Administrator **Date of Completion:** May 27, 2021	

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	11. During an interview on 2/12/2021 at 4:48 PM, OT F indicated she saw patients in Michigan for at least two years, agency (Saint Joseph VNA) staff admitted the patients, if patients had a complaint or needed to speak with a clinician, home care agency D patients called St. Joseph VNA Home Care cell numbers, and stated "We give them our name and number they can call, but the [home] folder has [home care agency D] numbers." She also indicated she never had an on-site supervisory visit (in Michigan) to evaluate her performance or to evaluate the patients' satisfaction with home care agency D patients, she reported to PT [physical therapist] A, case conferences were conducted with agency staff, home care agency D's office was located in Muskegon, she hadn't spoken with anyone at home care agency D for over two years, and the patients' home folders were specific to the state they lived in. 12. During an interview on 2/12/2021 at 5:41 PM, RN G indicated he saw patients in Michigan for "... probably not quite a year ....", agency staff with Michigan nursing licenses admitted the patients, if patients had a complaint or needed to speak with a clinician, home care agency D patients would call the toll free (corporate) number. He also indicated he never had an on-site supervisory visit (for Michigan patients he provided services to) to evaluate his performance or to evaluate the patients' satisfaction with home care agency D patients, he reported to RN (Clinical Manager) D, and case conferences were conducted with agency staff every morning via Zoom conference. He stated "Our main office is Livonia [Michigan]. There could very well be another satellite, not sure. Calls go through [agency] office."			

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	13. During an interview on 2/26/2021 at 2:26 PM, person J (Corporate CEO [chief executive officer], President, Governing Body Member) indicated the agency does provide staff for home care agency D patients, the staff were dually licensed in both states, and that made them eligible to see home care agency D's patients.			
N 0470 Bldg. 00	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review and interview, the skilled nurse failed to follow standard precautions (a group of infection practices that apply to all patients regardless of suspected or confirmed infection status at the time health care is delivered, and are based on the principle that all blood, body fluids, secretions, excretions, may contain transmissible infectious agents) for 1 of 3 home visits observed with patients who required wound care. (#1) The findings include: 1. Review of an undated agency policy titled "Hand Hygiene" stated "... To prevent transfer of germs and transmission of infections to patients and caregivers ... Indications for staff performing hand hygiene are: ... Before and after each procedure ... After contact with any contaminated materials ... Before [accessing] patient's clean supplies ... All employees are responsible for implementing hand hygiene procedures ... {hand hygiene] After removing gloves ... After contact	N 0470	N 470 410 IAC 17-12-1(m)**STANDARD: G682 Infection Prevention CFR(s)484.70(a)** **Plan:** ·All direct care and clinical staff received education by the Administrator regarding the requirement to adhere to infection prevention policies, including the Hand Hygiene policy during verbal staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Follow up in-service education was conducted by the Administrator or designee by May 13, 2021 for all direct care and clinical staff. This training included, but was not limited to the following: ·OSHA standard precautions, current CDC guidance and the Agency Hand Hygiene policy to prevent the	05/13/2021

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	with blood, body fluids, ... non-intact skin and wound dressings ... Moving from contaminated patient body site to clean site during patient care ...." 2. Review of a reference CDC (Centers for Disease Control and Prevention) web-based site (https://www.cdc.gov/hai/ca_uti/uti.html) titled "Catheter-associated Urinary Tract Infections (CAUTI)" stated "... A urinary tract infection (UTI) ... is ... the most common type of healthcare-associated infection ...." 3. A home visit of patient #1 was observed on 2/11/2021 at 10:00 AM, start of care date 4/7/2020, and primary diagnosis of encounter for attention to cystostomy (suprapubic catheter - an opening in the lower abdomen where a tube is inserted directly into the bladder for urine drainage). LPN [licensed practical nurse] HH removed a soiled dressing from the patient's right buttock, and performed wound care. After wound care was completed, LPN HH failed to remove his contaminated gloves, perform hand hygiene, and don new gloves before moving to the patient's suprapubic catheter site (to perform a dressing change and care of the site. The clinical manager was present during the home visit and indicated standard precautions were not followed.		transmission of infections and communicable diseases, with a particular focus on hand hygiene and glove changing procedures, to ensure such precautions are maintained during all care, services and treatments provided. ·The Agency requirement for Hand Hygiene competency to be initiated for all direct care and clinical staff during orientation and observed by Clinical Managers during home supervisory visits. ·Agency to perform a baseline training/competency assessment of all staff during re-education. ·Education will be provided through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The Agency maintains an infection control program to prevent and control infectious and communicable disease as identified by the Centers for Disease Control and Prevention (“CDC”) and to reduce the risk of transmission of microbes from both recognized and unrecognized sources of infection. The infection control program also supports compliance with the Indiana Occupational Safety and Health Administration guidelines. The Agency Administrator is responsible for ensuring	

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			compliance with the Agency infection control program. **Person Responsible:** Clinical Manager **Date of Completion:** May 13, 2021 **Compliance:** ·Beginning the week of May 10, 2021, three (3) home supervisory visits will be made weekly to validate compliance with the standard. The supervisory visits will be performed by the Clinical Manager or designee and will include hand hygiene validation from representatives of all disciplines. Weekly home visit validations will continue until 100% of all direct care and clinical staff members have been observed and passed competency assessment requirements. ·Once met, three (3) home visit validations will be performed by the Clinical Manager or designee monthly until 100% compliance for 3 consecutive months. ·Once the threshold is met, three (3) home visit validations will be performed by the Clinical Manager or designee completed quarterly. ·If the threshold is not reached, the Administrator will ensure additional training for individual staff and continue weekly supervisory visits until the threshold is met. ·These findings will be reviewed by the clinical team monthly and	

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			quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	
N 0478 Bldg. 00	410 IAC 17-12-2(d) Q A and performance improvement Rule 12 Sec. 2(d) If personnel under contracts are used by the home health agency, there shall be a written contract between those personnel and the home health agency that specifies the following: (1) That patients are accepted for care only by the primary home health agency. (2) The services to be furnished. (3) The necessity to conform to all applicable home health agency policies including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency. (6) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation. (7) The procedures for payment for services furnished under the contract. Based on record review and interview, the agency failed to maintain overall responsibility for the services it provided under arrangement with home care agency D (a home care agency in Muskegon, Michigan with same corporate ownership as agency), and failed to maintain overall responsibility for the manner in which they were furnished. The findings include:	N 0478	N 478 410 IAC 17-12-2(d) 17-12-2(d) **G978 Must Have a Written Agreement: CFR(s): 484.105(e)(2)(i-iv)** **Plan:** ·Saint Joseph VNA will cease to provide staffing to support patients in Michigan effective June 30,	05/28/2021

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	IDOH [Indiana Department of Health] has no reciprocal agreements with surrounding states for the home health program. Review of an agency document for scheduled home visits on 2/12/2021, titled "Worker Schedule Report" evidenced agency staff was scheduled to see patients for home care agency D, and stated "... Assigned Branch: MIH [Saint Joseph VNA] ... Assigned Branch MUH [home care agency D] ...." Record review failed to evidence any written agreement between Saint Joseph VNA Home Care and agency D. During an interview on 2/9/2021 at 11:05 AM, the administrator/clinical manager indicated the agency saw patients in Michigan, and stated "... It's our staff, our patients. Our clinicians have both state's licenses." During an interview on 2/9/2021 at 2:10 PM, the administrator indicated she was told by the colleague relations partner, person C (Human Resource-HR) the agency was contracted with home care agency D, and as requested by the surveyor, she indicated she would submit a copy of the contract. During an interview on 2/9/2021 at 2:57 PM, the colleague relations partner, person C indicated the agency had no contracts on premises, the agency had no access, and any contracts were "... up at corporate." During an interview on 2/9/2021 at 2:49 PM, the administrator stated "... They [home care agency D] pay us for the [agency staffing] labor." When asked if there was a written contract, she stated		2021 or date of discharge of final patient under care. ·In order to permit a30-day transition of patients a written agreement was executed between Mercy Health VNS (Muskegon, MI) and Saint Joseph VNA (Agency) to permit clinical staffing to be performed under arrangements for at the direction of the Agency and the Agency Administrator effective May 1, 2021. ·All staff received education on March 17-18, 2021 by the Administrator that patients from Michigan will not be managed through the Saint Joseph VNA Home Care office. ·Education attendance was tracked with sign-in sheets. Individual meetings were provided for the clinicians that did not participate in the in-service. ·Referring providers and facilities will be sent written notification of the transition plan during the week of May 10, 2021. **Compliance:** ·No new Michigan patients will be brought on service for care under arrangements. Ceased acceptance of new referrals on May 6th, 2021. Last admission	

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	"... not needed because we are same organization per [colleague relations partner, person C]." During an interview on 2/26/2021 at 2:26 PM, person J (Corporate CEO, President, Governing Body Member) indicated the agency did staff home care agency D's patients, the staff were dually licensed in both states, and that made them eligible to see those patients.		was performed on April 26, 2021 ·All patients from Michigan are either discharged if course of care is complete or transitioned to a Michigan provider. **Person Responsible:** Administrator **Date of Completion:** May 28, 2021	
N 0484 Bldg. 00	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on observation, record review and interview, the home health agency failed to coordinate care amongst the different disciplines/entities that provided care to the agency's patients for 6 of 15 records reviewed (#1, 3, 6, 7, 8, 9). The findings include: 1. Review of an agency policy, with an approval/reviewed date of 4/2020 titled "Care Management and the Plan of Care" stated "... Agency staff maintain liaison among disciplines	N 0484	N 484 410 IAC 17-12-2(g) 17-13-1(a)(2) **G606 Integrate all services CFR(s)484.60(d)(3)** **Plan:** ·All clinical staff received education by the Administrator regarding the requirement for coordination and communication between all disciplines providing care to assure identification of patient needs and factors that	05/27/2021

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SAINT JOSEPH VNA HOME CARE	3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545

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	to ensure that coordinated care is provided and supports the objectives in the plan of care ... regularly coordinates patient care activities with the physician and/or other members of the health care team and documents communications ... also shares and receives patient information with other providers of care, treatment or services ...." 2. Record review for patient #1 was completed on 2/10/2021 and again on 3/2/2021, start of care date 4/7/2020, primary diagnosis encounter for attention to cystostomy (suprapubic catheter- an opening in the lower abdomen where a tube is inserted directly into the bladder for drainage of urine). Review of a document titled "Home Health Certification and Plan of Care" for certification period 12/3/2020 - 1/31/2021 indicated skilled nursing services (effective 12/13/2020) once every 2 weeks for two weeks, then once every 4 weeks for 4 weeks, and 2 PRN (as needed) visits for bleeding, cardiac, catheter issues, diabetic, falls, pain, respiratory, or skin breakdown. The clinical record evidenced the patient developed open wound(s) on 1/5/2021, an order for wound care was received on 1/7/2021, and no wound care was performed during a nursing visit on 1/11/2021. Review of a document dated 1/5/2021, titled "Client Coordination Note Report" evidenced new wounds were identified, and stated "... Stage 2 pressure sores each side of sacrum ...." Review of a document dated and signed by the administrator/clinical manager 1/7/2021, titled "Physician Order" stated "... SN [skilled nurse] to perform/teach wound care to client/caregiver. Cleanse left buttock wound with normal saline or wound cleanser, cover with duoderm bordered		could affect patient safety and treatment effectiveness in accordance with the Care Management and the Plan of Care policy during verbal staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Follow up in-service education was conducted by the Administrator or designee by May 13, 2021 for the clinical and home health aide staff. This training included, but was not limited to: ·Review of the agency Care Management and the Plan of Care policies. ·The case conferencing documentation process and the requirement for regular communication between all disciplines providing care, LPN communication to the RN, and reporting/communicating changes in patient status and symptoms. ·LPNs will be instructed to document coordination with the RN case manager following each visit. The RN case manager and Clinical Manager will ensure that follow up visits to address reported changes in patient status will be completed by an RN. LPNs will be supervised in accordance with Agency policy. ·Follow up in-service education will be provided to all clinical staff by the Administrator or designee by May 27, 2021. This training will include, but not be limited to:	

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	dressing on M/W/PRN [Monday/ Wednesday/as needed] , all other days by client/caregiver ...." Review of a document signed and dated 1/11/2021 by LPN [licensed practical nurse] K titled "Visit Note Report ... SN Subsequent Visit" stated "... Wound care not provided: awaiting orders ...." During an interview on 2/10/2021 at 12:40 PM, the administrator/clinical manager indicated it was clear the nurse did not review the record/order prior to her visit, and stated "Yeah, there's no coordination from RN [registered nurse] to LPN for wound orders." RN B (Performance Improvement/PI Manager and Educator) and administrator/clinical manager agreed there was an issue with interdisciplinary communication. PT [physical therapist] A (Clinical Manager) also indicated it was a problem. 3. Record review for patient #3 was completed on 2/22/2021 and again on 3/2/2021, start of care date 10/10/2020, primary diagnosis urinary tract infection (UTI),site not specified, and other pertinent (but not limited to) diagnoses of cerebral palsy, morbid (severe) obesity, epilepsy, history of falling, and pacemaker. Review of a document titled "Home Health Certification and Plan of Care" for certification period 2/7/2021- 4/7/2021, indicated the patient received skilled nursing, PT services, and home health aide. The clinical record evidenced the patient was hospitalized in observation status 2/11/2021 - 2/14/2021. Review of a document dated 2/9/2021, titled "Visit Note Report ... SN Subsequent Visit" evidenced the nurse performed an aide supervisory visit, but there were no aide visits made.		·Integration of services, coordination of care with other members of interdisciplinary clinical team and with external entities, including physicians, who are providing services to the patient. ·Appropriate coordination of care and communication related to delegation to and supervision of LPN's, Therapy Assistants, and home health aides. ·Reporting of adverse patient events and appropriate follow up. ·Methods and performance of formal and informal care coordination with interdisciplinary team members and outside entities who provide services to patients, and documentation of care coordination activities. ·Additional in-service education and corrective action will be conducted by the Administrator or designee by May 27, 2021 as described in the "specific action for clinical records" section that follows. ·Education will be provided through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The Clinical Manager or designee will review all active patient records to ensure evidence of documentation of communication from	

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	Review of a document dated 2/14/2021, titled "Discharge Summary" from hospital M, indicated medications including (but not limited to) Centrum Silver Men's oral tablet daily after breakfast, Docusate sodium (colace) 100mg (milligrams) twice daily after breakfast and dinner, and furosemide 40mg, 0.5 tab (20mg) daily after breakfast were prescribed. Review of a document dated 2/15/2021, titled "Visit Note Report ... PT Subsequent Visit" indicated no medication changes were identified, the patient sustained a fall on 2/14/2021, and failed to evidence care coordination with an RN/Clinical Supervisor for post-hospitalization medication reconciliation or report of fall. During an interview on 2/22/2021 at 1:24 PM, the administrator/clinical manager indicated no home health aide visits had been made as ordered, and RN B indicated there wasn't follow up with a nurse for the fall. During an interview on 3/2/2021 at 2:30 PM, the administrator/clinical manager indicated she didn't see a medication reconciliation was completed after the patient returned home from the hospital on 2/14/2021, and agreed the medications listed in the EMR (electronic medical record) were not updated to match the medication changes on the hospital discharge documents. 4. Record review for patient #6 was completed on 2/26/2021 and again on 3/2/2021, start of care date 1/31/2021, for certification period 1/31/2021 - 3/31/2021, which evidenced the patient received skilled nursing services for NPWT (negative pressure wound therapy), and was seen by wound clinic A every Thursday.		interdisciplinary team members to the RN Case Manager and other team members regarding changes in patient status. ·The Clinical Manager will conduct regular case conferences and case review with primary clinicians on a regular basis, ensuring input from all active disciplines is gathered, to ensure there is evidence of communication from interdisciplinary team members to the RN Case Manager and other team members regarding changes in patient status and to ensure appropriate and timely coordination of care with outside health entities who provide service to agency patents. **·Specific action taken for clinical records #1, #3, #6, #7, #8 and #9:** ·Agency action to mitigate and resolve noted deficiencies in individual client records was limited in some cases due to discharge of patient prior to or shortly after survey exit interview as well as due to agency was not provided with chart/patient identifiers or information regarding identified deficits at time of survey exit. ·Clinical record #1 ·Agency reviewed clinical record and was able to verify noncompliance with coordination between RN and LPN as cited by surveyor.	

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	During a home visit on 2/23/2021 at 10:00 AM, review of the patient's home folder evidenced a document from wound clinic A dated 2/18/2021, titled "Physician Orders". The document evidenced wound care orders to the left leg which included (but was not limited to), the placement of adaptic (vaseline impregnated gauze) to the wound bed (to prevent the foam dressing from sticking the the wound bed), and zinc (protective barrier cream) to red areas (on the surrounding skin). During observation of wound care, the nurse failed to apply adaptic to the wound bed, and failed to apply zinc to the red areas. After wound care was completed, the nurse reviewed the EMR, indicated she made an error, she didn't apply the adaptic prior to the application of foam, and the agency got the order yesterday (2/22/2021). Review of a document dated 2/20/2021, titled "Visit Note Report ... SN Subsequent Visit" failed to evidence the nurse applied adaptic to the wound bed prior to the application of the foam, and failed to apply zinc to the red areas as indicated in the physician order. During an interview on 2/24/2021 at 11:18 AM, the administrator/clinical manager agreed the current wound care order dated 2/18/2021, was in the home folder (readily accessible to nurses prior to providing wound care), and the agency failed to coordinate wound care treatment orders for skilled nurse visits 2/20/2021 and 2/23/2021. 5. A home visit of patient #7 was observed on 2/23/2021 at 1:50 PM, start of care date 1/22/2021, for certification period 1/22/2021 - 3/22/2021. The patient received physical and occupational therapy services, and skilled nursing services was		·Education to be completed by Administrator or designee by May 27, 2021. ·Counselling and 1:1 education related to coordination between RN and LPN to be completed with nursing staff involved in patient care. ·Education to all clinical staff on coordination of services and communication between clinicians including delegation to LPN's to be provided. ·Patient was discharged from agency services on 3/10/2021 ·Clinical record #3 ·Agency reviewed clinical record and was able to verify noncompliance with integration and coordination of services as cited by surveyor. ·Education to be completed by Administrator or designee by May 27, 2021. ·1:1 education and counselling related to integration of services and appropriate supervision of home health aide services and staff to be completed with nursing staff involved in patient care. ·Corrective action and 1:1 education with Physical Therapist who performed 2/15/21 visit post-hospitalization regarding appropriate reporting and follow-up actions in response to adverse events such as falls. ·Education to all	

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	ordered on 2/18/2021, for wounds. The patient's primary diagnosis was COVID-19, and other diagnoses, which included (but was not limited to), pneumonia due to COVID-19, acute respiratory failure with hypoxia (deprivation of oxygen), acute on chronic systolic (congestive) heart failure, obstructive sleep apnea, type 2 diabetes with diabetic chronic kidney disease, non-ST elevation (NSTEMI) myocardial infarction (heart attack), constipation, long term (current) use of aspirin, and long term (current) use of anticoagulants. Record review completed on 2/24/2021, and again on 3/2/2021, evidenced a document dated 1/22/2021, by PT X titled "Visit Note Report" which stated "... Visit Type: ... PT OASIS [Outcome and Assessment Information Set] Admission" evidenced the patient had no pain, and failed to evidence any lower extremity edema, skin breakdown or open skin area(s). Review of a document dated 2/4/2021, titled "Visit Note Report ... PT Subsequent Visit" evidenced medication changes were identified during the visit, failed to evidence what medications(s) were changed, and evidenced no care coordination with a nurse/clinical manager or physician occurred, and stated "... care coordination ... NO ...." Review of a document dated 2/6/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced medication changes were identified during the visit, failed to evidence what medications(s) were changed, and evidenced no care coordination with a nurse/clinical manager or physician occurred, and stated "... care coordination ... NO ...."		clinical staff to be provided including: ·Coordination and integration of services and delegation to and supervision of home health aide staff to be provided. ·Reporting of adverse patient events and appropriate follow up. ·Education to Clinical Manager regarding appropriate action and documentation required if unable to provide services as requested and/or ordered. ·Agency implemented process to require reassessment and medication reconciliation by appropriately licensed clinical staff with appropriate care coordination following hospital observation stays. ·Education was provided to all clinical staff by Administrator or designee by May 13, 2021. ·Clinical manager to formally notify the ordering physician by May 27, 2021 of agency failure to provide home health aide services as ordered on 485-Plan of Treatment and document this notification in the clinical record. ·Clinical manager to enter late entry documentation (labeled as such appropriately) describing the communication to patient and caregiver regarding unavailability of aide services and appropriate offer	

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	Review of a document dated 2/8/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had bilateral lower extremity edema (swelling), and evidenced no care coordination with a nurse/clinical manager or physician occurred, and stated "... care coordination ... NO ...." Review of a document dated 2/11/2021 titled "Visit Note Report ... OT Add-On Evaluation" evidenced the patient complained of fatigue and shortness of breath with exertion, mild foot pain (no complaint of pain prior to this visit per record review), the patient stated "... Feels like skin is stretching [describing his pain] ....", red areas were assessed on skin (patient explained it was an allergic reaction to lotion), and evidenced no care coordination with a nurse/clinical manager or physician occurred. to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/12/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had weeping edema to both lower extremities, medication changes were identified during the visit, a medication reconciliation was performed, failed to evidence what medications(s) were changed, and evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/16/2021 titled "Visit Note Report ... OT Subsequent Visit" evidenced the patient's pain was described as "burning ... stabbing", rated from 5-7 (on a pain scale 0-10, with 0 being no pain, and 10 being the most severe), pain was located to the right foot, 2nd and 3rd toes, patient was weak and unsteady, and		to transfer care to another provider. ·Clinical record #6 ·Agency reviewed clinical record and was able to verify noncompliance with integration and coordination of services as cited by surveyor. ·Education to be provided to all clinical staff by Administrator or designee by May 27, 2021. ·Coordination and integration of services including with other members of interdisciplinary clinical team and with external entities, including physicians, who are providing services to the patient. ·Clinical record #7 ·A full and comprehensive assessment was performed with patient on 3/14/2021 and documented in a Resumption of Care OASIS on this same date. Record review by agency leadership confirms assessment included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment. ·Subsequent comprehensive assessments were completed on 3/22/2021 (Recertification OASIS documented) and at Discharge on 5/08/2021. The patient's plan of care was also updated in conjunction with the recertification	

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	evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/18/2021 titled "Visit Note Report ... OT Subsequent Visit" evidenced the patient was seen in the emergency department on 2/17/2021 for complaint of intractable pain in legs (10/10), legs seeping, and was given antibiotics for infection in legs per patient report. Coordination did occur this visit with RN clinical manager to request a nurse. Review of a document dated 2/18/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient was seen in the emergency department on 2/17/2021 (via ambulance) for bilateral lower extremity weeping edema, blisters on right foot 2nd toe, and had a new antibiotic. The document stated "... The dressing was soaked totally and needed to be replaced, PT recommended to request daughter to replace soaked dressing when she gets home ...." The document evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/19/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had weeping edema to both lower extremities, failed to evidence the integrity of the dressings/bandages, evidenced the patient had pain 8/10 on pain scale, and pain to touch. The document evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." During an interview on 2/24/2021 at 11:27 AM		assessment performed on 3/22/2021. ·Interdisciplinary case conferences were completed with input/participation from all active, treating disciplines to review patient's condition and plan of care on 4/06/2021 and 5/06/2021. ·Education to be provided to all clinical staff by the Administrator or designee by May 27th, 2021 to include: ·Formal and informal care coordination with interdisciplinary team members and outside entities, and documentation of care coordination activities. ·The Clinical Manager will conduct regular case conferences and case review with primary clinicians on a regular basis to ensure adequate care coordination with the interdisciplinary team members and outside entities, and to ensure documentation of care coordination activities completed during case conferences. ·Patient was discharged from agency services on 5/08/2021 ·Clinical record #8 ·Agency reviewed clinical record and was able to verify noncompliance with care coordination as cited by surveyor. ·Education to be completed by Administrator or designee by May 27, 2021. ·Education to all	

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	family stated they called 911 about "10 minutes ago [2/24/2021]" for chest pain, and stated "... [chest pain] It's been off and on since he got home from the hospital ...." She also indicated he got up this morning, he wasn't feeling good, he (patient) "... took like 6 nitros [nitroglycerin for chest pain] no relief." She also indicated he was coughing quite a bit after the nurse left yesterday (2/23/2021), and he didn't have a good night. When asked if the patient complained of pain since he came home from the hospital prior to the initiation of home health services (start of care), she stated "Yes. His feet, he never feels good. So much pain." The patient was subsequently seen in the emergency department on 2/17/2021 for swelling, draining, and intractable pain in both legs, and was prescribed antibiotics. He was seen in the emergency room again on 2/24/2021 and was admitted with complaint of shortness of breath, heart failure, and chest pain. He remained hospitalized upon survey exit. 6. Record review for patient #8 was completed on 2/24/2021 and again on 3/2/2021, start of care date 6/11/2016, primary diagnosis quadriplegia (paralyzed from the neck down), unspecified, and other pertinent (but not limited to) diagnoses of, pressure ulcer left buttock, rheumatoid arthritis, depression, anxiety, tobacco use, and diabetes. Review of the document titled "Home Health Certification and Plan of Care" for certification period 6/11/2016 - 8/9/2016, indicated (but was not limited to) skilled nursing orders for wound care 3 times per week, foley catheter changes, patient/caregiver teaching related to wound care, management of health conditions, and caregiver was to provide wound care on non-nursing visit days. Review of a document dated 6/13/2016, titled		clinical staff on performance and documentation of coordination of services to be provided as described above. ·1:1 education clinical nursing staff involved in care of this patient not possible as all involved nurses no longer employed by the agency. ·Patient was discharged from agency services on 6/20/2016 ·Clinical record #9 ·Education to be completed by Administrator or designee by May 27, 2021. ·Education to all clinical staff on performance and documentation of coordination of services to be provided as described above. ·The Clinical Manager will conduct regular case conferences and case review with primary clinicians on a regular basis to ensure adequate care coordination with the interdisciplinary team members and outside entities, and to ensure documentation of care coordination activities completed during case conferences. ·Process for reporting and monitoring lab results to be implemented as described above. ·Patient was discharged from agency services on 10/14/2020 **Person Responsible:**	

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	""Visit Note Report ... SN Subsequent Visit" stated "... Usual blood sugar readings: "200 to 300 Am fasting. Some times [sic] over 500 late in the day...." and evidenced the wound on the right upper buttock was worse, a new wound on the left posterior lower buttock, a new wound on the sacrum, a stool sample was obtained, and evidenced no care coordination with a nurse/clinical manager or physician occurred to report high blood sugar readings and worsening/new wounds. This document stated "... care coordination ... not applicable ...." Review of a document dated on 6/20/2016, titled "Visit Note Report ... SN Subsequent Visit - As Needed" evidenced the visit was for patient complaint of occluded urinary catheter, urine was dark amber colored, and stated "... Upon arrival after milking foley urine flowed free ...." The document failed to evidence coordination with a nurse/clinical manager or physician for signs of UTI (urinary tract infection) such as dark colored urine and occluded catheter, and stated "... care coordination ... NO ...." 7. Record review for patient #9 was completed on 3/2/2021, start of care date 7/23/2020, evidenced a document titled "Home Health Certification and Plan of Care" for dates 9/21/2020 - 11/19/2020, with primary diagnosis encounter for attention to cystsostomy (urinary drainage tube), other pertinent diagnoses including (but not limited to), laceration without foreign body of left upper arm, diabetes, heart failure, and indicated the patient received skilled nursing services. Review of a document titled "Home Health Certification and Plan of Care" for certification period 9/21/2020 - 11/19/2020 failed to evidence the presence of a cardiac pacemaker.		Administrator **Date of Completion:** May 27, 2021 **Compliance:** ·Beginning May 14, 2021, 100% of admissions, resumptions of care, and recertifications will be audited weekly to ensure compliance with this standard. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the admissions, resumption of care, and recertifications for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of a document dated 9/22/2020 titled "Visit Note Report ... RN Recert with Skill" stated "... Cardiovascular assessment ... WNL [within normal limits] ... indwelling/suprapubic catheter ... leaking from penis ... mental status ... WNL ... alert ... oriented to person ... oriented to place ... forgetful ..." The document failed to evidence presence of a cardiac pacemaker. Review of a document dated 9/25/2020 titled "Visit Note Report ... SN Subsequent Visit" stated "... Cardiovascular assessment ... pacemaker ... Indicate type of pacemaker and rate ... unknown ....", evidenced purulent (indicative of infection) drainage from arm wound, and evidenced no care coordination with a nurse/clinical manager or physician occurred for care coordination regarding the patient's pacemaker and purulent drainage, and stated "... care coordination ... NO ...." Review of a document dated 9/29/2020 titled "Visit Note Report ... SN Subsequent Visit" evidenced urine was dark amber color, the patient was confused, and evidenced no care coordination with a nurse/clinical manager or physician occurred for care coordination regarding the patient's signs and symptoms of UTI (dark amber color urine, confusion), and stated "... care coordination ... NO ...." Review of a document dated 10/2/2020, titled "Client Coordination Note Report" stated "... Son expressed concerned [sic] that patient has come down with a UTI due to increased confusion and hallucinations ...." Review of a document dated 10/2/2020 titled "Visit Note Report ... SN Subsequent Visit" stated "... Cardiovascular assessment ... edema ... lower right			

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	... lower left ... cough ... son [name] wants to get a UA [urinalysis lab test] to rule out a UTI ...." Review of an additional document dated 10/2/2020, titled "Client Coordination Note Report" stated "... Went back to patient home and obtained a urine sample. Dropped sample off ...." Review of a document dated 10/14/2020, titled "Visit Note Report ... SN Subsequent Visit" stated "... Cardiovascular assessment ... edema ... lower right ... lower left ... cough ... confused ....", and evidenced no care coordination with a nurse/clinical manager or physician occurred for care coordination regarding the patient's edema, cough, confusion, or urinalysis follow up, and stated "... care coordination ... NO ...." Review of a document received on 3/1/2021, (not part of patient's agency clinical record) dated and signed by physician N on 10/20/2020, titled "Physician New Clinic Note" stated "... I [physician N] reviewed patient's urine culture from 2 days ago showing a Pseudomonas infection that is resistant to oral antibiotics ... I will send him down to the emergency room where he will likely benefit from an admission and treatment for urosepsis ...." During an interview on 3/1/2021 at 11:04 AM, the patient's family indicated the reason the patient was discharged in October (2020), was due to hospitalization for a bad infection, he required IV [intravenous] antibiotics, then went to a skilled nursing facility for rehab, and when he got out, they (home health agency) wouldn't see him again because of their caseload. He also indicated the patient had recurrent UTIs, and whenever he got a UTI, he got very confused. Finally, he indicated the patient had a pacemaker, and stated "Yes, left			

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	side ....", indicated it paced at 70 bpm (beats per minute), it was inserted about a year ago or two, about 8 years left on a 10 year battery, it was checked every 6 months, and he took him to an outpatient facility for the checks. During an interview on 3/2/2021 at 2:30 PM, the administrator/clinical manager indicated the agency didn't usually call for lab results, the lab faxed them to the agency if they were critical, the agency has identified a problem with UTIs, and lack of care coordination. RN B indicated she didn't see follow up for UA [urinalysis] results or for pacemaker in the patient's record.			
N 0488 Bldg. 00	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient			

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	following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on observation, record review and interview, the agency failed to ensure patients were provided a 15 day notice of their intent to discharge for 2 of 2 discharge records who required discharge notice. (#4, 12). The findings include: 1. Review of an agency policy with an approval/revised date of 4/2020, titled "Discharge Transfer Policy and Procedure" stated "... Give reasonable notice to the patient and family before termination of services to allow the patient to arrange for alternative care as needed ...." The policy failed to evidence a notice of discharge to agency patients must be given at least 15 days before the agency discharged the patients. 2. Record review for patient #4 was completed on 2/24/2021 and again on 2/25/2021, start of care date 1/31/2021, discharge date 2/23/2021, for certification period 1/31/2021 - 3/31/2021. Record review evidenced a document dated 2/9/2021, titled "Client Coordination Note Report" which stated "... SN [skilled nurse] NOMNC [medicare notice of non-coverage form/discharge notice] signed for discharge on 2/23/2021 ...." During a home visit on 2/23/2021 at 11:45 AM, the nurse performed a discharge from agency visit, which was less than 15 days after notice to discharge was given. During this time, the administrator/clinical manager indicated she	N 0488	N 488 410 IAC 17-12-2(i) and (j) and N 490 410 IAC 17-12-2(k) **PLAN** ·All staff received verbal education by the Administrator on the need for 15-day notice of discharge per Indiana regulation on 3/4/2021. ·Additional in-service education on the need for 15-day notice of discharge per Indiana regulation was provided to all staff by the Administrator or designee by May 13, 2021. ·Education will be provided through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service education. ·The Clinical Manager will conduct regular case conferences and case review with primary clinicians on a regular basis to ensure discharge planning occurs	05/13/2021

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	thought 14 days notice was required for discharge notice. 3. Record review for patient #12 was completed on 2/25/2021 and again on 3/2/2021, start of care date 1/3/2019, discharge date 2/4/2019, for certification period 1/3/2019 - 3/3/2019. Record review evidenced a document entered by former administrator K, dated 1/21/2019, titled "Client Coordination Note Report" which indicated the patient's neighbor called to request a home health aide due to the wife was unable to perform the care herself, and the document stated "... Currently we have only one bathaid [sic] who physically can't see everyone and we are in the process for recruiting another ... Also advised if we [sic] wants to choose another agency as we have limited HHA [home health aide] support at this time ...." Review of a document dated and signed by agency staff and the patient on 1/28/2019, titled "THAH [Trinity Health at Home] Home Health Notice of Medicare Non-Coverage V2" stated "... The effective date of your current home health services will end ... 02/01/2019 ... Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current home health services after the effective date indicated above ...." Review of a document dated 2/4/2019, titled "Visit Note Report ... PT [physical therapy] Discharge from Agency" evidenced the patient was discharged from the agency, 7 days after notice of discharge was given to the patient. 4. During an interview on 2/26/2021 at 11:25 AM, the administrator indicated the agency discharge policy was not specific to IDOH [Indiana		and 15-day notice of discharge if documented applicable. ·Agency has a process in place to ensure that the discharge visit is scheduled/completed no less than 15 days following the delivery of the 15-day discharge notice to applicable patients, and that the patient remains active with agency and continues to receive all required/ordered services throughout the 15-day discharge period. ·Clinical Manager or designee reviews date of all completed discharge notifications to ensure 15-day notice period compliance and continuation of services, adjusting date of scheduled discharge visit when necessary. **Person Responsible:** Administrator **Date of Completion:** 5/13/2021 **Compliance** ·Beginning May 14, 2021, 100% of scheduled discharge charts will be audited for compliance with the 15-day notice of discharge and immediate corrections made if needed. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the charts with scheduled discharges, 3 months	

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	Department of Health] regulations.		or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	
N 0490 Bldg. 00	410 IAC 17-12-2(k) Q A and performance improvement Rule 12 Sec. 2(k) A home health agency must continue, in good faith, to attempt to provide services during the five (5) day period described in subsection (i) of this rule. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented. Based on record review and interview, the agency failed to attempt to provide services during the fifteen (15) day discharge period for 1 of 2 discharge records reviewed who required discharge notice. (#12). The findings include:	N 0490	N 488 410 IAC 17-12-2(i) and (j) and N 490 410 IAC 17-12-2(k)	05/13/2021

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	1. Review of an agency policy with an approval/revised date of 4/2020, titled "Discharge Transfer Policy and Procedure" stated "... Care is taken to ensure that the needs of the patient are met ... Give reasonable notice to the patient and family before termination of services to allow the patient to arrange for alternative care as needed ...." The policy failed to evidence the agency must continue, in good faith, to attempt to provide services during the fifteen (15) day discharge period, and failed to evidence if the home health agency could not provide such services during that period, its continuing attempts to provide the services must be documented. 2. Record review for patient #12 was completed on 2/25/2021 and again on 3/2/2021, start of care date 1/3/2019, discharge date 2/4/2019, for certification period 1/3/2019 - 3/3/2019. Record review evidenced a document entered by former administrator K, dated 1/21/2019, titled "Client Coordination Note Report" which indicated the patient's neighbor called to request a home health aide due to the wife was unable to perform the care herself, and the document stated "... Currently we have only one bathaid [sic] who physically can't see everyone and we are in the process for recruiting another, administrator asked if caregiver can continue doing it [bathing the patient] for a while. Also advised if we [sic] wants to choose another agency as we have limited HHA [home health aide] support at this time ...." Review of a document dated and signed by agency staff and the patient on 1/28/2019, titled "THAH [Trinity Health at Home] Home Health Notice of Medicare Non-Coverage V2" stated "... The effective date of your current home health services will end ... 02/01/2019 ... Your Medicare provider and/or health plan have determined that		**PLAN** ·All staff received verbal education by the Administrator on the need for 15-day notice of discharge per Indiana regulation on 3/4/2021. ·Additional in-service education on the need for 15-day notice of discharge per Indiana regulation was provided to all staff by the Administrator or designee by May 13, 2021. ·Education will be provided through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service education. ·The Clinical Manager will conduct regular case conferences and case review with primary clinicians on a regular basis to ensure discharge planning occurs and 15-day notice of discharge if documented applicable. ·Agency has a process in place to ensure that the discharge visit is scheduled/completed no less than 15 days following the delivery of the 15-day discharge notice to applicable patients, and that the patient remains active with agency and continues to receive all required/ordered services throughout the 15-day discharge period. ·Clinical Manager or designee reviews date of all	

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	Medicare probably will not pay for your current home health services after the effective date indicated above ...." Review of a document dated 2/4/2019, titled "Visit Note Report ... PT [physical therapy] Discharge from Agency" evidenced the patient was discharged from the agency, 7 days after notice of discharge was given to the patient, and failed to evidence documentation the agency attempted to provide the services needed during the discharge period. 3. During the entrance conference on 2/9/2021 at 11:05 AM, when asked what the agency did if a home health aide was needed, but there was no aide available, the administrator/clinical manager indicated they would offer OT [occupational therapy] to meet the personal care needs of the patient, or refer to another agency. 4. During an interview on 2/26/2021 at 11:25 AM, the administrator indicated the agency discharge policy was not specific to IDOH [Indiana Department of Health] regulations, the agency had only one aide to cover entire service area, including Michigan patients, and the agency had trouble staffing aides for several years.		completed discharge notifications to ensure 15-day notice period compliance and continuation of services, adjusting date of scheduled discharge visit when necessary. **Person Responsible:** Administrator **Date of Completion:** 5/13/2021 **Compliance** ·Beginning May 14, 2021, 100% of scheduled discharge charts will be audited for compliance with the 15-day notice of discharge and immediate corrections made if needed. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the charts with scheduled discharges, 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and	

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			quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	
N 0520 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. Based on observation, record review and interview, the agency failed to ensure the physical therapist (PT) performed a complete comprehensive assessment that provided the agency with a total picture of the patient's current health status, in order for the agency to meet the patient's healthcare needs for 3 of 3 records reviewed with physical therapy as the only skilled service. (#7, 13, 14) The findings include: 1. Review of an agency policy, with an approval/review date of 4/2020, titled "Initial Assessment and Admission for Services" stated "... For-therapy-only [sic] cases, the therapist is the primary case manager ... staff begins the initial or comprehensive assessment ... discipline specific SOC/ROC [start of care/resumption of care] electronic assessments ... admitting staff provides appropriate care including ... observation and assessment, dressing changes, teaching and other services ... The clinician completes patient system assessment during the initial visit...."	N 0520	**CONDITION LEVEL G 510 Comprehensive Assessment of Patients CFR(s)484.55** Refer to: ·G528 Health, psychosocial, functional, cognition CFR(s)484.55(c)(1) ·G544 Update of the Comprehensive assessment CFR(s)484.55(d) N 520 410 IAC 17-13-1(a) N 541 17-14-1(a)(1)(B) **G528 Health, psychosocial, functional, cognition CFR(s)484.55(c)(1)** **Plan:** ·All Therapist staff (Physical Therapy, Occupational Therapy and Speech Therapy) staff	05/13/2021

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	2. Review of an agency policy with an approval/review date of 4/2020, titled "Care Management and the Plan of Care" stated "... During visits and other patient contacts, the clinician regularly reevaluates the client's medical condition ... assesses the patient using the appropriate comprehensive assessment form ... the therapist requests a physician order for 1 or more nursing visit(s) if the patient ... has care needs which are not within the therapist's scope of practice ...." 3. Review of an agency job description dated 05/08/2019, titled "Physical Therapist" stated "... Accurately assesses clients at admission and other required time points ... Reports changes in client condition as appropriate and in a timely manner ...." 4. A home visit of patient #7 was observed on 2/23/2021 at 1:50 PM , start of care date 1/22/2021, for certification period 1/22/2021 - 3/22/2021. The patient received physical and occupational therapy services, and skilled nursing services was ordered on 2/18/2021. The patient's primary diagnosis was COVID-19, and other diagnoses included (but not limited to) pneumonia due to COVID-19, acute respiratory failure with hypoxia (deprivation of oxygen), acute on chronic systolic (congestive) heart failure, obstructive sleep apnea, type 2 diabetes with diabetic chronic kidney disease, non-ST elevation (NSTEMI) myocardial infarction (heart attack), constipation, long term (current) use of aspirin, and long term (current) use of anticoagulants. During the home visit, The patient presented sitting upright in his recliner with both legs elevated 90 degrees to his body, and feet rested on a firm, ridged pillow, which caused visible		received education by the Administrator regarding performing a complete comprehensive assessment that provides the agency with a total picture of the patient's current health status during verbal staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Additional education was conducted by the Administrator or designee by May 13, 2021 for the clinical (Therapist and Nursing) staff including the following: ·Review of agency Initial Assessment, Admission for Services and Care Management and the Plan of Care, and Physical Therapist Policies. ·Elements of comprehensive assessment and timepoints, and specific assessment areas including full body physical, psychosocial and cognitive assessment and assessment of skin integrity, wounds, cardiac status and vital signs, and follow up with the physician and RN regarding any finding that requires additional follow up. ·Performing a complete comprehensive assessment in accordance with the Agency Initial Assessment, Admission for Services and Care Management and the Plan of Care, and Physical Therapist Policies. ·Education will be provided through mandatory in services and attendance will be tracked with	

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	pitting into both posterior ankles. His abdomen was significantly distended. He was not wearing socks, and had no footwear visible in his immediate area. Both lower legs were extremely swollen, dark red, shiny, and had multiple small open areas. His left great toe presented with a black necrotic (dead body tissue) area approximately 1.0cm (centimeters) in diameter. His right 2nd toe was swollen, with a large blister present. He had a large SDTI (suspected deep tissue injury) on his right heel. The nurse assessed his buttocks/backside which revealed an open stage 2 pressure injury on his (left side) gluteal cleft (groove between the buttocks) just below his tailbone. The wound center was yellow, and the surrounding skin was dark purple. He did not have a pressure relieving cushion on his chair. He was wearing an incontinence brief, which was soiled. His skin on his bottom was moist and hyperpigmented (darker than normal color for patient). He indicated he had an old hospital bed that did not work (the head of the bed no longer elevated) so he was sleeping in his recliner since hospital discharge, as he had chest pain and difficulty breathing while in a supine (lying on back) position, his CPAP (Continuous Positive Airway Pressure machine that forces air into lungs, generally worn during sleep) was broken and he was waiting on a new one, his legs were like this since hospital discharge and getting worse, he had severe pain to the touch of the right heel and with any movement of both feet/lower legs, he had very limited ROM (range of motion) of both lower legs and feet due to swelling and severe pain, he had no footwear that fit him, and a nurse came out to see him for the first time last week (he also indicated he thought a nurse was coming from day one). He also indicated he had a heart attack while in the hospital, and he had ongoing chest pain and poor endurance, and he		sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The Clinical Manager or designee will review all active patient records to ensure comprehensive assessments are complete and updated to reflect the patient's current health status. **·Specific action taken for clinical records #7, #13 and #14:** ·Agency action to mitigate and resolve noted deficiencies in individual client records was limited in some cases due to discharge of patient prior to or shortly after survey exit interview as well as due to agency was not provided with chart/patient identifiers or information regarding identified deficits at time of survey exit. ·Clinical record #7: ·A full and comprehensive assessment was performed with patient on 3/14/2021 and documented in a Resumption of Care OASIS on this same date. Record review by agency leadership confirms assessment included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment. ·Subsequent comprehensive assessments were	

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	only changed his brief once daily, because it was "too hard to do more than that." Record review completed on 2/24/2021, and again on 3/2/2021, evidenced a document dated 1/22/2021, by PT [physical therapist] II titled "Visit Note Report" which stated "... Visit Type: ... PT OASIS [Outcome and Assessment Information Set] Admission" indicated the patient had no pain, a standard mattress was appropriate at that time, had minimal to no risk for skin breakdown. Additionally, the document stated "... Was integumentary [skin] assessed? No ... Not applicable ... Was cardiovascular system assessed? No ... Not applicable ... Respiratory assessment findings ... WNL [within normal limits] ... Was genitourinary system assessed? No ... Not applicable ... Gastrointestinal assessment ... Not assessed due to not applicable ... [patient statement] 'I have no pain' ... Patient does not need ... HHA [home health aide] ... or SN [skilled nurse] ... Was Endocrine [conditions such as, but not limited to diabetes, thyroid issues]/Hematopoietic [system of organs and tissues involved in the production of cellular blood components] assessed? No ... Not applicable ... Head and neck assessment findings ... Not assessed due to not applicable ... sleeps in recliner ...." The document failed to evidence a complete comprehensive assessment was completed to evidence the patient's current health status, the therapist failed to request a physician order to add skilled nursing for the patient's complex medical condition upon admission, the patient was subsequently seen in the emergency department on 2/17/2021 for swelling, draining, and intractable pain in both legs, and was prescribed antibiotics. He was seen in the emergency room again on 2/24/2021 and was admitted. He remained hospitalized upon survey		completed on 3/22/2021 (Recertification OASIS documented) and at Discharge on 5/08/2021. The patient's plan of care was also updated in conjunction with the recertification assessment performed on 3/22/2021. ·Clinical record #13 ·A full and comprehensive assessment was performed with patient on 2/24/2021 and documented in a Skilled Nursing Evaluation note. Record review by agency leadership confirms assessment included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment. ·A subsequent comprehensive assessment was also completed on 3/17/2021 in conjunction with patient's agency discharge ·Clinical record #14: ·Agency was unaware of assessment deficits in chart #14 until after receipt of the survey findings on April 28, 2021. ·Patient was discharged from services on 3/23/2021. **Person Responsible:** Administrator **Date of Completion:** May 13, 2021	

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	157005	A. BUILDING 00 B. WING	03/02/2021

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	exit. During an interview on 2/24/2021 at 11:27 AM, family stated they called 911 about "10 minutes ago [2/24/2021]" for chest pain, and stated "... [chest pain] It's been off and on since he got home from the hospital ...." She also indicated he got up this morning, he wasn't feeling good, he (patient) "... took like 6 nitros [nitroglycerin for chest pain] no relief." She also indicated he was coughing quite a bit after the nurse left yesterday (2/23/2021), and he didn't have a good night. When asked if the patient complained of pain since he came home from the hospital prior to the initiation of home health services (start of care), she stated "Yes. His feet, he never feels good. So much pain." During an interview on 2/24/2021 at 2:25 PM, the administrator/clinical manager indicated she thought PT's weren't taught how to listen to heart and lung sounds in therapy school, the PT clinical manager indicated she'd always been told not to listen to lung sounds, it wasn't in the PT scope of practice, PTs were supposed to check skin, respiratory status but not heart and lung sounds, and if there were cardiac issues, they referred nursing. When queried why a nurse wasn't referred upon start of care to complete a comprehensive assessment (patient's primary diagnosis was COVID-19, and additional pertinent respiratory and cardiac diagnoses), the administrator/clinical manager stated "I can't answer that. I don't know." 5. A home visit of patient #13 was observed on 2/25/2021 at 1:50 PM , start of care date 1/22/2021, and primary diagnosis of displ intertroch fx L femur, subs for clos fx w routn heal (left hip fracture which required surgical intervention). The		**Compliance:** ·Beginning May 14, 2021, 100% of admissions, resumption of care, and recertifications will be audited weekly to ensure compliance with this standard. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the admissions, resumption of care, and recertifications for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks, then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and reported quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	

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	patient received physical and occupational therapy services, and skilled nursing and home health aide services were ordered on 2/22/2021. Review of a document dated 2/18/2021 by PT X titled "Visit Note Report" stated "... Visit Type: ... PT OASIS Admission" indicated there were no structural barriers in the patient's home, but stairs to enter the home, and stairs within the home were observed, the integumentary system was not assessed- "not applicable", the cardiovascular system was assessed, the respiratory system was not assessed- "not assessed due to not applicable", the genitourinary system was not assessed- "not applicable", the gastrointestinal system was not assessed- "not applicable", the head and neck was not assessed- "not assessed due to not applicable", and the immunologic assessment was not completed- "not assessed due to not applicable". The document failed to evidence a complete comprehensive assessment was completed to evidence the patient's current health status. 6. Record review for patient #14 was completed on 3/2/2021, start of care date 1/28/2021, primary diagnosis sepsis (a serious infection that causes your immune system to attack your body) due to E coli (bacteria). Review of a document dated and signed 1/28/2021, by PT Y titled "Visit Note Report" stated "... Visit Type: ... PT OASIS Admission" stated "... Was integumentary assessed? No ... not appropriate at time of evaluation ....", indicated pain in spine, and need for OT (occupational therapy), skilled nursing and home health aide services. The document failed to evidence a complete comprehensive assessment was completed to evidence the patient's current health status.			

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	Review of a document dated and signed 1/30/2021 by RN [registered nurse] U titled "Visit Note Report ... RN Add-On Evaluation" indicated no skin issues were identified, the patient had no pain, and no further nursing visits were necessary. Review of a document dated and signed 2/1/2021 by OT [occupational therapist] F titled "Visit Note Report ... OT Add-On Evaluation" stated "... Was integumentary [skin] assessed? No ....", and indicated the patient had left hip/groin pain. Review of a document dated and signed 2/2/2021, by PT Z titled "Visit Note Report ... PT Subsequent Visit" stated "... Pain on bed sore on bottom ....", and failed to evidence the patient's skin was assessed. Review of a document dated and signed 2/4/2021, by PT Z titled "Visit Note Report ... PT Subsequent Visit" stated "... Pain ... left buttocks pressure sore ... checked patient's buttocks while in bathroom and noted there looked like a stage II pressure sore [a partial thickness wound caused by pressure]; called MD [medical doctor] and gor [sic] order for SN to eval ...." 7. During an interview on 2/22/2021 at 1:24 PM, when asked why the PTs weren't doing complete physical assessments including (but not limited to) skin, cardiovascular, and respiratory assessments, PT clinical manager A indicated they probably weren't doing it if there was a nurse involved, if no nurse was involved then they would always do the assessments, and she always did a full assessment for the initial evaluation, but not necessarily every visit thereafter. During this interview, she also stated "PT don't do heart/lungs sounds."			

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	8. During an interview on 3/2/2021 at 2:30 PM, the administrator/clinical manager agreed the comprehensive assessments were not complete, and indicated the agency immediately addressed the concern regarding incomplete comprehensive assessments as soon as it was brought to her attention on 2/24/2021.			
N 0527 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on observation, record review and interview, the agency failed to ensure the physician was notified of changes in the patient's condition for 6 of 15 records reviewed (#3, 7, 8, 9). Findings include: 1. Review of an agency policy approval/reviewed date 4/2020 titled "Care Management and the Plan of Care" stated "... Agency staff maintain liaison among disciplines to ensure that coordinated care is provided and supports the objectives in the plan of care ... regularly coordinates patient care activities with the physician and/or other members of the health care team and documents communications ... also shares and receives patient information with other providers of care, treatment or services ...." 2. Record review for patient #3 was completed on 2/22/2021 and again on 3/2/2021, start of care date 10/10/2020, primary diagnosis urinary tract infection (UTI), site not specified, and other	N 0527	N 527 410 IAC 17-13-1(a)(2); 17-14-1(a)(1)(B) **G544 Update of the Comprehensive assessment CFR(s)484.55(d)** **Plan:** ·All Therapist staff (Physical Therapy, Occupational Therapy and Speech Therapy) and Nursing staff received education by the Administrator regarding performing a complete comprehensive re-assessment as frequently as the patient's condition warranted and requirement to document changes in patient condition and notify the physician and RN case manager in accordance with the Agency Services and Care Management and the Plan of Care and Physician Orders policy, Physical Therapist and Primary Care Nurse job descriptions during verbal staff report on 3/3/21 and at	05/27/2021

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	pertinent (but not limited to) diagnoses of cerebral palsy, morbid (severe) obesity, epilepsy, history of falling, and pacemaker. Review of a document titled "Home Health Certification and Plan of Care" for certification period 2/7/2021- 4/7/2021 indicated the patient received skilled nursing and PT services, and home health aide. The record evidenced the patient was hospitalized in observation status 2/11/2021 - 2/14/2021. Review of a document dated 2/14/2021 titled "Discharge Summary" from hospital M indicated medications including (but not limited to) Centrum Silver Men's oral tablet daily after breakfast, Docusate sodium (colace) 100mg (milligrams) twice daily after breakfast and dinner, and furosemide 40mg, 0.5 tab (20mg) daily after breakfast. Review of a document dated 2/15/2021 titled "Visit Note Report ... PT [physical therapy] Subsequent Visit" indicated no medication changes were identified (there were medication changes), and the record failed to evidence the physician was notified for post-hospitalization medication reconciliation for the new/changed medications. During an interview on 3/2/2021 at 2:30 PM, the administrator/clinical manager indicated she didn't see a medication reconciliation was completed after the patient returned home from the hospital on 2/14/2021, and agreed the medications listed in the EMR (electronic medical record) were not updated to match the medication changes on the hospital discharge documents. 3. A home visit of patient #7 was observed on 2/23/2021 at 1:50 PM, start of care date 1/22/2021, for certification period 1/22/2021 - 3/22/2021. The patient received physical and occupational		staff meeting on 3/17/21 and 3/18/21. ·Follow up in-service education was conducted by the Administrator or designee by May 13, 2021 for the Therapist and Nursing staff including the following: ·Review of agency Services and Care Management, the Plan of Care, Physician Order policies, Physical Therapist and Primary Care Nurse job descriptions. ·Performing a complete comprehensive re-assessment as frequently as the patient's condition warrants, requirement to document changes in patient condition and notification to the physician and RN case manager in accordance with the Agency Services and Care Management and the Plan of Care and Physician Orders policy. ·Further in-service education will be conducted by Administrator or designee by May 27, 2021 for all clinical staff to include the following: ·Identification and documentation of a change in patient condition and/or significant change in condition and appropriate follow-up actions when either are observed including timely notification to the physician/provider, reassessment of patient by appropriately licensed clinician(s), appropriate revision to the plan of care and	

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	therapy services, and skilled nursing services was ordered on 2/18/2021, for wounds. The patient's primary diagnosis was COVID-19, and other diagnoses, which included (but was not limited to), pneumonia due to COVID-19, acute respiratory failure with hypoxia (deprivation of oxygen), acute on chronic systolic (congestive) heart failure, obstructive sleep apnea, type 2 diabetes with diabetic chronic kidney disease, non-ST elevation (NSTEMI) myocardial infarction (heart attack), constipation, long term (current) use of aspirin, and long term (current) use of anticoagulants. Record review completed on 2/24/2021, and again on 3/2/2021, evidenced a document dated 1/22/2021, by PT X titled "Visit Note Report" which stated "... Visit Type: ... PT OASIS [Outcome and Assessment Information Set] Admission" evidenced the patient had no pain, and failed to evidence any lower extremity edema, skin breakdown or open skin area(s). Review of a document dated 2/4/2021, titled "Visit Note Report ... PT Subsequent Visit" evidenced medication changes were identified during the visit, failed to evidence what medications(s) were changed, and evidenced no care coordination with a nurse/clinical manager or physician occurred, and stated "... care coordination ... NO ...." Review of a document dated 2/6/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced medication changes were identified during the visit, failed to evidence what medications(s) were changed, and evidenced no care coordination with a nurse/clinical manager or physician occurred, and stated "... care coordination ... NO ...."		coordination of care. ·Performance of appropriate reassessment and use of appropriate assessment tools and documents including evaluations/reevaluations and, for significant changes in condition, the Follow-up OASIS assessment. ·Education will be provided through mandatory in-services and attendance will be tracked with sign-in sheets. Individual meetings will be provided for the clinicians that did not participate in the in-service. ·The Clinical Manager or designee will review all active patient records to ensure comprehensive assessments are complete and updated to reflect the patient's current health status. ·The Clinical Manager will conduct regular case conferences and case review with primary clinicians on a regular basis to ensure the patient's comprehensive assessment is updated based on changes in the patient's status. **·Specific action taken for clinical records #1, #7 and #14:** ·Agency action to mitigate and resolve noted deficiencies in individual client records was limited in some cases due to discharge of patient prior to or shortly after survey exit interview as well as due to agency was not provided with chart/patient identifiers or information regarding	

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	Review of a document dated 2/8/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had bilateral lower extremity edema (swelling), and evidenced no care coordination with a nurse/clinical manager or physician occurred, and stated "... care coordination ... NO ...." Review of a document dated 2/11/2021 titled "Visit Note Report ... OT Add-On Evaluation" evidenced the patient complained of fatigue and shortness of breath with exertion, mild foot pain (no complaint of pain prior to this visit per record review), the patient stated "... Feels like skin is stretching [describing his pain] ....", red areas were assessed on skin (patient explained it was an allergic reaction to lotion), and evidenced no care coordination with a nurse/clinical manager or physician occurred. to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/12/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had weeping edema to both lower extremities, medication changes were identified during the visit, a medication reconciliation was performed, failed to evidence what medications(s) were changed, and evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/16/2021 titled "Visit Note Report ... OT Subsequent Visit" evidenced the patient's pain was described as "burning ... stabbing", rated from 5-7 (on a pain scale 0-10, with 0 being no pain, and 10 being the most severe), pain was located to the right foot, 2nd		identified deficits at time of survey exit. ·Clinical record #1: ·Agency reviewed patient's plan of care and condition at multidisciplinary case conferences on 2/23/2021 and 3/10/2021 to collaborate and coordinate regarding any noted or potential changes in condition or patient needs. A comprehensive reassessment was also performed by physical therapy and documented in a therapy reassessment note on 2/24/2021. ·Patient was discharged from service on 3/10/2021 following agency notification that patient had elected and was admitted to hospice services. ·Clinical record #7: ·A full and comprehensive assessment was performed with patient on 3/14/2021 and documented in a Resumption of Care OASIS on this same date. Record review by agency leadership confirms assessment included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment. ·A full and comprehensive assessment was performed with patient on 3/22/2021 and documented in a Recertification OASIS on this same date. Record review by agency leadership	

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	and 3rd toes, patient was weak and unsteady, and evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/18/2021 titled "Visit Note Report ... OT Subsequent Visit" evidenced the patient was seen in the emergency department on 2/17/2021 for complaint of intractable pain in legs (10/10), legs seeping, and was given antibiotics for infection in legs per patient report. Review of a document dated 2/18/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient was seen in the emergency department on 2/17/2021 (via ambulance) for bilateral lower extremity weeping edema, blisters on right foot 2nd toe, and had a new antibiotic. The document stated "... The dressing was soaked totally and needed to be replaced, PT recommended to request daughter to replace soaked dressing when she gets home ...." The document evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." Review of a document dated 2/19/2021 titled "Visit Note Report ... PT Subsequent Visit" evidenced the patient had weeping edema to both lower extremities, failed to evidence the integrity of the dressings/bandages, evidenced the patient had pain 8/10 on pain scale, and pain to touch. The document evidenced no care coordination with a nurse/clinical manager or physician occurred to report assessment findings, and stated "... care coordination ... NO ...." During an interview on 2/24/2021 at 11:27 AM family stated they called 911 about "10 minutes		confirms assessment included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment. ·Patient was discharged from services on 5/08/2021. ·Clinical record #14: ·Agency was unaware of assessment deficits in chart #14 until following receipt of the survey findings on April 28, 2021. ·Patient was discharged from services on 3/23/2021. **Person Responsible:** PI Manager **Date of Completion:** May 27, 2021 **Compliance:** ·Beginning May 14, 2021, 100% of admissions, resumptions of care, and recertifications will be audited weekly to ensure compliance with this standard. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the admissions, resumption of care, and recertifications for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%,	

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	ago [2/24/2021]" for chest pain, and stated "... [chest pain] It's been off and on since he got home from the hospital ...." She also indicated he got up this morning, he wasn't feeling good, he (patient) "... took like 6 nitros [nitroglycerin for chest pain] no relief." She also indicated he was coughing quite a bit after the nurse left yesterday (2/23/2021), and he didn't have a good night. When asked if the patient complained of pain since he came home from the hospital prior to the initiation of home health services (start of care), she stated "Yes. His feet, he never feels good. So much pain." The patient was subsequently seen in the emergency department on 2/17/2021 for swelling, draining, and intractable pain in both legs, and was prescribed antibiotics. He was seen in the emergency room again on 2/24/2021 and was admitted with complaint of shortness of breath, heart failure, and chest pain. He remained hospitalized upon survey exit. 4. Record review for patient #8 was completed on 2/24/2021 and again on 3/2/2021, start of care date 6/11/2016, primary diagnosis quadriplegia (paralyzed from the neck down), unspecified, and other pertinent (but not limited to) diagnoses of, pressure ulcer left buttock, rheumatoid arthritis, depression, anxiety, tobacco use, and diabetes. Review of the document titled "Home Health Certification and Plan of Care" for certification period 6/11/2016 - 8/9/2016, indicated (but was not limited to) skilled nursing orders for wound care 3 times per week, foley catheter changes, patient/caregiver teaching related to wound care, management of health conditions, and caregiver was to provide wound care on non-nursing visit days. Review of a document dated 6/13/2016, titled ""Visit Note Report ... SN Subsequent Visit"		staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	

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	stated "... Usual blood sugar readings: "200 to 300 Am fasting. Some times [sic] over 500 late in the day...." and evidenced the wound on the right upper buttock was worse, a new wound on the left posterior lower buttock, a new wound on the sacrum, a stool sample was obtained, and evidenced no care coordination with the physician occurred to report high blood sugar readings and worsening/new wounds. This document stated "... care coordination ... not applicable ...." Review of a document dated on 6/20/2016, titled "Visit Note Report ... SN Subsequent Visit - As Needed" evidenced the visit was for patient complaint of occluded urinary catheter, urine was dark amber colored, and stated "... Upon arrival after milking foley urine flowed free ...." The document failed to evidence coordination with the physician for signs of UTI (urinary tract infection) such as dark colored urine and occluded catheter, and stated "... care coordination ... NO ...." 5. Record review for patient #9 was completed on 3/2/2021, start of care date 7/23/2020, evidenced a document titled "Home Health Certification and Plan of Care" for dates 9/21/2020 - 11/19/2020, with primary diagnosis encounter for attention to cystsostomy (urinary drainage tube), other pertinent diagnoses including (but not limited to), laceration without foreign body of left upper arm, diabetes, heart failure, and indicated the patient received skilled nursing services. Review of a document titled "Home Health Certification and Plan of Care" for certification period 9/21/2020 - 11/19/2020 failed to evidence the presence of a cardiac pacemaker. Review of a document dated 9/22/2020 titled "Visit Note Report ... RN Recert with Skill" stated "...			

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	Cardiovascular assessment ... WNL [within normal limits] ... indwelling/suprapubic catheter ... leaking from penis ... mental status ... WNL ... alert ... oriented to person ... oriented to place ... forgetful ..." The document failed to evidence presence of a cardiac pacemaker. Review of a document dated 9/25/2020 titled "Visit Note Report ... SN Subsequent Visit" stated "... Cardiovascular assessment ... pacemaker ... Indicate type of pacemaker and rate ... unknown ....", evidenced purulent (indicative of infection) drainage from arm wound, and evidenced no care coordination with a nurse/clinical manager or physician occurred for care coordination regarding the patient's pacemaker and purulent drainage, and stated "... care coordination ... NO ...." Review of a document dated 9/29/2020 titled "Visit Note Report ... SN Subsequent Visit" evidenced urine was dark amber color, the patient was confused, and evidenced no care coordination with a nurse/clinical manager or physician occurred for care coordination regarding the patient's signs and symptoms of UTI (dark amber color urine, confusion), and stated "... care coordination ... NO ...." Review of a document dated 10/2/2020, titled "Client Coordination Note Report" stated "... Son expressed concerned [sic] that patient has come down with a UTI due to increased confusion and hallucinations ...." Review of a document dated 10/2/2020 titled "Visit Note Report ... SN Subsequent Visit" stated "... Cardiovascular assessment ... edema ... lower right ... lower left ... cough ... son [name] wants to get a UA [urinalysis lab test] to rule out a UTI ...."			

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	Review of an additional document dated 10/2/2020, titled "Client Coordination Note Report" stated "... Went back to patient home and obtained a urine sample. Dropped sample off ...." Review of a document dated 10/14/2020, titled "Visit Note Report ... SN Subsequent Visit" stated "... Cardiovascular assessment ... edema ... lower right ... lower left ... cough ... confused ....", and evidenced no care coordination with a nurse/clinical manager or physician occurred for care coordination regarding the patient's edema, cough, confusion, or urinalysis follow up, and stated "... care coordination ... NO ...." Review of a document received on 3/1/2021, (not part of patient's agency clinical record) dated and signed by physician N on 10/20/2020, titled "Physician New Clinic Note" stated "... I [physician N] reviewed patient's urine culture from 2 days ago showing a Pseudomonas infection that is resistant to oral antibiotics ... I will send him down to the emergency room where he will likely benefit from an admission and treatment for urosepsis ...." During an interview on 3/1/2021 at 11:04 AM, the patient's family indicated the reason the patient was discharged in October (2020), was due to hospitalization for a bad infection, he required IV [intravenous] antibiotics, then went to a skilled nursing facility for rehab, and when he got out, they (home health agency) wouldn't see him again because of their caseload. He also indicated the patient had recurrent UTIs, and whenever he got a UTI, he got very confused. Finally, he indicated the patient had a pacemaker, and stated "Yes, left side ....", indicated it paced at 70 bpm (beats per minute), it was inserted about a year ago or two,			

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	about 8 years left on a 10 year battery, it was checked every 6 months, and he took him to an outpatient facility for the checks. During an interview on 3/2/2021 at 2:30 PM, the administrator/clinical manager indicated the agency didn't usually call for lab results, the lab faxed them to the agency if they were critical, the agency has identified a problem with UTIs, and lack of care coordination. RN B indicated she didn't see follow up for UA [urinalysis] results or for pacemaker in the patient's record.			
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on observation, record review and interview, the agency failed to ensure a comprehensive re-assessment was completed for all agency patients as frequently as the patients' condition warranted for 3 of 3 clinical records reviewed with a significant change in condition. (#1, 7, 14) The findings include: 1. Review of an agency policy, with an approval/review date of 4/2020, titled "Care Management and the Plan of Care" stated "... During visits and other patient contacts, the clinician regularly reevaluates the client's medical condition ... assesses the patient using the appropriate comprehensive assessment form ...	N 0541	. **CONDITION LEVEL G 510 Comprehensive Assessment of Patients CFR(s)484.55** Refer to: ·G528 Health, psychosocial, functional, cognition CFR(s)484.55(c)(1) ·G544 Update of the Comprehensive assessment CFR(s)484.55(d) N 520 410 IAC 17-13-1(a) N 541 17-14-1(a)(1)(B) **G528 Health, psychosocial,**	05/13/2021

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	The case manager/nurse/therapist: ... Reassesses the patient condition ... As appropriate ... Contacts the attending physician whenever the patient has ... Condition changes ... Completes comprehensive assessments including ... Follow-up when a significant change in condition occurs ...." 2. Review of an agency job description dated 05/08/2019, titled "Physical Therapist" stated "... Accurately assesses clients at admission and other required time points ... Reports changes in client condition as appropriate and in a timely manner ...." 3. Review of an agency job description dated (revised) 3/17/2019, titled "Primary Care Nurse (PCN)" stated "... The RN [registered nurse] is accountable for the client assessment ...." 4. Record review for patient #1 was completed on 2/10/2021, and again on 3/2/2021, start of care date 4/7/2020, primary diagnosis encounter for attention to cystostomy (suprapubic catheter- an opening in the lower abdomen where a tube is inserted directly into the bladder for drainage of urine). Review of a document titled "Home Health Certification and Plan of Care" for certification period 12/3/2020 - 1/31/2021, indicated skilled nursing services (effective 12/13/2020) once every 2 weeks for two weeks, then once every 4 weeks for 4 weeks, and 2 PRN (as needed) visits for bleeding, cardiac, catheter issues, diabetic, falls, pain, respiratory, or skin breakdown. The document failed to evidence the patient had current skin breakdown. Review of a document dated and signed by RN P on 12/30/2020, titled "Visit Note Report ... SN [skilled nurse] Subsequent Visit" evidenced no		**functional, cognition CFR(s)484.55(c)(1)** **Plan:** ·All Therapist staff (Physical Therapy, Occupational Therapy and Speech Therapy) staff received education by the Administrator regarding performing a complete comprehensive assessment that provides the agency with a total picture of the patient's current health status during verbal staff report on 3/3/21 and at staff meeting on 3/17/21 and 3/18/21. ·Additional education was conducted by the Administrator or designee by May 13, 2021 for the clinical (Therapist and Nursing) staff including the following: ·Review of agency Initial Assessment, Admission for Services and Care Management and the Plan of Care, and Physical Therapist Policies. ·Elements of comprehensive assessment and timepoints, and specific assessment areas including full body physical, psychosocial and cognitive assessment and assessment of skin integrity, wounds, cardiac status and vital signs, and follow up with the physician and RN regarding any finding that requires additional follow up. ·Performing a complete comprehensive assessment in	

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	skin breakdown/open area(s), and a request was made for PT (physical therapy) to evaluate. Review of a document dated and signed by PT AA on 1/5/2021, titled "Visit Note Report ... PT Add-On Evaluation" stated "... Integumentary assessment findings: Stage 2 pressure sores along both lateral borders of sacrum [lower back] and dry skin causing itchiness all around that area ....", and evidenced the RN was notified. Review of a document dated and signed 1/6/2021, by the administrator/clinical manager titled "Physician Order" stated "... SN visit for wound/skin assessment ...." Review of a document dated and signed by LPN [licensed practical nurse] K on 1/7/2021, titled "Visit Note Report ... SN [skilled nurse] Subsequent Visit" stated "... Patient has an open area to L [left] upper buttock. It has been draining serous [a clear to pale yellow watery fluid that is found in the body] fluid. Right buttock has no open area or drainage. Buttocks are purple in color as patient does not move off of them ... This area is not listed in skin areas yet as this writer has no wound care orders as of yet. Approximately 3 cm [centimeters] x .05cm [sic] x 0.1cm. Patient unable to stand for long ... poor hydration ... tried to call physician [for orders] ...." The record failed to ensure a comprehensive re-assessment (including the administration of the OASIS) was completed on or after 1/6/2021 by a registered nurse. During an interview on 2/10/2021 at 12:40 PM, the administrator/clinical manager agreed the visit on 1/7/2021, made by a LPN should have been an RN comprehensive re-assessment visit due to the new skin breakdown.		accordance with the Agency Initial Assessment, Admission for Services and Care Management and the Plan of Care, and Physical Therapist Policies. ·Education will be provided through mandatory in services and attendance will be tracked with sign-in sheets. Individual meeting will be provided for the clinicians that did not participate in the in-service. ·The Clinical Manager or designee will review all active patient records to ensure comprehensive assessments are complete and updated to reflect the patient's current health status. **·Specific action taken for clinical records #7, #13 and #14:** ·Agency action to mitigate and resolve noted deficiencies in individual client records was limited in some cases due to discharge of patient prior to or shortly after survey exit interview as well as due to agency was not provided with chart/patient identifiers or information regarding identified deficits at time of survey exit. ·Clinical record #7: ·A full and comprehensive assessment was performed with patient on 3/14/2021 and documented in a Resumption of Care OASIS on this same date. Record review by agency leadership confirms assessment	

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	5. A home visit of patient #7 was observed on 2/23/2021 at 1:50 PM, start of care date 1/22/2021, for certification period 1/22/2021 - 3/22/2021. The patient received physical and occupational therapy services, and skilled nursing services was ordered on 2/18/2021. The patient's primary diagnosis was COVID-19, and other diagnoses included (but not limited to) pneumonia due to COVID-19, acute respiratory failure with hypoxia (deprivation of oxygen), acute on chronic systolic (congestive) heart failure, obstructive sleep apnea, type 2 diabetes with diabetic chronic kidney disease, non-ST elevation (NSTEMI) myocardial infarction (heart attack), constipation, long term (current) use of aspirin, and long term (current) use of anticoagulants. During the home visit, The patient presented sitting upright in his recliner with both legs elevated 90 degrees to his body, and feet rested on a firm, ridged pillow, which caused visible pitting into both posterior ankles. His abdomen was significantly distended. He was not wearing socks, and had no footwear visible in his immediate area. Both lower legs were extremely swollen, dark red, shiny, and had multiple small open areas. His left great toe presented with a black necrotic (dead body tissue) area approximately 1.0cm (centimeters) in diameter. His right 2nd toe was swollen, with a large blister present. He had a large SDTI (suspected deep tissue injury) on his right heel. The nurse assessed his buttocks/backside which revealed an open stage 2 pressure injury on his (left side) gluteal cleft (groove between the buttocks) just below his tailbone. The wound center was yellow, and the surrounding skin was dark purple. He did not have a pressure relieving cushion on his chair. He was wearing an incontinence brief, which was soiled. His skin on his bottom was moist and		included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment. ·Subsequent comprehensive assessments were completed on 3/22/2021 (Recertification OASIS documented) and at Discharge on 5/08/2021. The patient's plan of care was also updated in conjunction with the recertification assessment performed on 3/22/2021. ·Clinical record #13 ·A full and comprehensive assessment was performed with patient on 2/24/2021 and documented in a Skilled Nursing Evaluation note. Record review by agency leadership confirms assessment included assessment of all body systems and the patient's health, psychosocial, functional and cognitive statuses. The plan of care was updated in conjunction with this assessment. ·A subsequent comprehensive assessment was also completed on 3/17/2021 in conjunction with patient's agency discharge ·Clinical record #14: ·Agency was unaware of assessment deficits in chart #14 until after receipt of the survey findings on April 28, 2021. ·Patient was discharged	

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	hyperpigmented (darker than normal color for patient). He indicated he had an old hospital bed that did not work (the head of the bed no longer elevated) so he was sleeping in his recliner since hospital discharge, as he had chest pain and difficulty breathing while in a supine (lying on back) position, his CPAP (Continuous Positive Airway Pressure machine that forces air into lungs, generally worn during sleep) was broken and he was waiting on a new one, his legs were like this since hospital discharge and getting worse, he had severe pain to the touch of the right heel and with any movement of both feet/lower legs, he had very limited ROM (range of motion) of both lower legs and feet due to swelling and severe pain, he had no footwear that fit him, and a nurse came out to see him for the first time last week (he also indicated he thought a nurse was coming from day one). He also indicated he had a heart attack while in the hospital, and he had ongoing chest pain and poor endurance, and he only changed his brief once daily, because it was "too hard to do more than that." Record review completed on 2/24/2021, and again on 3/2/2021, evidenced a document dated 1/22/2021, by PT X titled "Visit Note Report" which stated "... Visit Type: ... PT OASIS [Outcome and Assessment Information Set] Admission" indicated the patient had no pain, a standard mattress was appropriate at that time, had minimal to no risk for skin breakdown. Additionally, the document stated "... Was integumentary [skin] assessed? No ... Not applicable ...." The document evidenced the patient had no pain, and failed to evidence any lower extremity edema, skin breakdown or open skin area(s). The patient was subsequently seen in the emergency department on 2/17/2021 for swelling, draining, and intractable pain in both		from services on 3/23/2021. **Person Responsible:** Administrator **Date of Completion:** May 13, 2021. **Compliance:** ·Beginning May 14, 2021, 100% of admissions, resumption of care, and recertifications will be audited weekly to ensure compliance with this standard. Audits will be completed until 100% compliance is met for 4 weeks. ·Once met, weekly audits will continue at 50% of the admissions, resumption of care, and recertifications for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks, then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and reported quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.	

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	legs, and was prescribed antibiotics. He was seen in the emergency room again on 2/24/2021, and was admitted with complaint of shortness of breath, chest pain. He remained hospitalized upon survey exit dated 03/02/2021. Review of a document dated and signed 2/12/2021, by PT BB titled "Visit Note Report ... PT Subsequent Visit" indicated the patient had weeping edema to both lower extremities. Review of a document dated and signed 2/16/2021, by OT CC titled "Visit Note Report ... OT Subsequent Visit" indicated the patient had pain to right foot, 2nd and 3rd toes, burning, and stabbing. Review of a document dated and signed 2/18/2021, by OT CC titled "Visit Note Report ... OT Subsequent Visit" evidenced the patient was seen in the emergency department on 2/17/2021 for complaint of pain and legs seeping, and was sent home on oral antibiotics for "infection in legs" per patient report, and a referral for skilled nursing was requested. Review of a document dated and signed 2/20/2021, by RN J titled "Visit Note Report ... RN Add-On Evaluation" evidenced the patient had lower extremity edema, open seeping wounds to both lower legs, open wound to left buttock (Pressure ulcer), abnormal heart sounds, abnormal breath sounds, poor appetite, and poor hydration. The record failed to evidence a comprehensive re-assessment (including the administration of the OASIS) was completed for the patient's change in condition. During an interview on 2/24/2021 at 11:27 AM, family stated they called 911 about "10 minutes			

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	ago [2/24/2021]" for chest pain, and stated "... [chest pain] It's been off and on since he got home from the hospital ...." She also indicated he got up this morning, he wasn't feeling good, he (patient) "... took like 6 nitros [nitroglycerin for chest pain] no relief." She also indicated he was coughing quite a bit after the nurse left yesterday (2/23/2021), and he didn't have a good night. When asked if the patient complained of pain since he came home from the hospital prior to the initiation of home health services (start of care), she stated "Yes. His feet, he never feels good. So much pain." During an interview on 2/24/2021 at 2:25 PM, the administrator/clinical manager indicated an add-on evaluation did not include OASIS elements. When asked why a nurse wasn't referred upon start of care to complete a comprehensive assessment, (patient's primary diagnosis was COVID-19, and additional pertinent respiratory and cardiac diagnoses), the administrator/clinical manager stated "I can't answer that. I don't know." 6. Record review for patient #14 was completed on 3/2/2021, start of care date 1/28/2021, primary diagnosis sepsis (a serious infection that causes your immune system to attack your body) due to E coli (bacteria). Review of a document dated and signed 1/28/2021 by PT Y titled "Visit Note Report" stated "... Visit Type: ... PT OASIS Admission" stated "... Was integumentary assessed? No ... not appropriate at time of evaluation ....", indicated pain in spine, and need for OT (occupational therapy), skilled nursing and home health aide services. The document failed to evidence a complete comprehensive assessment was completed to evidence the patient's current health status.			

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	Review of a document dated and signed 1/30/2021, by RN U titled "Visit Note Report ... RN Add-On Evaluation" indicated no skin issues were identified, the patient had no pain, and no further nursing visits were necessary. Review of a document dated and signed 2/1/2021, by OT F titled "Visit Note Report ... OT Add-On Evaluation" stated "... Was integumentary [skin] assessed? No ....", and indicated the patient had left hip/groin pain. Review of a document dated and signed 2/2/2021, by PT Z titled "Visit Note Report ... PT Subsequent Visit" stated "... Pain on bed sore on bottom ....", and failed to evidence the patient's skin was assessed. Review of a document dated and signed 2/4/2021, by PT Z titled "Visit Note Report ... PT Subsequent Visit" stated "... Pain ... left buttocks pressure sore ... checked patient's buttocks while in bathroom and noted there looked like a stage II pressure sore [a partial thickness wound caused by pressure]; called MD and gor [sic] order for SN to eval ...." Review of a document dated and signed by RN J on 2/6/2021 titled "Visit Note Report ... RN Add-On Evaluation" evidenced the patient had poor hydration, was a high nutritional risk, and had a stage 2 pressure injury to the left buttock. The record failed to evidence a comprehensive re-assessment (including the administration of the OASIS) was completed for the patient's change in condition.			
N 9999 Bldg. 00				

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	INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017]: Chapter 2.5. Drug Testing of Employees Sec. 0.5. This chapter does not apply to a home health employee licensed under IC 25. Sec. 1. (a) After giving a job applicant written notice of the home health agency's drug testing policy, a home health agency shall require a job applicant who is seeking employment with the home health agency for a position that will have direct contact with a patient to be tested for the illegal use of a controlled substance. (b) A home health agency may use a job applicant's: (1) refusal to submit to a drug test; or (2) positive test result from a drug test; as a basis for refusing to hire the job applicant. (c) If a job applicant is hired by the home health agency before the job applicant's results of the drug test are received, the hired individual may not have any contact with patients until the home health agency obtains results of the drug test that indicate that the individual tested negative on the drug test. If the drug test results indicate that the individual tested positive on the drug test, the home health agency shall discharge or discipline the individual. If the home health agency disciplines the individual, the individual may have no direct contact with a patient for at least six (6) months. Sec. 2. (a) A home health agency must:(1) have a written drug testing policy that is distributed to all employees; and (2) require each employee to acknowledge receipt of the policy. (b) A home health agency shall randomly test: (1) at least fifty percent (50%) of the home health agency's employees who: (A) have direct contact with patients; and (B) are not licensed by a board or commission under IC 25; at least annually; or (2) when the home health agency has reasonable suspicion that an employee is engaged in the illegal use of a controlled substance. (c) A home health agency	N 9999	**Note, N9999 Final Observations** ·St Joseph VNA's policy for drug testing of employees has been updated to align with Indiana Home Health Agencies Regulations on 03/04/2021 **Person Responsible:** Administrator **Date of Completion:** 3/04/2021.	03/04/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157005	A. BUILDING 00 B. WING	03/02/2021

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	shall either discharge or discipline with a minimum of a six (6) month suspension an employee who refuses to submit to a drug test. Sec. 3. If an employee tests positive on a drug test, and the employee does not have a valid prescription for the substance for which the employee tested positive on the drug test, the home health agency shall have the results of the test verified by a confirmation test. The employee shall pay for the confirmation test. If the positive test result is confirmed, the home health agency shall either discharge the employee or suspend the employee from coming into direct contact with patients for at least six (6) months after the date of the confirmation test result. An employee who has a valid prescription for the substance for which the employee tested positive on a drug test may not be terminated or suspended under this subsection. Sec. 4. A home health agency that: (1) discharges or disciplines an employee; or (2) refuses to hire a job applicant; because of a positive drug test result or a refusal to submit to a drug test is considered to have discharged, disciplined, or refused to hire the individual for just cause. Sec. 5. (a) A home health agency, when acting in good faith, is immune from civil liability for: (1) conducting employee drug testing in compliance with this chapter; or (2) taking an employee disciplinary action or discharging an employee in compliance with this chapter as a result of the employee drug testing. (b) Subsection (a) does not apply to actions that constitute gross negligence or willful or wanton misconduct. THIS STATE RULE WAS NOT MET BY AS EVIDENCED BY: Based on record review and interview, the agency failed to have a written drug testing policy			

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	specific to Indiana state rule. The findings include: 1. Review of a Trinity Health at Home policy with effective date 1/1/2020, titled "Drug Free Workplace" failed to evidence employee drug testing guidelines based on current Indiana state rule. 2. During an interview on 3/2/2021 at 2:30 p.m., the administrator and colleague relations partner, person C (human resource department) agreed the current drug testing policy did not include agency/employee requirements under the Indiana state rule.			