STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157078	A. BUILDING B. WING	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOME CARE SERVICES INC	1909 SOUTH HEATON STREET, KNOX , IN, 46534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	This survey was a Federal Re-certification, a focused Infection Control and State licensure survey in conjunction with a complaint for a home health agency. Complaint: IN00358569 - substantiated with findings Survey Dates: 8/9/2021 - 8/18/2021 Facility ID: 157078 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Community Home Care Services, Inc. is precluded from providing its own home health aide training and competency evaluation for a period of two years from 08/18/2021 - 08/18/2023, due to being found out of compliance with Conditions of Participation 484.60 Care Planning, Coordination of Care and Quality of Care, 484.65 Quality	G0000		2021-11-22

	Assessment and Performance Improvement, 484.75 Skilled Professional Services and 484.105 Organization and Administration of Services.			
N0000	Initial Comments This survey was a State re-licensure survey in conjunction with a complaint for a home health agency. Complaint: IN00358569 - substantiated with findings Survey Dates: 8/9/2021 - 8/18/2021 Facility ID: 157078	N0000		2021-11-22
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Survey Dates: 8/9/2021 - 8/18/2021 Facility ID: 157078 At this Emergency	E0000		2021-11-22

	Preparedness survey, Community Home Care Services, Inc. was found to not be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.			
E0006	Plan Based on All Hazards Risk Assessment 484.102(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.	E0006	The Administrator will	2021-11-22

	(2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. Review of an agency policy, revised March 2019 and obtained 8/9/2021, titled Emergency Operations Plan and Policies stated, & The emergency preparedness program includes but is not limited to, the following elements: & The plan: Is based on and includes a documented, facility-based (Agency) and community-based risk assessment, utilizing an all-hazards approach &. Review of an agency policy, revised March 2019 and obtained 8/9/2021, titled Agency Facility-Based and Community-Based Risk Assessment Policy stated, & The Agency will develop strategies to address emergent events identified by the risk assessments. & Weather related events (Agency will develop strategies based on emergent weather events for service area,		implement an Emergency Management Plan per agency policy, “Emergency Operations Plan and policies. The emergency management plan will include an all-hazards approach for both facility and community based emergent events. The emergency management plan will be evaluated by Administrator and QAPI Program and revised if indicated at least every 2 years with approval from the governing body. 1) Agency emergency management plan evaluation/assessment will include an all-hazards approach for both facility and community based emergent events specific to the location of the agency. 2) Agency’s hazard and vulnerability risk assessment will include all emergency event strategies the agency experiences.	

	e.g., tornado, severe thunderstorm, hurricane, ice storm, snow, flooding, etc.). Review of an agency binder titled Emergency Preparedness on 8/9/2021 failed to evidence a documented facility-based and community-based risk assessment. Review failed to evidence the plan considered hazards most likely to occur specific to the location of the agency. During an interview on 8/9/2021 at 1:54 PM, the alternate clinical manager indicated the risk assessment should be included in the emergency preparedness plan but she could not locate it. The alternate clinical manager indicated the plan should include strategies for extreme winter weather and blizzard and indicated there was not any included in the agency specific emergency preparedness plan.		The Administrator is responsible for the agency's QAPI program meeting all requirements of the federal regulations. Per agency policy, "Emergency Operations Planand policies", the agency administrator will implement an Emergency ManagementPlan that will include a hazard and vulnerability risk assessment of facilityand community-based hazards and strategies toaddress emergent events Theadministrator will revise and implement the Emergency Management Plan peragency policy, *"Emergency Operations Plan and Policies*. The emergencymanagement plan will include an all-hazards approach for both facility andcommunity-based emergent events specific to the location of the agencyincluding the management of the consequences of power failures, naturaldisasters, and other emergencies that would affect the HHA's ability to providecare. Agency's hazard and vulnerability risk assessment will include allemergency event strategies the agency experiences. The agency will also	

			health department, tribal, regional,State, and Federal emergency preparedness officials, and management resourcesto engage in collaborative planning and an integrated response during adisaster or emergent situation Indicatedin E0006 The administrator willensure the *"Emergency Preparedness Binder"* will have evidence of theemergency management plan to include an all-hazards approach for both facilityand community-based emergent events specific to the location of the agencyincluding the management of the consequences of power failures, naturaldisasters, and other emergencies that would affect the HHA's ability to providecare. Agency's hazard and vulnerability risk assessment will include allemergency event strategies the agency experiences. The agency will also participate in theDistrict 10 Healthcare Coalition, local health department, tribal, regional, State,and Federal emergency preparedness officials, and management resources toengage in	

			integrated response during a disasteror emergent situation Indicated in E0006 TheAdministrator is responsible for the agency's QAPI program meeting allrequirements of the federal regulations.	
E0009	Local, State, Tribal Collaboration Process 484.102(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years (annually for LTC facilities). The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. Review of an agency policy, revised March 2019 and obtained 8/9/2021, titled Emergency Operations Plan and Policies stated, & The Agency will refer to and utilize the Healthcare COOP & [and] Recovery Planning resource document from the Assistant Secretary for Preparedness and	E0009	The administrator will reviseand implement the Emergency Management Plan per agency policy, "EmergencyOperations Plan and Policies. The emergency management plan will include anall-hazards approach for both facility and community-based emergent eventsspecific to the location of the agency including the management of theconsequences of power failures, natural disasters, and other emergencies thatwould affect the HHA's ability to provide care. Agency's hazard andvulnerability risk assessment will include all emergency event strategies theagency experiences. The agency will also participate in the District10 Healthcare Coalition, local health department, tribal, regional, State, andFederal emergency preparedness officials, and management resources to engage incollaborative planning and an integrated response	2021-11-22

	strategies to ensure continuity of operations. ... While the responsibility for ensuring a coordinated disaster preparedness response lies upon the state and local emergency planning authorities, the Agency will document its efforts to contact these officials to engage in collaborative planning for an integrated emergency response. Agency will participate in a healthcare coalition as it may provide assistance in planning and addressing broader community needs that may also be supported by local health department and emergency management resources &. Review of an agency binder titled Emergency Preparedness on 8/9/2021 evidenced a document titled Healthcare COOP & Recovery Planning , revised June 2017, which stated, & State Health Authority Essential Supporting Activities include: Collect situational assessment data from Local/Regional Health Departments & Local/Regional Health Department Essential Supporting Activities include: Collect situational assessment data on the impact of the disruption of public service delivery in the local and regional area. Partner with local emergency management and social services &. Review failed to evidence documented efforts to contact local and State emergency preparedness		during a disaster or emergentsituation. Indicatedin E0009. The Administrator is responsible for the agency's QAPI program meetingall requirements of the federal regulations Theadministrator will revise and implement the Emergency Management Plan peragency policy, "Emergency Operations Plan and Policies. The emergencymanagement plan will include an all-hazards approach for both facility andcommunity-based emergent events specific to the location of the agencyincluding the management of the consequences of power failures, naturaldisasters, and other emergencies that would affect the HHA's ability to providecare. Agency's hazard and vulnerability risk assessment will include allemergency event strategies the agency experiences. The agency will also participate in theDistrict 10 Healthcare Coalition, local health department, tribal, regional,State, and Federal emergency preparedness officials, and management resourcesto engage in collaborative planning and an integrated response during adisaster or emergent situation.	

	officials per Agency s policy. Review failed to evidence the emergency preparedness plan included a process for cooperation and collaboration with local, regional, State and Federal emergency preparedness officials to maintain an integrated response during a disaster or emergency. During an interview on 8/9/2021 at 1:54 PM, the alternate clinical manager indicated the policy indicated the agency would have a process for collaboration with emergency preparedness officials and indicated she did not see in the emergency preparedness plan the agency had any collaboration with local and state emergency preparedness officials.		Indicatedin E0009 Theadministrator will ensure the *“Emergency Preparedness Binder”* will haveevidence of the emergency management plan to include an all-hazards approachfor both facility and community-based emergent events specific to the locationof the agency including the management of the consequences of power failures,natural disasters, and other emergencies that would affect the HHA’s ability toprovide care. Agency’s hazard and vulnerability risk assessment will includeall emergency event strategies the agency experiences. The agency will also participate in theDistrict 10 Healthcare Coalition, local health department, tribal, regional,State, and Federal emergency preparedness officials, and management resourcesto engage in collaborative planning and an integrated response during adisaster or emergent situation	

			Indicatedin E0009 The Administrator is responsible for the agency's QAPI program meetingall requirements of the federal regulations	
E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.] At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. 1. Review of an agency policy, revised March 2019 and obtained 8/9/2021, titled Emergency Operations Plan and Policies stated, & Mitigation activities & will be undertaken in an effort to lessen the severity and impact of a potential emergency. Such activities include: & Developing an individual emergency preparedness plan for each patient as part of the comprehensive assessment. Individual patient preparation: prioritizing patient who might require care/service during	E0017	Theadministrator will revise the patient individualized emergency preparednessplan. The plan development is part of the comprehensive assessment. TheIndividualized emergency plan includes: patient demographics, emergency contactname and phone number, physician name and contact number, Diagnosis,priority/acuity level based on care/services provided, functional status,patient/caregiver independence, instruction on limited contact with others,wearing masks, signs and symptoms of COVID-19 and to inform HHA if patientdevelops symptoms. In the event of developing symptoms or possible exposure,patient physician will be notified. Advanced planning for supplies,medications, food and equipment needed for therapies such as: oxygen,infusion/IV, ventilator, dialysis and NG tube. Also identifying who willevacuate and transport patient with relocation address and phone number. Asindicated in E0017 (#1)	2021-11-22

	emergency and advanced planning for extra supplies, equipment, medications, food and home evacuation &. 2. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021 and electronically signed by registered nurse (RN) K. This document indicated the patient s diagnoses included, but were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the left buttock and quadriplegia. This document indicated the patient had 3 Stage II pressure ulcers consisting of 2 to the left groin and 1 pressure ulcer to the buttocks. This document indicated the patient had a foley catheter (a thin, sterile tube inserted into the bladder to drain urine). Review evidenced an agency document titled Individual Patient Emergency Preparedness Plan , dated 6/18/2021 and signed by registered nurse (RN) K, which failed to evidence the document was complete and individualized to include the name of the patient s physician and phone number, diagnosis and the wound care		TheAdministrator is responsible for the agency's QAPI program meeting allrequirements of the federal regulations. Theadministrator will revise the patient individualized emergency preparednessplan. The plan development is part of the comprehensive assessment. TheIndividualized emergency plan includes: patient demographics, emergency contactname and phone number, physician name and contact number, Diagnosis,priority/acuity level based on care/services provided, functional status,patient/caregiver independence, instruction on limited contact with others,wearing masks, signs and symptoms of COVID-19 and to inform HHA if patientdevelops symptoms. In the event of developing symptoms or possible exposure,patient physician will be notified. Advanced planning for supplies,medications, food and equipment needed for therapies such as: oxygen,infusion/IV, ventilator, dialysis and NG tube. Also identifying who willevacuate and transport patient with relocation address and phone number as pertag E0017	

	and foley catheter care supplies necessary for the patient. This document indicated the patient would evacuate to another location in the event of an emergency but failed to evidence to which location. The document failed to evidence the priority/acuity level of the patient. During an interview on 8/12/2021 at 12:18 PM, the alternate clinical manager indicated the emergency preparedness plan for the patient should be specific and complete. 3. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Start of Care , dated 7/14/2021 and electronically signed by RN H, which indicated the patient s diagnosis was Type II Diabetes (a chronic condition where the body is impaired in the way it regulates and uses sugar as fuel). Review evidenced an undated agency document titled Individual Patient Emergency Preparedness Plan , signed by registered nurse (RN) K, which failed to evidence the document was complete and individualized to include the diagnosis and the evacuation plan in the event of an emergency. During an interview on 8/12/2021 at 10:01 AM, the alternate clinical		Oncall staff will have access to the Emergency Preparedness forms completed forpatients. TheAdministrator is responsible for the agency's QAPI program meeting allrequirements of the federal regulations. Theadministrator will revise the patient individualized emergency preparednessplan. The plan development is part of the comprehensive assessment. TheIndividualized emergency plan includes: patient demographics, emergency contactname and phone number, physician name and contact number, Diagnosis, priority/acuitylevel based on care/services provided, functional status, patient/caregiverindependence, instruction on limited contact with others, wearing masks, signsand symptoms of COVID-19 and to inform HHA if patient develops symptoms. In theevent of developing symptoms or possible exposure, patient physician will benotified. Advanced planning for supplies, medications, food and equipmentneeded for therapies such as: oxygen, infusion/IV, ventilator, dialysis and NGtube. Also identifying who will evacuate and transport	

	emergency preparedness plan was not complete. 4. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced an undated agency document titled Individual Patient Emergency Preparedness Plan , signed by RN H. Review failed to evidence the document was complete to include an emergency contact name and phone number. The document indicated the patient s evacuation location was a local hotel but failed to include the name of the hotel, address and phone number. During an interview on 8/16/2021 at 10:45 AM, the alternate clinical manager indicated the individualized patient emergency preparedness plan should be complete to include the evacuation location.		patient with relocationaddress and phone number. As indicated in E0017(#4) TheAdministrator is responsible for the agency's QAPI program meeting allrequirements of the federal regulations. Theadministrator will revise the patient individualized emergency preparednessplan. The plan development is part of the comprehensive assessment. TheIndividualized emergency plan includes: patient demographics, emergency contactname and phone number, physician name and contact number, Diagnosis,priority/acuity level based on care/services provided, functional status,patient/caregiver independence, instruction on limited contact with others,wearing masks, signs and symptoms of COVID-19 and to inform HHA if patientdevelops symptoms. In the event of developing symptoms or possible exposure,patient physician will be notified. Advanced planning for supplies,medications, food and equipment needed for therapies such as: oxygen,infusion/IV, ventilator, dialysis and NG tube. Also identifying who willevacuate and transport patient with relocation address and phone number. Asindicated in E0017 (#6) (#7)	

			TheAdministrator is responsible for the agency's QAPI program meeting allrequirements of the federal regulations. Each active patient clinical record wasreviewed to assure a patient individualized Emergency Preparedness plan wasdeveloped and uploaded to the patient's EMR. The Plan includes the following information: patient demographics, emergency contact nameand phone number, physician name and contact number, diagnosis, priority/acuitylevel based on care/services provided, functional status, patient/caregiverindependence, instruction on limited contact with others, wearing masks, andinformation related to external organizations participating in the care of thepatient. The information is also uploadedto the EMR and the following reports will be pulled daily by the Administratorand added to the Emergency Preparedness Binder which contains a copy of each activepatient's Emergency Preparedness Plan as well as the following reports pulleddaily: 1. PatientEmergency Preparedness: Shows the patients address, CM, Phone	

			number 2. Clientsemergency Preparedness priority classification: Shows patients ranked by theirEP priority rating The Administrator in training maintains theEmergency Preparedness Binder and keeps it securely for access in the event ofa declared emergency.	
E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.] At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. 5. Clinical record review on 8/10/2021 for patient #4, start of care 7/29/2021, evidenced an agency document titled Individual Patient Emergency Preparedness Plan which was signed by RN H. This document	E0017	Theadministrator will revise the patient individualized emergency preparednessplan. The plan development is part of the comprehensive assessment. TheIndividualized emergency plan includes: patient demographics, emergency contactname and phone number, physician name and contact number, Diagnosis,priority/acuity level based on care/services provided, functional status,patient/caregiver independence, instruction on limited contact with others,wearing masks, signs and symptoms of COVID-19 and to inform HHA if patientdevelops symptoms. In the event of developing symptoms or possible exposure,patient physician will be notified. Advanced planning for supplies,medications, food and equipment needed for	2021-11-22

	had an area subtitled Emergency Plan which indicated the patient s emergency contact and phone number, stated If necessary, patient will evacuate to : Family transported by car & Relative/Friend (Name/Phone Number): ___ & Hotel (Name/Phone Number): ___ & Shelter (Location) ___ &. This document failed to evidence the emergency plan had been completed. Review failed to evidence which family member, neighbor, hotel and/or shelter the patient could relocate to in the event of an emergency. 6. Clinical record review on 8/10/2021 for patient #5, start of care 2/24/2021, evidenced an agency document titled Individual Patient Emergency Preparedness Plan which was signed by former employee K, RN. This document had an area subtitled Relevant Healthcare Information which stated & Patient/caregiver Independent: & but failed to indicate Yes or or No. Another area subtitled Emergency Plan which indicated the patient s emergency contact and phone number, stated If necessary, patient will evacuate to : Family transported by car & Hotel (Name/Phone Number): ___ & Shelter (Location) ___ &. This document failed to evidence		therapies such as: oxygen,infusion/IV, ventilator, dialysis and NG tube. Also identifying who willevacuate and transport patient with relocation address and phone number. Asindicated in E0017 (#1) TheAdministrator is responsible for the agency's QAPI program meeting allrequirements of the federal regulations. Theadministrator will revise the patient individualized emergency preparednessplan. The plan development is part of the comprehensive assessment. TheIndividualized emergency plan includes: patient demographics, emergency contactname and phone number, physician name and contact number, Diagnosis,priority/acuity level based on care/services provided, functional status,patient/caregiver independence, instruction on limited contact with others,wearing masks, signs and symptoms of COVID-19 and to inform HHA if patientdevelops symptoms. In the event of developing symptoms or possible exposure,patient physician will be notified. Advanced planning for supplies,medications, food and equipment needed for therapies such as: oxygen,infusion/IV, ventilator,	

	the emergency plan had been completed. Review failed to evidence whether the patient/caregiver was independent. Review failed to evidence which neighbor, hotel and/or shelter the patient could relocate to in the event of an emergency. 7. Clinical record review on 8/17/2021 for patient #7, start of care 6/28/2021, evidenced an agency document titled Individual Patient Emergency Preparedness Plan which was signed by RN H. This document had an area subtitled Emergency Plan which indicated the patient s emergency contact and phone number, stated If necessary, patient will evacuate to : Family transported by car & Relative/Friend (Name/Phone Number): ___ & Hotel (Name/Phone Number): ___ & Shelter (Location) ___ &. This document failed to evidence the emergency plan had been completed. Review failed to evidence which family member, neighbor, hotel and/or shelter the patient could relocate to in the event of an emergency.		dialysis and NG tube. Also identifying who willevacuate and transport patient with relocation address and phone number as pertag E0017 Oncall staff will have access to the Emergency Preparedness forms completed forpatients. TheAdministrator is responsible for the agency's QAPI program meeting allrequirements of the federal regulations. Theadministrator will revise the patient individualized emergency preparednessplan. The plan development is part of the comprehensive assessment. TheIndividualized emergency plan includes: patient demographics, emergency contactname and phone number, physician name and contact number, Diagnosis, priority/acuitylevel based on care/services provided, functional status, patient/caregiverindependence, instruction on limited contact with others, wearing masks, signsand symptoms of COVID-19 and to inform HHA if patient develops symptoms. In theevent of developing symptoms or possible	

			exposure, patient physician will benotified. Advanced planning for supplies, medications, food and equipmentneeded for therapies such as: oxygen, infusion/IV, ventilator, dialysis and NGtube. Also identifying who will evacuate and transport patient with relocationaddress and phone number. As indicated in E0017(#4) TheAdministrator is responsible for the agency's QAPI program meeting allrequirements of the federal regulations. Theadministrator will revise the patient individualized emergency preparednessplan. The plan development is part of the comprehensive assessment. TheIndividualized emergency plan includes: patient demographics, emergency contactname and phone number, physician name and contact number, Diagnosis,priority/acuity level based on care/services provided, functional status,patient/caregiver independence, instruction on limited contact with others,wearing masks, signs and symptoms of COVID-19 and to inform HHA if patientdevelops symptoms. In the event of developing symptoms or possible exposure,patient physician will be notified. Advanced planning for supplies,medications, food	

			and equipment needed for therapies such as: oxygen,infusion/IV, ventilator, dialysis and NG tube. Also identifying who willevacuate and transport patient with relocation address and phone number. Asindicated in E0017 (#6) (#7) TheAdministrator is responsible for the agency's QAPI program meeting allrequirements of the federal regulations. Each active patient clinical record wasreviewed to assure a patient individualized Emergency Preparedness plan wasdeveloped and uploaded to the patient's EMR. The Plan includes the following information: patient demographics, emergency contact nameand phone number, physician name and contact number, diagnosis, priority/acuitylevel based on care/services provided, functional status, patient/caregiverindependence, instruction on limited contact with others, wearing masks, andinformation related to external organizations participating in the care of thepatient. The information is also uploadedto the EMR and the following reports will be pulled daily by the Administratorand added to the	

			Emergency Preparedness Binder which contains a copy of each activepatient's Emergency Preparedness Plan as well as the following reports pulleddaily: 1. PatientEmergency Preparedness: Shows the patients address, CM, Phone number 2. Clientsemergency Preparedness priority classification: Shows patients ranked by theirEP priority rating The Administrator in training maintains theEmergency Preparedness Binder and keeps it securely for access in the event ofa declared emergency.	
E0030	Names and Contact Information 484.102(c)(1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities].	E0030	Theadministrator will revise and maintain compliance of the *EmergencyPreparedness Communication Plan.* Thecommunication plan includes names and contact information for staff andentities providing services under arrangement or contract, patient physicians,volunteers if applicable Contact information for the following: Federal, State,tribal, regional, or local emergency preparedness staff and other sources ofassistance	2021-11-22

	(v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following:		such as: wound clinic services, Ostomy clinic and hospital contactinformation. Primaryand alternate means for communicating with agency staff, federal, state,tribal, regional, and local emergency management agencies. During an emergencystaff will primarily communicate by telephone or cellular phone. This *EmergencyPreparedness Communication Plan* will be reviewed and updated at least every2 years as per tag E0030 TheAdministrator is responsible for the agency's QAPI program meeting allrequirements of the federal regulations. Theadministrator will revise and maintain compliance of the *EmergencyPreparedness Communication Plan.* Thecommunication plan includes names and contact information for staff andentities providing services under arrangement or contract, patient physicians,volunteers if applicable Contact information for the following: Federal, State,tribal, regional, or local emergency preparedness staff	

	(1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). 1. Review of an agency policy, revised March 2019 and obtained 8/9/2021, titled Communication Plan and Policy for Emergency Operations Plan (EOP) stated, & The Agency has developed and maintains an emergency preparedness communication plan that complies with federal, state and local laws. The communication		such as: wound clinic services, Ostomy clinic and hospital contactinformation. Primaryand alternate means for communicating with agency staff, federal, state,tribal, regional, and local emergency management agencies. During an emergencystaff will primarily communicate by telephone or cellular phone. This *EmergencyPreparedness Communication Plan* will be reviewed and updated at least every2 years as per tag E0030 The Administrator is responsible for the agency’s QAPI program meetingall requirements of the federal regulations Eachactive patient clinical record was reviewed to assure a patient specificEmergency Preparedness plan was developed and uploaded to the patient’s EMR. Thisplan includes the name and contact information for other agencies participatingin the health care delivery to all patients utilizing external organizations andthe specific information related to other healthcare entities under	

	plan is reviewed and updated at least annually. & The communication plan includes the following: Names and contact information for the following: Staff &. 2. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced agency documents titled Skilled Visit Note . Document dated 6/24/2021 and electronically signed by former employee licensed practical nurse (LPN) B indicated the patient was seen at the wound clinic on 6/23/2021. Document dated 8/9/2021 and electronically signed by registered nurse (RN) L indicated the patient would continue to follow up with the wound clinic weekly. Review failed to evidence the name and contact number of the wound clinic. During an interview on 8/12/2021 at 12:53 PM, administrator in training D indicated the patient s wound physician was physician C from wound clinic D.		information isuploaded in the patient's EMR to be accessed by the clinical team in the eventof an emergency. The report is reviewedby Administrator weekly to assure all content is available on the report forall active patients and has the report available via the EMR and in printfashion daily.	

	3. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Skilled Visit Note , dated 7/21/2021 and electronically signed by former employee LPN B, indicated the patient had a surgical wound to the front of the left foot. Review failed to evidence the name and contact number of the wound clinic. During an interview on 8/12/2021 at 10:33 AM the alternate clinical manager indicated the patient had a paper from the wound clinic at the patient's home that explained the wound care. Review on 8/13/202 of documents from the wound clinic at hospital I, which the alternate clinical manager identified were requested of and received on 8/13/2021 from the patient s wound clinic, evidenced a document titled 06/28/2021 Follow Up in SM [hospital I] Wound Ostomy Clinic , dated 6/28/2021 and electronically signed by physician J. This document indicated the wound clinic provided wound care services for the wound on the left foot on 7/7/2021 and 7/26/2021. 4. Review on 8/9/2021 of an agency binder titled Emergency Preparedness failed to evidence the contact information for wound clinic D and the wound clinic at hospital I.			

	5. During an interview on 8/10/2021 at 1:54 PM, the alternate clinical manager indicated the contact information for other agencies providing services to agency patients should be included in the communication plan.			
E0031	Emergency Officials Contact Information 484.102(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and	E0031	Theadministrator will revise and maintain compliance of the *EmergencyPreparedness Communication Plan.* Thecommunication plan includes names and contact information for staff andentities providing services under arrangement or contract, patient physicians,volunteers if applicable Contact information for the following: Federal, State,tribal, regional, or local emergency preparedness staff and other sources ofassistance such as: wound clinic services, Ostomy clinic and hospital contactinformation. Primaryand alternate means for communicating with agency staff, federal, state,tribal, regional, and local emergency management agencies. During an emergencystaff will primarily communicate by telephone or cellular phone. This *EmergencyPreparedness*	2021-11-22

	Certification Agency. (iv) The State Protection and Advocacy Agency. Review of an agency policy, revised March 2019 and obtained 8/9/2021, titled Communication Plan and Policy for Emergency Operations Plan (EOP) stated, & The Agency has developed and maintains an emergency preparedness communication plan that complies with federal, state and local laws. The communication plan is reviewed and updated at least annually. & The communication plan includes the following: & Contact information for the following: Federal, state, tribal, regional or local emergency preparedness staff. Other sources of assistance &. Review on 8/9/2021 of an agency document titled Patient Current Information , dated 8/9/2021, evidenced patient #1 with an address in Marshall County, Indiana. Review on 8/9/2021 of an agency binder titled Emergency Preparedness evidenced an agency document titled Communication Plan: Other Sources of Assistance Contact Information , revised October 2017, which indicated the emergency preparedness staff was the police, fire and ambulance in Demotte, Indiana. Review failed to evidence the		*Communication Plan* will be reviewed and updated at least every2 years as per tag E0030 The Administrator is responsible for the agency's QAPI program meetingall requirements of the federal regulations	

	information for the city in which the agency was located. Review failed to evidence the health department contact information for Marshall County, Indiana. During an interview on 8/10/2021 at 1:54 PM, the alternate clinical manager indicated the local health department for all the counties the agency services patients should be included in the communication plan. The alternate clinical manager indicated the local contact information listed in the communication plan was for agency G and was not specific to their agency.			
E0037	EP Training Program 484.102(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E0037	Theadministrator will revise the policy, *Emergency Operations Plan TrainingProgram* to include risk assessment, policies and procedures, communication,and emergency operations plan. The agency will provide the following: initialtraining in emergency preparedness policies and procedures to all new andexisting staff, individuals providing services under the arrangement andvolunteers (if applicable). Provide emergency preparedness training at leastannually. Annual training will be modified each year, incorporating any lessonslearned from the most recent exercises, real-life emergencies occurring withinthe last year and during annual review of the emergency	2021-11-22

	*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new		operations plan by theQAPI program. Maintainingdocumentation of the training and demonstrate staff competency of emergencyprocedures evident by*: Employee Training: Emergency operations plan form*.This will demonstrate knowledge of: Emergency Operations plan trainingperformed, Community and facility based (agency) risk assessment (HVA)presented, Testing and implementation of plan and staff roles reviewed anddiscussed: staff notification, prioritized patient, agency, and community commandstructure. Emergency Communication plan reviewed and discussed to include:communication during emergency, including back-up communication, alternatemeans of communication, sharing patient information with other settings perHIPAA regulations. Indicatedin E0037 TheAdministrator is responsible for the agency's QAPI program meeting allrequirements of the federal regulations.	

under arrangement, and volunteers, consistent with their expected role.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of all emergency preparedness training.

(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:

(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least every 2 years.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:

(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least every 2 years.

(iii) Maintain documentation of the training.

	(iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Review of an agency policy, revised March 2019 and obtained 8/9/2021, titled Emergency Operations Plan (EOP) Training Program stated, & The Agency will do the following: & Provide initial training in emergency preparedness policies and procedures to all new and existing staff & Provide emergency preparedness training at least annually & Maintain documentation of the training &. Review of an agency binder titled Employee Inservices on 8/10/2021 evidenced an agency document titled Employee Training: Emergency Operations Plan (EOP) , dated 11/26/2019 for registered nurse H, date of hire 12/16/2019, which failed to evidence the signature and date of the instructor. Review failed to evidence emergency			

	was complete as indicated by a signature of the instructor. Personnel record review on 8/16/2021 for former employee licensed practical nurse (LPN) E, date of hire 2/17/2020, failed to evidence emergency preparedness training was provided. During an interview on 8/10/2021 at 1:54 PM, the alternate clinical manager indicated emergency preparedness training would be either in the personnel file or in the inservice binder and indicated annual inservices were usually completed in January or February each year. During an interview on 8/16/2021 at 10:11 AM, the alternate clinical manager indicated the personnel file for former employee LPN E did not include emergency preparedness training.			
E0039	EP Testing Requirements 484.102(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible,	E0039	Theadministrator will revise the policy, *Emergency Operations Plan TrainingProgram* to include risk assessment, policies and procedures, communication,and emergency operations plan. The agency will provide the following: initialtraining in emergency preparedness policies and procedures to all new andexisting staff, individuals providing services under the arrangement andvolunteers (if applicable). Provide emergency	2021-11-22

	every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise		preparedness training at leastannually. Annual training will be modified each year, incorporating any lessonslearned from the most recent exercises, real-life emergencies occurring withinthe last year and during annual review of the emergency operations plan by theQAPI program Emergency Communication plan reviewed and discussed to include:communication during emergency, including back-up communication, alternatemeans of communication, sharing patient information with other settings perHIPAA regulations The Administrator is responsible for the agency's QAPI program meetingall requirements of the federal regulations	

every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and

needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]

(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]

(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual			

	the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. Review of an agency policy, revised March 2018 and obtained 8/9/2021, titled Testing Program for Emergency Operations Plan (EOP) stated, & The Agency will conduct exercises to test the EOP at least annually. The Agency will do the following: Participate in a			

	community-based or when a community-based exercise is not accessible, an individual, facility-based exercise. & Conduct an additional exercise that may include, but is not limited to the following: A second full-scale exercise that is community-based or individual, facility-based. A tabletop exercise &. Review on 8/9/2021 of an agency binder titled Emergency Preparedness failed to evidence an exercise to test the emergency preparedness plan. During an interview on 8/10/2021 at 1:54 PM, the alternate clinical manager indicated she could not locate an emergency preparedness exercise and indicated an exercise should be completed every year.			
G0374	Accuracy of encoded OASIS data 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. 1. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Reporting of OASIS Information stated, & Agency staff will ensure that the accuracy of OASIS data reflects the patient s status at time of assessment and data collection &. 2. Review of an agency policy,	G0374	The agency hascontracted with consultants to assist the Administrator in quality functions toinclude: 1. Review of thecomprehensive assessments at start of care, recertifications, resumption ofcare and discharges to assure accurate, timely, compliant, and comprehensivePlans of Care, providing recommendations to clinicians for additions,enhancements or changes to documentation and	2021-11-22

	revised March 2019 and obtained 8/18/2021, titled Initial Assessments/Comprehensive Assessments stated, & Drug Regimen Review: Each patient s comprehensive assessment includes a review of all medications the patient is currently taking (prescription, non-prescription, herbs, home remedies, etc.) as well as times of medication administration and routes. The Agency nurse must consider and document each medication that the patient is taking to identify: Significant side effects. Significant drug interactions. Noncompliance with medications. Duplicative therapy. Potential adverse effects. Medication reactions. Significant medication issues & Concerns identified by clinician during medication review must be reported to physician &. 3. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced an undated agency document on 8/10/2021 titled Patient Medications which indicated the patient s medication included Ketoconazole (an antifungal medication used to treat skin infections) with a start date of 4/2/2021, Simvastatin (medication used to treat high cholesterol) with a start date of 4/2/2021, Norco 5-325 mg (medication used to treat pain) with a start date of 4/23/2021 and Eliquis (a type of		plan of care. 2. Medicationreconciliation to include significant side effects, significant druginteractions, noncompliance with medications, duplicative therapy, potentialadverse effects, medication reactions and significant medication issuesparticular to high-risk medications. Physicians will be notified of any highrisk medications. 3. Quality review ofclinician documentation to assure that clinicians are documenting only tointerventions ordered by the physician and that orders exist for all servicesprovided including recording vital signs and noting variances, height andweight 4. Review of functionallimitations and assuring OASIS responses correlate with the clinician’s assessment. 5. Evaluate if cliniciansnotify physicians of change in clinical status appropriately, 6. Participate indevelopment and implementation of QAPI program, and 7. Participate ineducation and training of agency staff related to regulations and best practiceclinical standards. The consultantscollaborate with the Administrator and provide services based on the request ofthe Administrator.	

	anticoagulant medication, a class of medications used to thin the blood to prevent blood clots) with a start date of 4/2/2021. Review of an undated agency document titled Drug Interactions indicated an interaction with a level 3 severity rating between Ketoconazole and Simvastatin. This document also indicated interactions with a level 2 severity rating between Norco and Ketoconazole and Eliquis and Ketoconazole. Review of an agency document titled Start of Care (D1) , dated 6/18/2021 and electronically signed by RN K, indicated there was no drug interaction and no issues were found during drug regimen review. This document indicated the patient was not taking any high risk medication to include anticoagulants. The document failed to evidence the OASIS was accurate to include the drug interactions and the high risk drug, Eliquis. Review failed to evidence the OASIS document was complete to include the patient s pulse. During an interview on 8/12/2021 at 12:26 PM, the alternate clinical manager indicated the OASIS document should have included the patient s pulse. At 12:53 PM, the alternate clinical manager indicated Eliquis was considered a high risk drug. At 12:55 PM,		Clinical Staff shall betrained regarding the accuracy of OASIS data. The Administrator isresponsible for assuring accuracy of encoded OASIS data. Ongoing review of the comprehensiveassessments and will assure compliance with documentation requirements. All active patients had clinical record review toassure accuracy of OASIS information including medication reconciliation. For those patients who reflectedduplicative drug therapy, interactions, adverse effects, or other issues thephysician was contacted to validate accuratemedication regime.	

	indicated the drug regimen review should have included the drug interactions. 4. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/ 22/2021 which was electronically signed by RN H on 7/21/2021 and the physician on 7/23/2021. The plan of care indicated the patient s medication included, but was not limited to, Allopurinol (a medication used to treat gout, a condition which causes severe pain, redness and tenderness in the joints), Warfarin Sodium (a type of anticoagulant medication), Clopidogrel (a medication used to prevent strokes), Amiodarone (a medication used to treat irregular heartbeats), Propylthiouracil (a medication used to treat a hyperactive thyroid), Pantoprazole Sodium (a medication used to treat acid reflux), Simvastatin (a medication used to treat high cholesterol) and Carvedilol (a medication used to treat high blood pressure and heart failure). Review evidenced an undated agency document titled Drug Interactions indicated an interaction with a level 3 severity rating between Allopurinol and			

	Sodium and Clopidogrel, Warfarin Sodium and Amiodarone, Warfarin Sodium and Propylthiouracil, Pantoprazole and Clopidogrel and Amiodarone and Simvastatin. This document also indicated interactions with a level 2 severity rating between Warfarin Sodium and Pantoprazole, Warfarin Sodium and Simvastatin, Amiodarone and Carvedilol and Propylthiouracil and Carvedilol. The document failed to evidence the drug interactions were reviewed by the clinician. Review of an agency document titled Start of Care (D1) , dated 7/14/2021 and electronically signed by RN H, indicated there was no drug interaction and no issues were found during drug regimen review. This document indicated the patient was not taking any high risk medication to include anticoagulants. The document failed to evidence the OASIS was accurate to include the drug interactions and the high risk drug, Warfarin Sodium. During an interview on 8/12/2021 at 10:03 AM, the alternate clinical manager indicated the RN should review all medications for drug interactions. 5. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced an agency document titled Home			

	Health Certification and Plan of Care for certification period 6/5/2021 8/3/2021, electronically signed and dated on 7/6/2021 by RN N, which indicated the patient s medication included, but was not limited to, Diltiazem (a medication used to treat high blood pressure and chest pain), Lovastatin (a medication used to treat high cholesterol), Dilantin (a medication used to treat seizures), Coumadin (a blood-thinning medication that is used to treat and prevent blood clots), Paxil (a medication used to treat depression and anxiety) and Escitalopram (a medication used to treat depression and anxiety). Review of an undated agency document titled Drug Interactions indicated an interaction with a level 3 severity rating between Diltiazem and Lovastatin and indicated a level 2 severity rating between Dilantin and Lovastatin, Dilantin and Diltiazem, Coumadin and Dilantin, Coumadin and Lovastatin, Coumadin and Paxil and between Coumadin and Escitalopram. Review of an agency document titled Recertification , completed on 6/2/2021 and signed by RN N, indicated there were no drug interactions. The document failed to evidence the OASIS was accurate to include the drug interactions. This document failed to evidence the OASIS			

	was complete to include the patient s height and weight. During an interview on 8/16/2021 at 10:50 AM, the alternate clinical manager indicated there were medication interactions and the OASIS should indicate the interactions were reviewed. The alternate clinical manager indicated the OASIS should have included the patient s height and weight. 6. Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced an agency document titled Comprehensive Adult Assessment, 485 P.O.C. [Plan of Care] Worksheet and Outcome and Assessment Information Set , dated 2/18/2021, and signed by former employee RN K, which failed to evidence the OASIS was complete to include immunization history. Review failed to evidence the OASIS was complete to include community agencies/social service screening. The OASIS document indicated the patient had a surgical wound from an amputation to the right 3rd toe, and the OASIS document failed to indicate the patient s wound in the nutritional health screening. During an interview on 8/18/2021 at 10:48 AM, the alternate clinical manager indicated immunization history should have been			

	10:50 AM, the alternate clinical manager indicated the community agencies/social service screening should have been completed on the OASIS assessment. At 10:51 AM, the alternate clinical manager indicated the surgical wound should have been included in the nutritional health screening. Review of an agency document titled Medication Profile , dated 2/18/2021 and signed by former employee RN K, indicated the patient s medication included Metformin (a type of hypoglycemic medication, a class of medication used to alter the blood sugar level). Review of an agency document titled Comprehensive Adult Assessment, 485 P.O.C. [Plan of Care] Worksheet and Outcome and Assessment Information Set , dated 2/18/2021 and signed by former employee RN K, indicated not applicable for the patient taking high risk medication to include hypoglycemics. Review failed to evidence the patient/caregiver was knowledgeable about special precautions associated with hypoglycemics. During an interview on 8/18/2021 at 10:55 AM, the alternate clinical manager indicated the RN should have reviewed the medications in the home at the start of care to look for drug			

	interactions. At 10:56 AM, the alternate clinical manager indicated the RN should have marked the patient was taking a high risk medication or documented the knowledge the patient had of the precautions associated with Metformin.			
G0374	Accuracy of encoded OASIS data 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. 7. During an observation on 8/11/2021, LPN (licensed practical nurse) I was observed performed a SN (skilled nurse) visit with patient #5. The patient and two family members were observed sitting in lift recliners, with their rolling walkers propped in front of them. The patient was hard of hearing, and LPN I had to speak very loudly, or the patient s family members would answer for the patient. Clinical record review on 8/12/2021, for patient #5, start of care 2/24/2021, primary diagnosis type 2 diabetes with chronic kidney disease, evidenced an agency document titled Recertification (D1) for the certification period of 6/24/2021 8/22/2021, which was signed by RN K. This document had an area subtitled Medications which stated Follow up/Recertification	G0374	The agency hascontracted with consultants to assist the Administrator in quality functions toinclude: 1. Review of thecomprehensive assessments at start of care, recertifications, resumption ofcare and discharges to assure accurate, timely, compliant, and comprehensivePlans of Care, providing recommendations to clinicians for additions,enhancements or changes to documentation and plan of care. 2. Medicationreconciliation to include significant side effects, significant druginteractions, noncompliance with medications, duplicative therapy, potentialadverse effects, medication reactions and significant medication issuesparticular to high-risk medications. Physicians will be notified of any highrisk medications. 3. Quality review ofclinician documentation to assure that clinicians are documenting only tointerventions ordered by the physician and that orders exist for all servicesprovided including recording vital signs and noting variances, height andweight	2021-11-22

	& 4. Drug interactions? & No &. An area subtitled Sensory Status which indicated the patient wore glasses and otherwise, the patient s ear/nose/throat [E/N/T] were within normal limits. Another area subtitled Endocrine indicated the patient was able to draw up and administer insulin. The section subtitled Diet indicated the patient was on a regular diet. A section of this document stated, (M1820) Current ability to Dress Lower Body Safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes: & Able to obtain, put on and remove clothing and shoes without assistance & Another section indicated the patient did not have functional limitations, including but not limited to hearing, endurance, and ambulation. The area subtitled Visit Summary stated Nursing Diagnosis/Summary: & [patient #5] & lives at home with [his/her] two [family members] & Remains homebound d/t [due to] decreased endurance & Compression stockings in place. Patient ambulates with rolling walker &. This document failed to be an accurate representation of the patient s current status. Record review of the recertification assessment failed to evidence drug interactions of		4. Review of functionallimitations and assuring OASIS responses correlate with the clinician's assessment. 5. Evaluate if cliniciansnotify physicians of change in clinical status appropriately, 6. Participate indevelopment and implementation of QAPI program, and 7. Participate ineducation and training of agency staff related to regulations and best practiceclinical standards. The consultantscollaborate with the Administrator and provide services based on the request ofthe Administrator. Clinical Staff shall betrained regarding the accuracy of OASIS data. The Administrator isresponsible for assuring accuracy of encoded OASIS data. Ongoing review of the comprehensiveassessments and will assure compliance with documentation requirements. All active patients had clinical record review toassure accuracy of	

	Review evidenced the patient was independent in dressing of their lower body. Review of an agency document titled Skilled Visit Note from 7/20/2021, which was signed by RN L, had an assessment section subtitled Sensory which indicated the patient had bilateral hearing aids. Record review of an agency document titled Drug Interactions which was received on 8/12/2021, indicated to have a total of 6 medication interactions which were as follows: Spironolactone with Potassium Chloride (listed twice) had a level 3 severity, Spironolactone with Losartan Potassium had a level 2 severity, Losartan Potassium with Potassium Chloride (listed twice) had a level 2 severity, and Carvedilol with NovoLIN had a level 1 severity. Review evidenced drug interactions of the patient s medications. During an interview on 8/11/2021, at 1:18 PM, the patient s family member indicated they assist the patient with applying light compression stockings and assists the patient with bathing. During an interview on 8/16/2021, at 10:06 AM, alternate clinical manager A indicated the recertification		OASIS information including medication reconciliation. For those patients who reflectedduplicative drug therapy, interactions, adverse effects, or other issues thephysician was contacted to validate accuratemedication regime.	

	assessment was not accurate. During an interview on 8/16/2021, at 10:13 AM, alternate clinical manager A indicated the recertification was contradictory within itself and to follow up assessments. During an interview on 8/16/2021, at 10:16 AM, alternate clinical manager A indicated a patient having bilateral hearing aids should not be documented as WNL (within normal limits).			
G0412	Written notice of patient's rights 484.50(a)(1)(i) (i) Written notice of the patient's rights and responsibilities under this rule, and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities; 1. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Consent for Treatment and Services stated, & The patient has the right to be informed in advance regarding the care to be furnished & The staff member performing the admission visit will explain the Consent/Release of Information form during the initial visit in addition to: Frequency of visits to be provided. Various disciplines to provide services. Fees for	G0412	The Agency process willassure that all paperwork is submitted by clinicians to the office in a timelyfashion. The office staff will trackreceipt in the office of all consents to treat/documentation of patient's receipt of their rights/responsibilities andcontact clinicians to submit missing paperwork to office. The Administrator isresponsible for assuring that all admission paperwork is submitted to theoffice timely Each active patient chart was reviewed to assure allpatient charts contained a consent form including notice of patient rights andconsent forms were uploaded to EMR. There is a consent form	2021-11-21

	specific services. Explanation of Medicare, Medicaid or other third party payors. Any charges to be paid by the patient. The Consent/Release of Information form is signed by the patient or designated responsible party. The Consent/Release of Information form will be placed in the medical record. 2. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, failed to evidence the Consent/Release of Information form per the agency s policy. Review failed to evidence the agency provided a written notice of the patient s rights and responsibilities in advance of furnishing care. During an interview on 8/12/2021 at 12:07 PM, office manager E indicated she could not find the consent to treat form indicating the patient was informed in writing of the notice of patient rights and responsibilities. Office manager E indicated the start of care documents may still be in the home but should have been brought into the office by the nurse and scanned into the medical record.		in the patient charts for clinical records #1and #4 which were uploaded to the EMR.	
G0412	Written notice of patient's rights 484.50(a)(1)(i) (i) Written notice of the patient's rights and responsibilities under this rule, and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section. Written notice must be understandable to persons who have limited	G0412	The Agency process willassure that all paperwork is submitted by clinicians to the office in a timelyfashion. The office staff will trackreceipt in the office of all consents to treat/documentation	2021-11-21

	English proficiency and accessible to individuals with disabilities; 3. Clinical record review on 8/10/2021 for patient #4, start of care 7/29/2021, failed to evidence the Consent/Release of Information form per the agency s policy. Review failed to evidence the agency provided a written notice of the patient s rights and responsibilities in advance of furnishing care. During an interview on 8/12/2021, at 12:17 PM, office manager E indicated the consent forms were not in the clinical record for patient #4 because RN [registered nurse] H still had them from the start of care.		of patient's receipt of their rights/responsibilities andcontact clinicians to submit missing paperwork to office. The Administrator isresponsible for assuring that all admission paperwork is submitted to theoffice timely Each active patient chart was reviewed to assure allpatient charts contained a consent form including notice of patient rights andconsent forms were uploaded to EMR. There is a consent form in the patient charts for clinical records #1and #4 which were uploaded to the EMR.	
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. 1. Review of an agency policy, revised March 2018 and	G0434	The Agency process willassure that all paperwork is submitted by clinicians to the office in a timelyfashion. The office staff will trackreceipt in the office of all consents to treat/documentation of patient's receipt of their rights/responsibilities andcontact clinicians to submit missing paperwork to office. Staffwill be re-educated to need to submit paperwork to office timely related toconsents and patient's rights documents including right to : - Participate in, be informedabout, and consentor refuse care in advance of and duringtreatment, where appropriate, with respect to--	2021-11-16

	Consent for Treatment and Services stated, & The patient has the right to be informed in advance regarding the care to be furnished and any subsequent changes in the care. & The staff member performing the admission visit will explain the Consent/Release of Information form during the initial visit in addition to: Frequency of visits to be provided. Various disciplines to provide services. Fees for specific services. Explanation of Medicare, Medicaid or other third party payors. Any charges to be paid by the patient. The Consent/Release of Information form is signed by the patient or designated responsible party. The Consent/Release of Information form will be placed in the medical record. 2. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Patient Bill of Rights and Responsibilities stated, & Patients have the right: & Participate in, be informed about and consent or refuse care in advance of and during treatment, where appropriate, with respect to: Completion of all assessments. The care to be furnished based on the comprehensive assessment. Establishing and revising the plan of care. The disciplines that will furnish the care. The frequency of visits. Expected outcomes of care, including patient-identified goals and		- Completion of all assessments; - Thecare to be furnished, based on the comprehensive assessment; - Establishing and revising the plan of care; - Thedisciplines that will furnish the care; - Thefrequency of visits; - Expectedoutcomes of care, including patient-identifiedgoals, and anticipated risks andbenefits; - Any factorsthat could impacttreatment effectiveness; and - Anychanges in the care to be furnished. Patientstatus will be reviewed prior to discharge to assure patients' progress togoals has been met and discharge is appropriate. The Administrator isresponsible for assuring that all admission paperwork is submitted to the officetimely and that patients are being discharged appropriately.	

	anticipated risks and benefits. Any factors that could impact treatment effectiveness. Any changes in the care to be furnished &. 3. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021 and electronically signed by registered nurse (RN) K. This document indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks and 2 times a week for 9 weeks and receive home health aide services 2 times a week for 9 weeks. Review failed to evidence the patient was informed of and consented to the services to be provided. Review evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/18/2021 to 8/16/2021 signed by the alternate clinical manager on 7/15/2021 and by the physician on 8/2/2021. This document indicated the patient was to receive skilled nursing 1 time a week for 9 weeks and 2 times a week for 9 weeks and receive home health aide services 2 times a week for 9 weeks. Review indicated the patient s expected outcome was the patient s wound would heal. Review failed to evidence the		Office staff willreview each Start of care chart to assure consent and patient rightsnotification document is in patient chart. The EMR of all patients were reviewed to assure consents includednotification of patient rights are documented in the patients EMR, and specifically for patients #1 (who is currently active) and #2 (patient discharged on 9/1/21), therecords include copy of the consent and patient rights notification that were signedat start of care.	

	consented to the services to be provided and the expected outcomes of care. Review failed to evidence the Consent/Release of Information form per the agency s policy. Review failed to evidence the patient was informed of and consented to the disciplines to provide services and the frequency of those services. During an interview on 8/12/2021 at 12:07 PM, office manager E indicated she could not find the consent to treat form which indicated the patient was informed of and consented to services to be provided. Office manager E indicated the start of care documents may still be in the home but should have been brought into the office by the nurse and scanned into the medical record. During an observation at the patient s home on 8/13/2021 at 7:02 PM, the agency s home folder was observed and failed to evidence a consent to treat form and a copy of the plan of care to include what services the patient was to provide, the disciplines to provide the services, the frequency of those services and expected outcomes.			

During an interview on 8/18/2021 at 12:19 PM, the alternate clinical manager indicated the agency s folder in the patient s home should include the plan of care.

4. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Service Agreement and Admission Consent which evidenced the patient was informed of and consented to skilled nursing and home health aide services.

Review of an agency document titled Occupational Therapy [OT] Evaluation , dated 8/2/2021, and electronically signed by OT M, indicated the patient was evaluated for OT services and indicated OT services would be provided 2 times a week for 3 weeks. Review failed to evidence the patient was notified of and consented to OT services in advance of OT services provided.

During an interview on 8/12/2021 at 9:49 AM, the alternate clinical manager indicated a new consent form would need to be signed by the patient to reflect the consent to OT services and uploaded into the electronic medical record. The alternate clinical manager indicated OT M was new and the agency needed to ensure everyone was made aware to update the consent forms with changes.

	Review of an agency document titled Occupational Therapy Evaluation , dated 7/28/2021, and electronically signed by OT M, evidenced the patient was to receive OT services 2 times a week for 3 weeks. Review of an agency document titled Supplemental Provider Order , dated 7/31/2021, and electronically signed by OT M, indicated OT services were to be provided 2 times a week for 3 weeks for ADL (activities of daily living) training, bathroom mobility and a home exercise program. Review of a document titled Therapy Visit Note , dated 8/6/2021, and electronically signed by OT M, evidenced the patient s problems included decreased functional mobility, safety awareness and ADLs. Review evidenced the plan for the next OT visit was to continue with safety training during tub transfers and the home exercise program. Review of a document titled Discharge/Transfer Summary , dated 8/9/2021, and electronically signed by OT M, evidenced a subsection titled Goals not met [and] reasons (If applicable): which stated, & Bathing not met due to need of someone to position shower bench and assist with lower body as there is a dressing on the (L)			

	evidence the patient was notified prior to the patient s discharge from OT services that goals were not met and patient was to be discharged from OT. During an interview on 8/18/2021 at 12:12 PM, the alternate clinical manager indicated the patient should have been provided a change of care notice form related to the discharge from OT services and should have been communicated with related to the discharge plans from OT prior to discharge. 17-12-3(b)(2)(D)(i)(AA) 17-12-3(b)(2)(D)(i)(BB) 17-12-3(b)(2)(D)(ii)(BB)			
G0436	Receive all services in plan of care 484.50(c)(5) Receive all services outlined in the plan of care. 3. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/18/2021 8/16/2021. The document was signed by the alternate clinical manager on 7/15/2021 and by the physician on 8/2/2021 and indicated the patient's diagnoses included, but were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is	G0436	Agency has implementedprocess related to scheduling – The scheduler will beresponsible for creating the calendar for each patient and each clinician willaccess the calendar to assure visits are accurate based on the Medicarecalendar week. Scheduler to review notesin EMR daily and contact each clinician if notes are not synched to EMR toassure visits for prior day were completed as scheduled. Visits missed will be rescheduled within the Medicareweek or Physicians will be notified of any missed	2021-11-22

	compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the left buttock, hypertension (high blood pressure) and quadriplegia (paralysis of all 4 limbs). Review evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/18/2021 8/16/2021. The document was signed by the alternate clinical manager on 7/15/2021 as receipt of the verbal start of care and by the physician on 8/2/2021. The plan of care failed to be established with the physician until the verbal start of care obtained by the alternate clinical manager on 7/15/2021. This document indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks and 2 times a week for 9 weeks. Review failed to evidence skilled nursing services were provided during the week of 7/25/2021. During an interview 8/12/2021 at 12:26 PM, the alternate clinical manger indicated former employee LPN B was scheduled for a skilled nursing visit on 7/26/2021 and 7/30/2021 but indicated former employee LPN B called off on 7/26/2021 and quit without notice on 7/30/2021. The alternate clinical manager		visits or variance to theordered visits. Physicians will bequeried as to need to alter Plan of care if there is a clinical impact to thepatient. Patients pendingdischarge will be reviewed 3 weeks prior to discharge to assess progress togoals. During case conference, decisionis made to recertify or discharge patients. If goals not met, plan for ongoing care vs. service needs post dischargewill be discussed with physician to determine need for ongoing care postdischarge from home health. Clinicianswill educated to this process and to document discharge planning and carerequired post discharge from agency and appropriate 15 day notification ofpending discharge to the patient. If disciplines areordered at referral and deemed not necessary, or if disciplines are notavailable, the physician will be contacted and orders revised. Clinicians to bere-educated to writing frequencies in new EMR for 9 week period (ex. SN 1 week9) vs. multiple frequencies for same discipline (SN 1 week 9, 2week 9). In addition, clinicians re-educated	

	indicated no other skilled nurse was available to provide skilled nursing services. 4. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/ 22/2021 which was electronically signed by RN H on 7/21/2021 and the physician on 7/23/2021. The plan of care indicated the patient s primary diagnosis was Type II Diabetes (a chronic condition where the body is impaired in the way it regulates and uses sugar as fuel) and evidenced the agency was to provide home health aide (HHA) services 2 times a week for 9 weeks. Review failed to evidence the agency provided home health aide services during the week of 7/4/2021, 7/25/2021 and 8/1/2021 as directed in the plan of care. During an interview on 8/12/2021 at 11:24 AM, the administrator in training D indicated there was a home health aide visit for 7/5/2021 but the visit note had not been downloaded into the electronic medical record and indicated the agency overlooked downloading the notes into the electronic medical record that day. The administrator in training D indicated there was a home		oncorrectly identifying verbal start of care order at start of care prior to oron SOC date and not 4 weeks into care. This was a clinician error in the new EMR and re-training has correctedthis issue. The agency has revisedthe order tracking process to assure follow up on unsigned orders and scanninginto EMR. If orders not returned signedwithin 2 weeks, the order will be sent to the physician office and officecalled to request signature on order. Iforder remains unsigned, the Administrator will follow up with physician officenotifying the office that patient discharge must be planned if the physician doesnot sign the plan of care/orders. The Administrator isresponsible for assuring that patients receive all services included in theplan of care. Ongoing review of the comprehensive assessments and qualityreview of the clinical notes will assure compliance with documentationrequirements. The agency hascontracted with consultants to assist the Administrator in quality functions toinclude assuring that patients receive all care delineated in the plan ofcare. Quality review of all cliniciandocumentation has been implemented to assure that	

	health aide visit scheduled on 7/30/2021 but the agency was unable to staff the visit. The administrator in training D indicated a home health aide visit was provided on 8/2/2021 but the visit note had not yet been downloaded into the electronic medical record. Requested copies of the visit notes for 7/5/2021 and 8/2/2021 and no additional documents were provided.		tointerventions ordered by the physician and that orders exist for all services The consultantscollaborate with the Administrator and provide services based on the request ofthe Administrator. The ongoing review ofOASIS, Plans of care and clinical notes will maintain the agency in compliancewith assuring patients receive care as ordered by physician Patient # 4 – This patient isdischarged from the agency as of 8/24/21, and as such the agency is unable toretrospectively impact this episode however training and processes have beenimplemented to prevent recurrence. Patient #1 – this patient remainsactive with the agency and the current episode of care contains appropriaterecertification order from prior episode. The verbal order for start of care documented in the EMR as 7/15/21 vs.6/17/21 SOC date was an error with data entry into the system due toimplementing a new EMR. Clinicians wereretrained on Point Click Care as per the Plan of Correction.	

			Patient #2 – This patient is discharged from theagency as of 9/1/21, and as such the agency is unable to retrospectively impactthis episode however training and processes have been implemented to preventrecurrence.	
G0436	Receive all services in plan of care 484.50(c)(5) Receive all services outlined in the plan of care. 1. Review of an agency policy titled Patient Bill of Rights and Responsibilities revised March 2018, stated Purpose The agency protects and promotes the rights of each individual in its care... Procedure 1. the agency protects and promotes the rights of each individual. In advance of furnishing care to the patient, during the initial evaluation visit before the initiation of treatment, the patient is informed both verbally and in writing of all rights... 7. Agency maintains documentation in the patients medical record demonstrating compliance with informing patient about rights. The patient's or legal representative signature confirming that he/ she received a copy of the rights/ responsibilities must be obtained ... 8. Patients will be informed of their rights on an ongoing basis as indicated ... 9. Agency will inform patient and/ or representative during the initial evaluation visit of responsibilities and transfer and discharge	G0436	Agency has implementedprocess related to scheduling – The scheduler will beresponsible for creating the calendar for each patient and each clinician willaccess the calendar to assure visits are accurate based on the Medicarecalendar week. Scheduler to review notesin EMR daily and contact each clinician if notes are not synched to EMR toassure visits for prior day were completed as scheduled. Visits missed will be rescheduled within the Medicareweek or Physicians will be notified of any missed visits or variance to theordered visits. Physicians will bequeried as to need to alter Plan of care if there is a clinical impact to thepatient. Patients pendingdischarge will be reviewed 3 weeks prior to discharge to assess progress togoals. During case conference, decisionis made to recertify or discharge patients. If goals not met, plan for ongoing care vs. service needs post dischargewill be discussed with	2021-11-22

	criteria per agency policy ... Patients have the right: ... Receive all services in the plan of care ... Participate in, be informed about and consent or refuse care in advance of and during treatment, where appropriate, with respect to: ... The care to be furnished based on the comprehensive assessment... The disciplines that will furnish the care ... Any changes in the care to be furnished .... 2. Clinical record review on 8/16/2021 for patient #4, start of care 7/29/2021, evidenced an agency document titled "Home Health Certification and Plan of Care" which was unsigned and failed to evidence a certification period. An area subtitled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)" stated Services for Occupational Therapist [OT]: & Effective on 08/08/2021: OT 2W2 [twice a week, for 2 weeks] & Summary of OT Orders: & ADL [activities of daily living] & Home Exercise Program & Summary of SN orders: & Monitor BP [blood pressure], Pulse, any increase or decrease of edema, noting decrease or increase of urine output, noting changes in level of activity, assess medication management of symptoms & Home safety interventions to include: no throw rugs, non cluttered walkways... Patient r		physician to determine need for ongoing care postdischarge from home health. Clinicianswill educated to this process and to document discharge planning and carerequired post discharge from agency and appropriate 15 day notification ofpending discharge to the patient. If disciplines areordered at referral and deemed not necessary, or if disciplines are notavailable, the physician will be contacted and orders revised. Clinicians to bere-educated to writing frequencies in new EMR for 9 week period (ex. SN 1 week9) vs. multiple frequencies for same discipline (SN 1 week 9, 2week 9). In addition, clinicians re-educated oncorrectly identifying verbal start of care order at start of care prior to oron SOC date and not 4 weeks into care. This was a clinician error in the new EMR and re-training has correctedthis issue. The agency has revisedthe order tracking process to assure follow up on unsigned orders and scanninginto EMR. If orders not returned signedwithin 2 weeks, the order will be sent to the physician office and officecalled	

	[right] shoulder incision site and staples will remain free from s/s [signs and symptoms] of infection &" The next section subtitled "22. Goals/Rehabilitation Potential Discharge Plans" stated "OT Goals ... Patient will perform bathe with SBA [stand by assist] ... Patient will perform dress with SBA ... Patient will be able to achieve ROM [range of motion] and strength of (R) UE [upper extremity] following MD instructions to safety perform ADLs/IADLs [instrumental ADLs, including but not limited to opening doors, housekeeping, and taking medications] ... SN Goals ... Patient will demonstrate vital signs within acceptable limits, dysrhythmias absent or controlled and no symptoms of failure he left says the patient safety will be enhanced as evidenced by well-lit pathways, secure drugs, uncluttered walkways and minimal usage of stairs by end of certification periods (9 weeks) ... The patients/ caregiver will verbalize understanding of (r/t [related to] wound treatment) surgical incision and staples, signs and symptoms of infection, and all aspects of associated care within two weeks period of time .... Review of an agency document titled "Discharge/Transfer Summary" from 8/11/2021 which was unsigned. This document had an area subtitled "Reason for Discharge" which stated, "Care Completed ... Condition on Discharge ... Vital Signs: (optional per		to request signature on order. Iforder remains unsigned, the Administrator will follow up with physician officenotifying the office that patient discharge must be planned if the physician doesnot sign the plan of care/orders. The Administrator isresponsible for assuring that patients receive all services included in theplan of care. Ongoing review of the comprehensive assessments and qualityreview of the clinical notes will assure compliance with documentationrequirements. The agency hascontracted with consultants to assist the Administrator in quality functions toinclude assuring that patients receive all care delineated in the plan ofcare. Quality review of all cliniciandocumentation has been implemented to assure that clinicians are documenting tointerventions ordered by the physician and that orders exist for all services The consultantscollaborate with the Administrator and provide services based on the request ofthe Administrator. The ongoing review ofOASIS, Plans of care and clinical notes will maintain the agency in compliancewith assuring patients receive care as ordered by physician	

	HHA Policy & Procedures) ..." Another area stated "Current Status ... Needs assist ... Outcomes ... Goals met ...." Review evidenced the patient still required assistance after discharge. Review failed to evidence the patient's goals were met. Review failed to evidence SN services were provided as outlined in the plan of care. Review evidenced an agency document titled "Discharge/Transfer Summary" from 8/11/2021, which was signed. This document had an area subtitled "Reason for Discharge" which stated, "Pt to continue with PT [physical therapy] services for diagnosis ..." Another area stated "Goals not met [and] reasons (if applicable): Eval [evaluation] only ...." Review failed to evidence the patient received OT therapy visits. Review failed to evidence OT services were provided as outlined in the plan of care. During an interview on 8/16/2021, at 12:45 PM, when queried if services were provided as ordered on the plan of care, the alternate clinical manager A indicated that in her opinion, the patient safety goal of having secured rugs should be a physical therapy goal and not nursing. The alternate clinical manager also indicated a		Patient # 4 – This patient isdischarged from the agency as of 8/24/21, and as such the agency is unable toretrospectively impact this episode however training and processes have beenimplemented to prevent recurrence. Patient #1 – this patient remainsactive with the agency and the current episode of care contains appropriaterecertification order from prior episode. The verbal order for start of care documented in the EMR as 7/15/21 vs.6/17/21 SOC date was an error with data entry into the system due toimplementing a new EMR. Clinicians wereretrained on Point Click Care as per the Plan of Correction. Patient #2 – This patient is discharged from theagency as of 9/1/21, and as such the agency is unable to retrospectively impactthis episode however training and processes have been implemented to preventrecurrence.	

	surgical incision if skilled nursing is no longer on the case.			
N0451	Home health agency administration/management 410 IAC 17-12-1(c)(8) Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence. Review of an agency policy titled Administrator: Defined revised March 2018, stated Policy The Administrator is responsible for the Agency s functions and all day-to-day operations of the Agency. The Administrator is appointed by and reports to the Governing Body & Responsibilities 1. The Governing Body has appointed the Administrator to run the Agency s day-to-day operations & 4. Administrative and supervisory functions are not delegated to another agency or organization. All services not furnished directly are monitored and controlled by the Agency & 6. The Administrator of the Agency has the following responsibilities: & Appointing a similarly qualified alternate to be available at all times during operating hours in the absence of the Administrator & 7. When the Administrator is not available,	N0451	An Administrator andAlternate Administrator have been designated for the Agency. The Alternate Administrator will beresponsible for day-to-day operations in the absence of the Administrator andare available during operating hours. The Governing Body hasappointed in writing these individuals to these positions. The Administrator JobDescription was signed by the Administrator and Alternate Administrator (asAlternate). An Organizational Charthas been completed, reviewed with staff, and posted in the agency for futurereference. The organizationalchart correlates with the Administrator/Alternate and ClinicalManager/Alternate on record with IDOH and CMS. The Administrator isresponsible	2021-11-15

	a qualified, pre-designated person who is authorized in writing by the Administrator and the Governing Body, assumes the same responsibilities and obligations as the Administrator & The Director of Clinical Services is the pre-designated person authorized in writing to act in the absence of the Administrator & 8. The Administrator or Director of Clinical Services is available during all operating hours &. Personnel record review on 8/10/2021, for alternate administrator C, date of hire unknown, but was identified by the alternate clinical manager as administrator since the change of ownership in January 2020, evidenced a document titled Job Description Administrator which was unsigned. Review on 8/17/2021, evidenced an untitled agency document which stated & Community Home Care Services & Knox, IN & Effective 01-01-2020 The Governing Body has appointed the following: & Administrator is [alternate administrator C] & Alternate administrator is [alternate clinical manager A] &. Review on 8/10/2021, evidenced		for ongoing compliance with assuring that the Administrator/Alternate Administrator and Director of Nursing and Alternate are designated bythe Governing Body and that changes in structure will be reported to the IDOHand CMS in a timely fashion. The QAPI program willaddress this requirement in quarterly meeting minutes assuring that no changesin Administrator/Alternate and DON/Alternate have occurred in prior quarter andassure the reporting to the state DOH and CMS have occurred timely.	

	an agency document titled Organizational Chart which stated &Administrator [Administrator/Clinical Manager B] & Assistant Administrator-Nursing- [alternate administrator C] & Director of Clinical Services [Administrator/Clinical Manager B] & Assistant Director of Clinical Services [alternate clinical manager A] &. Review evidenced the Organizational Chart information to be consistent with the information provided to the Indiana Department of Health. Review evidenced inconsistencies of the administrative personnel documentation within the agency. During an interview on 8/10/2021, at 3:26 PM, alternate clinical manager A indicated their job title was alternate administrator and alternate clinical manager. During an interview on 8/10/2021, at 3:41 PM, alternate clinical manager A indicated alternate administrator C was a corporate employee and probably listed himself as the alternate administrator of Community Home Care Services until more official plans came through.			

N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. 15. During an interview on 8/13/2021 at 8:58 AM, HHA G indicated she did not receive inservice training.	N0458	All personnel files ofclinical and office staff have had 100% review to assure that all the followingelements are included in each file: 1. Signed job descriptionfor all employees 2. Qualifications asidentified in job descriptions 3. Criminal History forpertinent individuals 4. Current license,certification or registration as appropriate 5. Documentation ofonboarding or orientation to job role, responsibilities that is signed by theemployee and the training individual 6. Evaluation conductedminimally annually that is signed by employee and supervisor The organizationalchart for the agency has been validated to confirm the correct structure andidentifies the Administrator/Alternate and DON/Alternate as that reported tothe DOH. The Administrator isresponsible for ensuring ongoing compliance	2021-11-18

			with personnel files. An audit of personnel files will be conductedquarterly for employees with expiring licenses, performance appraisals due andnew employee criminal history checks.	
G0458	Outcomes/goals have been achieved 484.50(d)(3) The transfer or discharge is appropriate because the physician or allowed practitioner, who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with §484.60(a)(2)(xiv) have been achieved, and the HHA and the physician or allowed practitioner, who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services; Review of an agency policy, revised and obtained 8/18/2021, titled Patient Bill of Rights and Responsibilities stated, & Patient will be discharged from Agency based on Agency Discharge Criteria Policy: & The discharge is appropriate because the physician who is responsible for the home health plan of care and the Agency agree that measurable outcomes and goals set forth in the plan of care have been achieved and the Agency and physician responsible for the home health plan of care agree that the patient no longer needs the Agency s services &. Clinical record review on 8/16/2021 for patient #6, start of	G0458	Patients pendingdischarge will be reviewed 3 weeks prior to discharge to assess progress togoals. During case conference, decisionis made to recertify or discharge patients. Discharge plans to be discussed with physician. If goals not met, plan for ongoing care vs.service needs post discharge will be discussed with physician to determine needfor ongoing care post discharge from home health. Clinicians willeducated to this process and to document discharge planning and care requiredpost discharge from agency and appropriate 15 day notification of pendingdischarge to the patient. The Administrator isresponsible for assuring patients are discharged after goals met, or thatpost-home care services are arranged for the patient before discharge.	2021-11-22

	agency document titled Plan of Care for certification period 4/19/2021 6/17/2021, signed by the alternate clinical manager and signed and dated on 6/30/2021 by the physician. This document indicated the patient s diagnoses included, but were not limited to, Type II Diabetes (a chronic condition where the body is impaired in the way it regulates and uses sugar as fuel), heart disease and hemiplegia (muscle weakness or partial paralysis on one side of the body) following a stroke. The plan of care indicated the patient was to receive skilled nursing services 1 time a week every other week for 9 weeks for a complete body assessment and fall prevention and diabetic care instruction. This document indicated the goals included, but were not limited to, no falls, patient will verbalize understanding of medications, caregiver will verbalize understanding of the use of the glucometer (a medical device used to measure sugar in the blood) and the patient will verbalize understanding of her diabetic regimen and all aspects of her care. The document indicated the patient s goal included the patient s blood pressure would remain within normal limits of a systolic blood pressure (the pressure of the blood against the walls of the arteries during the contraction of the heart and indicated as the top number of the blood pressure		Review of dischargecharts will assure ongoing compliance	

	reading) range of 100-160 and a diastolic blood pressure(the pressure of the blood against the walls of the arteries while the heart is at rest and indicated as the bottom number of the blood pressure reading) range of 60-90. Review of an agency document titled Discharge Summary , dated 6/14/2021 and signed by former employee RN K, indicated the date of discharge was 6/14/2021. Review evidenced agency documents titled Nursing Visit Record , all signed by former employee, RN [registered nurse] K. The Nursing Visit Record dated 05/03/2021, indicated the patient had a fall and failed to evidence the patient s goal was met of no falls. The document dated 6/3/2021, indicated the patient s blood pressure was 109/50 and 110/48 and failed to evidence the patient s goal was met of blood pressure within normal limits. The document dated 6/3/2021 indicated the next skilled nurse visit was 6/17/2021. Review of the documents for the certification period of 4/19/2021 6/17/2021 failed to indicate the patient s progress to goals related to the patient s verbalized understanding of the medications, the caregiver s verbalized understanding of the use of the glucometer and the patient s verbalized			

	regimen. Review failed to evidence the agency and physician agreed the patient s goals were met and patient no longer required services prior to patient discharge. During an interview on 8/18/2021 at 11:46 AM, the alternate clinical manager indicated the patient s goals were not met and was unsure why the patient was discharged when the goals were not met. The alternate clinical manager indicated she was unsure how the discharge was initiated because there was no documentation in the clinical record with the physician regarding discharge prior to the patient s discharge.			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2.	N0458	All personnel files ofclinical and office staff have had 100% review to assure that all the followingelements are included in each file: 1. Signed job descriptionfor all employees 2. Qualifications asidentified in job descriptions 3. Criminal History forpertinent individuals	2021-11-18

	(4) A copy of current license, certification, or registration. (5) Annual performance evaluations. 1. Review evidenced an agency policy titled, Personnel Records revised October 2017, stated Policy personnel files will be established and maintained for all staff. All information will be considered confidential and will be made available to authorized management personnel only... Purpose To maintain personnel files on current and former employees... Procedures 1. the personnel record or personal information for an employee will include, but not be limited to, the following: & Performed appraisal/evaluation forms & Criminal history check, if required by law & Job description: reviewed and signed by employee &. 2. Review evidenced an agency policy revised October 2017, titled Employee Orientation which stated Policy Each employee of the Agency will complete an orientation period & Procedure 1. Orientation for all employees will be coordinated, performed and documented by supervisory staff, peers and/or preceptors & 2. The Orientation		4. Current license,certification or registration as appropriate 5. Documentation ofonboarding or orientation to job role, responsibilities that is signed by theemployee and the training individual 6. Evaluation conductedminimally annually that is signed by employee and supervisor The organizationalchart for the agency has been validated to confirm the correct structure andidentifies the Administrator/Alternate and DON/Alternate as that reported tothe DOH. The Administrator isresponsible for ensuring ongoing compliance with personnel files. An audit of personnel files will be conductedquarterly for employees with expiring licenses, performance appraisals due andnew employee criminal history checks.	

	document orientation for all staff, including contract staff &. 3. Review evidenced an agency policy titled, Job Description revised October 2017, stated Policy Each employee will be furnished with a job description upon employment & Purpose To outline the responsibilities, requirements and scope of each position & 3. The job description is reviewed by the employee at time of hire/orientation and any time the job description changes &. 4. Review evidenced an agency policy titled, Performance Appraisals/ Evaluations revised October 2017, stated Purpose To review job performance based upon an employee s job description; to clarify duties and responsibilities; to determine the appropriateness of the description and the need for further training & Procedure & 2. The evaluation must be signed by the employee and supervisor & Additional [accrediting body] Requirements & 1. Personnel evaluations are completed, shared, reviewed, and signed by the designated manager/ supervisor and personnel no less frequently than every twelve (12) months & 2. Qualified personnel observe and evaluate each direct care staff member performing			

	their job duties at least annually as part of the performance evaluation &. 5. Personnel record review on 8/10/2021, for alternate administrator C, date of hire unknown, but was identified by the alternate clinical manager as an employee since the change of ownership in January 2020, evidenced a document titled Job Description Administrator which was unsigned. Review failed to evidence an annual evaluation had been performed within the last 12 months, at time of review. Review evidenced an untitled agency document which stated & Community Home Care Services & Knox, IN & Effective 01-01-2020 The Governing Body has appointed the following: & Administrator is [alternate administrator C] & Alternate administrator is [alternate clinical manager A] &. Review evidenced an agency document titled Organizational Chart which stated &Assistant Administrator-Nursing- [alternate administrator C] &. During an interview on 8/10/2021, at 3:41 PM, the alternate clinical manager A indicated alternate administrator C was a corporate employee and probably listed himself as the			

	Community Home Care Services until more official plans came through. 6. Personnel record review on 8/10/2021, for office manager E, start date 3/16/2020, evidenced a document from entity G, titled Employee Orientation Checklist which was dated 3/11/2020, incomplete and unsigned at time of review. Review failed to evidence a signed and completed orientation, a signed job description, and an annual evaluation in the employee s file. During an interview on 8/10/2021, at 3:49 PM, alternate clinical manager A stated, Here is an orientation that isn t filled out. The alternate clinical manager indicated they could not locate a signed job description or an annual evaluation in the office manager E s personnel file at time of review. 7. Personnel record review on 8/10/2021, for the administrator in training D, start date 6/1/2020, failed to evidence a signed job description for the administrator role they were hired for. During an interview on 8/10/2021, at 3:33 PM, alternate clinical manager A, indicated a signed administrator job description for could not be located in the administrator in training D s personnel file at time of review			

	8. Personnel record review on 8/11/2021, for home health aide (HHA) G, first patient contact date 7/30/2021, evidenced an agency document titled Functionalized Job Description for the position of Certified Home Health Aide, which was unsigned by the employee. Review failed to evidence a job description for the employee s role as data specialist. During an interview on 8/11/2021, at 3:56 PM, the alternate clinical manager indicated the job description for HHA G was not signed. 9. Personnel record review on 8/11/2021, for registered nurse (RN) H, start date of 12/16/2019, evidenced an agency document titled Orientation Checklist which was signed by the RN on 4/26/2019. This document had an area for a supervisor s signature which remained blank at time of review. Review failed to evidence an orientation to the job had been completed. Review failed to evidence documentation of a performance evaluation had been performed within the last 12 months, at time of review. During an interview on 8/11/2021, at 3:59 PM, alternate clinical manager A stated, Unfortunately, I am not seeing it when queried if RN H s annual			

personnel file.

10. Personnel record review on 8/11/2021, for Occupational Therapist (OT) M, date of hire 6/16/2021, evidenced an agency document titled Orientation Checklist which was undated and signed by the OT. This document had an area for a supervisor s signature which remained blank at time of review. Review failed to evidence an orientation to the job had been completed.

11. Personnel record review on 8/16/2021, for former employee E, licensed practical nurse (LPN), date of hire 2/17/2020, evidenced an untitled document that was verification of licensure which occurred on 5/6/2021. Review failed to evidence license verification was performed prior to first patient contact on 2/18/2020. Review failed to evidence documentation of orientation to the job.

12. Personnel record review on 8/11/2021, for HHA J, first patient contact date 6/14/2021, failed to evidence a signed job description in the employee file, or that a criminal history background check was performed.

13. Personnel record review on 8/11/2021, for licensed practical nurse (LPN) I, first patient contact date 8/4/2021, failed to evidence a criminal history background check was

	performed. 14. During an interview on 8/11/2021, at 3:48 PM, alternate clinical manager A indicated some of the completed background checks were sent to a different home care office by mistake, instead of Community Home Care Services in Knox, IN.			
N0460	Home health agency administration/management 410 IAC 17-12-1(g) Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment. 1. Review evidenced an agency policy titled, Personnel Records revised October 2017, stated	N0460	The personnel file ofthe supervising nurse (Clinical Manager) has been reviewed to assure it iscompliant with regulation and includes a criminal background history, a validcurrent nursing license, documentation of orientation to the job. A performance evaluation has been conductedto assure compliance with the annual requirement. The Administrator is responsible for ensuring ongoing compliance withmaintaining current personnel record of the Clinical Manager. On a quarterly basisthe Office Staff will conduct a personnel file audit assuring all currentlicensure and evaluation documents are present.	2021-11-19

	established and maintained for all staff. All information will be considered confidential and will be made available to authorized management personnel only ... Purpose To maintain personnel files on current and former employees... Procedures 1. The personnel record or personal information for an employee will include, but not be limited to, the following: & Verification of education, certification and/or licensure & Agency employee orientation &. 2. Review evidenced an agency policy titled, License, Registration or Certification Requirements revised October 2017, stated Policy The employee will be responsible for maintaining a current license for any position requiring such... Purpose To provide a mechanism whereby the Agency assures that all personnel license(s) or certification(s) are kept current and are documented in Agency records & Procedure ... 2. When current licensure, certification and/ or registration are required by law and/ or regulation to practice a profession, the Agency verifies such credentials with the primary source at time of hire and prior to or upon expiration of credentials. Primary source verification will occur through the applicable State Board of practice for: registered nurses ... If required by state law ... 4. Primary source			

	verification of current licensure, registration and/ or certification may be performed via secure electronic access or by telephone. All such verification will be documented &. 3. Personnel review on 8/10/2021, for administrator/clinical manager B, date of hire 4/29/1996, evidenced an unsigned Registered Nurse (RN) license, with an expiration date of 10/31/2021. Review failed to evidence the RN license was current and verified as indicated by the agency policy and required by State law. During an interview on 8/10/2021, at 3:54 PM, the alternate clinical manager A stated No when queried if the administrator/clinical manager B s RN license had been verified. The alternate clinical manager indicated there was not documentation in the personnel file, but verification of licensure is performed annually.			
N0462	Home health agency administration/management 410 IAC 17-12-1(h) Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the	N0462	Allpersonnel files of clinical staff have been reviewed to assure that theclinicians have had a physical examination by a physician or nurse practitioner no more than one hundred eighty(180) days beforethe date that the employee has direct	2021-11-19

	communicable diseases to patients. An agency policy titled Skilled professional Services revised March 2018, stated Purpose To define skilled professional services and responsibilities & Procedure & 2. Skilled professional services are authorized, delivered and supervised only by health care professionals who meet the appropriate qualifications and who practice according to the Agency s policies and procedures . & Personnel record review on 8/11/2021, for RN H, date of hire 12/16/2019, first patient contact date of 5/6/2021, evidenced a document from entity F, titled Encounter which was an overview of a physical exam that occurred on 12/11/2019. This document failed to evidence documentation RN H was free of communicable disease prior to first patient contact. During an interview on 8/11/2021, at 1:59 PM, alternate clinical manager A stated No when queried if the physical exam document titled Encounter stated RN H was free of communicable disease.		patient contact. The physicalexamination shall be of sufficient scope to ensure that the employee will notspread infectious or communicable diseases topatients. Ifa clinician has not had the appropriate physical examination, they will notperform care until negative exam result has been submitted to the office,reviewed and entered into employee's personnel file. The Administrator isresponsible for ensuring ongoing compliance with personnel files. An audit of personnel files will be conductedquarterly assuring all field clinicians have a physical examination completeddeclaring them free from communicable disease.	

N0466	Home health agency administration/management 410 IAC 17-12-1(j) Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). 1. Review evidenced an agency policy titled, Personnel Records revised October 2017, stated Policy personnel files will be established and maintained for all staff. All information will be considered confidential and will be made available to authorized management personnel only... Purpose To maintain personnel files on current and former employees ... Procedures & 3. Employee health information must be maintained in files separate from personnel files and in a separate location & 8. Personnel records will be retained for minimally five years after employee leaves the Agency, or according to applicable state law &. 2. Personnel record review on 8/16/2021, for former employee B, licensed practical nurse (LPN), date of hire 6/7/2021,	N0466	The personnel filereview conducted for all employees will assure the required medical informationto include physical examinations, tuberculosis evaluations and clinicalfollow-ups are maintained in separate medical files and treated as confidentialmedical records. The medical recordswill be maintained in a confidential secure area separate from the remainder ofthe personnel file. The Administrator isresponsible for ensuring ongoing compliance with personnel files. An audit of personnelfiles will be conducted quarterly current and former employees haveconfidentiality of the medical information in their personnel files.	2021-11-19

	evidenced confidential medical documents such as a physical examination and tuberculosis skin test results were being maintained with the personnel file information such as job description and orientation. Review failed to evidence the former employee s file was maintained to protect confidentiality of personal health information. 3. Personnel record review on 8/16/2021, for former employee E, licensed practical nurse (LPN), date of hire 2/17/2020, evidenced confidential medical documents such as a physical examination and tuberculosis skin test results were being maintained with the personnel file information such as job description and performance evaluation. Review failed to evidence the former employee s file was maintained to protect confidentiality of personal health information. 4. During an interview on 8/16/2021, at 10:18 AM, alternate clinical manager A indicated the files should be separate, but were combined since they are former employees.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must	N0488	The Agency has edited thepolicy entitled “Agency DischargeCriteria” to include the	2021-11-20

	develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Review of an agency policy, revised and obtained 8/18/2021, titled Discharge Criteria stated, & Patient will be discharged from		responsibility to provide thepatient with a notification of discharge at least fifteen calendar days beforeservices are stopped. The policy alsodelineates the exceptions to this which include the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency’s services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. The patient is provided with this policy as a component of the Patient Rights section of the Patient handbook provided The agency process isto pull a	

	services as follows: & The discharge is appropriate because the physician who is responsible for the home health plan of care and the Agency agree that measurable outcomes and goals set forth in the plan of care have been achieved and the Agency and physician responsible for the home health plan of care agree that the patient no longer needs the Agency s services. & The patient is informed of discharge plan in a timely manner and acknowledges understanding reason. Physician and other care providers will be informed and knowledgeable of discharge. Discharge planning begins at time of admission and will be reflected in the documentation &. Review failed to evidence the agency s policy was developed to include a 15 day notice of discharge to the patient. Review of an agency policy, revised July 2020 and obtained 8/18/2021, titled Home Health Change of Care Notice (HHCCN) and Advance Beneficiary Notice (ABN) stated, & HHCCNs are issued to patients receiving the home health care benefit for notification of plan of care changes. The Agency must provide the HHCCN whenever it reduces or terminates patient s home health services due to physician/provider orders or limitations of the Agency in providing the specific service &.		with expiring certification within3 weeks prior to end of episode. Scheduler to review report weekly to determine any ends of episodeswithin upcoming 3-week period. Process is to review with clinicians each ofthese patients progress to goals 3 weeks prior to end of episode to makedecision of probable discharge vs. recertification. Should the discharge be probable, the patientwill be provided with the discharge notification at least 15 days prior to theend of services. The agency policy “Discharge Criteria” has been edited to include the 15 day noticeof discharge to the patient. The PatientRights document provided to the patient at start of care has been edited toinclude the 15 day notice of discharge to the patient. Clinicians and clinicalManagers will be trained toward these processes as well as related to ABN andHHCCN issuance as per regulations. Clinical record reviewswill be completed of 100% of discharge patients to assure ABNs being deliveredat least 15 days prior to ending services. Staff will be provided copies of forms to	

	Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced an agency document titled Plan of Care for certification period 4/19/2021 6/17/2021, signed by the alternate clinical manager and signed and dated on 6/30/2021 by the physician. This document indicated the patient s primary diagnosis was Type II Diabetes (a chronic condition where the body is impaired in the way it regulates and uses sugar as fuel). The plan of care indicated the patient was to receive skilled nursing services 1 time a week every other week for 9 weeks for a complete body assessment and fall prevention and diabetic care instruction. Review of an agency document titled Discharge Summary , dated 6/14/2021 and signed by former employee RN K, indicated the date of discharge was 6/14/2021. Review failed to evidence the agency provided a notice of discharge to the patient 15 calendar days prior to discharge. During an interview on 8/18/2021 at 11:46 AM, the alternate clinical manager indicated the agency should have provided the patient with a HHCCN form to inform the patient of discharge but indicated no HHCCN form was provided to the patient.		provide to patients oncedischarge plans made. Staff have beenre-educated to the use of the CMS HHCCN when service frequencies have beenaltered from the Start of care frequencies. 100% chart review ofdischarge patients will be reviewed to assure ongoing compliance withregulation. Once 90% complianceobtained, chart review will be reduced to 50% for 6 months with re-evaluationof ongoing chart review activity through QAPI program. The Administrator isresponsible for assuring patients receive timely notification of discharge. TheScheduler is responsible for obtaining the reports of pending ends ofepisodes. Clinical Manager will reviewthe pending discharges with clinicians	

G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; 1. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Initial Assessments/Comprehensive Assessments stated, & The assessment will reflect the patient s current health status & The Initial Comprehensive Assessment also includes: Physical assessment/review of systems and pertinent physical findings &. 2. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021, and electronically signed by registered nurse (RN) K. This document indicated the patient s diagnoses included, but were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the left buttock and quadriplegia (paralysis of all 4 limbs). This document indicated the patient had 3 Stage II pressure ulcers consisting of 2 to the left groin	G0528	To assure comprehensiveand individualized Plans of Care the agency has implemented a process where allcomprehensive assessments completed by the admitting/recertifying clinicianwill be reviewed and updated by the agency leadership and consultants. Should additional interventions or revisionsto frequencies based on documentation by clinician be needed on the Plan ofCare and based on the OASIS documentation, edits to the POC will be made andreturned to the clinician for review, edit and approval. This includes assuring all cliniciansparticipating in care have orders for care on POC, and all identified problemshave individualized interventions and measurable goals and timelines related tothe diagnosis. Clinicians conductingthe comprehensive OASIS assessment review, revise and approve the Plan of Careto assure inclusion of appropriate interventions. Clinicians conductingthe OASIS	2021-11-22

	and 1 pressure ulcer to the buttocks. This document indicated the patient had a foley catheter (a thin, sterile tube inserted into the bladder to drain urine) and was incontinent (loss of control) of bowel. The document included a risk of developing pressure ulcers assessment which indicated there was no impairment to the patient s sensory perception, the skin was rarely moist and friction/shear was a potential problem. Review on 8/13/2021, of documents from wound clinic D, which the alternate clinical manager identified were requested of and received on 8/13/2021, from the patient s wound clinic, evidenced a document from wound clinic D titled Final Report , dated 7/21/2021, and electronically signed by physician H. This document stated, & Observing transfer, we can see that there is significant shearing that occurs. Until he is appropriately offloaded I think that his wounds will continue to worsen &. During an observation of care at the patient s home on 8/13/2021, at 8:00 PM, the patient was observed to require assistance to turn to his side in bed and was observed to be incontinent of bowel. Patient was observed to have below-the-knee amputations to both legs and had		approve the Plan of Care to assure accuratewound assessments, inclusion of appropriate interventions related to woundcare, wound care and skin integrity maintenance, prevention of shearing andsensory impairments impacting patient. Plans of care will be reviewed to assureinclusion of accurate frequency of discipline visits. Re-education ofclinicians will be conducted related to comprehensive assessment and documentationof the location, size, and description of the wound to include thewound bed and surrounding skin and any odor and drainage the wound care prevention, interventions, and documentation. 100% clinical record reviews of all SOC, resumptions of care, andrecertifications will be performed to assure comprehensive documentation and POCexists. This process will assure ongoingcompliance with individualized, comprehensive plans of care. The Administrator is responsible for assuring compliance with accuracyof Plans of Care. The	

	limited use of his arms and legs. Review failed to evidence the skilled nurse accurately assessed the patient s current health and functional status to include the actual problem of the friction/shear related to the patient s quadriplegia and limited mobility, the degree of which the skin was exposed to moisture related to the patient s bowel incontinence and the limited sensory perception related to the patient s quadriplegia. During an interview on 8/16/2021, at 10:43 AM, the alternate clinical manager indicated the patient s risk assessment for pressure ulcer development should not have been scored with no sensory impairment and the skin was rarely moist. The alternate clinical manager stated, It seems to definitely be a problem, the shearing. 3. Clinical record review on 8/9/2021, for patient #2, start of care 6/24/2021, evidenced of an agency document titled Start of Care (D1) , dated 7/14/2021, and electronically signed by RN H, which failed to indicate the patient had any wounds. Review of agency documents titled Skilled Visit Note , dated 6/30/2021, and electronically signed by former employee licensed practical nurse (LPN) B,		Plan of Care and visit note will assure compliance withcomprehensive Plan of care and documentation.	

surgical wound on the left foot. Document dated 8/4/2021, electronically signed by RN L, indicated the patient had a wound to the left foot with a start date of 6/15/2021.

Review on 8/13/2021 of documents from the wound clinic at hospital I, which the alternate clinical manager identified were requested of and received on 8/13/2021, from the patient s wound clinic, evidenced a document titled 06/28/2021 Follow Up in SM [hospital I] Wound Ostomy Clinic , dated 6/28/2021 and electronically signed by physician J. This document stated, & Patient presents today status post partial excision [surgical removal] of bone left 1st metatarsal [a bone in the foot]. & Incision site remains closed. Sutures removed. & Dressing orders: Betadine [a medication used to clean wounds] to incision site and covered by Hydrofera Blue [a type of absorptive foam dressing for wounds]. Dressing frequency: 3 times per week &.

During an interview on 8/12/2021 at 10:27 AM, the alternate clinical manager indicated the patient had the wound at the start of care on 6/24/2021 and the skilled nurse should have included in the comprehensive assessment the location, size, and description of the wound to include the

	and any odor and drainage. 4. Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced an agency document titled Comprehensive Adult Assessment, 485 P.O.C. [Plan of Care] Worksheet and Outcome and Assessment Information Set , dated 2/18/2021 and signed by former employee RN K. This document indicated the diagnoses included, but were not limited to, orthopedic (the branch of medicine dealing with muscle or bone) aftercare and cellulitis (a bacterial skin infection which can cause the skin to be painful, red, swollen and hot to the touch) of the right lower limb. Review of the assessment indicated the patient had 1 surgical wound but failed to indicate the location in the comprehensive assessment. The diagram of the body failed to indicate a location of the wound. Review failed to evidence the assessment of the cellulitis to the right lower limb. During an interview on 8/18/2021 at 10:59 AM, the alternate clinical manager indicated the location of the wound and the type of dressing in place should have been included in the assessment. 17-14-1(a)(1)(A) or (B)			

N0529	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Coordination of Patient Care stated, & Staff provides the physician with patient information on an ongoing basis regarding: Current condition and changes in condition. Outcomes of care and service. Changes in the environment and/or caregiver support. Results of relevant laboratory tests &. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Compliance with Laws and Regulations and Disclosure of Information stated, & The Agency and its staff will furnish services in compliance with all applicable federal, state and local laws and regulations &. Clinical record review on 8/12/2021 for patient #3, start of	N0529	The Agency completes a patientcare summary and mails this summary to the attending physician every 60days. The Administrator is responsiblefor assuring this is completed and documentation exists in the EMR indicating thatthe summary had been sent. ClinicalRecord review will be conducted to assure the 60 day summaries have been sentto the physician. Clinical record reviewswill be conducted to assure the 60 day summaries are being completed and sentto physicians. Clinicalsummaries will include changes in status during the prior 60 day period,current condition and changes in condition,falls, new medications ordered, outcomes of care and service, infections,changes in the environment and/or caregiver support as well as results of relevant laboratory tests. 100% of patient dischargedand recertified charts will be reviewed to assure compliance until 100%accuracy identified. Then 20% chartaudit will be conducted	2021-11-20

	care 10/8/2020, evidenced an agency document titled OASIS Follow-Up , completion date 4/2/2021 and signed by registered nurse (RN) N, indicated the patient began Nitrofurantoin (an antibiotic, which is a class of medication used to treat infection) on 3/31/2021 and was to take the medication twice a day for 7 days for a urinary tract infection. This document also indicated the patient had a fall on 3/31/2021. Review of an agency document titled Plan of Care for certification period 2/4/2021 4/5/2021, signed by RN O, indicated the patient s goals included no falls. Review of an agency document titled Plan of Care for certification period 4/6/2021 6/4/2021, signed by RN B, indicated a section titled Progress Notes which stated, & Goals met for the last certification period & Review failed to evidence the summary included the patient s goal for no falls was not met and failed to indicate the patient s urinary tract infection and antibiotic therapy. Review evidenced an agency document titled Skilled Visit Note , dated 6/21/2021 and electronically signed by RN N. This document indicated the patient had increased incontinence (loss of control of		quarterly to assure ongoing compliance.	

	bowel and/or bladder) and an unsteady gait. Review indicated the patient recently finished antibiotics. Review of an agency document titled Home Health Certification and Plan of Care for certification period 6/5/2021 8/3/2021, electronically signed and dated 7/6/2021 by RN N, indicated a visit summary but failed to evidence the physician was provided a written summary to include the patient s use of and reason for antibiotic therapy, increased incontinence and unsteady gait. During an interview on 8/16/2021 at 11:19 AM, the alternate clinical manager indicated the plan of care should include a summary of the patient s status and services provided the past 60 days on the plan of care for the next certification period which should be sent to the physician at least every 60 days. The alternate clinical manager indicated the summary should include changes in the patient s status, falls and infections.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. 1. Review of an agency policy,	G0536	TheAgency will be educated regarding the medication reconciliation workflow in theEMR (Point Click Care) to identify potential adverse effects and drugreactions, including ineffective drugtherapy, significant side effects, significant	2021-11-20

	revised March 2018 and obtained 8/18/2021, titled Medication Profile stated, & The comprehensive assessment (OASIS) performed at time of admission includes a review of all medications that the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicative drug therapy and noncompliance with drug therapy. The admitting RN [registered nurse], PT [physical therapist] or SLP [speech language pathologist] checks all medications a patient may be taking and documents on the medication profile. & The nurse or therapist will add all new/changed medication(s) to the medication profile. & The medication profile will be reviewed every home visit and updated as changes occur. When Skilled Nursing is ordered, the RN and LPN [licensed practical nurse] review the medications with the patient on an ongoing basis to ensure the understanding of medication use. The review will include side effects, storage and administration of all medications &. 2. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Initial Assessments/Comprehensive Assessments stated, & Drug		drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Field clinicians areresponsible for identifying any changes to medications on each office visit. The Agencyoffice RN will reconcile the patient's medication at the timeof admission and ongoing basis to identify anypotential adverse effects and drug interactions, including ineffective drug therapy, significant interactions, duplicate drug therapy andnon-compliance with drug therapy. At the time of admission, the admitting RN, PT [physical therapist], or SPL [speechlanguage pathologist] will create anddocument a complete list ofmedications that the patient is taking at home,including dose, strength, route and frequency. Any concern or discrepancieswill be reconciled by an RN withthe patient's physician. Discrepancies include duplications, omissions, changes, contraindications, and/or unclearinformation. Medications ordered while the patientis receiving care will be compared to the medicationlist profile. Themedication list/profile will beupdated with each new or changedmedication.	

	Regimen Review: Each patient s comprehensive assessment includes a review of all medications the patient is currently taking (prescription, non-prescription, herbs, home remedies, etc.) as well as times of medication administration and routes. The Agency nurse must consider and document each medication that the patient is taking to identify: Significant side effects. Significant drug interactions. Noncompliance with medications. Duplicative therapy. Potential adverse effects. Medication reactions. Significant medication issues & Concerns identified by clinician during medication review must be reported to physician &. 3. During an observation at the home of patient #1 on 8/13/2021 at 8:21 PM, RN H was observed leaving the patient s home without reviewing the patient s medication. During an interview on 8/13/2021 at 8:23 PM, the patient indicated his medication included diazepam (a medication used to treat seizures, muscle spasms and anxiety) 10 milligrams (mg) four times a day. The patient indicated he alternates Bactrim (antibiotic) twice a day for 3 months and then Macrobid (antibiotic) twice a day for 3 months as a preventive measure for urinary tract infections.		Whennew order is documented for medication, reconciliation will occur prior to medbeing added to medication list. AgencyRN will confirm any questions or duplicative drug therapy with orderingphysician. Staffnurses will be trained as to area within EMR to document medicationreconciliation has occurred and results. Allclinicians will be trained to document med reconciliation at each visit toinclude medications added or discontinuing on medication profile anymedications (such as antibiotics) which have been discontinued. The Administrator isresponsible for implementing and monitoring the above plans of correction bythe identified dates. Monitoring of ongoingcompliance with regulation includes the following: 1. Review of active patient records to determineaccuracy and reconciliation of medication	

	Clinical record review on 8/10/2021 evidenced an agency document titled Patient Medications , which failed to evidence the patient s medication included diazepam, Bactrim and Macrobid. This document indicated the patient s medication included Ketoconazole, start date 4/2/2021, (an antifungal medication used to treat skin infections), Simvastatin, start date 4/2/2021, (medication used to treat high cholesterol), Norco 5-325 mg, start date 4/23/2021, (medication used to treat pain) and Eliquis, start date 4/2/2021, (a blood thinning medication used to prevent blood clots). This document failed to evidence a signature of the clinician who completed the medication review and a date of when the medication review was completed. Review of an undated agency document titled Drug Interactions indicated an interaction with a level 3 severity rating between Ketoconazole and Simvastatin. This document also indicated interactions with a level 2 severity rating between Norco and Ketoconazole and Eliquis and Ketoconazole. The document failed to evidence the drug interactions were reviewed by a registered nurse. Review of an agency document		profiles. 2. Ongoing record review of every new SOC,resumption of care and Recertification to assure medication profiles areaccurate and reconciled. 3. Clinical record review to be conducted toassure compliance with medication reconciliation accuracy– 100% of all records to be reviewed until100% compliance achieved; record review to then be completed for 20% of recordsto assure ongoing compliance with med reconciliation. Administrator isresponsible for monitoring activities to assure ongoing compliance.	

	6/18/2021 and electronically signed by RN K, indicated there was no drug interaction and no issues were found during drug regimen review. The document failed to evidence the drug interactions were reviewed. During an interview on 8/12/2021 at 12:55 PM, the alternate clinical manager indicated the drug regimen review should have included the drug interactions and should have been reported to the physician. 4. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/ 22/2021 which was electronically signed by RN H on 7/21/2021 and the physician on 7/23/2021. The plan of care indicated the patient s medication included, but was not limited to, Allopurinol (a medication used to treat gout, a condition which causes severe pain, redness and tenderness in the joints), Warfarin Sodium (a medication used to thin the blood and prevent/treat blood clots), Clopidogrel (a medication used to prevent strokes), Amiodarone (a medication used to treat irregular heartbeats), Propylthiouracil (a medication used to treat a hyperactive thyroid), Pantoprazole Sodium (a			

	reflux), Simvastatin (a medication used to treat high cholesterol) and Carvedilol (a medication used to treat high blood pressure and heart failure). Review evidenced an undated agency document titled Drug Interactions indicated an interaction with a level 3 severity rating between Allopurinol and Warfarin Sodium, Warfarin Sodium and Clopidogrel, Warfarin Sodium and Amiodarone, Warfarin Sodium and Propylthiouracil, Pantoprazole and Clopidogrel and Amiodarone and Simvastatin. This document also indicated interactions with a level 2 severity rating between Warfarin Sodium and Pantoprazole, Warfarin Sodium and Simvastatin, Amiodarone and Carvedilol and Propylthiouracil and Carvedilol. The document failed to evidence the drug interactions were reviewed by a registered nurse. Review of an agency document titled Start of Care (D1) , dated 7/14/2021 and electronically signed by RN H, indicated there was no drug interaction and no issues were found during drug regimen review. The document failed to evidence the drug interactions were reviewed. During an interview on 8/12/2021 at 10:03 AM, the alternate clinical manager indicated the RN			

should review all medications for drug interactions.

5. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/5/2021 8/3/2021, electronically signed and dated on 7/6/2021 by RN N, which indicated the patient s medication included, but was not limited to, Diltiazem (a medication used to treat high blood pressure and chest pain), Lovastatin (a medication used to treat high cholesterol), Dilantin (a medication used to treat seizures), Coumadin (a blood-thinning medication that is used to treat and prevent blood clots), Paxil (a medication used to treat depression and anxiety) and Escitalopram (a medication used to treat depression and anxiety).

Review of an undated agency document titled Patient Medications indicated the patient s medication included Diltiazem, Lovastatin, Dilantin, Coumadin, Paxil and Escitalopram. This document failed to evidence a signature of the clinician who completed the medication review and a date of when the medication review was completed.

Review of an undated agency

	indicated an interaction with a level 3 severity rating between Diltiazem and Lovastatin and indicated a level 2 severity rating between Dilantin and Lovastatin, Dilantin and Diltiazem, Coumadin and Dilantin, Coumadin and Lovastatin, Coumadin and Paxil and between Coumadin and Escitalopram. The document failed to evidence the interactions were reviewed by a registered nurse. Review of an agency document titled Recertification , completed on 6/2/2021 and signed by RN N, failed to evidence the drug interactions were reviewed. During an interview on 8/16/2021 at 10:50 AM, the alternate clinical manager indicated there were medication interactions and the nurse should have documented the interactions were reviewed. 6. Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced an agency document titled Plan of Care for certification period 2/18/2021 4/18/2021, signed by RN A and dated and signed by the physician on 6/8/2021, which indicated the patient s medication included aspirin (a medication used to treat inflammation and reduce the risk of heart attacks) and lisinopril (a type of ACE inhibitor drug used to treat high blood pressure and heart failure by relaxing your			

veins and arteries).

Review of a document on 8/18/2021 titled Lisinopril Drug Summary website https://www.pdr.net/drug-summary/Prinivil-lisinopril-376 indicated a moderate drug interaction between lisinopril and aspirin.

Review of an agency document titled Medication Profile , dated 2/18/2021 and signed by former employee RN K, indicated the patient s medication included

	indicated no potential contraindications had been identified. Review failed to evidence the RN reviewed the medication and identified the contraindication between lisinopril and aspirin. Review of an agency document titled Comprehensive Adult Assessment, 485 P.O.C. [Plan of Care] Worksheet and Outcome and Assessment Information Set , dated 2/18/2021 and signed by former employee RN K, indicated no issues were found during drug regimen review. The document failed to evidence the drug interactions were reviewed. During an interview on 8/18/2021 at 10:55 AM, the alternate clinical manager indicated the RN should have reviewed the medications in the home at the start of care to look for drug interactions.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. 7. During an observation at the home of patient #4, on 8/11/2021 at 9:23 AM, physical therapist (PT) F was observed assessing	G0536	TheAgency will be educated regarding the medication reconciliation workflow in theEMR (Point Click Care) to identify potential adverse effects and drugreactions, including ineffective drugtherapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.	2021-11-20

	inquired about the patients pain. Patient #4 indicated they do not take the "Norco [hydrocodone-acetaminophen]" anymore and the doctor did not recommend taking aspirin. The patient indicated just taking "Tylenol [acetaminophen - a mild pain reliever]" when needed, and alluded to the bottle of over the counter (OTC) acetaminophen on the kitchen table.		Field clinicians areresponsible for identifying any changes to medications on each office visit. The Agencyoffice RN will reconcile the patient's medication at the timeof admission and ongoing basis to identify anypotential adverse effects and drug interactions, including ineffective drug therapy, significant interactions, duplicate drug therapy andnon-compliance with drug therapy. At the time of admission, the admitting RN, PT [physical therapist], or SPL [speechlanguage pathologist] will create anddocument a complete list ofmedications that the patient is taking at home,including dose, strength, route and frequency. Any concern or discrepancieswill be reconciled by an RN withthe patient's physician. Discrepancies include duplications, omissions, changes, contraindications, and/or unclearinformation. Medications ordered while the patientis receiving care will be compared to the medicationlist profile. Themedication list/profile will beupdated with each new or changedmedication. Whennew order is documented	

	Clinical record review on 8/10/2021, for patient #4, start of care 7/29/2021, evidenced an agency document titled Home Health Certification and Plan of Care which was indicated to be the current plan of care received on 8/10/2021, diagnosis of age-related osteoporosis with current fracture to right humerus (upper arm), with a history of falls. This document had an area subtitled 10. Medications which indicated the patient s ordered medications included but was not limited to Feosol (Iron supplement), Hydrocodone-acetaminophen (opioid pain medicine combined with a mild pain reliever) as needed for moderate pain, Milk of magnesia (laxative) as needed for constipation, and Pantoprazole Sodium (antacid). Record review failed to evidence the patient was ordered another option for pain management. Review failed to evidence the patient had OTC acetaminophen ordered on the plan of care.		occur prior to medbeing added to medication list. AgencyRN will confirm any questions or duplicative drug therapy with orderingphysician. Staffnurses will be trained as to area within EMR to document medicationreconciliation has occurred and results. Allclinicians will be trained to document med reconciliation at each visit toinclude medications added or discontinuing on medication profile anymedications (such as antibiotics) which have been discontinued. The Administrator isresponsible for implementing and monitoring the above plans of correction bythe identified dates. Monitoring of ongoingcompliance with regulation includes the following: 1. Review of active patient records to determineaccuracy and reconciliation of medication profiles. 2. Ongoing record review of	

	Review of an undated agency document titled Drug Interactions indicated an interaction with a level 2 severity rating between Pantoprazole Sodium and Feosol. This document also indicated interactions with a level 1 severity rating between Milk of Magnesia and Feosol. The document failed to evidence the drug interactions were reviewed by a registered nurse. Review of an agency document titled Start of Care (D1) , dated 7/29/2021 and electronically signed by RN H, indicated there was no drug interaction and no issues were found during drug regimen review. The document failed to evidence the drug interactions were reviewed. During an interview on 8/16/2021 at 12:36 PM, alternate clinical manager A indicated RN H was responsible for reviewing and updating the medication profile. The clinical manager indicated they could not identify when a medication review had been performed in the clinical record. 17-14-1(a)(1)(B)		care and Recertification to assure medication profiles areaccurate and reconciled. 3. Clinical record review to be conducted toassure compliance with medication reconciliation accuracy– 100% of all records to be reviewed until100% compliance achieved; record review to then be completed for 20% of recordsto assure ongoing compliance with med reconciliation. Administrator isresponsible for monitoring activities to assure ongoing compliance.	
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be	G0544	To assure comprehensiveand individualized Plans of Care the agency has implemented a process where allcomprehensive assessments completed by the	2021-11-22

	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- 1. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Reassessments/Update of the Comprehensive Assessment stated, & The comprehensive assessment (including OASIS data elements) must be updated and revised as frequently as the patient s condition warrants due to a major improvement or decline in health status &.		admitting/recertifying clinicianwill be reviewed and updated by the agency leadership and consultants. Should additional interventions or revisionsto frequencies based on documentation by clinician be needed on the Plan ofCare and based on the OASIS documentation, edits to the POC will be made andreturned to the clinician for review, edit and approval. This includes assuring all cliniciansparticipating in care have orders for care on POC, and all identified problemshave individualized interventions and measurable goals and timelines related tothe diagnoses. Clinicians conductingthe comprehensive OASIS assessment review, revise and approve the Plan of Careto assure inclusion of appropriate interventions. 100% clinical recordreviews will be conducted of all SOC, resumptions of care, and recertificationsto assure comprehensive POC. Changes in the patient's condition will result in updates to thecomprehensive assessment and physician contacted to obtain orders to modify theplan of care. Clinicians will	

	2. Clinical record review on 8/10/2021 and 8/18/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021 and electronically signed by registered nurse (RN) K. This document indicated the patient s diagnoses included, but were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the left buttock and quadriplegia (paralysis of all 4 limbs). This document indicated the patient had 3 Stage II pressure ulcers consisting of 2 to the left groin and 1 pressure ulcer to the buttocks. This document indicated the patient s weight was 280 pounds. Review of a document provided by the alternate clinical manager on 8/13/2021 titled Final Report from wound clinic D, dated 6/23/2021 and electronically signed by physician H, indicated the patient had 2 wounds to the left groin and a wound to the right ischium. Review evidenced an agency document titled Skilled Visit Note , dated 7/23/2021 and electronically signed by former employee licensed practical		modification to clinical findings such as new wounds,orders from wound care clinics, weight gain or loss or changes to functionalabilities/limitations. These and allother changes must be documented with notification of physician to patientstatus changes. The Administrator isresponsible for assuring compliance with the requirement to update thecomprehensive assessment with changes to the patient's status. Review of OASIS assessmentsand quality review of patient charts will assure compliance with thesedocumentation requirements. Patient #1 – This patient remains active withthe agency and the current plan of care is comprehensive and includes ordersfor care to all wound sites and documentation supports that documentationreflects all changes in status or new findings such as wounds are communicatedto the physician. As per plan of correction, trainingand workflow including review of all Plans of Care and clinician notes has beenput in place to assure ongoing communication with physicians and prevention ofrecurrence of this issue.	

	nurse (LPN) B. This document evidenced the skilled nurse assessed a pressure area to the coccyx (the area on the lower back above the buttocks) measuring 0.5 cm in length, 0.5 cm in width and 0.1 cm in depth with a wound treatment of cleanse with normal saline and apply Optifoam (an absorbent foam dressing with an adhesive border). Review failed to evidence the comprehensive assessment, to include the OASIS data elements, was revised due to the patient s new wound. Review of an agency document titled Skilled Visit Note , dated 8/2/2021 and electronically signed by registered nurse (RN) L, indicated the patient s weight was 240 pounds and failed to evidence the physician was notified of the 40 pound weight loss since the comprehensive assessment on 6/18/2021. Review failed to evidence the comprehensive assessment, to include the OASIS data elements, was revised due to the patient s weight loss. During an interview on 8/12/2021 at 1:26 PM, the alternate clinical manager indicated weight loss and a new wound would be considered a significant change in the patient s health status. 3. Clinical record review on 8/9/2021 for patient #2, start of		Patient #2 –This patient is discharged from the agency as of 9/1/21, and as such the agencyis unable to retrospectively impact this episode however training and processeshave been implemented to prevent recurrence. Patient #5 – This patient remains active withthe agency and the current OASIS and Plan of Care has been reviewed foraccuracy and contains accurate assessments including functional limitations,ability to safely dress and ability to prepare/administer medications, by theclinician completing the recertification assessment.	

	care 6/24/2021, evidenced an agency document titled Start of Care , with an assessment date of 6/24/2021, and electronically signed by RN H, which indicated the patient s weight was 185 pounds. Review of an agency document titled Skilled Visit Note , dated 8/4/2021 and electronically signed by RN L, evidenced the patient s weight was 150 pounds. Review failed to evidence the comprehensive assessment, to include the OASIS data elements, was revised due to the patient s weight loss. During an interview on 8/12/2021 at 11:19 AM, the alternate clinical manager indicated the weight loss would be considered a significant change in condition and the comprehensive assessment was not revised.			
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- 4. During an observation on 8/11/2021, LPN (licensed practical nurse) I was observed	G0544	To assure comprehensiveand individualized Plans of Care the agency has implemented a process where allcomprehensive assessments completed by the admitting/recertifying clinicianwill be reviewed and updated by the agency leadership and consultants. Should additional interventions or revisionsto frequencies based on documentation by clinician be needed on the Plan ofCare and	2021-11-22

	with patient #5. The patient was observed sitting in a lift recliner, with a rolling walker propped in front of her. The patient was hard of hearing, and LPN I had to speak very loudly, or the patient s family members would answer for the patient. The patient wore light compression socks, which the caregiver indicated to have applied for the patient. The caregiver also indicated they prepared the patient s medications every day, which included assisting the patient with checking their blood sugar and administering insulin medications by injection. Clinical record review on 8/12/2021, for patient #5, start of care 2/24/2021, primary diagnosis type 2 diabetes with chronic kidney disease, evidenced an agency document titled Recertification (D1) for the certification period of 6/24/2021 8/22/2021, which was signed by RN K. This document had an area subtitled Sensory Status which indicated the patient wore glasses and otherwise, the patient s ear/nose/throat [E/N/T] were within normal limits. Another area subtitled Endocrine indicated the patient was able to draw up and administer insulin. A section of this document stated, (M1820) Current ability to Dress Lower Body Safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes: & Able to obtain,		based on the OASIS documentation, edits to the POC will be made andreturned to the clinician for review, edit and approval. This includes assuring all cliniciansparticipating in care have orders for care on POC, and all identified problemshave individualized interventions and measurable goals and timelines related tothe diagnoses. Clinicians conductingthe comprehensive OASIS assessment review, revise and approve the Plan of Careto assure inclusion of appropriate interventions. 100% clinical recordreviews will be conducted of all SOC, resumptions of care, and recertificationsto assure comprehensive POC. Changes in the patient’s condition will result in updates to thecomprehensive assessment and physician contacted to obtain orders to modify theplan of care. Clinicians will beeducated to need for modification to clinical findings such as new wounds,orders from wound care clinics, weight gain or loss or changes to functionalabilities/limitations. These and allother changes must be documented with notification of physician to patientstatus	

	put on and remove clothing and shoes without assistance . & Review of this document failed to evidence the patient did not have functional limitations, including but not limited to hearing, vision, endurance, and ambulation. During an interview on 8/16/2021, at 10:10 AM, when queried if the patient was independent with medications, alternate clinical manager A indicated the OASIS reassessment indicated they were. The administrator in training D and alternate clinical manager A were informed the observations made of the patient s E/N/T and functional limitations were inconsistent with the most recent reassessment. During an interview on 8/16/2021, at 10:16 AM, alternate clinical manager A indicated a patient s condition can change from the comprehensive assessment. Review failed to evidence a comprehensive reassessment was performed since the recertification on 6/21/2021, which indicated the patient s current condition. 17-14-1(a)(1)(B)		changes. The Administrator isresponsible for assuring compliance with the requirement to update thecomprehensive assessment with changes to the patient's status. Review of OASIS assessmentsand quality review of patient charts will assure compliance with thesedocumentation requirements. Patient #1 – This patient remains active withthe agency and the current plan of care is comprehensive and includes ordersfor care to all wound sites and documentation supports that documentationreflects all changes in status or new findings such as wounds are communicatedto the physician. As per plan of correction, trainingand workflow including review of all Plans of Care and clinician notes has beenput in place to assure ongoing communication with physicians and prevention ofrecurrence of this issue.	

			Patient #2 –This patient is discharged from the agency as of 9/1/21, and as such the agencyis unable to retrospectively impact this episode however training and processeshave been implemented to prevent recurrence. Patient #5 – This patient remains active withthe agency and the current OASIS and Plan of Care has been reviewed foraccuracy and contains accurate assessments including functional limitations,ability to safely dress and ability to prepare/administer medications, by theclinician completing the recertification assessment.	
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. 1. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled	G0570	To assure comprehensiveand individualized Plans of Care the agency has implemented a process where allcomprehensive assessments completed by the admitting/recertifying clinicianwill be reviewed and updated by the agency leadership and consultants. Should additional interventions or revisionsto frequencies based on documentation by clinician be needed on the Plan ofCare and based on the OASIS documentation, edits to the POC will be made andreturned to the clinician for review, edit and approval. This includes assuring all cliniciansparticipating in care have orders for care on POC, and all identified problemshave	2021-11-22

	Services Furnished and Written Agreements/Contracts among Providers stated, & The Agency will make available part-time or intermittent skilled nursing [SN] services and at least one other therapeutic service (PT [physical therapist], OT [occupational therapist], SLP [speech language pathologist], MSW [medical social worker] or HHA [home health aide]) on a visiting basis to patient s home. The Agency will furnish one of the qualifying services (SN, PT or SLP) directly through the Agency staff. The second qualifying and additional services may be provided under arrangement (written agreement/contract) with another agency or organization &. 2. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Assessment and Reassessment Guidelines stated, & Assessment data gathered by each discipline will be used to assess the patient s needs and problems initially and on an ongoing basis &. 3. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Care Planning Process stated, & All initial and ongoing assessments will utilize relevant baseline data to determine patient problems, needs, interventions and goals &. 4. Clinical record review on		individualized interventions and measurable goals and timelines related tothe diagnosis. Clinicians conductingthe comprehensive OASIS assessment review, revise and approve the Plan of Careto assure inclusion of appropriate interventions. Clinicians conductingthe OASIS assessment review, revise and approve the Plan of Care to assureaccurate wound assessments, inclusion of appropriate interventions related towound care, wound care and skin integrity maintenance, prevention of shearingand sensory impairments impacting patient. Plans of care will be reviewed to assure inclusion of accurate frequencyof discipline visits. Re-education ofclinicians will be conducted related to comprehensive assessment and documentationof the location, size, and description of the wound to include thewound bed and surrounding skin and any odor and drainage the wound care prevention, interventions, and documentation. Staff will be educatedto meeting	

	8/10/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021 and electronically signed by registered nurse (RN) K. This document indicated the patient s diagnoses included, but were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the left buttock and quadriplegia (paralysis of all 4 limbs). This document indicated the patient had 3 Stage II pressure ulcers consisting of 2 to the left groin and 1 pressure ulcer to the buttocks. One pressure ulcer to the left groin was assessed to be 1 centimeter (cm) in length, 1 cm in width and 0.2 cm in depth and had a wound treatment of cleanse with normal saline (a solution of salt and water used to clean wounds), apply collagen (a wound treatment used to stimulate new tissue growth), cover with an ABD pad (a thick absorbent wound dressing used to absorb fluid and keep from pooling on the wound site) and secure with tape 3 times a week. One pressure ulcer to the left groin was assessed to be 1 cm in length, 0.3 cm in width and 0.2 cm in depth and had a wound treatment of cleanse with normal saline, cover with an ABD pad		all required elements of this condition of participation including: 1. Ensuringthe plan of care was reviewed by thephysician, individualized and followed by all agencystaff as per G0572 2. Ensuringthe plan of care included all required information / elements for the treatmentof the patient as per tag G0574 3. Ensuringthat services and treatment were provided as ordered by a physician as per tag G0578 4. Assuringthat all treatments providedby agency staff were ordered by a physician as pertag G0580 5. Ensuring thephysician's verbal orders were documented inthe patient's clinical record to include a signature, date and time of the order and to ensure the verbalorders were authenticated and dated by the physicianas per tag G0584 6. Ensuringthe plan of care was reviewed by the patients primary care physician at least every 60 days as pertag G0588 7. Ensuring physicians were promptly notified of achange in	

	and secure with tape 3 times a week. The wound to the buttocks was assessed to be 1 cm in length, 0.5 cm in width, 0.2 cm in depth and had a wound treatment of cleanse with normal saline, apply collagen, cover with an ABD pad and secure with tape 3 times a week. This document indicated the patient had an amputation of both legs and the patient s ability to transfer to and from bed to a chair required supervision. Review indicated the patient was at risk for falls and skin breakdown. This document indicated the patient required assistance with dressing and bathing and was dependent for toileting. This document indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks and 2 times a week for 9 weeks and receive home health aide (HHA) services 2 times a week for 9 weeks. Review evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/18/2021 8/16/2021. The document was signed by the alternate clinical manager on 7/15/2021 and by the physician on 8/2/2021 and indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks and 2 times a week for 9 weeks and was to receive home health aide services 2 times a week. The		the patient's condition asper tag G0590 8. Ensuringthe plan of care was revised to reflect current health status and nursing needs as per tag G0592 9. Ensuringthe patient and physician werecommunicated with regarding revisionsto the plan of care related to theplans for the patient’s discharge as per tagG0598 10. Assuringcoordination of care for all services providedto the patient as per tag G0606 11. Ensuring the written visit schedule was provided topatients as per tag G0614 12. Ensuringwritten instructions were provided to the patient for the patient's medication schedule and instructions asper tag G0616 and 13. Ensuring written instructions were provided to the patient for the name and contactinformation for the clinical manager as per tag G0622 Clinicians to bere-educated to writing frequencies in new EMR for 9 week period (ex. SN 1 week9) vs. multiple frequencies for same discipline (SN 1 week 9, 2week 9). In addition, clinicians re-educated oncorrectly identifying verbal	

	plan of care indicated the patient s activities permitted were to be up as tolerated and wheelchair activity. The plan of care indicated the home health aide was to assist with bathing and personal care. The plan of care stated, & Summary of SN [skilled nurse] Orders: & Wound care will be performed by . & and failed to evidence what the wound care treatment was and to what wound locations. The plan of care indicated the patient s goal was for the wound to be healed. Review failed to evidence home health aide services were provided since 7/28/2021. During an interview on 8/12/2021 at 1:36PM, the alternate clinical manager indicated the home health aide that was providing home health aide services for the patient quit and there was no other home health aide available to provide visits. During an interview on 8/13/2021 at 8:29 PM, the patient indicated he needed a home health aide and indicated the agency has not told him when he would receive a home health aide visit again. Review on 8/13/2021 of documents from wound clinic D, which the alternate clinical manager identified were requested of and received on 8/13/2021, from the patient s wound clinic, evidenced a document		prior to oron SOC date and not 4 weeks into care. This was a clinician error in the new EMR and re-training has correctedthis issue. Agency has implementedprocess related to scheduling – The scheduler will beresponsible for creating the calendar for each patient and each clinician willaccess the calendar to assure visits are accurate based on the Medicarecalendar week. Scheduler to review notesin EMR daily and contact each clinician if notes are not synched to EMR toassure visits for prior day were completed as scheduled. Visits missed will be rescheduled within the Medicareweek or Physicians will be notified of any missed visits or variance to theordered visits. Physicians will bequeried as to need to alter Plan of care if there is a clinical impact to thepatient.	

	clinic D, dated 6/23/2021 and electronically signed by physician H. The document indicated the patient had 2 wounds to the left groin and a wound to the right ischium. Review of a document titled Final Report , dated 7/21/2021, and electronically signed by physician H, stated, & He refuses to be Hoyer [a medical device used to lift and transfer a person with minimal physical effort] to in the wound care center but instead is transferring himself. Observing transfer, we can see that there is significant shearing that occurs. Until he is appropriately offloaded I think that his wounds will continue to worsen &. During an observation of care on 8/13/2021 at 7:19 PM, the patient was observed to have 2 open areas on the left groin. Each open area appeared the length of a large paperclip and as wide as the width of a pen. Both open areas appeared to have a depth of the length of a pinky fingernail. RN H stated, One is more medial, but there are two here. The patient was observed to have 2 open areas to the right ischium (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis). The lateral open area on the right ischium appeared to be the length of a large paperclip, the width of the diameter of a pen and the depth of a tip of a pen. The medial open area of the		Case conferenceidentifies patient with change in status warranting change in orders, additionof a discipline as well as appropriateness for discharge. Patients with goals not met will be reviewedto determine whether discharge is warranted or community resources necessarypost discharge from home health. The agency requestsdocumentation from each wound clinic visit on a weekly basis for patientsvisiting wound care clinics. Wound care training tobe conducted related to preventative skin care measures to prevent shearing aswell as treatment interventions. Coordination with wound care clinic process established with agencycontacting wound care clinic weekly following patient visit to confirm anychanges to wound care treatment. Orderswill be obtained for any changes to treatment protocol. Plans of care and all visit notes undergoquality review to assure inclusion of appropriate orders on POC anddocumentation of wound care based on orders provided.	

	right ischium appeared to be in the peri wound (the area surrounding the wound) of the lateral open area on the right ischium and have the size of a dime with just the top layer of skin removed and a red wound base. At 7:45 PM, RN H stated, There s a little excoriated [the breakdown of skin due to prolonged exposure to moisture] part here. To me, there s really another wound here. Some may call it one. The patient was observed to require assistance for turning in bed, was dependent for bowel incontinence care and had a below the knee amputation on both legs. Review evidenced agency documents titled Skilled Visit Note , electronically signed by former employee licensed practical nurse B, which failed to evidence the skilled nurse provided wound care to the wounds identified at the comprehensive assessment. The document dated 6/29/2021, indicated the skilled nurse provided wound care to a wound L ish and R ish and failed to evidence wound care to 3 wounds as identified at the comprehensive assessment. Document dated 7/2/2021 stated, & Dressing changed per orders from wound clinic & to L dressing & R dressing & Both wounds are beefy red &. and failed to evidence the skilled nurse		The agency providespatients with a visit schedule following start of care or at recertification toassure they are aware of the visit frequencies of all disciplines. 100% of clinical noteswill be reviewed to assure documentation includes clinical care coordinationwith external/community care providers. 100% clinical recordreviews of all SOC, resumptions of care, and recertifications will be performedto assure comprehensive documentation and POC exists. This process will assure ongoing compliancewith individualized, comprehensive plans of care. All clinical notesdocumented by clinicians will undergo quality review to assure documentationcorrelates with orders and patient is receiving all care and servicesordered. The Administrator isresponsible for assuring compliance with accuracy of Plans of Care. The ongoing quality review of each Plan ofCare and visit note will	

	provided wound care to 3 wounds as identified at the comprehensive assessment. Document dated 7/5/2021 stated, & L [left] dressing had med [medium] amount of drainage & Dressing changed per order & R [right] dressing had small amount of red/tan drainage note. Dressing changed per order & and failed to evidence the skilled nurse provided wound care to 3 wounds as identified at the comprehensive assessment. Document dated 7/7/2021, stated, & Dressing changed on both wounds &. and failed to evidence the skilled nurse provided wound care to 3 wounds as identified at the comprehensive assessment. Document dated 7/19/2021, indicated the skilled nurse provided wound care to wound #1 identified on the groin and wound #2 identified as Other location and failed to evidence the skilled nurse provided wound care to 3 wounds as identified on the comprehensive assessment. Document dated 7/23/2021, indicated the skilled nurse provided wound care to wound #1 identified as the left groin and wound #2 identified as Other location and failed to evidence the skilled nurse provided wound care to 3 wounds as identified on the comprehensive assessment. During an interview on 8/12/2021 at 12:59 PM, the alternate clinical manager indicated the skilled		comprehensive Plan of care anddocumentation. Patient #1 – This patient remains active with the agency and thecurrent plan of care is comprehensive and includes orders for care to all woundsites and that frequencies are accurate on the plan of care and all disciplinesare visiting the patient as per the ordered frequencies. As per plan ofcorrection, training and workflow including review of all Plans of Care andclinician notes has been put in place to assure ongoing communication withphysicians and prevention of recurrence of this issue. Patient #2 – This patient is discharged from the agencyas of 9/1/21, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence. Patient #3 – This patient remains active withthe agency and the OASIS assessment for the current episode of care is accurateand all disciplines are appropriate to the services needed by the patient. Patient #6 - Thispatient was discharged from the agency at the time of the survey, and as suchthe agency is unable to retrospectively impact this episode however trainingand processes have been implemented to prevent	

	nurse should have provided wound care 2 times a week. At 1:05 PM, the alternate clinical manager indicated L ish and R ish most likely was referring to the 2 wounds to the left groin and stated, The plan of care isn t ready by the time of the next nurse s visit so the next nurse may not know what the wounds are called. Review evidenced agency documents titled Skilled Visit Note , electronically signed by former employee LPN B. Document dated 6/23/2021 indicated the patient was bedbound and stated, & Pt [patient] upper body is weak from being bed bound as wounds heal. Pt is thinking about PT/OT when cleared by wound dr [doctor] &. Document dated 7/2/2021 stated, & Pt has noticed a lose [sic] in upper body strength at this time due to being bedbound due to wounds on gluteal area &. Review failed to evidence the patient received a physical therapy evaluation to assess the loss in upper body strength. During an interview on 8/12/2021 at 1:00 PM, the alternate clinical manager indicated there were not any orders or care coordination with the wound care clinic or the wound physician. At 1:08 PM, the alternate clinical manager indicated the physician		recurrence.	

	therapy evaluation related to the patient s decrease in upper body strength. 5. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Start of Care , with an assessment date of 6/24/2021, and electronically signed by RN H, which failed to evidence the patient had any wounds. Review indicated the patient had a left partial foot amputation and a below the knee amputation of the right leg. Review evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/ 22/2021, which was electronically signed by RN H on 7/21/2021, and the physician on 7/23/2021. The plan of care indicated the patient s primary diagnosis was Type II Diabetes (a chronic condition where the body is impaired in the way it regulates and uses sugar as fuel) and indicated the patient was to receive skilled nursing services 1 time a week for 4 weeks and then 1 time every other week for 5 weeks. The plan of care failed to evidence interventions or goals related to wounds. Review of agency documents titled Skilled Visit Note , dated 6/30/2021 and electronically signed by former employee LPN			

surgical wound on the left foot but failed to evidence wound care was provided. Document dated 7/7/2021, and electronically signed by former employee LPN B stated, & Pt has dressing applied to L foot. He sees the dr [doctor] today &. Review failed to evidence wound care was provided. Document dated 7/15/2021, and electronically signed by former employee LPN B indicated the patient s incision is free from signs and symptoms of infections but fails to evidence the location of the incision, and the document fails to evidence wound care was provided. Review fails to evidence the skilled nurse provided wound care prior to 7/21/2021. Document dated 8/4/2021, electronically signed by RN L, indicated the patient had a wound to the left foot with a start date of 6/15/2021.

Review on 8/13/2021 of documents from wound clinic D, which the alternate clinical manager identified were requested of and received on 8/13/2021, from the patient s wound clinic at hospital I, evidenced a document titled 06/28/2021 Follow Up in SM [hospital I] Wound Ostomy Clinic , dated 6/28/2021 and electronically signed by physician J. This document stated, & Patient presents today status post partial excision [surgical removal] of bone left 1st metatarsal [a bone in the foot]. & Incision site remains closed. Sutures removed. &

	Dressing orders: Betadine [a medication used to clean wounds] to incision site and covered by Hydrofera Blue [a type of absorptive foam dressing for wounds]. Dressing frequency: 3 times per week &. During an interview on 8/12/2021 at 11:28 AM, the alternate clinical manager indicated the agency had been informed by the RN and HHA that former employee LPN B was not providing wound care and former employee LPN B was no longer employed with the agency. Review of an agency document titled Occupational Therapy Evaluation , evaluation date 7/28/2021 and electronically signed by occupational therapist (OT) M, indicated occupational therapy services would be provided 2 times a week for 3 weeks and indicated the patient required assistance for functional tasks of activities of daily living (ADL) due to decreased range of motion and strength of the left shoulder. Review of an agency document titled Supplemental Provider Order , dated 7/31/2021 and electronically signed by OT M and dated 8/10/2021 and signed by the physician, indicated OT services were to be provided 2 times a week for 3 weeks for ADL training, bathroom mobility and home exercise program.			

	Review of a document titled Discharge/Transfer Summary , dated 8/9/2021 and electronically signed by OT M, evidenced a subsection titled Goals not met [and] reasons (If applicable): which stated, & Bathing not met due to need of someone to position shower bench and assist with lower body as there is a dressing on the [left] foot &. Review indicated the OT provided services 1 time during week 2 and did not receive OT services during week 3. Review failed to evidence communication with the physician regarding the discharge from OT services and failed to evidence a physician s order for the discharge of OT services. Review failed to evidence the patient received OT services 2 times a week for 3 weeks as the patient was assessed to need. During an interview on 8/18/2021 at 12:12 PM, the alternate clinical manager indicated she was unaware the OT had discharged the patient for services and the record did not have any documentation for why OT M discharged the patient from services. 6. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced agency documents titled Recertification , identified by the alternate clinical manager as comprehensive assessments,			

	dated 6/2/2021 and 8/2/2021 and electronically signed by RN N. The document dated 6/2//2021 indicated the patient s diagnoses included, but were not limited to, atrial fibrillation (irregular heartbeat which may cause the heart to pump less effectively which may result in swelling of hands, feet, or other body parts) and dementia (a progressive disorder causing impaired ability to remember, think and make decisions that interferes with everyday activities). Review indicated the patient had a history of falls, and the patient s risk for falls was assessed to score at 6 on 6/2/2021 and increased to 7 on 8/2/2021. Review evidenced the patient was independent for toilet hygiene on 6/2/2021 and requiring substantial assistance on 8/2/2021. Review indicated the patient was independent with the ability to sit to stand, chair to bed transfer, toilet transfer and walking 10 feet at the assessment on 6/2/2021 and assessed on 8/2/2021 requiring substantial assistance for sit to stand, chair to bed transfer, toilet transfer and walking 10 feet. The document dated 6/2/2021 indicated the patient was independent for dressing, and the document dated 8/2/2021 indicated the patient required assistance for dressing. Review of document dated 6/2/2021 indicated the patient was independent for toileting, and the			

	document dated 8/2/2021 indicated the patient was dependent for toileting. Review indicated the patient was able to transfer and ambulate with assistance at the assessment on 6/2/2021 to being assessed on 8/2/2021 to be unable to transfer self and chairfast. The document dated 8/2/2021 stated, & Caregiver/spouse noted increased weakness over the past 2 weeks with her ambulation &. Review failed to evidence home health aide and therapy services were provided. During an interview on 8/16/2021 at 11:17 AM, the alternate clinical manager indicated the physician should have been contacted with a request for an order for PT to evaluate the patient and indicated the patient had a need for therapy at 11:44 AM. At 11:48 AM, the alternate clinical manager indicated she was unsure why home health aide services were not provided and indicated it was possibly because the patient s spouse provided personal care. The alternate clinical manager indicated there was no documentation the patient was offered home health aide and therapy services. 7. Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced an agency document titled Comprehensive Adult			

	Care] Worksheet and Outcome and Assessment Information Set , dated 2/18/2021 and signed by former employee RN K. The document indicated the patient s diagnoses included, but were not limited to, orthopedic (the branch of medicine dealing with muscle or bone) aftercare, cellulitis (a bacterial skin infection which can cause the skin to be painful, red, swollen and hot to the touch) of the right lower limb and Type II Diabetes. The comprehensive assessment indicated the patient was at risk for falls and had neuropathy (a condition usually caused by diabetes causing weakness, numbness and pain usually in the hands and feet). Review of an agency document titled Encounter Certification , dated 3/8/2021 and signed and dated by the physician on 5/26/2021, indicated the patient had significant right sided hemiparesis (muscle weakness or partial paralysis on one side of the body) and was at risk for falls. Review of agency documents titled Nursing Visit Record , signed by former employee RN K, failed to evidence the skilled nurse provided fall prevention education on documents dated 2/23/2021, 2/25/2021, 3/2/2021, 3/4/2021, 3/9/2021, 3/11/2021, 3/16/2021 and 3/18/2021. Review of document dated 3/11/2021 indicated the patient			

	had right sided paralysis due to a stroke. Review indicated the skilled nurse assessed the patient to have decreased endurance on 3/25/2021 and assessed the patient to have decreased endurance, balance and gait requiring the use of assistance with a walker on 3/30/2021. On document dated 5/3/2021, the skilled nurse documented the patient had a fall. Review failed to evidence therapy services were provided related to the patient s assessed decreased endurance, balance and gait. During an interview on 8/18/2021 at 11:24 AM, the alternate clinical manager indicated she would have had PT evaluate this patient and the physician should have been contacted to request an order for a PT evaluation. The alternate clinical manager indicated the patient had a need for physical therapy that was not met. 17-13-1(a)			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or	G0572	To assure comprehensiveand individualized Plans of Care the agency has implemented a process where allcomprehensive assessments completed by the admitting/recertifying clinicianwill be reviewed and updated by the agency leadership and consultants. Should additional interventions or revisionsto	2021-11-20

	allowed practitioner is consulted to approve additions or modifications to the original plan. 1. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Plan of Care CMS #485 and Physician Orders stated, & 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 & Each patient must receive the home health services that are written in an individualized plan of care & which is established, periodically reviewed & and signed by a doctor of medicine & If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan &. 2. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021 and electronically signed by registered nurse (RN) K. This document indicated the patient s diagnoses included, but were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed		frequencies based on documentation by clinician be needed on the Plan ofCare and based on the OASIS documentation, edits to the POC will be made andreturned to the clinician for review, edit and approval. This includes assuring all cliniciansparticipating in care have orders for care on POC, and all identified problemshave individualized interventions and measurable goals and timelines related tothe diagnoses. Clinicians conductingthe comprehensive OASIS assessment review, revise and approve the Plan of Careto assure inclusion of appropriate interventions. 100% clinical recordreviews will be conducted of all SOC, resumptions of care, and recertificationsto assure comprehensive POC. The Agency staff willbe re-trained on the scheduling module for the newly implemented EMR and willutilize the schedule within the EMR to assure that allevaluations, OASISassessments and visits are entered into the discipline specific schedules asordered by	

	between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the left buttock, hypertension (high blood pressure) and quadriplegia (paralysis of all 4 limbs). This document indicated the patient had 3 Stage II pressure ulcers consisting of 2 to the left groin and 1 pressure ulcer to the buttocks. One pressure ulcer to the left groin was assessed to be 1 centimeter (cm) in length, 1 cm in width and 0.2 cm in depth and had a wound treatment of cleanse with normal saline (a solution of salt and water used to clean wounds), apply collagen (a wound treatment used to stimulate new tissue growth), cover with an ABD pad (a thick absorbent wound dressing used to absorb fluid and keep from pooling on the wound site) and secure with tape 3 times a week. One pressure ulcer to the left groin was assessed to be 1 cm in length, 0.3 cm in width and 0.2 cm in depth and had a wound treatment of cleanse with normal saline, cover with an ABD pad and secure with tape 3 times a week. The wound to the buttocks was assessed to be 1 cm in length, 0.5 cm in width, 0.2 cm in depth and had a wound treatment of cleanse with normal saline, apply collagen, cover with an ABD pad and secure with tape 3 times a week. This document indicated the patient		or supplemental order. If uponassessment a referred discipline is deemed not necessary by the admittingclinician, the primary care physician (PCP) will be contacted to revise theinitial referral order and revise the orders to include necessary disciplinesand document discussion with physician. The scheduler will beresponsible for creating the calendar for each patient and each clinician willaccess the calendar to assure visits are accurate based on the Medicarecalendar week. Scheduler to review notesin EMR daily and contact each clinician if notes not synched to EMR to assurevisits for prior day werecompleted as scheduled. Visits missedwill be rescheduled within the week or Physicians will be notified of anymissed visits or variance to the ordered visits. Physicians will be queried as to need toalter Plan of care if there is a clinical impact to the patient. Wound care training tobe conducted related to preventative skin care measures to prevent shearing aswell as treatment interventions. Coordination with wound care clinic process established with	

	was at risk for skin breakdown. Review evidenced an agency document titled Skilled Visit Note , dated 6/24/2021 and electronically signed by former employee licensed practical nurse (LPN) B. This document stated, & Pt [patient] seen on 6/23/2021 in wound clinic and no new orders record [sic] in regards to wounds &. Dressing changed per orders from wound clinic &. Review evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/18/2021 8/16/2021. The document was signed by the alternate clinical manager for the verbal start of care on 7/15/2021 and by the physician on 8/2/2021. The plan of care failed to be established with the physician until the verbal start of care obtained by the alternate clinical manager on 7/15/2021. This document indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks and 2 times a week for 9 weeks. The plan of care failed to be individualized to the frequency of skilled nursing services. The document indicated the skilled nurse was to provide catheter care. The plan of care stated, & Wound care will be performed by &. and failed to be individualized to include the location of the patient s wounds and wound		agencycontacting wound care clinic weekly following patient visit to confirm anychanges to wound care treatment. Orderswill be obtained for any changes to treatment protocol. Plans of care and all visit notes undergoquality review to assure inclusion of appropriate orders on POC anddocumentation of wound care based on orders provided. Therapists will beeducated to the need to perform vital signs on visits for covid-19 screening inaddition to therapy interventions and to notify physician of changes in vitalsigns or other clinical findings. Staff will be educated thatthe scheduler will be notified of any variances to visits scheduled for the dayby clinicians. Staff will be instructedin process to follow if missed visit or variance to ordered frequency toinclude notification of physician and discerning whether impact to patient’s clinical status. Home Health Aideswill be educated as to need to follow plan of care specific to performingvisits	

	care to be provided. Review of the plan of care failed to evidence the skilled nursing interventions included a head-to-toe assessment to include obtaining patient s vital signs for blood pressure related to patient s diagnosis of hypertension and a skin assessment related to patient s assessed risk of skin breakdown. The plan of care failed to evidence it was individualized to include the care the patient received at the wound clinic to include the name of the wound clinic. Review failed to evidence the plan of care included preventative measures related to the patient s risk of skin breakdown as assessed at the start of care.		patient. Scheduler will follow up on visits notentered into the EMR the day following the scheduled visit to assure documentation iscompleted or the visit is rescheduled or missed visit. If missed, the physician is notified of themissed visit. Staff training to beconducted related to following the plan of care as ordered to include educationof patient related to diagnoses, assessment of pain, ordered interventions andpatient measurable goals. Communicationto physician is needed if pain interventions, including non-pharmacologicinterventions ordered are not allowing patient to achieve goals toward paincontrol. Monitoring of ongoingcompliance with regulation includes the following: - Review of activepatient records to determine accuracy of scheduling module and missed visitmanagement and physician notification of schedule variances to orders. - Review of HHA notes foraccuracy in documentation to Aide plan of care. - Clinical record reviewto be conducted to assure compliance	

	During an interview on 8/12/2021 at 12:12 PM, the alternate clinical manager indicated the plan of care was supposed to indicate skilled nursing services 2 times a week for 9 weeks and the skilled nurse 1 time a week for 9 weeks was a mistake. At 12:30 PM, the alternate clinical manager indicated the plan of care should include the individualized vital sign parameters and the skilled nursing interventions should include obtain the patient s vital signs and head-to-toe assessment. At 1:07 PM, the alternate clinical manager indicated the wound clinic name and treatment provided should be included on the plan of care. During an interview on 8/16/2021 at 10:16AM, the alternate clinical manager indicated interventions that should have been included on the plan of care to prevent skin breakdown are education on the importance of turning and repositioning and education on the use of hoyer (a mechanical lift device used to lift a patient with minimal effort) to reduce risk of shearing. Review failed to evidence skilled nursing services were provided during the week of 7/25/2021. During an interview 8/12/2021 at 12:26 PM, the alternate clinical manager indicated former employee LPN B was scheduled for a skilled nursing visit on		with scheduling and therapist and HHAdocumentation accuracy – 100% of all records tobe reviewed until 100% compliance achieved; record review to then be completedfor 20% of records to assure ongoing compliance. The Administrator isresponsible for implementing and monitoring the above plans of correction bythe identified dates. Ongoing review ofeach Plan of Care and each visit note completed by clinicians will assurecompliance with documentation to orders. Patient #1 – This patient remains active with the agency and thecurrent plan of care is comprehensive and includes orders for care to all woundsites and that frequencies are accurate on the plan of care and all disciplinesare visiting the patient as per the ordered frequencies. As per plan ofcorrection, training and workflow including review of all Plans of Care andclinician notes has been put in place to assure ongoing communication withphysicians and prevention of recurrence of this issue. Patient #2 – This patient is discharged from the agencyas of 9/1/21, and as such the agency is unable to retrospectively	

	7/26/2021 and 7/30/2021 but indicated former employee LPN B called off on 7/26/2021 and quit without notice on 7/30/2021. The alternate clinical manager indicated no other skilled nurse was available to provide skilled nursing services. Review of agency documents titled Skilled Visit Note , dated 7/5/2021, 7/7/2021 and 7/9/2021 and electronically signed by former employee LPN B, evidenced skilled nursing services were provided 3 times during the week of 7/4/2021 and failed to evidence skilled nursing services were provided as ordered in the plan of care. During an interview on 8/12/2021 at 1:35 PM, the administrator in training indicated the visit on 7/7/2021 was a PRN (as needed) visit. During an interview on 8/12/2021 at 1:35 PM, the alternate clinical manager indicated the PRN visit was not included in the plan of care. 3. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/ 22/2021 which was electronically signed by RN H on 7/21/2021 and the physician on 7/23/2021. The plan of care		impact thisepisode however training and processes have been implemented to preventrecurrence. Patient #3 – This patientremains active with the agency and the OASIS assessment and the Plan of Carefor the current episode of care is comprehensive and accurate, and alldisciplines are appropriate to the services needed by the patient. Patient #4 - This patient is dischargedfrom the agency as of 8/24/21, and as such the agency is unable toretrospectively impact this episode however training and processes have beenimplemented to prevent recurrence. Patient #5 - This patient remains active with the agency and the OASISassessment and the Plan of Care for the current episode of care iscomprehensive and accurate, and all disciplines services have been providedaccording to ordered frequencies. Patient #6 - This patient wasdischarged from the agency at the time of the survey, and as such the agency isunable to retrospectively impact this episode however training and processeshave been implemented to prevent recurrence. Patient #7 - This patient was discharged from the agency at the time ofthe survey, and as such the agency is unable to	

	physician until the verbal start of care on 7/21/2021 obtained by RN H. The plan of care indicated the patient s primary diagnosis was Type II Diabetes (a chronic condition where the body is impaired in the way it regulates and uses sugar as fuel) but failed to evidence it was individualized to include interventions and measurable outcomes related to the diabetes. The document stated, & The patient/caregiver will verbalize understanding of (r/t [related to] cardiopulmonary [relating to the heart and lungs]/hematology [relating to the blood] diagnosis) _____ and all aspects of associated care within _____ period of time &. The document failed to evidence the plan of care was individualized to include a measurable goal. The plan of care evidenced the agency was to provide home health aide (HHA) services 2 times a week for 9 weeks. During an interview on 8/12/2021 at 9:57 AM, the alternate clinical manager indicated the interventions and goals related to diabetes that should have been included on the plan of care included educating the patient on the signs and symptoms of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar), parameters for blood sugar results and instructing the patient on how to check blood		retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence.	

	manager indicated the goal had blanks because it was an automated goal and should have been filled in based on the patient assessment. Review of an agency document titled Start of Care , with an assessment date of 6/24/2021 and electronically signed by RN H, failed to evidence the patient had any wounds. Review evidenced the patient s pain to legs and back was assessed to be a 3 on a scale of 0-10, with 0 being no pain and 10 being the most severe, with a frequency of daily but not constantly and a pain goal of a rating less than 2 on a scale of 0-10. The plan of care failed to evidence the patient s pain treatment and goals were included in the plan of care. During an interview on 8/12/2021 at 10:36 AM, the alternate clinical manager indicated the interventions and goal for the patient s pain should be included in the plan of care. Review of agency documents titled Skilled Visit Note , dated 6/30/2021 and electronically signed by former employee LPN B, indicated the patient had a surgical wound on the left foot. Document dated 8/4/2021, electronically signed by RN L, indicated the patient had a wound to the left foot with a start date of 6/15/2021. The plan of			

	care failed to evidence the patient s wound and wound care interventions and goals. Review on 8/13/2021 of documents from the wound clinic at hospital I, which the alternate clinical manager identified were requested of and received on 8/13/2021 from the patient s wound clinic, evidenced a document titled 06/28/2021 Follow Up in SM [hospital I] Wound Ostomy Clinic , dated 6/28/2021 and electronically signed by physician J. This document stated, & Patient presents today status post partial excision [surgical removal] of bone left 1st metatarsal [a bone in the foot]. & Incision site remains closed. Sutures removed. & Dressing orders: Betadine [a medication used to clean wounds] to incision site and covered by Hydrofera Blue [a type of absorptive foam dressing for wounds]. Dressing frequency: 3 times per week &. During an interview on 8/12/2021 at 10:27 AM, the alternate clinical manager indicated the patient had the wound at the start of care on 6/24/2021 and the plan of care should include interventions and goals related to the patient s wound. Review evidenced agency documents titled Skilled Visit Note . Document dated			

	7/29/2021 and electronically signed by RN H evidenced the RN assessed the patient s pain to be 3 on a scale of 0-10. This document indicated the patient s pain goal was a rating of 2 on a scale of 0-10. Review failed to evidence the RN assessed the patient s pain treatment. Document dated 8/4/2021 and electronically signed by RN L, evidenced the RN assessed the patient s pain to be 6 on a scale of 0-10. This document failed to evidence the RN assessed the location of the pain and the patient s pain treatment and effectiveness. During an interview on 8/12/2021 at 10:36 AM, the alternate clinical manager indicated pain should be assessed at every skilled visit and the RN should have assessed for nonpharmacologic treatment such as repositioning, heat and ice. Review failed to evidence the agency provided home health aide services during the week of 7/4/2021, 7/25/2021 and 8/1/2021. During an interview on 8/12/2021 at 11:24 AM, the administrator in training D indicated there was a home health aide visit for 7/5/2021 but the visit note had not been downloaded into the electronic medical record and indicated the agency overlooked downloading the notes into the			

	electronic medical record that day. The administrator in training D indicated there was a home health aide visit scheduled on 7/30/2021 but the agency was unable to staff the visit. The administrator in training D indicated a home health aide visit was provided on 8/2/2021 but the visit note had not yet been downloaded into the electronic medical record. Requested copies of the visit notes dated 7/5/2021 and 8/2/2021 and no additional documents provided. 4. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/5/2021 8/3/202, signed and dated by RN N on 7/6/2021. Review indicated the patient s primary diagnosis was atrial fibrillation (irregular heartbeat which may cause the heart to pump less effectively which may result in swelling of hands, feet, or other body parts). Review indicated skilled nursing was to provide services 1 time a week for 9 weeks and evidenced the skilled nursing goals stated, & The patient s safety (r/t [related to] psychological/behavioral diagnosis) will be enhanced throughout the home care service as evidenced by _____ within _____ period of time. The patient/caregiver will verbalize understanding of (r/t fall			

risk) ____ and all aspects of associated care within ___ period of time. & The patient/caregiver will have ____, as evidenced by ____ within _____ period of time &. Review failed to evidence the goals were individualized related to the patient s primary diagnosis.

During an interview on 8/16/2021 at 10:47 AM, the alternate clinical manager indicated the blanks in the plan of care should have been completed and the goals were not patient specific.

5. Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced an agency document titled Comprehensive Adult Assessment, 485 P.O.C. [Plan of Care] Worksheet and Outcome and Assessment Information Set , dated 2/18/2021 and signed by former employee RN K. This document indicated the diagnoses included, but were not limited to, orthopedic (the branch of medicine dealing with muscle or bone) aftercare and cellulitis (a bacterial skin infection which can cause the skin to be painful, red, swollen and hot to the touch) of the right lower limb. Review of the assessment indicated the patient had 1 surgical wound but failed to indicate the location in the comprehensive assessment.

Review of an agency document

	2/18/2021 and signed by former employee RN K, indicated the patient s medication included, but was not limited to, Doxycycline (an antibiotic used to treat infection) twice a day for 10 days for an infection. Review of an agency document titled Nursing Visit Record , dated 2/25/2021 and signed by former employee RN K, indicated the nurse removed a compression wrap over the dressing to the right 3rd toe, dressing assessed to be dry and intact and compression wrap reapplied. Review evidenced an agency document titled Plan of Care for certification period 2/18/2021 4/18/2021, signed by RN A and dated and signed by the physician on 6/8/2021, indicated skilled nursing services were to be provided 1 time a week for 1 week, then 2 times a week for 3 weeks and then 1 time a week for 5 weeks. Review failed to evidence the plan of care was individualized to include skilled nursing interventions related to the patient s diagnosis of the orthopedic aftercare and cellulitis to the right lower limb. Review failed to evidence skilled nursing interventions for the surgical wound identified during the comprehensive assessment to include a compression wrap. The plan of care indicated the skilled nurse was to instruct the			

	patient on fall preventions, instruct the patient on the use of the glucose (blood sugar) measuring device and instruct on the diabetic care to include diet, activity, stress, skin care and foot care. Review of agency documents titled Nursing Visit Record, dated 3/30/2021, 4/6/2021 and 5/17/2021 and signed by former employee RN K, failed to evidence the skilled nurse provided patient instruction as directed in the plan of care. Review failed to evidence the skilled nurse provided patient instruction on the use of the glucose measuring device during the certification period 2/18/2021 4/18/2021. During an interview on 8/18/2021 at 11:12 AM, the alternate clinical manager indicated there were no orders for wound care to the surgical wound and indicated the plan of care should include skilled nursing interventions to not remove the dressing until follow-up appointment date, monitor for break-through drainage, swelling and pain. The alternate clinical manager indicated the plan of care should include interventions for the cellulitis such as monitoring the area for redness, warmth, pain and swelling. At 11:30 AM, the alternate clinical manager indicated the skilled nurse does			

	visit but something should be documented for patient education at every visit. 6. During an interview on 8/12/2021 at 11:20 AM, former employee LPN B indicated she conducted home visits without a plan of care, medication list, physician orders and patient diagnoses because the RN that started the case was not done with the plan of care by the time the next skilled nurse visit was due.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. 7. Clinical record review on 8/16/2021, for patient #4, start of care 7/29/2021, diagnosis of age-related osteoporosis with current fracture to right humerus (upper arm) and a history of falls,	G0572	To assure comprehensiveand individualized Plans of Care the agency has implemented a process where allcomprehensive assessments completed by the admitting/recertifying clinicianwill be reviewed and updated by the agency leadership and consultants. Should additional interventions or revisionsto frequencies based on documentation by clinician be needed on the Plan ofCare and based on the OASIS documentation, edits to the POC will be made andreturned to the clinician for review, edit and approval. This includes assuring all cliniciansparticipating in care have orders for care on POC,	2021-11-20

	evidenced an agency document titled Home Health Certification and Plan of Care which was indicated to be the current plan of care received on 8/10/2021. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated Services for Occupational Therapist [OT]: & Effective on 08/08/2021: OT 2W2 [twice a week, for 2 weeks] & Summary of OT Orders: & ADL [activities of daily living] & Home Exercise Program & Summary of SN orders: & Monitor BP [blood pressure], Pulse, any increase or decrease of edema, noting decrease or increase of urine output, noting changes in level of activity, assess medication management of symptoms & Home safety interventions & pt [patient] r [right] shoulder incision site and staples will remain free from s/s [signs and symptoms] of infection &. Review failed to evidence frequencies for skilled nurse [SN] services to be provided. Review failed to evidence OT visit note documentation. Review failed to evidence the agency followed the SN and OT frequencies as ordered on the plan of care. Review failed to evidence OT performed the prescribed activities as ordered on the plan of care.		and all identified problemshave individualized interventions and measurable goals and timelines related tothe diagnoses. Clinicians conductingthe comprehensive OASIS assessment review, revise and approve the Plan of Careto assure inclusion of appropriate interventions. 100% clinical recordreviews will be conducted of all SOC, resumptions of care, and recertificationsto assure comprehensive POC. The Agency staff willbe re-trained on the scheduling module for the newly implemented EMR and willutilize the schedule within the EMR to assure that allevaluations, OASISassessments and visits are entered into the discipline specific schedules asordered by the physician on the planof care or supplemental order. If uponassessment a referred discipline is deemed not necessary by the admittingclinician, the primary care physician (PCP) will be contacted to revise theinitial referral order and revise the orders to include necessary disciplinesand document	

	8. Clinical record review on 8/16/2021, for patient #5, start of care 2/24/2021, diagnosis of type 2 diabetes with chronic kidney disease, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/22/2021. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated Services for Skilled Nurse: & SN [skilled nurse] 1W9 [once a week, for 9 weeks] 06/24/2021 08/21/2021 & Review of agency documents titled Skilled Visit Note failed to evidence a SN visit was conducted the week of 7/25/2021 7/31/2021. Review failed to evidence the agency met the frequency of visits ordered on the plan of care. During an interview on 8/16/2021, at 10:25 AM, when queried on why the patient missed a SN visit, alternate clinical manager A indicated the primary clinician for that patient was no longer with the company and could not meet the frequency of visits. Alternate clinical manager A agreed there was not documentation of physician notification.		discussion with physician. The scheduler will beresponsible for creating the calendar for each patient and each clinician willaccess the calendar to assure visits are accurate based on the Medicarecalendar week. Scheduler to review notesin EMR daily and contact each clinician if notes not synched to EMR to assurevisits for prior day werecompleted as scheduled. Visits missedwill be rescheduled within the week or Physicians will be notified of anymissed visits or variance to the ordered visits. Physicians will be queried as to need toalter Plan of care if there is a clinical impact to the patient. Wound care training tobe conducted related to preventative skin care measures to prevent shearing aswell as treatment interventions. Coordination with wound care clinic process established with agencycontacting wound care clinic weekly following patient visit to confirm anychanges to wound care treatment. Orderswill be obtained for any changes to treatment protocol. Plans of care and all visit notes undergoquality review to assure inclusion of appropriate orders on POC anddocumentation of	

	During an interview on 8/16/2021, at 10:26 AM, when queried if the patient was notified of the missed visit, the administer in training D indicated they did not document every time a patient was called. 9. Clinical record review on 8/17/2021, for patient #7, start of care 6/28/2021, diagnosis of aftercare of surgical incision on the GU [genitourinary] system, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/28/2021 8/26/2021. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated Services for Skilled Nurse: Effective 6/29/2021: SN: 1W6 [once a week, for 6 weeks] &. Review failed to evidence the patient received SN visits as ordered in the plan of care. Review failed to evidence a SN visit took place between the start of care on 6/29/2021, until the discharge date on 7/20/2021. Review failed to evidence documentation of missed visits and/or physician notifications. During an interview on 8/17/2021, at 2:29 PM, alternate clinical manager A indicated the patient refused SN visits and there was not documentation of		wound care based on orders provided. Therapists will beeducated to the need to perform vital signs on visits for covid-19 screening inaddition to therapy interventions and to notify physician of changes in vitalsigns or other clinical findings. Staff will be educated thatthe scheduler will be notified of any variances to visits scheduled for the dayby clinicians. Staff will be instructedin process to follow if missed visit or variance to ordered frequency toinclude notification of physician and discerning whether impact to patient's clinical status. Home Health Aideswill be educated as to need to follow plan of care specific to performingvisits according to ordered frequencies for each patient. Scheduler will follow up on visits notentered into the EMR the day following the scheduled visit to assure documentation iscompleted or the visit is rescheduled or missed visit. If missed, the physician is notified of themissed visit. Staff training to beconducted	

	the missed visits or physician notifications in the clinical record at the time of review. 17-13-1(a)		related to following the plan of care as ordered to include educationof patient related to diagnoses, assessment of pain, ordered interventions andpatient measurable goals. Communicationto physician is needed if pain interventions, including non-pharmacologicinterventions ordered are not allowing patient to achieve goals toward paincontrol. Monitoring of ongoingcompliance with regulation includes the following: - Review of activepatient records to determine accuracy of scheduling module and missed visitmanagement and physician notification of schedule variances to orders. - Review of HHA notes foraccuracy in documentation to Aide plan of care. - Clinical record reviewto be conducted to assure compliance with scheduling and therapist and HHAdocumentation accuracy – 100% of all records tobe reviewed until 100% compliance achieved; record review to then be completedfor 20% of records to assure ongoing compliance.	

			The Administrator isresponsible for implementing and monitoring the above plans of correction bythe identified dates. Ongoing review ofeach Plan of Care and each visit note completed by clinicians will assurecompliance with documentation to orders. Patient #1 – This patient remains active with the agency and thecurrent plan of care is comprehensive and includes orders for care to all woundsites and that frequencies are accurate on the plan of care and all disciplinesare visiting the patient as per the ordered frequencies. As per plan ofcorrection, training and workflow including review of all Plans of Care andclinician notes has been put in place to assure ongoing communication withphysicians and prevention of recurrence of this issue. Patient #2 – This patient is discharged from the agencyas of 9/1/21, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence. Patient #3 – This patientremains active with the agency and the OASIS assessment and the Plan of Carefor the current episode of care is comprehensive and accurate, and alldisciplines are appropriate to the services needed by the patient.	

			Patient #4 - This patient is dischargedfrom the agency as of 8/24/21, and as such the agency is unable toretrospectively impact this episode however training and processes have beenimplemented to prevent recurrence. Patient #5 - This patient remains active with the agency and the OASISassessment and the Plan of Care for the current episode of care iscomprehensive and accurate, and all disciplines services have been providedaccording to ordered frequencies. Patient #6 - This patient wasdischarged from the agency at the time of the survey, and as such the agency isunable to retrospectively impact this episode however training and processeshave been implemented to prevent recurrence. Patient #7 - This patient was discharged from the agency at the time ofthe survey, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence.	
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the	G0574	Patient individualizedplans of care will be created and reviewed by Agency leadership	2021-11-22

	following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. 1. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Plan of Care CMS #485 and Physician Orders stated, & The individualized plan of care must include the following: All pertinent diagnoses & The types of services, supplies and equipment required & All medications and treatments. Safety measures to protect against injury. A description of the patient s risk for emergency		and consultinggroup to assure inclusion of the following: (i) All pertinentdiagnoses; (ii) Thepatient's mental, psychosocial, and cognitive status; (iii) Thetypes of services, supplies, and equipmentrequired; (iv) The frequency and duration of visits to be made; (v)Prognosis; (vi)Rehabilitationpotential; (vii)Functionallimitations; (viii)Activities permitted; (ix)Nutritionalrequirements; (x)Allmedications and treatments; (xi)Safety measures to protect against injury; (xii) Adescription of the patient's risk for emergency department visits and hospital re-admission, and all necessaryinterventions to address the underlying risk factors. (xiii) Patient and caregiver educationand training to facilitate timely discharge; (xiv) Patient-specificinterventions and education; measurable outcomes	

	department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. Patient and caregiver education and training to facilitate timely discharge. & Patient-specific interventions and education, measurable outcomes and goals identified by the Agency and patient. &" 2. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Medication Orders stated, & Each patient s record will reflect a diagnosis, condition or indication for use for each medication ordered & Indications for use must be included in PRN [as needed] medication orders or if medication is ordered for a condition not usually treated with that medication &." 3. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021 and electronically signed by registered nurse (RN) K. This document indicated the patient s diagnoses included, but were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting		and goals identified by the HHA and thepatient; (xv) Information relatedto any advanced directives;and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. To assurecomprehensive and individualized Plans of Care the agency has implemented aprocess where all comprehensive assessments completed by theadmitting/recertifying clinician will be reviewed and updated by the agencyleadership and consultants. Shouldadditional interventions or revisions to frequencies based on documentation byclinician be needed on the Plan of Care and based on the OASIS documentation,edits to the POC will be made and returned to the clinician for review, editand approval. This includes assuring allclinicians participating in care have orders for care on POC, and all identifiedproblems have individualized interventions and measurable goals and timelinesrelated to the diagnoses. Clinicians conductingthe comprehensive OASIS assessment review, revise and approve the Plan of Careto assure inclusion of appropriate interventions. Clinicians conductingthe OASIS assessment review, revise and approve the Plan of Care to assureinclusion of appropriate interventions and parameters which if patient	

	the left buttock, quadriplegia (paralysis of all 4 limbs), hypertension (high blood pressure) and chronic embolism (an obstruction of an artery, typically by a blood clot or air bubble) and thrombosis (formation of a blood clot within a blood vessel) of left iliac vein (a vein located in the abdomen). This document indicated the patient had 3 Stage II pressure ulcers consisting of 2 to the left groin and 1 pressure ulcer to the buttocks. One pressure ulcer to the left groin was assessed to be 1 centimeter (cm) in length, 1 cm in width and 0.2 cm in depth and had a wound treatment of cleanse with normal saline (a solution of salt and water used to clean wounds), apply collagen (a wound treatment used to stimulate new tissue growth), cover with an ABD pad (a thick absorbent wound dressing used to absorb fluid and keep from pooling on the wound site) and secure with tape 3 times a week. One pressure ulcer to the left groin was assessed to be 1 cm in length, 0.3 cm in width and 0.2 cm in depth and had a wound treatment of cleanse with normal saline, cover with an ABD pad and secure with tape 3 times a week. The wound to the buttocks was assessed to be 1 cm in length, 0.5 cm in width, 0.2 cm in depth and had a wound treatment of cleanse with normal saline, apply collagen, cover with an ABD pad and secure with		exhibitsassessment outside of parameter physician will be notified, wound caresupplies, safety precautions, equipment, glucometers and blood glucose testingequipment, medications, mental status, and functional limitations. Plans of care will be reviewed to assureinclusion of accurate frequency of discipline visits. 100% clinical recordreviews of all SOC, resumptions of care, and recertifications will be performedto assure comprehensive POC exists. Thisprocess will assure ongoing compliance with individualized, comprehensive plansof care. The Administrator isresponsible for assuring compliance with accuracy of Plans of Care. The ongoing quality review of each Plan ofCare and visit note will assure compliance with comprehensive Plan of care anddocumentation Patient#1 – This patientremains active with the agency and the current plan of care is comprehensiveand includes orders for care to all wound sites and that frequencies areaccurate on the plan of care. The current Plan of Care includes ordered diabetictesting supplies to include glucometer, lancets, etc. Patient #2– Thispatient is	

	tape 3 times a week. This document indicated the patient had a foley catheter (a thin, sterile tube inserted into the bladder to drain urine). This document indicated the patient was at risk for skin breakdown. Review evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/18/2021 8/16/2021. The document was signed by the alternate clinical manager on 7/15/2021 and by the physician on 8/2/2021 and indicated the patient s medication included, but was not limited to, Eliquis (a blood thinning medication used to prevent blood clots) twice a day and Ketoconazole (an antifungal medication used to treat skin infections) twice a day externally. Review failed to evidence bleeding precautions were included in the plan of care. Review failed to evidence to where Ketoconazole was to be applied externally. Review evidenced the plan of care stated, & Summary of SN [skilled nurse] Orders: & catheter care &. The plan of care failed to evidence the specific care the SN was to perform to provide catheter care and failed to evidence paralysis as a functional limitation. During an interview on 8/12/2021 at 12:07 PM, the alternate clinical manager indicated bleeding		discharged from the agency as of 9/1/21, and as such the agency isunable to retrospectively impact this episode however training and processeshave been implemented to prevent recurrence. Patient #3 – This patient remains active with the agencyand the OASIS assessment and the Plan of Care for the current episode of careis comprehensive and accurate, including the medical supplies necessary andmedication set-up as a skilled nursing intervention. Vital sign parameters areincluded on the current plan of care. Patient #4 - This patient isdischarged from the agency as of 8/24/21, and as such the agency is unable toretrospectively impact this episode however training and processes have beenimplemented to prevent recurrence. Patient#5 - This patient remains active with the agency and the OASISassessment and the Plan of Care for the current episode of care is comprehensiveand accurate, inclusive of information related to diet considering diabeticdiagnosis, functional limitations have been addressed to include accuratefunctional limitations and endurance and use of walker. Vital sign parameters were individualized andincluded on the plan of care. Patient #6 - Thispatient was discharged from the agency at the time of the survey, and as	

	precautions should be included in the plan of care. At 12:09, the alternate clinical manager indicated she was not sure where the Ketoconazole was to be applied but the plan of care should specify to where the medication was to be applied. AT 12:15 PM, the alternate clinical manager indicated the plan of care should indicate what specific catheter care should be provided to include the location of the catheter and protocol for the cleaning and changing of the drainage bag. During an observation of care on 8/13/2021 at 7:19 PM at the patient s home, RN H was observed removing the wound dressing to the patient s left groin and 2 open areas were noted. RN H was observed moistening dry gauze by squirting clear liquid from a syringe labeled Sodium Chloride 0.9% [normal saline] and wiping the patient s open areas on the left groin with the moistening gauze. At 7:30 PM, RN H was observed cutting with scissors a white material she identified as alginate (a wound absorption treatment which encourages new tissue growth) to a smaller piece which RN H was observed placing on the 2 open areas on the left groin. RN H explained she would cover the wounds with gauze since the patient did not have an ABD pad. RN H was observed placing folded gauze pads over		retrospectively impact this episode however trainingand processes have been implemented to prevent recurrence.	

	the open areas on the left groin and secured gauze with tape. At 7:35 PM, RN H was observed rolling the patient to the left side in bed and a dressing was noted to the right buttock. RN H removed the dressing from the right buttock and 2 open areas were observed to the right ischium (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis). At 7:44 PM, RN H was observed moistening gauze with clear liquid from a syringe labeled Sodium Chloride 0.9% and then observed wiping the open areas to the right ischium with the moistened gauze. At 7:48 PM, RN H was observed cutting with scissors a white material she identified as alginate and placed over open areas on right ischium, covered with folded gauze and secured gauze with tape. Review failed to evidence the plan of care included wound care supplies alginate, gauze and tape and failed to evidence the medication included Sodium Chloride 0.9% During an interview on 8/12/2021 at 12:17 PM, the alternate clinical manager indicated the plan of care should include the wound care supplies. During an interview on 8/13/2021 at 8:23 PM, the patient indicated his medication included			

	diazepam (a medication used to treat seizures, muscle spasms and anxiety) 10 milligrams (mg) four times a day. The patient indicated he alternates Bactrim (antibiotic) twice a day for 3 months and then Macrobid (antibiotic) twice a day for 3 months as a preventive measure for urinary tract infections. Review failed to evidence the plan of care included the medication diazepam, Bactrim and Macrobid. During an interview on 8/18/2021 at 12;37 PM, the alternate clinical manager indicated all the medication taken by the patient should be included on the plan of care. 4. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/ 22/2021 which was electronically signed by RN H on 7/21/2021 and the physician on 7/23/2021. The plan of care indicated the patient s primary diagnosis was Type II Diabetes (a chronic condition where the body is impaired in the way it regulates and uses sugar as fuel). This document evidenced the patient s medication included, but was not limited to, Iodosorb (a medicated gel used to treat wounds) as needed to the left foot and Warfarin Sodium			

	(a medication used to thin the blood and prevent/treat blood clots) daily. Review failed to evidence the plan of care included the indications for when the Iodosorb was to be applied to the left foot. Review failed to evidence the safety measures included bleeding precautions. During an interview on 8/12/2021 at 9:39 AM, the alternate clinical manager indicated she was unsure why the plan of care did not include when or why the Iodosorb should be applied and indicated at 9:40 AM bleeding precautions should be included in the plan of care. Review of agency documents titled Skilled Visit Note , electronically signed by former employee LPN B, evidenced the patient s blood sugar result was 123 on document dated 6/30/2021, 132 on document dated 7/15/2021 and 144 on document dated 7/21/2021. Review of the document dated 7/21/2021 evidenced the assessment included a glucometer (a medical device which helps to determine the amount of sugar in the blood) reading. Document dated 8/4/2021 and electronically signed by RN L indicated the patient s blood sugar was 127. The plan of care failed to evidence the medical supplies needed to obtain the patient s blood sugar such as a			

	glucometer. During an interview on 8/12/2021 at 10:59 AM, the alternate clinical manager indicated medical supplies related to the patient s diabetes to include a glucometer, lancets (a small blade with a sharp point used to obtain a drop of blood) and strips (used with glucometers to test the amount of sugar in the blood). The alternate clinical manager indicated the agency s focus for the patient was more on the wounds than the diabetes. 5. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/5/2021 8/3/2021, signed and dated by RN N on 7/6/2021. Review indicated the patient s primary diagnosis was atrial fibrillation (irregular heartbeat which may cause the heart to pump less effectively which may result in swelling of hands, feet, or other body parts). Review indicated skilled nursing was to provide services 1 time a week for 9 weeks and obtain a weekly INR lab test (a lab test which monitors the clotting time of blood). Review failed to evidence the plan of care included the medical supplies to obtain the INR lab test. The plan of care stated, & Summary of SN Orders: & patient-specific			

parameters for notifying the physician of changes in vital signs or other clinical findings &. but failed to indicate the individualized vital sign parameters.

Review of an agency document titled Skilled Visit Note , dated 6/21/2021 and electronically signed by RN N, indicated the nurse set up the patient s medications. The plan of care failed to indicate the skilled nursing interventions included medication set-up.

During an interview on 8/16/2021 at 11:23 AM, the alternate clinical manager indicated the supplies needed for the INR lab test should be included in the plan of care. At 11:47 AM, the alternate clinical manager indicated the individualized vital sign parameters and the skilled nursing intervention for medication set-up should be included in the plan of care.

6. Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced an agency document titled Medication Profile , dated 2/18/2021 and signed by former employee RN K, which indicated the patient s medication included, but was not limited to, Doxycycline (an antibiotic used to treat infection) twice a day for 10 days for an infection.

Review evidenced an agency

	document titled Plan of Care for certification period 2/18/2021 4/18/2021, signed by RN A and dated and signed by the physician on 6/8/2021, indicated the patient s diagnoses included, but were not limited to, cellulitis (a bacterial skin infection which can cause the skin to be painful, red, swollen and hot to the touch) of the right lower limb and Type II Diabetes. Review failed to indicate the plan of care included Doxycycline in the list of patient s medications. The plan of care indicated the skilled nurse was to instruct on the use of a glucose (blood sugar) monitoring device. The plan of care failed to indicate the medical supplies included the glucose monitoring device and testing supplies. During an interview on 8/18/2021 at 10:57 AM, the alternate clinical manager indicated Doxycycline should have been included in the plan of care. At 11:21 AM, the clinical manager indicated the plan of care should include the glucometer and testing supplies.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi)	G0574	Patient individualizedplans of care will be created and	2021-11-22

	The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. 7. Clinical record review on 8/10/2021, for patient #4, start of care 7/29/2021, evidenced an agency document titled Home Health Certification and Plan of Care which was indicated to be the current plan of care received on 8/10/2021, diagnosis of age-related osteoporosis with current fracture to right humerus (upper arm), with a history of falls. This document failed to evidence information including,		reviewed by Agency leadership and consultinggroup to assure inclusion of the following: (i) All pertinentdiagnoses; (ii) Thepatient's mental, psychosocial, and cognitive status; (iii) Thetypes of services, supplies, and equipmentrequired; (iv) The frequency and duration of visits to be made; (v)Prognosis; (vi)Rehabilitationpotential; (vii)Functionallimitations; (viii)Activities permitted; (ix)Nutritionalrequirements; (x)Allmedications and treatments; (xi)Safety measures to protect against injury; (xii) Adescription of the patient's risk for emergency department visits and hospital re-admission, and all necessaryinterventions to address the underlying risk factors. (xiii) Patient and caregiver educationand training to facilitate timely discharge; (xiv) Patient-specificinterventions and	

	but not limited to: Supplies/equipment, safety measures, nutritional requirements, functional limitations, activities permitted, services/frequencies for skilled nursing, mental status, and prognosis, as well as physician name and location, and the nurse performing the assessment, which was required to individualize a plan of care. During an interview on 8/17/2021, at 12:08 PM, alternate clinical manager A indicated the individualized patient information was on the care plan located in the electronic medical record. Alternate clinical manager A indicated the document received on 8/10/2021, titled Home Health Certification and Plan of Care was probably printed while the document was still in the QA [quality assurance] process. The alternate clinical manager indicated the information of the nurse completing the assessment would not be shown on the plan of care until it was sent to the physician. She also indicated the physician s name and contact information would not be displayed until the document was signed. The alternate clinical manager indicated the clinician that entered the skilled nurse frequencies, did not complete the documentation process correctly.		education; measurable outcomes and goals identified by the HHA and thepatient; (xv) Information relatedto any advanced directives;and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. To assurecomprehensive and individualized Plans of Care the agency has implemented aprocess where all comprehensive assessments completed by theadmitting/recertifying clinician will be reviewed and updated by the agencyleadership and consultants. Shouldadditional interventions or revisions to frequencies based on documentation byclinician be needed on the Plan of Care and based on the OASIS documentation,edits to the POC will be made and returned to the clinician for review, editand approval. This includes assuring allclinicians participating in care have orders for care on POC, and all identifiedproblems have individualized interventions and measurable goals and timelinesrelated to the diagnoses. Clinicians conductingthe comprehensive OASIS assessment review, revise and approve the Plan of Careto assure inclusion of appropriate interventions. Clinicians conductingthe OASIS assessment review, revise and approve the Plan of Care to assureinclusion of appropriate interventions and parameters	

	8. During an observation on 8/11/2021, at 1:07 PM, patient #5 was observed in their home during a skilled nurse visit. The patient was observed to be hard of hearing. The skilled nurse had to speak very loud for the patient to understand and many times, the patient s caregivers would answer for the patient. During the visit, patient #5 sat in a recliner chair with an assisted lift, and a walker was placed in front of the patient s body. The patient wore light compression socks, which the caregiver indicated to have applied for the patient. The caregiver also indicated they prepared the patient s medications every day, which included assisting the patient with checking their blood sugar and insulin medications by injection. During an interview on 8/16/2021, at 9:55 AM, alternate clinical manager A indicated glucometer, test strips, and other supplies required for checking blood sugars should be listed on the plan of care. The alternate clinical manager indicated the patient s diagnosis of type 2 diabetes should have been taken into concern before reporting a regular diet on the plan of care. The alternate clinical manager indicated functional limitations should have mentioned the patient s hearing and endurance as a concern, and the activities permitted should have included		which if patient exhibitsassessment outside of parameter physician will be notified, wound caresupplies, safety precautions, equipment, glucometers and blood glucose testingequipment, medications, mental status, and functional limitations. Plans of care will be reviewed to assureinclusion of accurate frequency of discipline visits. 100% clinical recordreviews of all SOC, resumptions of care, and recertifications will be performedto assure comprehensive POC exists. Thisprocess will assure ongoing compliance with individualized, comprehensive plansof care. The Administrator isresponsible for assuring compliance with accuracy of Plans of Care. The ongoing quality review of each Plan ofCare and visit note will assure compliance with comprehensive Plan of care anddocumentation Patient#1 – This patientremains active with the agency and the current plan of care is comprehensiveand includes orders for care to all wound sites and that frequencies areaccurate on the plan of care. The current Plan of Care includes ordered diabetictesting supplies to include glucometer, lancets, etc.	

	the patient s walker on the plan of care. At 10:02 AM, the alternate clinical manager indicated signs and symptoms of covid-19 are monitored by checking temperatures and obtaining information about travel, exposure, and cough/respiratory symptoms. The alternate clinical manager indicated the SN orders were not complete to include parameters individualized to the patient on the plan of care. 9. During an interview on 8/16/2021, at 12:11 PM, alternate clinical manager A indicated the agency had tried to narrow down the time it takes to QA the plan of care and would work to have it completed sooner 17-13-1(a)(1)(D)(ii, vi, vii, ix, x, xiii)		Patient #2– Thispatient is discharged from the agency as of 9/1/21, and as such the agency isunable to retrospectively impact this episode however training and processeshave been implemented to prevent recurrence. Patient #3 – This patient remains active with the agencyand the OASIS assessment and the Plan of Care for the current episode of careis comprehensive and accurate, including the medical supplies necessary andmedication set-up as a skilled nursing intervention. Vital sign parameters areincluded on the current plan of care. Patient #4 - This patient isdischarged from the agency as of 8/24/21, and as such the agency is unable toretrospectively impact this episode however training and processes have beenimplemented to prevent recurrence. Patient#5 - This patient remains active with the agency and the OASISassessment and the Plan of Care for the current episode of care is comprehensiveand accurate, inclusive of information related to diet considering diabeticdiagnosis, functional limitations have been addressed to include accuratefunctional limitations and endurance and use of walker. Vital sign parameters were individualized andincluded on the plan of care. Patient #6 - Thispatient was discharged from the agency at	

			suchthe agency is unable to retrospectively impact this episode however trainingand processes have been implemented to prevent recurrence.	
G0578	Conformance with physician orders 484.60(b) Standard: Conformance with physician or allowed practitioner orders. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Plan of Care CMS #485 and Physician s Orders stated, & Care and services provided will be provided according to physician orders &. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Supplemental Provider Order , dated 7/31/2021 and electronically signed by occupational therapist (OT) M and dated 8/10/2021 and signed by the physician. This document indicated OT services were to be provided 2 times a week for 3 weeks for activities of daily living (ADL) training, bathroom mobility and home exercise program. Review of a document titled Discharge/Transfer Summary , dated 8/9/2021 and electronically signed by OT M, evidenced a subsection titled Goals not met	G0578	For plan of care conformancerelated to missed visits, the agency has implemented a process related toscheduling – The scheduler will beresponsible for creating the calendar for each patient and each clinician willaccess the calendar to assure visits are accurate based on the Medicarecalendar week. Scheduler to review notesin EMR daily and contact each clinician if notes are not synched to EMR toassure visits for prior day were completed as scheduled. Visits missed will be rescheduled within the Medicareweek or Physicians will be notified of any missed visits or variance to theordered visits. Physicians will bequeried as to need to alter Plan of care if there is a clinical impact to thepatient. Patients pendingdischarge will be reviewed 3 weeks prior to discharge to assess progress togoals. During case conference, decisionis made to recertify or discharge patients. If goals not met, plan for ongoing	2021-11-22

	[and] reasons (If applicable): which stated, & Bathing not met due to need of someone to position shower bench and assist with lower body as there is a dressing on the [left] foot &. Review indicated the OT provided services 1 time during week 2 and did not provide OT services during week 3. Review failed to evidence the agency communicated with the physician regarding the discharge from OT services and failed to evidence a physician s order for the discharge of OT services. Review failed to evidence OT provided services 2 times a week for 3 weeks as ordered by the physician. During an interview on 8/18/2021 at 12:12 PM, the alternate clinical manager indicated the physician should have been notified prior to the OT discharge related to the inability to meet patient needs and the request to discharge from OT services. The alternate clinical manager indicated there was not a verbal order obtained from the physician for the discharge of OT services.		care vs. service needs post dischargewill be discussed with physician to determine need for ongoing care postdischarge from home health. Clinicianswill educated to this process and to document discharge planning and carerequired post discharge from agency and appropriate 15 day notification ofpending discharge to the patient. The Administrator isresponsible assuring visit frequencies are met, physicians are notified ofmissed visits and discharge planning assures patient goals are met prior todischarge or post home health care coordination is conducted. Ongoing clinicalrecord review of clinician notes will assure compliance with this requirement.	
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. 1. Review of an agency policy,	G0580	To assure comprehensiveand individualized Plans of Care the agency has implemented a process where allcomprehensive assessments completed by the admitting/recertifying clinicianwill	2021-11-22

	revised March 2019 and obtained 8/18/2021, titled Plan of Care CMS #485 and Physician Orders stated, & All patient care orders, including verbal orders, must be recorded in the plan of care. & Drug, services and treatments are administered by staff only as ordered by physician &. 2. Review of an undated agency policy, obtained 8/18/2021, titled Integumentary Application of Wound Dressing stated, & Procedure: & Review physician s orders. & Dress wound with appropriate dressings following manufacturer s guidelines and physician orders &. 3. Clinical record review on 8/10/2021 and 8/18/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021 and electronically signed by registered nurse (RN) K. This document indicated the patient s diagnoses included, but were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the left buttock and quadriplegia (paralysis of all 4 limbs). This document indicated the patient had 3 Stage II pressure ulcers		be reviewed and updated by the agency leadership and consultants. Should additional interventions or revisionsto frequencies based on documentation by clinician be needed on the Plan ofCare and based on the OASIS documentation, edits to the POC will be made andreturned to the clinician for review, edit and approval. This includes assuring all cliniciansparticipating in care have orders for care on POC, and all identified problemshave individualized interventions and measurable goals and timelines related tothe diagnoses. Clinicians conductingthe comprehensive OASIS assessment review, revise and approve the Plan of Careto assure inclusion of appropriate interventions. Clinician visit notesare quality reviewed to assure documentation correlates with ordered care andif orders are not identified, orders are obtained prior to care delivery. Thisincludes frequencies, wound orders, interventions and medicationreconciliation.	

	consisting of 2 to the left groin and 1 pressure ulcer to the buttocks. One pressure ulcer to the left groin was assessed to be 1 centimeter (cm) in length, 1 cm in width and 0.2 cm in depth and had a wound treatment of cleanse with normal saline (a solution of salt and water used to clean wounds), apply collagen (a wound treatment used to stimulate new tissue growth), cover with an ABD pad (a thick absorbent wound dressing used to absorb fluid and keep from pooling on the wound site) and secure with tape 3 times a week. One pressure ulcer to the left groin was assessed to be 1 cm in length, 0.3 cm in width and 0.2 cm in depth and had a wound treatment of cleanse with normal saline, cover with an ABD pad and secure with tape 3 times a week. The wound to the buttocks was assessed to be 1 cm in length, 0.5 cm in width, 0.2 cm in depth and had a wound treatment of cleanse with normal saline, apply collagen, cover with an ABD pad and secure with tape 3 times a week. Review of agency documents titled Skilled Visit Note , electronically signed by former employee licensed practical nurse (LPN) B, indicated wound treatment was performed on 6/22/2021 to the left groin and right gluteal fold area and the document stated, & Wound care performed as ordered by this		100% clinical record reviewsof all SOC, resumptions of care, and recertifications will be performed toassure comprehensive POC exists. Thisprocess will assure ongoing compliance with individualized, comprehensive plansof care. The Administrator isresponsible for assuring compliance with accuracy of Plans of Care. The ongoing quality review of each Plan ofCare and visit note will assure compliance with comprehensive Plan of care anddocumentation. Patient #1 – This patient remains active with the agency and thecurrent plan of care is comprehensive and includes orders for care to all woundsites and that frequencies are accurate on the plan of care and EMR documentscommunication with wound care clinic. Patient #2 – This patient is discharged from the agencyas of 9/1/21, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence. Patient #4 - This patient is dischargedfrom the agency as of 8/24/21, and as such the agency	

	writer &. Document dated 6/29/2021 stated, & Wounds: L ish & Wound cleansed with NS [normal saline] and dressing applied per order. & R ish & Area cleaned with NS and dressing applied per order &. Document dated 7/2/2021 stated, & Dressing changed per orders from wound clinic &. Document dated 7/5/2021 stated, & L dressing had med [medium] amount of drainage & Dressing changed per order. R dressing had small amount of red/tan drainage. Dressing changed per order &. Document dated 7/7/2021 stated, & Dressing changed on both wounds &. Document dated 7/15/2021 stated, & Dressings changed per order &. Document dated 7/19/2021 indicated the nurse cleansed the wounds to the groin and to a site with a location stated as Other with normal saline and packed with alginate (absorbent wound treatment), covered with an ABD pad and secured with tape. This document stated, & Wound dressings changed per order &. Document dated 7/23/2021 evidenced the skilled nurse cleansed the wound to the left groin with normal saline, covered with an ABD pad and secured with tape and cleansed the wound to the right ischium (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis) with normal saline, packed with		is unable toretrospectively impact this episode however training and processes have beenimplemented to prevent recurrence.	

	alginate collagen, covered with an ABD pad and secured with tape. This document indicated the skilled nurse cleansed a wound to the coccyx (the lower back above the buttocks) with normal saline and applied optifoam (a foam dressing with an adhesive border). Review failed to evidence a physician order for wound care as performed by the skilled nurse. Review of agency documents titled Skilled Visit Note , electronically signed by registered nurse (RN) L, indicated the RN cleansed the wounds to the left groin and right ischium with normal saline, packed with collagen, covered with an ABD pad and secured with tape on document dated 8/2/2021. Document dated 8/6/2021 indicated the RN cleansed the wound to the left groin with normal saline, packed with prism, covered with gauze and secured with tape and cleansed the wound to the right ischium with normal saline, packed with prism (an absorbent wound treatment), covered with an ABD pad and secured with tape. Document dated 8/9/2021 indicated the RN cleansed the wounds to the left groin and right ischium with normal saline, packed with prism alginate, covered with gauze and an ABD pad and secured with tape. Review failed to evidence a			

as performed by the skilled nurse.

Review evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/18/2021 8/16/2021. The document was signed by the alternate clinical manager on 7/15/2021 and by the physician on 8/2/2021 and indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks and 2 times a week for 9 weeks. The plan of care stated, & Wound care will be performed by &. and failed to be individualized to include the location of the patient s wounds and wound care to be provided.

Review failed to evidence physician orders for wound care.

During an interview on 8/12/2021 at 12:12 PM, the alternate clinical manager indicated the plan of care was supposed to indicate skilled nursing services 2 times a week for 9 weeks and the skilled nurse 1 time a week for 9 weeks was a mistake. At 1:00 PM, the alternate clinical manager indicated she did not see any wound care orders or information from the patient s wound clinic.

During an observation of care on 8/13/2021 at 7:19 PM at the patient s home, RN H was observed removing the wound dressing to the patient s left groin

	each appeared the length of a large paperclip and as wide as the width of a pen. Both open areas appeared to have a depth of the length of a pinky fingernail. RN H stated, One is more medial, but there are two here. RN H was observed to place her gloved right thumb along the length of the lateral left groin open area and then pinch her right thumb with her left thumb and forefinger. RN H then placed her right thumb over the tag on her nurse bag and stated, The length is from H to I. RN H was then observed to place her gloved right thumb along the width of the lateral left groin open area and then pinch her right thumb with her left thumb and forefinger. RN H placed her right thumb over the tag on her nurse bag and stated, The width is from H to O. RN H was observed placing her gloved right thumb into the lateral left groin open area and was observed pinching her right thumb with her left thumb and forefinger. RN H was observed placing her gloved right thumb over the tag on her nurse bag and stated, The depth is H. At 7:25 PM, RN H placed a retractable tape measure against the tag on her nurse bag and stated, The measurements are just under 1.5 inches, ¾ inch and ½ inch deep. RN H was observed moistening dry gauze by squirting clear liquid from a syringe labeled Sodium Chloride 0.9% [normal saline] and wiping			

	the patient s open areas on the left groin with the moistening gauze. At 7:30 PM, RN H was observed cutting with scissors a white material she identified as alginate (a wound absorption treatment which encourages new tissue growth) to a smaller piece which RN H was observed placing on the 2 open areas on the left groin. RN H explained she would cover the wounds with gauze since the patient did not have an ABD pad. RN H was observed placing folded gauze pads over the open areas on the left groin and secured gauze with tape. At 7:35 PM, RN H was observed rolling the patient to the left side in bed and a dressing was noted to the right buttock. RN H removed the dressing from the right buttock and 2 open areas were observed to the right ischium (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis). The lateral open area on the right ischium appeared to be the length of a large paperclip, the width of the diameter of a pen and the depth of a tip of a pen. The medial open area of the right ischium appeared to be in the peri wound (the area surrounding the wound) of the lateral open area on the right ischium and have the size of a dime with just the top layer of skin removed and a red wound base. At 7:44 PM, RN H was observed moistening gauze with clear liquid from a syringe			

	labeled Sodium Chloride 0.9% and then observed wiping the open areas to the right ischium with the moistened gauze. At 7:45 PM, RN H measured the lateral open area on the right ischium with a retractable tape measure and stated, There s a little excoriated [the breakdown of skin due to prolonged exposure to moisture] part here. To me, there s really another wound here. Some may call it one. At 7:48 PM, RN H was observed cutting with scissors a white material she identified as alginate and placed over open areas on right ischium, covered with folded gauze and secured gauze with tape. During an interview on 8/13/2021 at 7:12 PM, RN H indicated she had a list of the patient s supplies and did not have the patient s wound care order but that it was probably at the office. During an interview on 8/18/2021 at 12:43 PM, the alternate clinical manager indicated there were not any wound care orders for the patient. 4. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced of an agency document titled Start of Care (D1) , dated 7/14/2021 and electronically signed by RN H, which failed to indicate the patient had any wounds. Review of an agency document			

titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/ 22/2021 which was electronically signed by RN H on 7/21/2021 and the physician on 7/23/2021, failed to evidence wound care orders.

Review of agency documents titled Skilled Visit Note , dated 7/21/2021 and electronically signed by former employee LPN B, indicated the patient had a surgical wound to the front of the left foot. The document indicated the skilled nurse cleansed the wound with normal saline, covered with kerlix (a type of gauze) and secured with tape. Document dated 7/29/2021 and electronically signed by RN H indicated the skilled nurse cleansed the wound to the left foot with wound wash, applied Iodosorb, covered with gauze and an ABD pad and secured with tape. Document dated 8/4/2021 and electronically signed by RN L indicated the skilled nurse cleansed the wound to the left foot with wound wash, covered with gauze and an ABD pad and secured with kerlix and tape.

Review of an agency document titled Supplemental Provider Order, electronically signed by RN H and dated 8/3/2021, stated, & wound care to lle [left lower extremity] forefoot, assess for s/s [signs and symptoms] of

	caregiver about wound care &. Review failed to evidence the document indicated what was the wound care to be provided and the frequency the wound care was to perform. During an interview on 8/12/2021 at 10:18 AM, the alternate clinical manager indicated the order on 8/3/2021 was incomplete. At 10:33 AM, the alternate clinical manager indicated there was not a physician order for wound care and the patient had a paper from the wound clinic that explained the wound care the nurses followed in the home. 5. During an interview on 8/12/2021 at 11:20 AM, former employee LPN B indicated she conducted home visits without a plan of care, medication list, physician orders and patient diagnoses because the RN that started the case was not done with the plan of care by the time the next skilled nurse visit was due.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner.	G0580	To assure comprehensiveand individualized Plans of Care the agency has implemented a process where allcomprehensive assessments completed by the	2021-11-22

	7. During an observation at the home of patient #4, on 8/11/2021 at 9:23 AM, physical therapist (PT) F was observed assessing the patient. At 9:51 AM, PT F inquired about the patient s pain. Patient #4 indicated they do not take the "Norco [hydrocodone-acetaminophen]" anymore and the doctor did not recommend taking aspirin. The patient indicated just taking "Tylenol [acetaminophen - a mild pain reliever]" when needed, and alluded to the bottle of over the counter (OTC) acetaminophen on the kitchen table. Clinical record review on 8/10/2021, for patient #4, start of care 7/29/2021, evidenced an agency document titled Home Health Certification and Plan of Care which was indicated to be the current plan of care received on 8/10/2021, diagnosis of age-related osteoporosis with current fracture to right humerus (upper arm), with a history of falls. This document had an area subtitled 10. Medications which indicated the patient s ordered pain medication was Hydrocodone-acetaminophen (opioid pain medicine combined with a mild pain reliever) as needed for moderate pain. Record review failed to evidence the patient was ordered another option for pain management. Record review failed to evidence an order for OTC acetaminophen from the patient's physician.		admitting/recertifying clinicianwill be reviewed and updated by the agency leadership and consultants. Should additional interventions or revisionsto frequencies based on documentation by clinician be needed on the Plan ofCare and based on the OASIS documentation, edits to the POC will be made andreturned to the clinician for review, edit and approval. This includes assuring all cliniciansparticipating in care have orders for care on POC, and all identified problemshave individualized interventions and measurable goals and timelines related tothe diagnoses. Clinicians conductingthe comprehensive OASIS assessment review, revise and approve the Plan of Careto assure inclusion of appropriate interventions. Clinician visit notesare quality reviewed to assure documentation correlates with ordered care andif orders are not identified, orders are obtained prior to care delivery. Thisincludes frequencies, wound orders, interventions and medicationreconciliation.	

	Review failed to evidence the patient was taking medications as ordered by the patient s physician. During an interview on 8/16/2021, at 12:36 PM, alternate clinical manager A indicated RN H was responsible for reviewing and updating the medication profile. The clinical manager indicated they could not identify when a medication review had been performed in the clinical record. 17-13-1(a)		100% clinical record reviewsof all SOC, resumptions of care, and recertifications will be performed toassure comprehensive POC exists. Thisprocess will assure ongoing compliance with individualized, comprehensive plansof care. The Administrator isresponsible for assuring compliance with accuracy of Plans of Care. The ongoing quality review of each Plan ofCare and visit note will assure compliance with comprehensive Plan of care anddocumentation. Patient #1 – This patient remains active with the agency and thecurrent plan of care is comprehensive and includes orders for care to all woundsites and that frequencies are accurate on the plan of care and EMR documentscommunication with wound care clinic. Patient #2 – This patient is discharged from the agencyas of 9/1/21, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence. Patient #4 - This patient is	

			dischargedfrom the agency as of 8/24/21, and as such the agency is unable toretrospectively impact this episode however training and processes have beenimplemented to prevent recurrence.	
G0584	Verbal orders 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Plan of Care CMS #485 and Physician Orders stated, & Verbal orders are put in writing, signed, timed and dated with the date of receipt by a RN or therapist responsible for furnishing or supervising ordered services &. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced an agency document titled Skilled Visit Note , dated 6/14/2021 and	G0584	The agency hascontracted with consultants to assist the Administrator in quality functions toinclude review of changes to the patient's plan of care and clinician documentation related to changes in patientstatus. If missing documentation is identified,the consultant will reach out to the clinician and Clinical Manager to validateand have clinician correct documentation including clinical notes, accuracy ofPlans of care, verbal orders and medication orders assuring orders aresigned, timed and dated with the date of receiptby a RN or therapist responsible forfurnishing or supervising ordered services. TheAdministrator isresponsible for assuring orders are documented appropriately. The ongoing qualityreview of each Plan of Care and visit notes will assure compliance withcomprehensive Plan of care	2021-11-16

	registered nurse (RN) N, which indicated the physician was notified of the patient s INR (a lab test which monitors the clotting time of blood) result and indicated new orders were received for a change in the dose of coumadin (a medication used to thin the blood to treat and/or prevent blood clots). Review of an agency document titled Supplemental Provider Order , electronically signed by RN N and dated 6/14/2021, indicated the coumadin 2.5 milligrams (mg) on Sunday, Monday, Wednesday, Thursday, and Friday was discontinued on 6/14/2021. Review failed to evidence the new dose the coumadin was changed to. Review of an agency document titled Home Health Certification and Plan of Care for certification period 6/5/2021 8/3/2021, electronically signed by RN N on 7/6/2021, indicated the patient s medication included, but was not limited to, coumadin 3 mg every day with a start date of 6/14/2021. Review failed to evidence the RN documented the verbal order of the coumadin dose change to include order, clinician signature, time and date. During an interview on 8/16/2021 at 11:00 AM, the alternate clinical manager indicated the RN added the coumadin dose change on		and documentation. All active clinical records were reviewed to assure that allplans of care and verbal orders are signed timely by the clinician and uploadedto the EMR. Patient #3 - This patient remains active with the agency, and the patient's currentCoumadin dose is accurate and was validated with the physician. All clinical notes, orders and plans of careare undergoing clinical review to assure they meet acceptable standards ofpractice.	

	the plan of care since the plan of care was not signed until July and indicated the verbal order should have been documented, signed and dated and sent to the physician for signature at the time the verbal order was received. 17-13-1(a)			
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. 1. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Plan of Care CMS #485 and Physician Orders stated, & The total Plan of Care will be reviewed and signed by the attending physician and Agency personnel involved in the patient s care as often as the severity of the patient s condition requires, but at least once every sixty (60) days &. 2. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced agency documents titled Plan of Care which indicated the plan of care for certification period 12/7/2020 2/4/2021 was signed by the physician on 1/12/2021 and indicated the plan of care for certification period 2/5/2021	G0588	To process Start ofCare and Recertification workflow and create Plan of Care in timely fashion, theagency has contracted with consultants to assist the Administrator in qualityfunctions to include review of the comprehensive assessments at start of care,recertifications, resumption of care and discharges to assure accurate, timely,compliant, and comprehensive Plans of Care, providing recommendations toclinicians for additions, enhancements or changes to documentation and plan ofcare. The agency has revisedthe order tracking process to assure follow up on unsigned orders and scanninginto EMR. If orders not returned signed within2 weeks, the order will be sent to the physician office and office called torequest signature on order. If orderremains unsigned, the Administrator will follow up with physician officenotifying the	2021-11-16

	4/5/2021 was signed by the physician on 4/21/2021. Review failed to evidence the physician reviewed the plan of care at least every 60 days. During an interview on 8/16/2021 at 11:07 AM, the alternate clinical manager indicated the physician should review the plan of care at least every 60 days. 3. Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced agency documents titled Plan of Care which indicated the plan of care for certification period 2/18/2021 4/18/2021 was signed by the physician on 6/8/2021. Review failed to evidence the plan of care was reviewed by the physician at least every 60 days. During an interview on 8/18/2021 at 10:48 AM, the alternate clinical manager indicated she discovered there was an issue that the plan of care had not been sent to the physician so she signed it and sent it to the physician.		office that patient discharge must be planned if the physiciandoes not sign the plan of care/orders. The Administrator isresponsible for assuring that Plans of Care are created, reviewed and issued tophysicians timely and that order tracking process assures timely return oforders. Ongoing review of thecomprehensive assessments and quality review of the clinical notes will assurecompliance with documentation requirements All active clinical records were reviewed to assure thepatient has a current plan of care. Clinical case conferences will be conducted to identify clinical changesin patient status, and clinicians were educated as to need to update physicianswith conditions, needs. All clinicalrecords are reviewed to include all clinical notes daily to assure no changesin condition are identified that require reporting to physician, all orders andplans of care are reviewed to assure compliance with physician update tochanges in status. An order trackingprocess is in place to assure that orders sent to physician are signed anduploaded to EMR. Patient#3 – This patient remains	

			active with the agency and the Plan of Care for thecurrent episode of care is reviewedand signed by the physician every 60 days. Patient #5 - Thispatient remains active with the agency and the Plan of Care for the currentepisode of care is reviewed and signed by the physician every 60 days. Patient#6 - This patient was discharged from the agency at the time of the survey,and as such the agency is unable to retrospectively impact this episode howevertraining and processes have been implemented to prevent recurrence.	
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date.	G0588	To process Start ofCare and Recertification workflow and create Plan of Care in timely fashion, theagency has contracted with consultants to assist the Administrator in qualityfunctions to include review of the comprehensive assessments at start of care,recertifications, resumption of care and discharges to assure accurate, timely,compliant, and comprehensive Plans of Care, providing recommendations toclinicians for additions, enhancements or changes to documentation and plan ofcare.	2021-11-16

	4. Clinical record review on 8/16/2021, for patient #5, start of care 2/24/2021, diagnosis of type 2 diabetes with chronic kidney disease, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/22/2021. Review failed to evidence a 60-day summary was sent to the physician. During an interview on 8/18/2021, at 10:30 AM, the alternate clinical manager A indicated the 60-day summary should be on the plan of care. They indicated the plan of care for certification period 6/24/2021 8/22/2021 was sent to the physician without a summary. 17-13-1(a)(2)		The agency has revisedthe order tracking process to assure follow up on unsigned orders and scanninginto EMR. If orders not returned signed within2 weeks, the order will be sent to the physician office and office called torequest signature on order. If orderremains unsigned, the Administrator will follow up with physician officenotifying the office that patient discharge must be planned if the physiciandoes not sign the plan of care/orders. The Administrator isresponsible for assuring that Plans of Care are created, reviewed and issued tophysicians timely and that order tracking process assures timely return oforders. Ongoing review of thecomprehensive assessments and quality review of the clinical notes will assurecompliance with documentation requirements All active clinical records were reviewed to assure thepatient has a current plan of care. Clinical case conferences will be conducted to identify clinical changesin patient status, and clinicians were educated as to need to update physicianswith conditions, needs. All	

			include all clinical notes daily to assure no changesin condition are identified that require reporting to physician, all orders andplans of care are reviewed to assure compliance with physician update tochanges in status. An order trackingprocess is in place to assure that orders sent to physician are signed anduploaded to EMR. Patient#3 – This patient remains active with the agency and the Plan of Care for thecurrent episode of care is reviewedand signed by the physician every 60 days. Patient #5 - Thispatient remains active with the agency and the Plan of Care for the currentepisode of care is reviewed and signed by the physician every 60 days. Patient#6 - This patient was discharged from the agency at the time of the survey,and as such the agency is unable to retrospectively impact this episode howevertraining and processes have been implemented to prevent recurrence.	

G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. 1. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Plan of Care CMS #485 and Physician Orders stated, & The Agency must promptly alert the relevant physician(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.... 2. Clinical record review on 8/10/2021 and 8/18/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021 and electronically signed by registered nurse (RN) K. This document indicated the patient s diagnoses included, but were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the left buttock, quadriplegia (paralysis of all 4 limbs), hypertension (high blood pressure) and chronic embolism (an obstruction of an artery, typically by a blood clot or air	G0590	Clinicians will be educated related to the responsibility to coordinatewith the physician when assessing changes in patient condition to include butnot be limited to: · New rashes, wounds orother integumentary issues · Balance, endurance,gait issues or changes in body strength identifying potential falls andrecommend possible need for therapy services · New wound clinic orders · Weight loss/gain · Mental changes toinclude depression, agitation · Change in bowel habits · Patient unmet goalsprior to pending discharge from agency · New medications · Pain variance abovethreshold to be communicated to physician; · Vital sign variances tonormal or to parameters set to report to physician; · Patient assessmentfindings not previously noted or new symptoms. Education will include visiting	2021-11-22

	bubble) and thrombosis (formation of a blood clot within a blood vessel) of left iliac vein (a vein located in the abdomen). This document indicated the patient had 3 Stage II pressure ulcers consisting of 2 to the left groin and 1 pressure ulcer to the buttocks. One pressure ulcer to the left groin was assessed to be 1 centimeter (cm) in length, 1 cm in width and 0.2 cm in depth and had a moderate amount of serous (clear) drainage. One pressure ulcer to the left groin was assessed to be 1 cm in length, 0.3 cm in width and 0.2 cm in depth and had a moderate amount of serous drainage. The wound to the buttocks was assessed to be 1 cm in length, 0.5 cm in width, 0.2 cm in depth and had a moderate amount of serous drainage. The wounds were assessed to have no odor. This document failed to evidence the patient had a rash at the time of start of care. This document indicated the patient s weight was 280 pounds and indicated there was no altered affect to include depression. Review of a document provided by the alternate clinical manager on 8/13/2021 titled Final Report from wound clinic D, dated 6/23/2021 and electronically signed by physician H, indicated the patient had 2 wounds to the left groin and a wound to the right ischium.		clinician communication with anddocumentation of physician notification and follow up with office RN to assurephysician follows up timely. Clinicians to be educated to alert office if noresponse from physician for office to follow up related to patient need. 100% of clinical notes will be reviewed to assure clinicians documentappropriate follow up and notification of physician of patient physical changesidentified during assessment. Clinicianswill be notified of any documentation issues. The Administrator is responsible for assuring documentation reflectscommunication of patient status changes to physician. The ongoing quality review of each Plan of Care and visit note willassure compliance with comprehensive Plan of care and documentation. Patient #1 – This patient remains active with the agency and thechart has been reviewed to assure the documentation is present that thephysician has been notified of any new patient issues or to changes in	

	During an observation of care on 8/13/2021 at 7:19 PM, the patient was observed to have 2 open areas on the left groin. Each open area appeared the length of a large paperclip and as wide as the width of a pen. Both open areas appeared to have a depth of the length of a pinky fingernail. RN H stated, One is more medial, but there are two here. The patient was observed to have 2 open areas to the right ischium (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis). The lateral open area on the right ischium appeared to be the length of a large paperclip, the width of the diameter of a pen and the depth of a tip of a pen. The medial open area of the right ischium appeared to be in the peri wound (the area surrounding the wound) of the lateral open area on the right ischium and have the size of a dime with just the top layer of skin removed and a red wound base. At 7:45 PM, RN H stated, There s a little excoriated [the breakdown of skin due to prolonged exposure to moisture] part here. To me, there s really another wound here. Some may call it one. Review evidenced an agency document titled Skilled Visit Note , dated 6/22/2021 and electronically signed by former employee licensed practical		collaboration with the wound care center is documented. Patient #2 – This patient is discharged from the agencyas of 9/1/21, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence. Patient #3 – This patient remains active withthe agency and the medication profile is accurate for the patient and has beenvalidated with the physician. Patient #4 - This patient is dischargedfrom the agency as of 8/24/21, and as such the agency is unable toretrospectively impact this episode however training and processes have beenimplemented to prevent recurrence. Patient #6 - This patient wasdischarged from the agency at the time of the survey, and as such the agency isunable to retrospectively impact this episode however training and processeshave been implemented to prevent recurrence.	

	stated, & Rash to upper body remains with pt [patient] scratching upper chest and neck folds &. Document failed to evidence the physician was notified of the patient s rash. During an interview on 8/12/2021 at 1:03 PM, the alternate clinical manager indicated there was no communication with the physician related to the patient s rash. Review evidenced agency documents titled Skilled Visit Note , electronically signed by former employee LPN B. Document dated 6/29/2021 stated, & Wounds: L ish. Had tan to dark drainage noted to dressing when removed &. Review failed to evidence the physician was notified of the change in wound drainage. Review of document dated 7/23/2021 indicted the skilled nurse assessed the wound to the left groin size to be 1.0 cm in length, 2.5 cm in width and 0.2 cm in depth and with a slight odor and assessed the wound to the right ischium to be 3.0 cm in length, 1.5 cm in width and 1.2 cm in depth with a slight odor. Review failed to evidence the physician was notified of the change in wound status related to the odor and the increase in wound size. The document dated 7/23/2021 evidenced the skilled nurse assessed a pressure area			

	lower back above the buttocks) measuring 0.5 cm in length, 0.5 cm in width and 0.1 cm in depth with a wound treatment of cleanse with normal saline and apply Optifoam (an absorbent foam dressing with an adhesive border). Review failed to evidence the skilled nurse notified the physician of the new open area to the coccyx. During an interview on 8/12/2021 at 1:06 PM, the alternate clinical manager indicated the physician should have been notified of the change in wound drainage and at 1:20 PM indicated the physician should have been notified of the wound odor and increase in size. At 1:23 PM, the alternate clinical manager indicated the physician was not notified of the new open area to the coccyx. Review evidenced an agency document titled Skilled Visit Note , dated 7/2/2021 and electronically signed by former employee licensed practical nurse (LPN) B. This document stated, & Pt has noticed a lose [sic] in upper body strength at this time due to being bedbound due to wounds on gluteal area &. Review failed to evidence the physician was notified of the decreased upper body strength. During an interview on 8/12/2021 at 1:08 PM, the alternate clinical manager indicated the physician was not notified of the decrease			

in upper body strength but should have been contacted for a therapy evaluation.

Review of an agency document titled Skilled Visit Note , dated 7/15/2021 and electronically signed by LPN B, stated, & Wound clinic is recommending whey protein for wound healing. Pt is attempting to get it &. Review failed to evidence the physician was notified of the recommendation by the wound clinic for whey protein.

During an interview on 8/12/2021 at 1:14 PM, the alternate clinical manager indicated the physician should have been informed of the recommendation for whey protein.

Review of an agency document titled Skilled Visit Note , dated 8/2/2021 and electronically signed by RN L, indicated the patient s weight was 240 pounds and failed to evidence the physician was notified of the 40 pound weight loss since the comprehensive assessment on 6/18/2021.

During an interview on 8/12/2021 at 1:26 PM, the alternate clinical manager indicated the RN should have investigated the weight loss and the physician should have been notified.

Review of an agency document titled Skilled Visit Note , dated

signed by RN L, indicated the patient was depressed and agitated. Review failed to evidence the physician was notified of the patient s change in mood and affect.

During an interview on 8/12/2021 at 1:28PM, the alternate clinical manager indicated the physician should have been notified of the patient s change in mood.

Review of an agency document titled Skilled Visit Note , dated 8/9/2021 and electronically signed by RN L, indicated the patient s last bowel movement was on 8/4/2021. Review failed to evidence the physician was notified of no bowel movement for 5 days.

During an interview on 8/12/2021 at 1:30PM, the alternate clinical manager indicated the physician should have been notified of no bowel movement in 5 days.

Review of an agency document titled Skilled Visit Note, dated 8/13/2021 and electronically signed by RN H, failed to evidence the RN notified the physician of the second open area to the right ischium as observed.

During an interview on 8/18/2021 at 12:43 PM, the alternate clinical manager indicated the physician should have been notified of the new open area to the right

should have been obtained.

3. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Start of Care , with an assessment date of 6/24/2021 and electronically signed by RN H, which indicated the patient s pain to legs and back was assessed to be a 3 on a scale of 0-10, with 0 being no pain and 10 being the most severe, with a frequency of daily but not constantly and a pain goal of a rating less than 2 on a scale of 0-10. This document evidenced the patient s blood pressure to be 138/68. Review evidenced the patient s weight was 185 pounds.

Review evidenced agency documents titled Skilled Visit Note , electronically signed by former employee LPN B, which assessed the patient s pain on document dated 6/30/2021, to be rated 4 on a scale of 0-10 and a frequency of all of the time. Document dated 7/7/2021, evidenced the skilled nurse assessed the patient s pain to be rated 6 on a scale of 0-10 daily but not constantly with a pain goal of 3 on a scaled of 0-10. Document dated 7/15/2021, evidenced the skilled nurse assessed the patient s pain to be rated 5 on a scale of 0-10 with a frequency of all of the time. Document dated 7/21/2021, evidenced the skilled nurse

	assessed the patient s pain to be rated 6 on a scale of 0-10 all of the time with a pain goal of 2 on a scale of 0-10. Document dated 8/4/2021, and electronically signed by RN L, evidenced the skilled nurse assessed the patient s pain to be 6 on a scale of 0-10 all of the time. Review failed to evidence the physician was notified of the patient s pain. During an interview on 8/12/2021 at 10:39 AM, the alternate clinical manager indicated the physician should be notified of pain when the pain is not relieved despite interventions or when the pain worsens. Review of an agency document titled Occupational Therapy Evaluation , dated 7/28/2021 and electronically signed by occupational therapist (OT) M, evidenced the patient s blood pressure was 104/52. Review of an agency document titled Skilled Visit Note , dated 7/29/2021 and electronically signed by RN H, evidenced the patient s blood pressure was 115/58. Review of agency documents titled Therapy Visit Note , electronically signed by OT M, evidenced the patient s blood pressure was 98/54 on 8/3/2021 and 104/51 on 8/9/2021. Review failed to evidence the			

	patient s low blood pressure assessments. During an interview on 8/12/2021 at 11:17 AM, the alternate clinical manager indicated the physician should have been notified of the change in blood pressure. Review of an agency document titled Skilled Visit Note , dated 8/4/2021 and electronically signed by RN L, evidenced the patient s weight was 150 pounds. Review failed to evidence the physician was notified of the 35 pound weight loss. During an interview on 8/12/2021 at 11:19 AM, the alternate clinical manager indicated the physician should have been notified of the weight loss and to at least get the accurate weight from the doctor. Review of an agency document titled Occupational Therapy Evaluation , dated 7/28/2021 and electronically signed by OT M, evidenced the patient was to receive OT services 2 times a week for 3 weeks.			

	Review of an agency document titled Supplemental Provider Order , dated 7/31/2021 and electronically signed by OT M, which indicated OT services were to be provided 2 times a week for 3 weeks for ADL (activities of daily living) training, bathroom mobility and a home exercise program. Review of a document titled Therapy Visit Note , dated 8/6/2021 and electronically signed by OT M, evidenced the patient s problems included decreased functional mobility, safety awareness and ADLs. Review evidenced the plan for the next OT visit was to continue with safety training during tub transfers and the home exercise program. Review of a document titled Discharge/Transfer Summary , dated 8/9/2021 and electronically signed by OT M, evidenced a subsection titled Goals not met [and] reasons (If applicable): which stated, & Bathing not met due to need of someone to position shower bench and assist with lower body as there is a dressing on the (L) [left] foot &. Review failed to evidence the physician was notified prior to the patient s discharge from OT services of the patient s unmet goals and upcoming discharge from OT services. During an interview on 8/18/2021			

	at 12:12 PM, the alternate clinical manager indicated the physician should have been notified prior to the OT discharge related to the inability to meet patient needs and the request to discharge from OT services. The alternate clinical manager indicated there was not a verbal order obtained from the physician for the discharge of OT services. 4. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced an agency document titled OASIS Follow-Up , completion date 4/2/2021 and signed by RN N, indicated the patient began Nitrofurantoin (an antibiotic, which is a class of medication used to treat infection) on 3/31/2021 and was to take the medication twice a day for 7 days for a urinary tract infection. This document also indicated the patient had a fall on 3/31/2021. Review failed to evidence the name of the physician who prescribed the antibiotic and failed to evidence the physician responsible for the plan of care was notified of the patient s Nitrofurantoin, urinary tract infection and fall. During an interview on 8/16/2021 at 11:21 AM, the alternate clinical manager indicated the physician should have been notified of the urinary tract infection, antibiotic and fall.			

	Review evidenced an agency document titled Skilled Visit Note , dated 7/19/2020 and electronically signed by former employee LPN B, which indicated the patient had a new medication. Review failed to indicate the name, dose, frequency and route of the new medication and failed to indicate the physician was notified of the new medication. Review of an agency document titled Home Health Certification and Plan of Care for certification period 6/5/2021 8/3/2021, dated 7/6/2021 and electronically signed by RN N, failed to indicate a revision to include a new medication. During an interview on 8/16/2021 at 11:13 AM, the alternate clinical manager indicated she was unsure of what the name and dose was of the new medication. The alternate clinical manager indicated she saw a start date of 7/19/2021 for Sinemet (a medication used to treat Parkinson s Disease; a progressive nervous system disorder that affects movement) on the medication list. Review of an undated agency document titled Patient Medications indicated the patient s medication included Sinemet twice daily with a start date of 7/19/2021. The plan of care failed to evidence the			

	patient s medication included Sinemet for the certification period of 6/5/2021 8/3/2021. Review failed to evidence the ordering physician of the medication and failed to evidence the physician responsible for the plan of care was notified of the patient s medication, Sinemet. 5. Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced an agency document titled Comprehensive Adult Assessment, 485 P.O.C. [Plan of Care] Worksheet and Outcome and Assessment Information Set , dated 2/18/2021 and signed by former employee RN K, which indicated the patient weighed 151.4 pounds. The comprehensive assessment indicated the patient was at risk for falls but failed to indicate any abnormal findings related to balance, endurance and gait. Review of an agency document titled Encounter Certification , dated 3/8/2021 and signed and dated by the physician on 5/26/2021, indicated the patient had significant right sided hemiparesis (muscle weakness or partial paralysis on one side of the body) and was at risk for falls. Review of agency documents titled Nursing Visit Record , signed by former employee RN			

	K, indicated the skilled nurse assessed the patient to have decreased endurance on 3/25/2021 and assessed the patient to have decreased endurance, balance and gait requiring the use of assistance with a walker on 3/30/2021. Review failed to evidence the physician was notified of the changes in the patient s endurance, balance and gait. Review of an agency document titled Adult Re-Assessment, 485 P.O.C. Recertification Worksheet and OASIS Follow-Up , dated 4/18/2021 and signed by RN K, indicated the patient weighed 185 pounds. Review failed to evidence the nurse notified the physician of the 34 pound weight gain. During an interview on 8/18/2021 at 11:24 AM, the alternate clinical manager indicated the physician should have been notified of the weight gain but could not find any documentation related to the patient s weight gain. At 11:35 AM, the alternate clinical manager indicated the physician should have been contacted related to the changes in the patient s endurance, balance and gait and should have requested an order for a therapy evaluation.			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant	G0590	Clinicians will be educated related to the responsibility to coordinatewith the physician	2021-11-22

	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. 6. During an observation on 8/11/2021 at 9:23 AM, PT [physical therapist] F performed a physical therapy visit in the home of patient #4, which included, but was not limited to assessing vital signs, range of motion, and assessing mobility. Observation of the patient's home evidenced to have common areas on one level, mostly carpeted, with unsecured rugs on top in the TV/ sitting rooms. During the visit, at 9:45 AM, PT F stated "OT says you're good!" to the patient, indicating the patient would be discharged from OT services, and PT would take over services. At 9:50 AM, PT F indicated SN [skilled nursing] services will be discharged as well and stated "[RN H name] said I can do the vitals." Clinical record review on 8/16/2021, for patient #4, start of care 7/29/2021, diagnosis of diagnosis of age-related osteoporosis with current fracture to right humerus (upper arm), evidenced an agency document titled Home Health Certification and Plan of Care which was indicated to be the current plan of care received on 8/10/2021. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)		when assessing changes in patient condition to include butnot be limited to: · New rashes, wounds orother integumentary issues · Balance, endurance,gait issues or changes in body strength identifying potential falls andrecommend possible need for therapy services · New wound clinic orders · Weight loss/gain · Mental changes toinclude depression, agitation · Change in bowel habits · Patient unmet goalsprior to pending discharge from agency · New medications · Pain variance abovethreshold to be communicated to physician; · Vital sign variances tonormal or to parameters set to report to physician; · Patient assessmentfindings not previously noted or new symptoms. Education will include visiting clinician communication with anddocumentation of physician notification and follow up with	

	which stated Services for Occupational Therapist [OT]: & Effective on 08/08/2021: OT 2W2 [twice a week, for 2 weeks] & Summary of OT Orders: & ADL [activities of daily living] & Home Exercise Program & Summary of SN orders: & Monitor BP [blood pressure], Pulse, any increase or decrease of edema, noting decrease or increase of urine output, noting changes in level of activity, assess medication management of symptoms & Home safety interventions & pt [patient] r [right] shoulder incision site and staples will remain free from s/s [signs and symptoms] of infection The next section subtitled "22. Goals/Rehabilitation Potential Discharge Plans" stated "OT Goals ... Patient will perform bathe [sic] with SBA [stand by assist] ... Patient will perform dress with SBA ... Patient will be able to achieve ROM [range of motion] and strength of (R) UE [upper extremity] following MD [medical doctor] instructions to safety perform ADLs/IADLs [instrumental ADLs, including but not limited to opening doors, housekeeping, and taking medications] ... SN Goals ... Patient will demonstrate vital signs within acceptable limits, dysrhythmias absent or controlled and no symptoms of failure & The patient safety will be enhanced as evidenced by well-lit pathways, secure drugs, uncluttered walkways and		office RN to assurephysician follows up timely. Clinicians to be educated to alert office if noresponse from physician for office to follow up related to patient need. 100% of clinical notes will be reviewed to assure clinicians documentappropriate follow up and notification of physician of patient physical changesidentified during assessment. Clinicianswill be notified of any documentation issues. The Administrator is responsible for assuring documentation reflectscommunication of patient status changes to physician. The ongoing quality review of each Plan of Care and visit note willassure compliance with comprehensive Plan of care and documentation. Patient #1 – This patient remains active with the agency and thechart has been reviewed to assure the documentation is present that thephysician has been notified of any new patient issues or to changes in patientcondition and collaboration with the wound care center is documented.	

	minimal usage of stairs by end of certification periods (9 weeks) ... The patients/ caregiver will verbalize understanding of (r/t [related to] wound treatment) surgical incision and staples, signs and symptoms of infection, and all aspects of associated care within two weeks period of time.... Review of an agency document titled "Discharge/Transfer Summary" dated 8/11/2021, and was evidenced to be unsigned by a SN. This document had an area subtitled "Reason for Discharge" which stated, "Care Completed ... Condition on Discharge ... Vital Signs: (optional per HHA Policy & Procedures) ..." Another area stated "Current Status ... Needs assist ... Outcomes ... Goals met ...." Review evidenced the patient required assistance after discharge. Review failed to evidence the patient's goals were met. Review failed to evidence SN services were provided as outlined in the plan of care, including but not limited to safety measures and wound care treatment. Review failed to evidence documentation of when the physician was notified that SN services were discharged. Review evidenced an agency document titled "Discharge/Transfer Summary" from 8/11/2021, which was		Patient #2 – This patient is discharged from the agencyas of 9/1/21, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence. Patient #3 – This patient remains active withthe agency and the medication profile is accurate for the patient and has beenvalidated with the physician. Patient #4 - This patient is dischargedfrom the agency as of 8/24/21, and as such the agency is unable toretrospectively impact this episode however training and processes have beenimplemented to prevent recurrence. Patient #6 - This patient wasdischarged from the agency at the time of the survey, and as such the agency isunable to retrospectively impact this episode however training and processeshave been implemented to prevent recurrence.	

	had an area subtitled "Reason for Discharge" which stated, "Pt to continue with PT [physical therapy] services for diagnosis ..." Another area stated "Goals not met [and] reasons (if applicable): Eval [evaluation] only ...." Review failed to evidence the patient received OT therapy visits. Review failed to evidence OT services were provided as outlined in the plan of care. Review failed to evidence documentation of when the physician was notified that OT services were discharged. 17-13-1(a)(2)			
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. 1. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Care Planning Process stated, & Initial care plan will be CMS #485 Plan of Care ... Demonstrates problems (diagnoses), interventions (physician orders) and long range goals. & The Nursing Care Plan Update form may be utilized to update the care plan between certification	G0592	The agency hascontracted with consultants to assist the Administrator in quality functions toinclude: A. Review of the comprehensive assessments atstart of care, recertifications, resumption of care and discharges to assureaccurate, timely, compliant, and comprehensive Plans of Care, providingrecommendations to clinicians for additions, enhancements or changes todocumentation, plan of care, new medication orders, B. Quality review of clinician documentation toassure that	2021-11-16

	and re-certifications to document modifications. Will reflect new problems, interventions, goals and goal evaluation/goal resolution &. 2. Clinical record review on 8/10/2021 and 8/18/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021 and electronically signed by registered nurse (RN) K. This document indicated the patient s diagnoses included, but were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the left buttock and quadriplegia (paralysis of all 4 limbs). This document indicated the patient had 3 Stage II pressure ulcers consisting of 2 to the left groin and 1 pressure ulcer to the buttocks. Review evidenced agency documents titled Skilled Visit Note , dated 7/23/2021 and electronically signed by former employee licensed practical nurse (LPN) B. These documents evidenced the skilled nurse assessed a pressure area to the coccyx (the area on the lower back above the buttocks) measuring 0.5 cm in length, 0.5		clinicians are documenting only to interventions ordered by thephysician and that orders exist for all services provided, C. Evaluate if clinicians notify physicians ofchange in clinical status appropriately, D. Review of updated orders augmenting Plan ofCare E. Participate in education and training ofagency staff related to regulations and best practice clinical standards. The consultantscollaborate with the Administrator and provide services based on the request ofthe Administrator. The Administrator isresponsible for assuring clinical coordination of care with external careproviders. Ongoing review of thecomprehensive assessments and quality review of the clinical notes will assurecompliance with documentation requirements. Should quality reviewreflect clinician did not notify physician of changes in patient clinicalcondition, the clinician will be queried to determine if physician notificationoccurred. Documentation of follow upwill be notated in the clinical record. All active clinical records were	

	cm in width and 0.1 cm in depth with a wound treatment of cleanse with normal saline and apply Optifoam (an absorbent foam dressing with an adhesive border). Review evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/18/2021 8/16/2021 which was signed by the alternate clinical manager on 7/15/2021 and by the physician on 8/2/2021. The plan of care failed to evidence a revision to include the new wound to the coccyx and the wound treatment which was applied on 7/23/2021. During an interview on 8/12/2021 at 1:21PM, the alternate clinical manager indicated the plan of care was not updated with the additional coccyx wound. 3. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/ 22/2021 which was electronically signed by RN H on 7/21/2021 and the physician on 7/23/2021. The plan of care indicated the patient s primary diagnosis was Type II Diabetes (a chronic condition where the body is impaired in the way it regulates and uses sugar as fuel) and failed to evidence the patient had a wound.		reviewed to assure thepatient has a current plan of care. Clinical case conferences will be conducted to identify clinical changesin patient status, and clinicians were educated as to need to update physicianswith conditions, needs. All clinicalrecords are reviewed to include all clinical notes on a daily basis to assureno changes in condition are identified that require reporting to physician, allorders and plans of care are reviewed to assure compliance with physicianupdate to changes in status. Patient #1 – This patient remains active withthe agency and the current plan of care is comprehensive and includes ordersfor care to all wound sites. Patient #2 **–** This patient is discharged from the agencyas of 9/1/21, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence. Patient #3 – This patient remains active withthe agency and the medication profile is accurate for the patient and has beenvalidated with the physician. Theclinical record of the current episode has been reviewed to assure that thephysician notification has occurred in the event of clinical changes in	

	Review of agency documents titled Skilled Visit Note , dated 6/30/2021 and electronically signed by former employee LPN B, indicated the patient had a surgical wound on the left foot. Document dated 7/21/2021 and electronically signed by former employee LPN B, indicated the skilled nurse cleansed the wound to the left foot with normal saline, covered with kerlix (a type of gauze) and secured with tape. Document dated 7/29/2021 and electronically signed by RN H indicated the skilled nurse cleansed the wound to the left foot with wound wash, applied Iodosorb, covered with gauze and an ABD pad and secured with tape. Document dated 8/4/2021, electronically signed by RN L, indicated the patient had a wound to the left foot with a start date of 6/15/2021.		status,new medications or functional status changes. Patient #4 - This patient is dischargedfrom the agency as of 8/24/21, and as such the agency is unable toretrospectively impact this episode however training and processes have beenimplemented to prevent recurrence. Patient #5 - This patient remains active with the agency and theclinical record of the current episode has been reviewed to assure that thephysician notification has occurred in the event of clinical changes in status,or functional limitation changes.	

	Review of an agency document titled Supplemental Provider Order , dated 8/3/2021 and electronically signed by RN H, stated, &wound care to lle [left lower extremity] forefoot, assess for s/s [signs and symptoms] of infection, educated patient and caregiver about wound care &. Review failed to evidence the plan of care was revised prior to 8/3/2021 regarding the wound to the left foot and failed to evidence the plan of care had been revised to reflect the wound treatment provided to the left foot. During an interview on 8/12/2021 at 10:27 AM, the alternate clinical manager indicated the patient had the wound at the start of care on 6/24/2021 and the RN missed it on the plan of care. The alternate clinical manager indicated there was no revision to the plan of care until the physician order was obtained on 8/3/2021. 4. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced an agency document titled OASIS Follow-Up , completion date 4/2/2021 and signed by registered nurse (RN) N, which indicated the patient began Nitrofurantoin (an antibiotic, which is a class of medication used to treat infection) on 3/31/2021 and was to take the medication twice a day for 7 days			

for a urinary tract infection.

Review of an agency document titled Plan of Care for certification period 2/4/2021 4/5/2021, signed by RN O, failed to evidence the plan of care was revised to include Nitrofurantoin in the list of patient s medication.

Review of an agency document titled Plan of Care for certification period 4/6/2021 6/4/2021, signed by RN B, indicated a section titled Progress Notes which stated, & Goals met for the last certification period & Review failed to evidence the summary included the patient s goal for no falls was not met and failed to indicate the patient s urinary tract infection and antibiotic therapy.

Review evidenced an agency document titled Skilled Visit Note , dated 6/21/2021 and electronically signed by registered nurse (RN) N. This document indicated the patient had increased incontinence (loss of control of bowel and/or bladder) and an unsteady gait. Review indicated the patient recently finished antibiotics.

Review of an agency document titled Home Health Certification and Plan of Care for certification period 6/5/2021 8/3/2021, electronically signed and dated 7/6/2021 by RN N, failed to evidence the plan of care was revised to include the antibiotic in

	the patient s list of medication. Review failed to evidence the plan of care was revised to include incontinence and ambulation related to unsteady gait as functional limitations. During an interview on 8/16/2021 at 11:06 AM, the alternate clinical manager indicated she did not know what antibiotic the patient had been taking and for what infection the patient was being treated with antibiotics. The alternate clinical manager indicated the plan of care should have been revised to include Nitrofurantoin, the incontinence and unsteady gait.			
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. 5. During an observation on 8/11/2021, at 9:23 AM, PT [physical therapist] F performed a physical therapy visit in the home of patient #4, which included, but was not limited to assessing vital signs, range of motion, and assessing mobility. During these assessments, PT F	G0592	The agency hascontracted with consultants to assist the Administrator in quality functions toinclude: A. Review of the comprehensive assessments atstart of care, recertifications, resumption of care and discharges to assureaccurate, timely, compliant, and comprehensive Plans of Care, providingrecommendations to clinicians for additions, enhancements or changes todocumentation, plan of care, new medication orders,	2021-11-16

	physician orders which were in the patient's home from the last doctor visit, which included, but was not limited to home exercises and directions for care of steri-strips [surgical tape strips used to close small wounds] over the surgical incision. Observation of the patient's home evidenced to have common areas on one level, mostly carpeted, with unsecured rugs on top in the TV and sitting rooms. During the visit, at 9:45 AM, PT F stated "OT [occupational therapy] says you're good!" to the patient, indicating the patient would be discharged from OT services. At 9:50 AM, PT F indicated SN services will be discharged as well. The patient indicated it was the first time hearing about discharge from the nursing. PT F stated "[RN H] said I can do the vitals." Observation evidenced the patient was being notified of the discharge of SN and OT services during a PT visit. Clinical record review on 8/16/2021, for patient #4, start of care 7/29/2021, diagnosis of diagnosis of age-related osteoporosis with current fracture to right humerus (upper arm), with a history of falls, evidenced an agency document titled Home Health Certification and Plan of Care which was indicated to be the current plan of care received on 8/10/2021. This document had an area subtitled 21. Orders		B. Quality review of clinician documentation toassure that clinicians are documenting only to interventions ordered by thephysician and that orders exist for all services provided, C. Evaluate if clinicians notify physicians ofchange in clinical status appropriately, D. Review of updated orders augmenting Plan ofCare E. Participate in education and training ofagency staff related to regulations and best practice clinical standards. The consultantscollaborate with the Administrator and provide services based on the request ofthe Administrator. The Administrator isresponsible for assuring clinical coordination of care with external careproviders. Ongoing review of thecomprehensive assessments and quality review of the clinical notes will assurecompliance with documentation requirements.	

	(Specify Amount/Frequency/Duration) which stated Services for Occupational Therapist [OT]: & Effective on 08/08/2021: OT 2W2 [twice a week, for 2 weeks] & Summary of OT Orders: & ADL [activities of daily living] & Home Exercise Program & Summary of SN orders: & Monitor BP [blood pressure], Pulse, any increase or decrease of edema, noting decrease or increase of urine output, noting changes in level of activity, assess medication management of symptoms & Home safety interventions & pt [patient] r [right] shoulder incision site and staples will remain free from s/s [signs and symptoms] of infection &. Review failed to evidence updated surgical incision care to include care of steri-strips. Review evidenced an agency document titled "Discharge/Transfer Summary" from 8/11/2021, which was unsigned. This document had an area subtitled "Reason for Discharge" which stated, "Care Completed ... Condition on Discharge ... Vital Signs: (optional per HHA Policy & Procedures) ..." Another area stated "Current Status ... Needs assist ... Outcomes ... Goals met ...." Review evidenced the patient still required assistance after discharge. Review failed to evidence SN services were provided as outlined in the plan		Should quality reviewreflect clinician did not notify physician of changes in patient clinicalcondition, the clinician will be queried to determine if physician notificationoccurred. Documentation of follow upwill be notated in the clinical record. All active clinical records were reviewed to assure thepatient has a current plan of care. Clinical case conferences will be conducted to identify clinical changesin patient status, and clinicians were educated as to need to update physicianswith conditions, needs. All clinicalrecords are reviewed to include all clinical notes on a daily basis to assureno changes in condition are identified that require reporting to physician, allorders and plans of care are reviewed to assure compliance with physicianupdate to changes in status. Patient #1 – This patient remains active withthe agency and the current plan of care is comprehensive and includes ordersfor care to all wound sites. Patient #2 – This patient is discharged from the agencyas of 9/1/21, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence. Patient #3 – This patient remains	

	of care, including but not limited to safety measures and wound care treatment, as evidenced in the observation. During an interview on 8/16/2021, at 12:45 PM, alternate clinical manager A indicated PT F could assess surgical wounds if skilled nursing was no longer on the case. During an interview on 8/16/2021, at 1:01 PM, alternate clinical manager A confirmed the directions for use of steri-strips should be included in the clinical record. 6. Clinical record review on 8/10/2021, for patient #5, start of care 2/24/2021, diagnosis of type 2 diabetes with chronic kidney disease, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/22/2021, which had a section that stated 18. A & [none indicated] & 18.B Activities permitted: & Up as tolerated & Review of the current plan of care failed to evidence the patient had functional limitations, including but not limited to hearing, vision, and ambulation.		active withthe agency and the medication profile is accurate for the patient and has beenvalidated with the physician. Theclinical record of the current episode has been reviewed to assure that thephysician notification has occurred in the event of clinical changes in status,new medications or functional status changes. Patient #4 - This patient is dischargedfrom the agency as of 8/24/21, and as such the agency is unable toretrospectively impact this episode however training and processes have beenimplemented to prevent recurrence. Patient #5 - This patient remains active with the agency and theclinical record of the current episode has been reviewed to assure that thephysician notification has occurred in the event of clinical changes in status,or functional limitation changes.	

	During an interview on 8/16/2021, at 10:17 AM, alternate clinical manager A confirmed the patient s functional limitations had been identified on 2/24/2021 and failed to be on the current plan of care. 17-14-1(a)(1)(C)			
G0598	Discharge plans communication 484.60(c)(3)(ii) (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). 1. Review of an agency policy, revised July 2020 and obtained 8/18/2021, titled Home Health Change of Care Notice (HHCCN) and Advance Beneficiary Notice (ABN) stated, & HHCCNs are issued to patients receiving the home health care benefit for notification of plan of care changes. The Agency must provide the HHCCN whenever it reduces or terminates patient s home health services due to physician/provider orders or limitations of the Agency in providing the specific service &. 2. Review of an agency policy,	G0598	The agency process isto pull a report in EMR identifying patients with expiring certification within3 weeks prior to end of episode. Scheduler to review report weekly to determine any ends of episodeswithin upcoming 3-week period. Process is to review with clinicians each ofthese patients progress to goals 3 weeks prior to end of episode to makedecision of probable discharge vs. recertification. Should the discharge be probable, the patientwill be provided with the discharge notification at least 15 days prior to theend of services.	2021-11-16

	titled Discharge Criteria stated, & Patient will be discharged from services as follows: & The discharge is appropriate because the physician who is responsible for the home health plan of care and the Agency agree that measurable outcomes and goals set forth in the plan of care have been achieved and the Agency and physician responsible for the home health plan of care agree that the patient no longer needs the Agency s services. & The patient is informed of discharge plan in a timely manner and acknowledges understanding reason. Physician and other care providers will be informed and knowledgeable of discharge. Discharge planning begins at time of admission and will be reflected in the documentation &. 3. Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced an agency document titled Plan of Care for certification period 4/19/2021 6/17/2021, signed by the alternate clinical manager and signed and dated on 6/30/2021 by the physician. Review of an agency document titled Nursing Visit Record , dated 6/3/2021 and signed by former employee RN K, indicated a visit was planned for 6/17/2021. Review of an agency document titled Discharge Summary , dated		The agency policy “Discharge Criteria” has been edited to include the 15-day noticeof discharge to the patient. The PatientRights document provided to the patient at start of care has been edited toinclude the 15-day notice of discharge to the patient. Clinicians andclinical Managers will be trained toward these processes as well as related toABN and HHCCN issuance as per regulations. Clinical record reviewswill be completed of 100% of discharge patients to assure ABNs being deliveredat least 15 days prior to ending services. Staff will be provided copies of forms to provide to patients oncedischarge plans made. Staff have beenre-educated to the use of the CMS HHCCN when service frequencies have beenaltered from the Start of care frequencies. 100% chart review ofdischarge patients will be reviewed to assure ongoing compliance withregulation. Once 90% complianceobtained, chart review will be reduced to 50% for 6 months with re-evaluationof ongoing chart review activity through QAPI program. The Administrator is	

	6/14/2021 and signed by former employee RN K, indicated the date of discharge was 6/14/2021. Review failed to evidence the agency communicated the revision to the plan of care related to discharge to the patient and physician prior to discharge. During an interview on 8/18/2021 at 11:46 AM, the alternate clinical manager indicated she was unsure of how the discharge was initiated and indicated there was no communication related to the discharge with the patient and physician prior to discharge. The alternate clinical manager indicated the agency should have provided the patient with a HHCCN form to inform the patient of discharge but indicated no HHCCN form was provided to the patient.		receive timely notification of discharge. The Scheduleris responsible for obtaining the reports of pending ends of episodes. Clinical Manager will review the pendingdischarges with clinicians.	
G0598	Discharge plans communication 484.60(c)(3)(ii) (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). 4. Clinical record review on 8/16/2021, for patient #7, start of care 6/28/2021, diagnosis of an	G0598	The agency process isto pull a report in EMR identifying patients with expiring certification within3 weeks prior to end of episode. Scheduler to review report weekly to determine any ends of episodeswithin upcoming 3-week period. Process is to review with clinicians each ofthese patients progress to goals 3 weeks prior to end of episode to makedecision of probable	2021-11-16

	abscess of the genitalia, evidenced an agency document titled Home Health Certification and Plan of Care for certification period for certification period 6/28/2021 8/26/2021. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated Services for Skilled Nurse: Effective 6/29/2021: SN: 1W6 [once a week, for 6 weeks] & Another area subtitled Patient Rehab Potential and Discharge Goals which stated & Patient, Caregiver, and/or Representative (if any) agreed with and participated in the discharge plans & Patient to be discharged when skill care is no longer needed &. Review evidenced an agency document titled Discharge from Agency (D1) from 7/20/2021 which was signed by RN H. Review failed to evidence the patient received skilled services after the start of care and prior to discharge. Review failed to evidence the physician was notified of the discharge. Review failed to evidence the patient received a discharge notice prior to the discharge assessment. Review failed to evidence efforts were made to perform skilled visits prior to discharge.		discharge vs. recertification. Should the discharge be probable, the patientwill be provided with the discharge notification at least 15 days prior to theend of services. The agency policy “Discharge Criteria” has been edited to include the 15-day noticeof discharge to the patient. The PatientRights document provided to the patient at start of care has been edited toinclude the 15-day notice of discharge to the patient. Clinicians andclinical Managers will be trained toward these processes as well as related toABN and HHCCN issuance as per regulations. Clinical record reviewswill be completed of 100% of discharge patients to assure ABNs being deliveredat least 15 days prior to ending services. Staff will be provided copies of forms to provide to patients oncedischarge plans made. Staff have beenre-educated to the use of the CMS HHCCN when service frequencies have beenaltered from the Start of care frequencies. 100% chart review ofdischarge patients will be reviewed to assure ongoing compliance withregulation. Once 90% complianceobtained, chart	

	During an interview on 8/17/2021, at 2:29 PM, the alternate clinical manager A confirmed the clinical record failed to evidence the physician had been notified of discharge. The alternate clinical manager indicated physician notification, patient notification, and efforts on behalf of the agency were not documented in the clinical record.		review will be reduced to 50% for 6 months with re-evaluationof ongoing chart review activity through QAPI program. The Administrator is responsiblefor assuring patients receive timely notification of discharge. The Scheduleris responsible for obtaining the reports of pending ends of episodes. Clinical Manager will review the pendingdischarges with clinicians.	
G0602	Communication with all physicians 484.60(d)(1) Assure communication with all physicians or allowed practitioners involved in the plan of care. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Coordination of Patient Care stated, & The Agency must: Assure communication with all physicians involved in the plan of care &. Clinical record review on 8/10/2021 and 8/18/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021 and electronically signed by registered nurse (RN) K. This document indicated the patient s diagnoses included, but	G0602	Clinicians are educatedto the need to communicate changes in the plan of care when orders are receivedfrom other physicians such as wound care clinic physicians, and otherspecialists involved in the plan of care. New orders or medications ordered will beupdated to the primary care physician. Ongoing quality reviewswill alert the clinician and Administrator to instances where changes are madewithout alerting the primary care physician. The Administrator isresponsible for assuring changes to plan of care are alerted to primary carephysician.	2021-11-16

	were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the left buttock and quadriplegia (paralysis of all 4 limbs). This document indicated the patient had 3 Stage II pressure ulcers consisting of 2 to the left groin and 1 pressure ulcer to the buttocks. Review of a document provided by the alternate clinical manager on 8/13/2021 titled Final Report from wound clinic D, dated 6/23/2021 and electronically signed by physician H, indicated the patient had 2 wounds to the left groin and a wound to the right ischium. During an observation of care on 8/13/2021 at 7:19 PM, the patient was observed to have 2 open areas on the left groin. Each open area appeared the length of a large paperclip and as wide as the width of a pen. Both open areas appeared to have a depth of the length of a pinky fingernail. RN H stated, One is more medial, but there are two here. The patient was observed to have 2 open areas to the right ischium (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis). The lateral open area on		All active clinical records were reviewed to assure theclinical changes in patient status, and clinicians were educated as to need toupdate all physicians involved with patient's care to changes in condition andneeds. Patient #1 – Thispatient remains active with the agency and the chart has been reviewed toassure the documentation is present that the physician has been notified of anynew patient issues or to changes in patient condition and collaboration withthe wound care center is documented.	

	the right ischium appeared to be the length of a large paperclip, the width of the diameter of a pen and the depth of a tip of a pen. The medial open area of the right ischium appeared to be in the peri wound (the area surrounding the wound) of the lateral open area on the right ischium and have the size of a dime with just the top layer of skin removed and a red wound base. At 7:45 PM, RN H stated, There s a little excoriated [the breakdown of skin due to prolonged exposure to moisture] part here. To me, there s really another wound here. Some may call it one. Review of an agency document titled Skilled Visit Note", dated 8/13/2021, and electronically signed by RN H, failed to evidence the RN notified physician H at wound clinic D of the second open area to the right ischium as observed. During an interview on 8/12/2021 at 1:23 PM, the alternate clinical manager indicated the wound clinic physician should have been notified of the second open area to the right ischium. 17-14-1(a)(1)(G)			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to	G0606	Agencyclinical staff and managers will be educated to need to clinically coordinatecare with external care providers to	2021-11-12

	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. 1. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Coordination of Patient Care stated, & The Agency must: Assure communication with all physicians involved in the plan of care. Integrate orders from all physicians involved in the plan of care to assure coordination of all services and interventions provided to the patient. 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 &. 2. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced agency documents titled Skilled Visit Note , electronically signed by former employee licensed practical nurse (LPN) B. Document dated 6/24/2021 stated, & Pt [patient] seen on 6/23/2021 in wound clinic and no new orders record [sic] in regards to wounds &. Dressing changed per orders from wound clinic &. Document dated 7/2/2021 stated, & Document dated 7/15/2021 stated, & Pt was seen at wound care on 7/14/21. Wound care took		include wound care clinics, home medical equipment providers, infusion therapy/pharmacy companies and community agencies. The agency requestsdocumentation from each wound clinic visit on a weekly basis for patientsvisiting wound care clinics. 100% of clinical noteswill be reviewed to assure documentation includes clinical care coordinationwith external/community care providers. The Administrator isresponsible for assuring clinical coordination of care with external careproviders. Ongoing quality review of theclinical notes will assure compliance with documentation of communication withexternal organizations involved in the care of the patient. Patient #1 – This patient remains active with the agency and thechart has been reviewed to assure the documentation is present that thephysician has been notified of any new patient issues or to changes in patientcondition and collaboration with the wound care center is documented. Patient #2 – This patient is discharged from the agencyas of	

	measurements &. Document dated 8/9/2021 and electronically signed by registered nurse (RN) L stated, & Patient will continue to follow up with wound care weekly &. Review failed to evidence care coordination with the wound clinic providing wound care services to the patient. During an interview on 8/12/2021 at 12:53 PM, the administrator in training D indicated the patient s wound physician was physician C from wound clinic D and stated, I don t have any documentation yet from their wound clinic. During an interview on 8/12/2021 at 1:00 PM, the alternate clinical manager indicated she could not locate care coordination with the wound clinic. At 1:06 PM, the alternate clinical manager indicated there was nothing specific documented in the weekly case conference notes related to the patient s wounds. 3. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Skilled Visit Note , dated 7/21/2021 and electronically signed by former employee LPN B, indicated the patient had a surgical wound to the front of the left foot. The document indicated the skilled nurse cleansed the wound with normal saline, covered with kerlix		9/1/21, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence. Patient #3 – This patient remains active withthe agency and the chart has been reviewed to assure that all changes in thepatient status including new medications are communicated to the nurse casemanager to ensure reconciling medications and inclusion in the Plan of Care andmedication profile. Patient #5 - This patient remains active with the agency and the OASISassessment for the current episode of care is comprehensive and accurate,inclusive of information functional limitations have been addressed to includeaccurate functional limitations and endurance and use of walker.	

	with tape. Review failed to evidence a physician order for the wound care provided. Review failed to evidence any services provided by a wound clinic and failed to evidence care coordination with a wound clinic. During an interview on 8/12/2021, at 10:33 AM when queried what was the physician s order for wound care, the alternate clinical manager indicated there was not a physician order for wound care and the patient had a paper from the wound clinic that explained the wound care the nurses followed in the home. The clinical manager indicated there was no care coordination with the wound clinic. Review on 8/13/2021, of documents from the wound clinic at hospital I, which the alternate clinical manager identified were requested of and received on 8/13/2021 from the patient s wound clinic, evidenced a document titled 06/28/2021 Follow Up in SM [hospital I] Wound Ostomy Clinic , dated 6/28/2021 and electronically signed by physician J. This document stated, & Patient presents today status post partial excision [surgical removal] of bone left 1st metatarsal [a bone in the foot]. & Incision site remains closed. Sutures removed. & Dressing orders: Betadine [a			

wounds] to incision site and covered by Hydrofera Blue [a type of absorptive foam dressing for wounds]. Dressing frequency: 3 times per week &.

Review of documents from the wound clinic at hospital I indicated the wound clinic provided wound care services for the wound on the left foot on 7/7/2021 and 7/26/2021.

Review of an agency document titled Start of Care , with an assessment date of 6/24/2021 and electronically signed by RN H, evidenced the patient s blood pressure to be 138/68.

Review of an agency document titled Occupational Therapy Evaluation , dated 7/28/2021 and electronically signed by occupational therapist (OT) M, evidenced the patient s blood pressure was 104/52. The document indicated the patient was to receive 2 visits a week for 3 weeks.

Review of agency documents titled Therapy Visit Note , electronically signed by OT M, evidenced the patient s blood pressure was 98/54 on 8/3/2021 and 104/51 on 8/9/2021.

Review failed to evidence the OT notified the nurse case manager of the patient's blood pressure.

During an interview on 8/12/2021

	manager indicated the OT should have notified the nurse case manager of the patient s blood pressure. Review of an agency document titled Discharge/Transfer Summary , dated 8/9/2021 and electronically signed by OT M, indicated the patient was discharged from OT services. The document stated, & Goals not met & Bathing not met due to need of someone to position shower bench and assist with lower body as there is a dressing of the [left] foot & [patient] states he will get a walk in bath with grab bars and seat that will allow him to be independent once dressing on left foot is no longer necessary &. Review of the document failed to evidence the OT coordinated the patient s discharge from OT services with the nurse case manager and communicated the patient s need for assistance to get into the shower and dressing. During an interview on 8/18/2021 at 12:12 PM, the alternate clinical manager indicated she was unaware OT M discharged the patient from OT services. During an interview on 8/18/2021 at 12:12 PM, administrator in training D indicated she was aware OT M discharged the patient from OT services but did not know why and indicated there was no documented care			

	coordination with the nurse case manager in the record. 4. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced an agency document titled Skilled Visit Note , dated 7/19/2020 and electronically signed by former employee LPN B, which indicated the patient had a new medication. Review failed to indicate the name, dose, frequency and route of the new medication, failed to evidence a physician order for the new medication and failed to indicate the LPN coordinated care with the nurse case manager related to the new medication as identified by the LPN. During an interview on 8/16/2021 at 11:13 AM, the alternate clinical manager indicated the LPN should have coordinated care with the nurse case manager regarding the new medication.			
G0606	Integrate all services 484.60(d)(3) 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. 5. Clinical record review on 8/16/2021, for patient #5, start of care 2/24/2021, diagnosis of type	G0606	Agencyclinical staff and managers will be educated to need to clinically coordinatecare with external care providers to include wound care clinics, home medical equipment providers, infusion therapy/pharmacy companies and community agencies.	2021-11-12

	disease, evidenced an agency document titled Home Health Certification and Plan of Care which was unsigned by the physician for certification period 6/24/2021 8/22/2021. This document failed to evidence the patient was hearing impaired. This document failed to evidence the patient had functional limitations During an observation on 8/11/2021 (input time), LPN (licensed practical nurse) I was observed performing a SN (skilled nurse) visit with patient #5. The patient and two family members were observed each sitting in lift recliners, with their rolling walkers propped in front of them. The patient was hard of hearing, and LPN I had to speak very loudly, or the patient s family members would answer for the patient. During the visit, the patient s family member/main caregiver indicated they assisted the patient with setting up medications, bathing and dressing. Review of agency documents titled Skilled Visit Note from 8/5/2021 and 8/11/2021, signed by LPN I, had a section subtitled Sensory which indicated the patient was hearing impaired. Review failed to evidence the LPN reported a change of condition in the patient s sensory status to the RN. Review failed to		The agency requestsdocumentation from each wound clinic visit on a weekly basis for patientsvisiting wound care clinics. 100% of clinical noteswill be reviewed to assure documentation includes clinical care coordinationwith external/community care providers. The Administrator isresponsible for assuring clinical coordination of care with external careproviders. Ongoing quality review of theclinical notes will assure compliance with documentation of communication withexternal organizations involved in the care of the patient. Patient #1 – This patient remains active with the agency and thechart has been reviewed to assure the documentation is present that thephysician has been notified of any new patient issues or to changes in patientcondition and collaboration with the wound care center is documented.	

	between all disciplines to maintain patient safety and a current plan of care. During an interview on 8/16/2021, at 10:16 AM, the alternate clinical manager A and administrator in training D were notified of the observations. The alternate clinical manager A indicated a patient s condition can change from the comprehensive assessment. 17-12-2(g, h)		Patient #2 – This patient is discharged from the agencyas of 9/1/21, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence. Patient #3 – This patient remains active withthe agency and the chart has been reviewed to assure that all changes in thepatient status including new medications are communicated to the nurse casemanager to ensure reconciling medications and inclusion in the Plan of Care andmedication profile. Patient #5 - This patient remains active with the agency and the OASISassessment for the current episode of care is comprehensive and accurate,inclusive of information functional limitations have been addressed to includeaccurate functional limitations and endurance and use of walker.	
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. 1. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Patient Bill of Rights and Responsibilities stated, & Patients have the right:	G0614	Agency staff willprovide patients with printed copy of visit schedule available within EMR toassure compliance with patient rights. Staff will be educatedto inform patients of changes to print copy and to update the home calendar	2021-11-10

	schedule and frequency &. 2. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Coordination of Patient Care stated, & Agency will coordinate care with the patient by providing a copy of written instructions outlining: Visit schedule, including frequency of visits by Agency personnel &. 3. During an observation of care at the home of patient #1, start of care 6/18/2021, on 8/13/2021 at 7:02 PM, the agency folder was observed with blank calendars for the months of June, July and August of 2021. The home observation failed to evidence a written visit schedule was provided to the patient. During an interview on 8/18/2021 at 12:19 PM, the alternate clinical manager indicated the agency should provide to the patient in the home folder a written visit schedule.		ifaware of changes to schedule. Staff will be educatedto assure a schedule is available in the home binder when performing homevisits. The Administrator isresponsible for assuring that patients receive schedules.	
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. 4. An observation was conducted at a home visit on 08/17/202,1 at 12:07 PM, with home health aide (HHA) J to observe the services being provided by the home	G0614	Agency staff willprovide patients with printed copy of visit schedule available within EMR toassure compliance with patient rights. Staff will be educatedto inform patients of changes to print copy and to update the home calendar	2021-11-10

	visit, at 2:00 PM, the patient's home folder was reviewed which failed to evidence a schedule for patient services being furnished by the agency. During an interview on 8/17/2021, at 1:20 PM, when queried about how they are informed of when staff was coming to the home, patient #2 stated Sometimes they call the night before. Sometimes they call early in the morning of the visit. And sometimes not at all. 5. Observation of a home visit was conducted on 8/11/2021at 10:00 AM, for patient #4, start of care 7/29/2021, diagnosis of age-related osteoporosis with fracture, to observe PT [physical therapist] F provide services. At 10:10 AM, the patient's home folder was reviewed and failed to evidence a schedule for patient services being furnished by the agency. 6. During an observation on 8/11/2021 1:00 PM, of a home visit for patient #5, start of care 2/24/2021, diagnosis of type 2 diabetes with chronic kidney disease, was conducted to observe LPN [licensed practical nurse] I provide care. At 1:14 PM, the patient's home folder could not be located for review		ifaware of changes to schedule. Staff will be educatedto assure a schedule is available in the home binder when performing homevisits. The Administrator isresponsible for assuring that patients receive schedules.	

	Observation failed to evidence a schedule for patient services being furnished by the agency.			
G0616	Patient medication schedule/instructions 484.60(e)(2) 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. 1. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Medication Profile stated, & The Agency must provide the patient and caregiver with a copy of written instructions outlining patient medication schedule/instructions &. 2. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Coordination of Patient Care stated, & Agency will coordinate care with the patient by providing a copy of written instructions outlining: & Patient medication schedule/instructions &. 3. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced an undated agency document titled Patient Medications . This document indicated, but was not limited to, Ketoconazole, start date 4/2/2021, (an antifungal medication used to treat skin	G0616	Patientswill be provided with a medication schedule and instructions which includemedication name, dosage and frequency and which, if any medications will be administered by HHA personnel and personnel acting on behalfof the HHA. Officestaff will print a medication schedule from the EMR and send to patient forinclusion in their home packet. The Administrator is responsible for assuring patients receive a medicationschedule and instructions and is notified if agency personnel will administerany of the medications on the list.	2021-11-16

	date 4/2/2021, (medication used to treat high cholesterol), Norco 5-325 mg, start date 4/23/2021, (medication used to treat pain) and Eliquis, start date 4/2/2021, (a blood thinning medication used to prevent blood clots). During an observation of care at the patient s home on 8/13/2021 at 7:02 PM, the agency folder was observed and failed to evidence written medication schedule and instructions. During an interview on 8/18/2021 at 12:19 PM, the alternate clinical manager indicated the agency s folder in the patient s home should include the plan of care and medication list. At 12:21 PM, the alternate clinical manager indicated the agency should provide the patient medication information sheets for written medication instructions.			
G0616	Patient medication schedule/instructions 484.60(e)(2) 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. 4. During an observation on 8/17/2021, at 12:00 PM, of a home visit for patient #2, start of care 6/24/2021, primary diagnosis of type 2 diabetes, was conducted to observe HHA J provide care. At 2:00PM, the	G0616	Patientswill be provided with a medication schedule and instructions which includemedication name, dosage and frequency and which, if any medications will be administered by HHA personnel and personnel acting on behalfof the HHA.	2021-11-16

	reviewed failed to evidence a current medication list was supplied by the agency. 5. During an observation on 8/11/202110:00 AM, of a home visit for patient #4, start of care 7/29/2021, diagnosis of age-related osteoporosis with fracture, was conducted to observe PT [physical therapist] F provide care. At 10:10 AM, the patient s home folder was reviewed failed to evidence a current medication list was supplied by the agency. 6. During an observation on 8/11/2021,at 1:00 PM, of a home visit for patient #5, start of care 2/24/2021, diagnosis of type 2 diabetes with chronic kidney disease, was conducted to observe LPN [licensed practical nurse] I provide care. At 1:14 PM, the patient's home folder could not be located for review by the client or caregiver. Observation failed to evidence a current medication list was supplied by the agency.		Officestaff will print a medication schedule from the EMR and send to patient forinclusion in their home packet. The Administrator is responsible for assuring patients receive a medicationschedule and instructions and is notified if agency personnel will administerany of the medications on the list.	
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager.	G0622	The patient admission handbooks have been updated to include the nameand contact information of the clinical	2021-11-16

	4. During an observation of care at the home of patient #1, start of care 6/18/2021, on 8/13/2021 at 7:02 PM, the agency folder was observed which indicated RN B was the clinical manager. Review failed to evidence the patient was informed in writing of RN A as the acting clinical manager. During an interview on 8/9/2021 at 10:40 AM, the alternate clinical manager, RN A, indicated RN B had been out of the office since the end of June due to medical leave. When queried who patients and staff were to contact in the absence of clinical manager, the alternate clinical manager indicated patients and staff were to contact the alternate clinical manager and stated, But I bet a letter did not go out to the patients about the long term change in the clinical manager.		manager. All patients on service received a copy ofthe notification and all new patients will receive the updated patienthandbook. The Administrator is responsible for assuring updates to the patient handbook with any changes to theclinical manager and updating active patients to new contact. QAPI will verify in quarterly meeting minutes that changes were madeappropriately upon changes to clinical manager role.	
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager. 1. An observation was conducted at a home visit on 08/17/2021 at 12:07 PM, with home health aide (HHA) J, to observe the services being provided by the home health aide. During the home visit at 2:00 PM the patient s home folder was reviewed and failed to evidence the contact information	G0622	The patient admission handbooks have been updated to include the nameand contact information of the clinical manager. All patients on service received a copy ofthe notification and all new patients will receive the updated patienthandbook. The Administrator is responsible for assuring updates to the patient handbook with any changes to theclinical manager and updating active patients to	2021-11-16

	of the clinical manager. 2. An observation was conducted at a home visit on 08/11/2021 at 10:00 AM, with physical therapist (PT) F, to observe the services being provided by the physical therapist. During the home visit at 10:10 AM the patient s home folder was reviewed and failed to evidence the contact information of the clinical manager. 3. An observation was conducted at a home visit on 08/11/2021 at 1:00 PM, with licensed practical nurse (LPN) I, to observe the services being provided by the physical therapist. Observation failed to evidence the contact information of the clinical manager that was available at the time of visit.		new contact. QAPI will verify in quarterly meeting minutes that changes were madeappropriately upon changes to clinical manager role.	
G0640	Quality assessment/performance improvement 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to	G0640	The Agency has contracted with consultants toassist the Administrator in quality functions to include participate indevelopment and implementation of a QAPI program. The consultants collaborate with theAdministrator and provide services based on the request of the Administrator.The Administrator will participate in the development and implementation ofQAPI program and TheAdministrator will schedule quarterly meetings to review all necessaryinformation included in QAPI. QAPImeeting to be held November 1st 2021 focusing on	2021-11-22

	improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 484: 65 Condition: Quality Assessment / Performance Improvement.		review of policies,tracking of tools and the focus of the program. Q3 2021 to be 1st QAPI review period as per tag G0640 The Administrator will developa QAPI program designed to implement, evaluate, and maintain an effective,ongoing, HHA-wide data-driven program. The Governing body involvement willensure the QAPI program focuses on indicators related to improved outcomes,including the use of emergent care services,hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrumof care, including the prevention and reduction of medical errors. The program measures, analyzesand tracks quality indicators, including adverse patient events and otheraspects of performance that enable the HHA to assess processes of care,operations, and services as per tag 0642 DNSand Administrator will ensure that QAPI meeting minutes, tracking logs andother documents are audited monthly for evidence that data is monitored,tracked, and trended related to the services provided – safety, effectiveness,and quality to determine opportunities for	

			willutilize quality indicator data, including measures derived from OASIS andclinical documentation, i.e., visit notes, as well as HHA documentation in thedesign of its program. Administrator/DNS will audit QAPI activities to ensurecompliance quarterly as per tag G0644 DNSor designee will ensure that QAPI activities focus on high-risk areas,considering incidence, prevalence, and severity of problems. All staff areeducated to requirements of the QAPI program as per tag G0648 TheDNS will ensure that the QAPI activities focus on high-risk, high volume orproblem- prone areas, considering incidence, prevalence and severity ofproblems. The DNS will audit the QAPImeeting minutes quarterly to ensure compliance as per tag G0650. DNSor designee will perform chart audits based on the IQIES report to identifypatients with potentially avoidable events. Once the patients are identified as havingpotentially	

			investigation will be completed forthose patients. As per tag G0654. Administratorwill ensure that QAPI activities are audited to ensure compliance quarterly andthat the Quality Improvement projects are documented, and progress measured toachieve projects. Administrator will audit QAPI projects on a quarterly basisto ensure compliance. As per tag G0656 TheAdministrator will ensure that the Quality Improvements projects are documentedand progress measures as well as including documentation to support the reasonsfor conducting the specific projects, and the measurable progress achieved onthese projects as per tag G0658 Administratorwill ensure agency-wide QAPI effortswhich addressed priorities for improved quality of care and patient safety andimprovement actions were evaluatedfor effectiveness as per tag G660. Administratorwill ensure that QAPI activities are audited to ensurecompliance quarterly and assure that the PI projects include: the number andscope of distinct improvement projectsconducted annually must reflect the scope, complexity, and past performance ofthe HHA's services and operations.	
G0642	Program scope 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in	G0642	The Administrator will developa QAPI program designed to implement, evaluate, and maintain an effective,ongoing, HHA-wide data-driven program. The Governing body involvement	2021-11-22

	those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Quality Assessment and Performance Improvement (QAPI) Plan and Program stated, &The Agency program will be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety and quality of care. 2. The Agency must measure, analyze and track quality indicators, including adverse patient events and other aspects of performance that enable the Agency to assess processes of care, services and operations &. During an interview on 8/9/2021 at 2:33 PM, after a request was made to the alternate clinical manager for the agency s QAPI data, the alternate clinical manager indicated there was nothing to provide for review for the agency s QAPI data. At 3:00 PM, the alternate clinical manager provided documents identified as patient satisfaction reports and indicated there was no other QAPI data. Review failed to evidence quality		willensure the QAPI program focuses on indicators related to improved outcomes,including the use of emergent care services,hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrumof care, including the prevention and reduction of medical errors. The program measures, analyzesand tracks quality indicators, including adverse patient events and otheraspects of performance that enable the HHA to assess processes of care,operations, and services as per tag 0642 The Administrator isresponsible for implementinga QAPI program that meets all regulations.	

	indicators and measurable data. During an interview on 8/10/2021 at 2:36 PM, the alternate clinical manager indicated registered nurse (RN) B printed quarterly quality averages compared to national averages and indicated she could not locate the data. The alternate clinical manager indicated she was not aware off hand of areas needing improvement in the agency. No additional documentation was provided. 17-12-2(a)			
G0644	Program data 484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Quality Assessment and Performance Improvement (QAPI) Plan and Program stated, & The Agency	G0644	DNSand Administrator will ensure that QAPI meeting minutes, tracking logs andother documents are audited monthly for evidence that data is monitored,tracked, and trended related to the services provided – safety, effectiveness,and quality to determine opportunities for improvement. The QAPI program willutilize quality indicator data, including measures derived from OASIS andclinical documentation, i.e., visit notes, as well as HHA documentation in thedesign of its program. Administrator/DNS will audit QAPI activities to ensurecompliance quarterly as per tag G0644. The Administrator isresponsible	2021-11-22

	quality indicators, including adverse patient events and other aspects of performance that enable the Agency to assess processes of care, services and operations. & The Agency will use the data to: Monitor the effectiveness and safety of services and quality of care. Identify opportunities for improvement. & The frequency and detail of the data collection must be approved by the Governing Body &. Review on 8/9/2021 of agency documents titled Governing Body Meeting Minutes , dated 10/7/2020, 3/23/2021 and 6/4/2021, failed to evidence the governing body approved the detail and frequency of the quality indicator data collection. During an interview on 8/9/2021 at 2:33 PM, after a request was made to the alternate clinical manager for the agency s QAPI data, the alternate clinical manager indicated there was nothing to provide for review for the agency s QAPI data. At 3:00 PM, the alternate clinical manager provided documents identified as patient satisfaction reports and indicated there was no other QAPI data. Review failed to evidence quality indicator data. During an interview on 8/10/2021 at 2:36 PM, the alternate clinical manager indicated the quality		for implementinga QAPI program that meets all regulations. The Governing Body will be sent QAPI meeting minutes and data collected by theAdministrator and a meeting held with the Governing Body to review the findingsof quarterly QAPI meetings and obtain agreement to the QAPI data to becollected. The Administrator will obtaina document signed by the Governing Body assuring review and approval of theQAPI findings on a quarterly basis and maintain this document in the agency'sQAPI binder. The Governing Body will be sent QAPI meeting minutes and data collected by theAdministrator and a meeting held with the Governing Body to review the findingsof quarterly QAPI meetings and obtain agreement to the QAPI data to becollected. The Administrator will obtaina document signed by the Governing Body assuring review and approval of theQAPI findings on a quarterly basis and maintain this document in the agency'sQAPI binder.	

	indicators the agency monitored were the improvement or decline in patient s ability to provide personal care, documentation, short and long term goals being patient specific, wounds and hospitalizations. The alternate clinical manager indicated she could not find any documentation of the collected data other than the patient satisfaction surveys. The alternate clinical manager indicated she believed the frequency of the data collection was quarterly but did not know if the governing body approved the detail of the data collection. The alternate clinical manager indicated there was no documentation of the governing body approval for the frequency and detail of the quality indicator data collection. 17-12-2(a)			
G0648	High risk, high volume, or problem-prone area 484.65(c)(1)(i) (i) Focus on high risk, high volume, or problem-prone areas; Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Quality Assessment and Performance Improvement (QAPI) Plan and Program stated, & The Agency s performance improvement activities will: Focus on high risk, high volume and problem-prone areas &.	G0648	DNSor designee will ensure that QAPI activities focus on high-risk areas,considering incidence, prevalence, and severity of problems. All staff areeducated to requirements of the QAPI program as per tag G0648. The Administrator is responsible for implementing a QAPI program that meets all regulations Clinical record reviews are	2021-11-22

	During an interview on 8/9/2021 at 2:33 PM, after a request was made to the alternate clinical manager for the agency s QAPI data and performance improvement activities, the alternate clinical manager indicated there was nothing to provide for review for the agency s QAPI data and activities. At 3:00 PM, the alternate clinical manager provided documents identified as patient satisfaction reports and indicated there was no other QAPI documentation. Review failed to evidence performance improvement activities. During an interview on 8/10/2021 at 2:36 PM, the alternate clinical manager indicated there was no performance improvement activities and the last activity was in 2018.		conducted each quarter toidentify what patient types fall into the categories of high risk, high volumeand problem prone. 10% of all clinicalrecords are reviewed to identify high risk, volume and problem prone areas. Adverse events are pulled from the IQIESsystem to evaluate potentially avoidable events. Each potentially avoidableevent has a thorough chart audit conducted to assure all interventions wereimplemented appropriately. Clinical record reviews are conducted each quarter toidentify what patient types fall into the categories of high risk, high volumeand problem prone. 10% of all clinicalrecords are reviewed to identify high risk, volume and problem prone areas. Adverse events are pulled from the IQIESsystem to evaluate potentially avoidable events. Each potentially avoidableevent has a thorough chart audit conducted to assure all interventions wereimplemented appropriately.	
G0650	Incidence, prevalence, severity of problems 484.65(c)(1)(ii) (ii) Consider incidence, prevalence, and severity of problems in those areas; and Review of an agency policy,	G0650	TheDNS will ensure that the QAPI activities focus on high-risk, high volume orproblem- prone areas, considering incidence,	2021-11-22

	revised March 2019 and obtained 8/18/2021, titled Quality Assessment and Performance Improvement (QAPI) Plan and Program stated, & The Agency s performance improvement activities will: & Consider incidence, prevalence and severity of problems in those areas &. During an interview on 8/9/2021 at 2:33 PM, after a request was made to the alternate clinical manager for the agency s QAPI data and performance improvement activities, the alternate clinical manager indicated there was nothing to provide for review for the agency s QAPI data and activities. At 3:00 PM, the alternate clinical manager provided documents identified as patient satisfaction reports and indicated there was no other QAPI documentation. Review failed to evidence performance improvement activities. During an interview on 8/10/2021 at 2:36 PM, the alternate clinical manager indicated there was no performance improvement activities and the last activity was in 2018.		prevalence and severity ofproblems. The DNS will audit the QAPImeeting minutes quarterly to ensure compliance as per tag G0650. The Administrator isresponsible for implementinga QAPI program that meets all regulations. ? Clinical record reviewsare conducted each quarter to identify what patient types fall into thecategories of agency specific incidence, prevalence and problem severity. 10% of clinical records are reviewed toidentify agency specific incidence, prevalence and problem severity areas. Adverse events are pulled from the IQIESsystem to evaluate potentially avoidable events. Each potentially avoidableevent has a thorough chart audit conducted to assure all interventions wereimplemented appropriately.	
G0654	Track adverse patient events 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes,	G0654	TheDNS will ensure that the QAPI activities focus on high-risk, high volume orproblem- prone areas,	2021-11-22

	and implement preventive actions. 1. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Quality Assessment and Performance Improvement (QAPI) Plan and Program stated, & Performance improvement activities must track adverse patient events, analyze their causes and implement preventive actions. & Adverse patient events are those patient events that are negative and unexpected, impact a patient s plan of care and have the potential to cause a decline in a patient s condition &. 2. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced an agency document titled Physical Therapy Functional Reassessment , dated 11/13/2020 and signed by physical therapist (PT) F, indicated the patient had a complaint of pain rated 4 on a scale of 0-10, with 0 being no pain and 10 being the most severe, to the left hip related to a fall on 10/25/2020. Review failed to evidence the fall was tracked and its cause analyzed.		considering incidence, prevalence and severity ofproblems. The DNS will audit the QAPImeeting minutes quarterly to ensure compliance as per tag G0650. The Administrator isresponsible for implementinga QAPI program that meets all regulations. Adverse events are identified in chart audits and the IQIES systemand are investigated, tracked and trended on the agency specific QAPI trendingtool. During the QAPI meeting trends areidentified and a Performance Improvement Plan (PIP) is created specific to thepatient events, identifying preventative actions. Clinicians and agencyleadership team are educated to the potentially avoidable events andpreventative actions. Subsequent QAPIreviews will be conducted to assure preventative actions were successful andsustained.	

Review of an agency document titled titled OASIS Follow-Up , completion date 4/2/2021 and signed by registered nurse (RN) N, indicated the patient had a fall on 3/31/2021. Review failed to evidence the fall was tracked and its cause analyzed.

During an interview on 8/16/2021 at 11:36 AM, the alternate clinical manager indicated there was no incident report completed for the falls on 10/25/2020 and 3/31/2021 to track and analyze the falls. The alternate clinical manager indicated a patient fall was considered an adverse event.

3. Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced an agency document titled Nursing Visit Record , dated 5/3/2021 and signed by former employee RN K, stated, & [Patient] had a fall on Friday, hit head, laid on floor for [approximately] 1 hr [hour] &. Review failed to evidence the fall was tracked and its cause analyzed.

During an interview on 8/18/2021 at 11:19 AM, the alternate clinical manager indicated an incident report had not been completed for the fall to track and analyze the fall and indicated an incident report should have been completed.

17-12-2(a)

G0656	Improvements are sustained 484.65(c)(3) The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Quality Assessment and Performance Improvement (QAPI) Plan and Program stated, & Agency must take actions aimed at performance improvement and, after implementing these actions, must measure its success and track performance to ensure that improvements are sustained &. During an interview on 8/9/2021 at 2:33 PM, after a request was made to the alternate clinical manager for the agency s QAPI data, the alternate clinical manager indicated there was nothing to provide for review for the agency s QAPI documentation. At 3:00 PM, the alternate clinical manager provided documents identified as patient satisfaction reports and indicated there was no other QAPI documentation. Review failed to evidence the agency took actions aimed at performance improvement and measure the success and track performance to ensure improvements were sustained. During an interview on 8/10/2021	G0656	Administratorwill ensure that QAPI activities are audited to ensure compliance quarterly andthat the Quality Improvement projects are documented, and progress measured toachieve projects. Administrator will audit QAPI projects on a quarterly basisto ensure compliance. As per tag G0656. The Administrator isresponsible for implementinga QAPI program that meets all regulations. Agency utilizes SMART goals and ongoing activitiesto meet the goals and track interventions identified on the specific PIP thatis in place. The clinical recordsreviewed in subsequent quarters are reviewed and trended to assure the PIPactivities resulted in success and that any interventions implemented resultedin sustained improvement. These trendsare reviewed at subsequent QAPI meetings and training is conducted when needed.	2021-11-22

	at 2:36 PM, the alternate clinical manager indicated the agency typically tracked its performance with reports of the agency s performance averages compared to the national averages and indicated there was not a report available for review. The alternate clinical manager indicated patient falls needed improvement and was unaware of performance improvement activities aimed at improving patient falls. 17-12-2(a)			
G0660	Executive responsibilities for QAPI 484.65(e)(1)(2)(3)(4) Standard: Executive responsibilities. The HHA's governing body is responsible for ensuring the following: (1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained; (2) That the HHA-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness; (3) That clear expectations for patient safety are established, implemented, and maintained; and (4) That any findings of fraud or waste are appropriately addressed. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled	G0660	TheGoverning Body through the Administrator will ensure agency-wide QAPI effortswhich addressed priorities for improved quality of care and patient safety andimprovement actions were evaluatedfor effectiveness as per tag G660including: 1. That an ongoingprogram for quality improvement and patient safetyis defined, implemented, and maintained; 2. That the HHA-widequality assessment and performance improvement efforts address priorities for improved qualityof care and patient safety,	2021-11-22

	Governing Body stated, & The Governing Body is responsible for assuring: That an ongoing program for Quality Assessment/Performance Improvement and patient safety is defined, implemented and maintained. That the Agency-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated for effectiveness &. During an interview on 8/9/2021 at 2:33 PM, after a request was made to the alternate clinical manager for the agency s QAPI data and performance improvement activities, the alternate clinical manager indicated there was nothing to provide for review for the agency s QAPI data and activities. At 3:00 PM, the alternate clinical manager provided documents identified as patient satisfaction reports and indicated there was no other QAPI documentation. Review failed to evidence QAPI data and performance improvement activities. During an interview on 8/10/2021 at 2:36 PM, the alternate clinical manager indicated all QAPI data was reported to the governing body by the administrator quarterly at a minimum either verbally or via email. The		and that all improvement actions are evaluated for effectiveness; 3. That clearexpectations for patientsafety are established, implemented, and maintained; and 4. That any findings of fraud or waste are appropriatelyaddressed. The Administrator isresponsible for implementinga QAPI program that meets all regulations.	

	alternate clinical manager indicated there was no documentation of QAPI data reported to the governing body.			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. 1. Review of an agency policy, revised July 2020, titled Standard Precautions stated, & The concept of body substance isolation encompasses all the principles of Standard Precautions/blood and body fluid precaution, and extends to all moist body parts/tissues/surfaces, including fluids, solids, tissues and moist areas & The principles of Standard Precautions are to be followed by all employees when contacting any such substances or areas. Standard Precautions include the following procedures: & Perform hand hygiene after removing gloves. (Note: Gloves do not replace handwashing.) &. 2. Review of an agency policy, revised March 2018, titled Exposure Control Plan: OSHA [Occupational Safety and Health Administration] Regulations stated, & Keep supplies off the floor and out of reach of children & Methods of Disinfection & Thermometers will be wiped with	G0682	Clinicians will beeducated related to wound assessments, treatments, interventions, anddocumentation. Education will include proper handwashing for minimum of 20seconds, sterile technique, bag technique, gloving, use of barriers, andmanagement of wound supplies and tablets. Competency assessmentswill be performed of clinicians to observe handwashing, bag technique andappropriate management of wound supplies. Documentation reviewsof clinical records will take place for 100% of clinical notes to assuredocumentation matches orders on plan of care or supplemental orders. Ride-along competencyassessments will be conducted by supervisor (s) to observe infection controlpractices in the field and mentor, re-train for any infection control errors.	2021-11-22

	alcohol pad after each use & Stethoscopes and blood pressure cuffs will be cleansed with Agency approved disinfectant after each use by the employee who has possession of the equipment & Nursing Bag Technique & Upon entering the home, place the bag on a clean surface; paper towels or plastic bag may be used to create a clean area if indicated & Remove all items which will be needed for the visit & Place items on one of the paper towels. Close the bag and give the patient care & Clean any visibly soiled items which will be returned to the bag &. 3. During an observation of care at the home of patient #1, start of care 6/18/2021, on 8/13/2021 at 7:17 PM, registered nurse (RN) H was observed removing the glove to her right hand. RN H was observed entering her nurse bag with the ungloved right hand, retrieved a tape measure and then applied a glove to the right hand. RN H was not observed to have performed hand hygiene after removing the glove to the right hand before applying another glove. At 7:19 PM, RN H removed the wound dressing to the patient s left groin and was observed placing her right thumb up against the wounds and then against the tag on the nurse bag. RN H was observed removing the gloves on both hands and then applied a new glove to the		The Administrator isresponsible assuring for infection control practices.	

	observed to have performed hand hygiene after removing the gloves and before applying new glove to the left hand. At 7:25 PM, RN H was observed measuring the tag on the nurse bag with the tape measure, removed the glove on her left hand and applied new gloves to both hands. RN H was not observed to have performed hand hygiene after removing the glove on the left hand and before applying new gloves. At 7:30 PM, RN H cleanses the wound to the patient s left groin and applies a clean dressing to the wounds. RN H was observed removing both gloves and then applied new gloves to both hands. RN H was not observed to have performed hand hygiene after cleansing the open areas and before applying the new wound dressing to the open areas on the left groin and was not observed to have performed hand hygiene after removing the gloves and before new gloves. At 7:35 PM, RN H rolled the patient to his left side and wiped a brown, soft substance from the patient s buttocks using the disposable pad underneath the patient and then removed a dressing from the patient s right buttock. Two open areas were observed on the right ischium (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis). RN H wiped a brown, soft substance from in between the buttocks			

	with disposable wipes, removed the disposable pad from under the patient s buttocks, removed gloves from her hands and placed them in the trash can. At 7:44 PM, RN H was observed applying new gloves and cleansed the wounds to the right ischium. At 7:48 PM, RN H was observed removing her gloves, applied new gloves and applied a clean dressing to the open areas on the left ischium. RN H was not observed to have performed hand hygiene after glove removal and before applying new gloves. During an interview on 8/18/2021 at 12:24 PM, the alternate clinical manager indicated hand hygiene should be performed after the removal of gloves and before applying new gloves and before entering the nurse bag.			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. 4. During an observation on 8/11/2021, at 1:00 PM, LPN (licensed practical nurse) I was observed performing a SN (skilled nurse) visit with patient #5. The patient and two family	G0682	Clinicians will beeducated related to wound assessments, treatments, interventions, anddocumentation. Education will include proper handwashing for minimum of 20seconds, sterile technique, bag technique, gloving, use of barriers, andmanagement of wound supplies and tablets. Competency assessmentswill be performed of clinicians to	2021-11-22

	members were observed sitting in lift recliners, with their wheelchairs propped in front of them. The patient was hard of hearing, and LPN I had to speak very loudly, or the patient s family members would answer for the patient. At 13:07 PM, LPN I indicated she just started and didn t have a barrier and placed her nurse bag on the floor. LPN I sanitized her hands with alcohol based hand rub (ABHR), opened nurse bag and retrieved a blood pressure cuff, thermometer, pulse oximeter and stethoscope. At 1:07 PM, obtained the patient s vital signs and then placed the blood pressure cuff, pulse oximeter, and thermometer directly on the floor. LPN I sanitized using ABHR and searched through her nurse bag. At 1:23 PM, LPN I pumped ABHR into hands and rubbed it into her stethoscope. LPN I retrieved a 4 inch by 4 inch (4 x 4) gauze dressing from nursing bag and pumped ABHR onto the gauze. LPN I wiped down the blood pressure cuff, pulse oximeter, and thermometer with ABHR on 4 x 4 gauze dressings and placed the items back into the nurse bag. Observation evidenced the LPN placed the reusable medical equipment on the floor. Observation failed to evidence the LPN used a barrier between the nurse bag and patient s floor in their home. Observation failed to evidence the nurse sanitized reusable		observe handwashing, bag technique andappropriate management of wound supplies. Documentation reviewsof clinical records will take place for 100% of clinical notes to assuredocumentation matches orders on plan of care or supplemental orders. Ride-along competencyassessments will be conducted by supervisor (s) to observe infection controlpractices in the field and mentor, re-train for any infection control errors. The Administrator isresponsible assuring for infection control practices.	

	medical equipment according to agency policy. Observation failed to evidence the LPN followed infection control procedures according to agency policy. During an interview on 8/11/2021, at 1:37 PM, LPN I indicated they did have the barrier mat or disinfectant wipes provided by the agency. During an interview on 8/18/2021, at 10:35 AM, alternate clinical manager A was informed the LPN did not use a barrier for the nurse bag or disinfectant wipes on the reusable medical equipment. Alternate clinical manager A indicated all field staff was supplied with those items and should have had them at the SN visit. 17-12-1(m)			
G0686	Infection control education 484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). 1. Review of an agency policy, revised March 2018, titled Exposure Control Plan: OSHA [Occupational Safety and Health Administration] Regulations stated, &_Employees will receive	G0686	Staff training relatedto wound care will be scheduled at the time of hire and on an annual basis forclinicians. Training will include woundassessments, treatments, interventions, and documentation. Education willinclude proper handwashing for minimum of 20 seconds, sterile technique, bagtechnique, gloving, use of barriers, and management of wound supplies	2021-11-22

	education and training during orientation and at least annually &. 2. Personnel record review on 8/10/2021 for physical therapist (PT) F, start date 1/13/2020, evidenced an agency document titled New Employee Inservice Log , signed by PT F and dated 1/13/2020, which indicated PT F received inservice training for infection control. Review failed to evidence PT F received infection control education annually per agency s policy since 1/13/2020. 3. Personnel record review on 8/10/2021 for registered nurse (RN) H, start date 12/16/2019, failed to evidence RN H received infection control education. 4. Personnel record review on 8/10/2021 for RN L, start date 6/7/2021, evidenced agency documents titled Tuberculosis [a contagious bacterial infection usually affecting the lungs] and Infection Control and Bloodborne Pathogens Break the Chain of Infection , signed by RN L. Review failed to evidence the forms were completed to include a date the training was completed, a signature of the instructor who provided the training and an assessment of the employee s competency of the education. 5. Personnel record review on 8/10/2021 for occupational		andtablets. Competency assessmentswill be performed of clinicians to observe handwashing, bag technique andappropriate management of wound supplies. Documentation reviewsof clinical records will take place for 100% of clinical notes to assuredocumentation matches orders on plan of care or supplemental orders. Handouts with teststhat are provided to clinicians will be reviewed/scored by the trainingclinician to assure the staff members understand the training. Ride-along competencyassessments will be conducted by supervisor (s) to observe infection control practicesin the field and mentor, re-train for any infection controlerrors. The Administrator isresponsible assuring for infection control practices.	

	6/16/2021, evidenced agency documents titled Tuberculosis [a contagious bacterial infection usually affecting the lungs] and Infection Control and Bloodborne Pathogens Break the Chain of Infection . Review failed to evidence the forms were completed to include a date the training was completed, OT M s signature indicating receipt of training, a signature of the instructor who provided the training and an assessment of the employee s competency of the education. 6. During an interview on 8/10/2021 at 4:04 PM, the alternate clinical manager indicated the education forms should have been completed when the training was provided and indicated there was no documentation of infection control education provided to RN H. The alternate clinical manager indicated infection control training should be completed annually and typically the training was offered in January and February every year. The alternate clinical manager indicated there was no additional documentation for PT F that the agency provided infection control education.			

G0700	Skilled professional services 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician or allowed practitioner and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.75 Skilled Professional Services.	G0700	Skilled nursing staffwill be educated related to their responsibilities including, but not limitedto those identified below: 1. provideongoing interdisciplinary involvement of all skilledprofessionals involved in the patient's care as per tag G0706 2. providethe services as indicated in the plan of care as pertag G0710 3. providethe patient and caregiver education as per tag G0714 4. prepareclinical notes as per tag G0716 and 5. participatein agency-sponsored in-services as per tag G0722. The agency hascontracted with consultants to assist the Administrator in quality functions toinclude: 1. Review of the comprehensive assessments atstart of care, recertifications, resumption of care and discharges to assureaccurate, timely, compliant, and comprehensive Plans of Care, providingrecommendations to clinicians for additions, enhancements or changes	2021-11-22

			care, 2. Quality review of clinician documentation toassure that clinicians are documenting only to interventions ordered by thephysician and that orders exist for all services provided, TheAdministrator is responsible for assuring compliance with these elements of theConditions of Participation. Qualityreviews of all OASIS events and clinician daily notes will assure cliniciansare documenting according to the plan of care.	
G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; 1. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Nursing Services stated, & Nursing care will be provided in accordance with the patient s plan of care, under supervision of a registered nurse. Professional nursing service will be provided by a registered nurse (RN) and include: Initial and ongoing comprehensive assessments of	G0706	Clinicians conducting initialand ongoing comprehensive assessments will be re-educated related to performingassessments for patient based on standards of practice: 1. Abdominal assessmentsfor patients with complaints of abdominal pain or no bowel movements formultiple days. Assessment should includeauscultating bowel sounds, assessing for tenderness, distention and abnormalfindings reported to	2021-11-16

	the patient s needs & The Licensed Practical Nurse or Licensed Vocational Nurse (LPN/LVN) will supplement the nursing care needs of the patient as provided by the Registered Nurse and include: Providing services in accordance with Agency policies &. 2. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Pain Assessment and Reassessment stated, & Each patient receiving skilled nursing services will have pain assessed initially and on an ongoing basis using established criteria & which may include: Location. Intensity (using pain rating scale). Duration. Frequency. Character & Current pain therapy or treatment. Effectiveness of current therapy or treatment. & Each patient receiving therapy services (PT [physical therapy], OT [occupational therapy] & will have pain assessed and reassessed as appropriate and relevant to the care provided by the therapist &. 3. Review on 8/18/2021 of a reference document titled Diagnosis of Constipation website https://www.niddk.nih.gov/health-information/digestive-diseases/constipation/diagnosis stated, & During a physical exam, a healthcare professional may & use a stethoscope to listen to sounds in your abdomen & check your abdomen for		physician and documented in EMR. 2. Patients withcomplaints of pain should be assessed for location, treatment initiatives inplace and effectiveness of pain. Painthat is not relieved by pain interventions or is assessed at above the expectedgoal/threshold should be reported to physician and documented in EMR. Quality review of theclinical notes will identify documentation issues and improve compliance toregulation. The Administrator is responsible for assuring clinicians are conductingappropriate clinical assessments and reporting abnormal assessments to thephysician. Patient #1 – This patient remains active with the agency and thecurrent plan of care is comprehensive and includes orders for care to all woundsites and that frequencies are accurate on the plan of care and all disciplinesare visiting the patient as per the ordered frequencies. As per plan ofcorrection, training and workflow including review of all Plans of Care andclinician notes	

	swelling, tenderness or pain &. 4. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/18/2021 8/16/2021, signed by the alternate clinical manager on 7/15/2021 and by the physician on 8/2/2021. This document indicated the patient s diagnoses included, but were not limited to, quadriplegia (paralysis of all 4 limbs). This document stated, Summary of HHA [home health aide] Orders & No BM [bowel movement] 3 Days &. Review of an agency document titled Skilled Visit Note , dated 7/12/2021 and electronically signed by former employee LPN B, which indicated the patient s last bowel movement was 3 days prior on 7/9/2021. The document failed to evidence the LPN assessed the abdomen for the type and location of bowel sounds present and failed to assess the abdomen for tenderness and distention related to no bowel movement in 3 days. Review of an agency document titled Skilled Visit Note , dated 8/9/2021 and electronically signed by RN L, indicated the patient s last bowel movement was on 8/4/2021 and indicated the patient was constipated. Review failed to evidence the RN		has been put in place to assure ongoing communication withphysicians and prevention of recurrence of this issue. Patient #2 – This patient is discharged from the agencyas of 9/1/21, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence.	

	assessed the abdomen for the type and location of bowel sounds present and failed to assess the abdomen for tenderness and distention related to no bowel movement in 5 days. During an interview on 8/12/2021 at 1:12 PM, the alternate clinical manager indicated the plan of care indicated the registered nurse was to be notified if the patient did not have a bowel movement in 3 days. The alternate clinical manager indicated the skilled nurse should assess the patient s abdomen for distention, tenderness and bowel sounds and indicated the physician should be notified if no bowel movement in 3 days for interventions. 5. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced agency documents titled Skilled Visit Note . Document dated 7/29/2021 and electronically signed by RN H evidenced the RN assessed the patient s pain to be 3 on a scale of 0-10, with 0 being no pain and 10 being the most severe. This document indicated the patient s pain goal was a rating of 2 on a scale of 0-10. Review failed to evidence the RN assessed the patient s pain treatment. Document dated 8/4/2021 and electronically signed by RN L, evidenced the RN assessed the patient s pain			

	document failed to evidence the RN assessed the location of the pain and the patient s pain treatment and effectiveness. During an interview on 8/12/2021 at 10:36 AM, the alternate clinical manager indicated pain should be assessed at every skilled visit and the RN should have assessed for nonpharmacologic treatment such as repositioning, heat and ice. 17-12-2(g)			
G0710	Provide services in the plan of care 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; 1. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Skilled Professional Services stated, & Skilled professional services include skilled nursing services & Skilled professionals must assume responsibility for, but not be restricted to the following: & Providing services that are ordered by the physician as indicated in the plan of care &. 2. Clinical record review on 8/10/2021 for patient #1, start of	G0710	The agency hascontracted with consultants to assist the Administrator in quality functions toinclude creation of a plan of care in timely fashion by reviewing review thecomprehensive assessments at start of care, recertifications, resumption ofcare and discharges to assure accurate, timely, compliant, and comprehensivePlans of Care. Recommendations areprovided to clinicians for additions, enhancements or changes to documentationand plan of care.	2021-11-22

	care 6/18/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/18/2021 8/16/2021. The document was signed by the alternate clinical manager on 7/15/2021 and by the physician on 8/2/2021 and indicated the skilled nurse was to assess the patient and caregivers for symptoms of Covid-19 and provide catheter (a thin, sterile tube inserted into the bladder to drain urine) care to the patient. This document indicated the patient had a foley catheter (a type of catheter). Review of an agency document titled Skilled Visit Note , dated 7/19/2021 and electronically signed by former employee LPN B, failed to evidence the document was complete to include the patient s temperature. During an interview on 8/12/2021 at 1:16 PM, the alternate clinical manager indicated the skilled nurse should obtain and document the patient s temperature at every visit and indicated the symptoms of Covid-19 included a fever. Review of agency documents titled Skilled Visit Note , dated 8/2/2021 and 8/6/2021 and electronically signed by RN L, failed to evidence the skilled nurse provided catheter care as		Clinical documentationis reviewed to assure the clinicians documented providing services as orderedby the physician in the plan of care. Staff training will beconducted to assure they correctly: · Assess patient/caregiverfor Covid-19 · Perform catheter careas ordered · Perform vital signs torule out Covid-19 · Assess for edema whenindicated on plan of care · Provide visitfrequencies as identified on the plan of care · Provide therapyinterventions as ordered on the plan of care and · All other interventionsordered on the plan of care.	

	directed on the plan of care. During an observation of care on 8/13/2021 at the patient s home, RN H arrived at the patient s home at 7:07 PM. At 7:30 PM, tubing was observed inserted into the patient s penis and draining into a plastic drainage bag in a bucket next to the patient s bed with yellow liquid. RN H was observed to depart from the patient s home at 8:21 PM. RN H was not observed to have provided catheter care during the skilled nursing visit as directed on the plan of care. During an interview on 8/12/2021 at 1:09 PM, the alternate clinical manager indicated the skilled nurse should provide catheter care at every visit. 3. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/ 22/2021 which was electronically signed by RN H on 7/21/2021 and the physician on 7/23/2021. The plan of care indicated the patient s diagnoses included, but were not limited to, atrial fibrillation (irregular heartbeat which may cause the heart to pump less effectively which may result in swelling of hands, feet, or other body parts) and heart failure (a progressive heart disease resulting in		Quality review ofclinical notes will assure compliance with provision of services in the plan ofcare. The Administrator isresponsible for assuring that services are provided as per the plan of care. All active clinical records were reviewed to assure that clinical records include vital sign parameters to report to physician, that patients were assessed for changes in status, all care was delivered as per frequencies and interventions ordered on the plan of care, that physicians were notified of clinical status changes of patients and plans of care updated with new orders for care.	

	damaged heart muscles which can cause swelling of hands, feet or other body parts). The plan of care indicated the skilled nurse was to monitor for an increase or decrease in edema (swelling). Review of agency documents titled Skilled Visit Note , dated 6/30/2021, 7/7/2021, 7/15/2021 and 7/21/2021 and electronically signed by former employee LPN B and dated 8/4/2021 and electronically signed by RN L, failed to evidence the skilled nurse assessed for edema. During an interview on 8/12/2021 at 10:53 AM, the alternate clinical manager indicated the skilled nurse should document the assessment of edema but nothing about edema was indicated. 4. During an interview on 8/12/2021 at 11:20 AM, former employee LPN B indicated she conducted home visits without a plan of care, medication list, physician orders and patient diagnoses because the RN that started the case was not done with the plan of care by the time the next skilled nurse visit was due.			
G0710	Provide services in the plan of care	G0710	The agency hascontracted with	2021-11-22

	484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; 5. Clinical record review on 8/16/2021, for patient #4, start of care 7/29/2021, evidenced an agency document titled Home Health Certification and Plan of Care which was indicated to be the current plan of care received on 8/10/2021, diagnosis of age-related osteoporosis with current fracture to right humerus (upper arm), with a history of falls. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated Services for Occupational Therapist [OT]: & Effective on 08/08/2021: OT 2W2 [twice a week, for 2 weeks] & Summary of OT Orders: & ADL [activities of daily living] & Home Exercise Program &." Review failed to evidence OT visit note documentation. Review failed to evidence the agency followed OT frequencies as ordered on the plan of care. Review failed to evidence OT performed the prescribed activities as ordered on the plan of care. 17-14-1(a)(1)(H) 17-14-1(a)(2)(F		consultants to assist the Administrator in quality functions toinclude creation of a plan of care in timely fashion by reviewing review thecomprehensive assessments at start of care, recertifications, resumption ofcare and discharges to assure accurate, timely, compliant, and comprehensivePlans of Care. Recommendations areprovided to clinicians for additions, enhancements or changes to documentationand plan of care. Clinical documentationis reviewed to assure the clinicians documented providing services as orderedby the physician in the plan of care. Staff training will beconducted to assure they correctly: · Assess patient/caregiverfor Covid-19 · Perform catheter careas ordered · Perform vital signs torule out Covid-19	

			· Assess for edema whenindicated on plan of care · Provide visitfrequencies as identified on the plan of care · Provide therapyinterventions as ordered on the plan of care and · All other interventionsordered on the plan of care. Quality review ofclinical notes will assure compliance with provision of services in the plan ofcare. The Administrator isresponsible for assuring that services are provided as per the plan of care. All active clinical records were reviewed to assure that clinical records include vital sign parameters to report to physician, that patients were assessed for changes in status, all care was delivered as per frequencies and interventions ordered on the plan of care, that physicians were notified of clinical status changes of patients and plans of care updated with new orders for care.	
G0714	Patient and caregiver education 484.75(b)(5) Patient and caregiver education; 1. Review of an agency policy, revised March 2018 and	G0714	Staff education to beconducted regarding importance to identify high risk medications and educatethe patient/caregiver on high risk medications to include anticoagulants,opioids,	2021-11-17

	obtained 8/18/2021, titled High-Alert and Hazardous Medications stated, & The following medications have been identified by the Agency as high-alert medications: Insulin [medication used to alter the blood sugar level] & Opiods [a class of prescription drugs used to treat severe pain], Antithrombotic agency (anticoagulants) [a class of medication used to thin the blood to prevent/treat blood clots], e.g., Warfarin & Oral hypoglycemic [a class of medication used to alter the blood sugar level], especially Metformin [a type of oral hypoglycemic medication] &. 2. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced an undated agency document titled Patient Medications . This document indicated the patient s medication included Eliquis, start date 4/2/2021, (a type of anticoagulant medication). Review of an agency document titled Start of Care (D1) , dated 6/18/2021 and electronically signed by registered nurse (RN) K, indicated the patient was not taking any high risk drugs and high risk drug education was indicated to be not applicable. During an interview on 8/12/2021 at 12:53 PM, the alternate clinical manager indicated Eliquis was an anticoagulant and indicated		hypoglycemic medications. The quality review ofclinical notes and initial review ofmedication profile, indications, contraindications, side effects will alert clinicians to high risk medication and need to educationpatients/caregivers. The Administrator isresponsible for assuring patient education related to medications, particularlyhigh risk meds. Quality review ofclinical notes will enhance compliance assuring patient education is completedas needed for medications. All active clinical records were reviewed to assure thatpatients were educated related to high risk drugs and that all medicationprofiles were evaluated for the patient taking high risk drugs. Patient #1 – This patient remains active with the agency anddocumentation exists in the EMR that the patient was educated in any high riskmedications the patient is taking as of this current episode of care. Patient #2 – This patient is	

	the RN should have provided high risk drug education for the Eliquis. 3. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/22/2021, which indicated the patient s medication included Warfarin Sodium (a type of anticoagulant medication). Review of an agency document titled Start of Care (D1) , dated 6/24/2021 and electronically signed by RN H, indicated the patient was not taking any high risk drugs and high risk drug education was indicated to be not applicable. During an interview on 8/12/2021 at 9:54 AM, the alternate clinical manager indicated Warfarin Sodium was a high risk drug and indicated the RN should have provided high risk drug education. 17-14-1(a)(1)(D)		discharged from the agencyas of 9/1/21, and as such the agency is unable to retrospectively impact thisepisode however training and processes have been implemented to preventrecurrence.	
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Review of an agency policy, revised March 2018, obtained 8/18/2021 titled Medical Record	G0716	Documentationre-training of clinicians to be conducted to assure documentation includeslocation of wounds, assessment findings related to the wound(s) and treatmentinterventions to each	2021-11-22

	Entries and Authentication stated, & All entries in patient records will be legible, clear, complete and appropriately authenticated, dated and timed. All entries in the medical records will be authenticated by staff signature and title. By authenticating entries in the patient s record, staff is validating the correctness of the information. &. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Nursing Services started, & Professional nursing service will be provided by a registered nurse and include: & Preparing clinical and progress notes &. Review of an undated agency policy, obtained 8/18/2021, titled Integumentary Pressure Ulcer and Wound Assessment stated, & Assess the wound(s) for location & Document in patient s record: & Findings from the assessment &. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced agency documents titled Skilled Visit Note , electronically signed by former employee licensed practical nurse (LPN) B, which on document dated 6/29/2021 stated, & Wounds: L ish & Wound cleansed with NS [normal saline] and dressing applied per		wound as per plan of care. Schedulers will assurenotes are created in the EMR for each visit for prior day. If visit not present in EMR on the dayfollowing the visit, the clinician will be contacted to assure the visit was completedand remind documentation must be in within 24 hours of performing visit. Allentries in the medical records will be authenticatedby staff signature and title. Qualityreview of clinical documentation will be completed for all notes to assuredocumentation according to standards and clinicians prompted to improvedeficient documentation. TheAdministrator is responsible for complete, accurate documentation andcompletion of the quality reviews will ensure more compliant documentation.	

	with NS and dressing applied per order &. Document dated 7/2/2021 stated, & Dressing changed per orders from wound clinic. Slight drainage noted to L [left] dressing that was dark red. & R [right] dressing had no drainage when removed &. Document dated 7/5/2021 stated, & L dressing had med [medium] amount of drainage & Dressing changed per order. R dressing had small amount of red/tan drainage. Dressing changed per order &. Document dated 7/7/2021 stated, & Dressing changed on both wounds. &. R wound dressing with no foul odor. L wound dressing had small amount of tan drainage noted &. Document dated 7/15/2021 stated, & Dressings changed per order &. Document dated 7/19/2021 indicated the nurse cleansed the wound to a site with a location stated as Other with normal saline and packed with alginate, covered with an ABD pad (an absorbent wound dressing) and secured with tape. The skilled nurse failed to prepare clinical notes to indicate where the wound care was provided. During an interview on 8/12/2021 at 1:05 PM, the alternate clinical manager indicated L ish and R ish most likely was referring to the 2 wounds to the left groin and stated, The plan of care isn t ready by the time of the next			

	may not know what the wounds are called. At 1:11 PM, the alternate clinical manager indicated the skilled nurse should document the wound care provided and to what location. During an observation of care on 8/13/2021 at the home of patient #1, start of care 8/10/2021, registered nurse (RN) H was observed to arrive at the patient s home at 7:07 PM. At 7:19 PM, RN H removed the dressing to the patient s left groin and 2 open areas were noted, each appeared the length of a large paperclip and as wide as the width of a pen. Both open areas appeared to have a depth of the length of a pinky fingernail. RN H stated, One is more medial, but there are two here. RN H was observed to cleanse the wounds to the left groin and apply a new dressing. At 7:35 PM, RN H removed a wound dressing to the patient s right buttocks and two open areas were observed to the right ischium (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis). At 7:45 PM, RN H stated, There s a little excoriated [the breakdown of skin due to prolonged exposure to moisture] part here. To me, there s really another wound here. Some may call it one. At 8:02 PM, RN H was observed obtaining the patient s vital signs and listening to the patient s chest and back			

	observed to depart from the patient s home at 8:21 PM. RN H was not observed to have listened to the patient s abdomen, touched the patient s abdomen, touched the patient s extremities and looked at the patient s pupils. The patient was observed to be alert and verbal, and RN H was not observed to assess the patient s pain. The patient did not verbalize a pain rating to RN H. Clinical record review on 8/18/2021 evidenced an agency document titled Skilled Visit Note , dated 8/13/2021 and electronically signed by RN H. This document indicated the RN assessed the patient s pupils to have an equal reaction, have present peripheral pulses, have present bowel sounds and a pain rating of 3 on a scale from 0-10, with 0 being no pain and 10 being the most severe. This document indicated 1 wound measurement to the left groin and 1 wound measurement to the right buttock and failed to evidence the measurement to the second open area on the patient s left groin and the second open area to the patient s right buttock. The document failed to evidence the RN prepared the clinical notes and documented the care provided as observed during the home visit. During an interview on 8/18/2021			

	at 1:21 PM, the alternate clinical manager indicated the RN should have documented the care as it was provided. The alternate clinical manager indicated the RN should have documented the assessment of all open areas. 17-14-1(a)(1)(E)			
G0722	Participate in HHA-sponsored in-service 484.75(b)(9) Participation in HHA-sponsored in-service training. 1. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Nursing Services stated, & Professional nursing service will be provided by a registered nurse [RN] and include: & Participating in inservice programs. & The Licensed Practical Nurse or Licensed Vocational Nurse (LPN/LVN) will supplement the nursing care needs of the patient as provided by the Registered Nurse &. 2. Personnel record review on 8/10/2021 for registered nurse (RN) H, start date 12/16/2019, failed to evidence RN H participated in in-service training. 3. Personnel record review on 8/10/2021 for RN L, start date 6/7/2021, evidenced agency documents titled Tuberculosis [a contagious bacterial infection usually affecting the lungs] and	G0722	Staff training andinservices are offered and staff will be reminded about the importance ofattendance at staff training. Sign insheets are completed by staff attending and training documents are signed bythe attendee and the trainer. Annual Training/NewHire Documents will be signed by the attendee and the trainer and dated whentraining occurred. Orientation will bereviewed with new hires and tests graded assuring the new employee understandonboarding. Staff members who donot participate in training consistently will be counseled as this is animportant part of employment.	2021-11-16

	Infection Control , Bloodborne Pathogens Break the Chain of Infection , Hazardous Materials/Waste , Wound Care and OSHA [Occupational Safety and Health Administration] Hazard Communication Program , signed by RN L. Review failed to evidence the forms were completed to include a date the training was completed, a signature of the instructor who provided the training and an assessment of the employee s competency of the education. 4. Personnel record review on 8/16/2021 for former employee LPN B, date of hire 6/7/2021, evidenced an agency document titled "Annual Training/New Hire Orientation", dated 6/7/2021 and signed by former employee LPN B. Review failed to indicate this document was reviewed by the agency to ensure the skilled nurse answered the questions correctly and completely to determine competency. During an interview on 8/11/2021 at 11:20 AM, former employee LPN B indicated her new-hire training consisted of being handed a manual and then being told to read it and take a test. Former LPN B indicated no one reviewed her training with her. During an interview on 8/16/2021 at 10:20 AM, the alternate clinical manager indicated the training tests should be reviewed and graded to ensure the staff		The Administrator isresponsible for assuring that staff training is documented, test scoresanalyzed and documented in personnel files.	

provided.

5. Personnel record review on 8/16/2021 for former employee LPN E, date of hire 2/17/2020, failed to evidence participation in in-service training.

During an interview on 8/16/2021 at 10:11 AM, the alternate clinical manager indicated there was no in-service training documented for former employee LPN E.

6. Review of an agency binder titled Employee Inservices on 8/10/2021 failed to evidence RN H, RN L and former employee LPN E participated in agency-sponsored in-service training.

7. During an interview on 8/10/2021 at 4:04 PM, the alternate clinical manager indicated the education forms should have been completed when the training was provided and indicated there was no documentation of participation for RN H in agency-sponsored in-service training. The alternate clinical manager indicated annual in-service training should be completed annually and typically the training was offered in January and February every year. The alternate clinical manager indicated there was no documentation of annual inservices for RN H.

17-14-1(a)(1)(G)

G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). 1. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Care Planning Process stated, & The patient care plan for the Home Health Aide [HHA] will be: Home Health Aide assignment sheet: developed by a Registered Nurse [RN] & prior to Home Health Aide rendering care. & The assignment sheet/plan of care will include: Type of service/procedure to be provided. Frequency of visits. Diagnosis/prognosis, if relevant to care. Functional limitation. Patient s mental status. Activities permitted. Nutritional requirements. Specific procedure to be performed including amount, frequency and duration. Safety measures including use of specific equipment.... 2. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Home	G0798	The Agency will educateclinicians to review patient home folders to assure a HHA care plan is in thehome for all patients receiving HHA services. Home Health Aides willbe trained to review the HHA Care Plan in the home folder prior to providingcare to assure the care plan is present and has not changed. If care plan notpresent, or if changes requested by patient, the HHA will contact the office toobtain orders for care. Due to an EMRmalfunction related to HHA care plan visualization by the HHA, the agency willinstruct RNs to create an NCR copy of a written care plan, leaving a copy inthe home at the time of SOC or when HHA services are initiated. The copy of the form will be scanned into theEMR. Resolution of this issue is expectedby the EMR company 1/2022. The agencywill update the care plan and assure a copy is in the home. The RN Case Managerand Administrator are responsible for assuring home health aide care isdelivered following a written care plan	2021-11-16

	Care for certification period 6/18/2021 8/16/2021 which indicated the patient was to receive home health aide services 2 times a week for 9 weeks. Review of untitled agency documents identified by the alternate clinical manager as HHA visit notes, dated 6/28/2021, 7/1/2021, 7/5/2021, 7/8/2021, 7/12/2021, 7/15/2021, 7/22/2021 and 7/28/2021 and completed by former employee A (HHA), indicated the HHA provided personal care to the patient. Review failed to evidence written patient care instructions to be performed by the HHA. During an interview on 8/11/2021 at 10:38 AM, former employee A (HHA) indicated she did not have a HHA care plan prior to providing care to the patient. During an interview on 8/12/2021 at 12:07 PM, office manager E stated, I couldn t find it. It might be in the home, when a request for a copy of the HHA care plan was made. During an observation of care at the patient s home on 8/13/2021 at 7:02 PM, the agency folder was observed and failed to evidence a written HHA care plan. 3. Clinical record review on		All active clinical records active with home health aideservices were reviewed to assure that a home health aide care plan was evidentin the chart. Patient #1 – This patient remainsactive with the agency and home health aideservices are not active in the patient's care currently. Patient #2 – Thispatient is discharged from the agency as of 9/1/21, and as such the agency isunable to retrospectively impact this episode however training and processeshave been implemented to prevent recurrence.	

	care 6/24/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/24/2021 8/ 22/2021 which was electronically signed by RN H on 7/21/2021 and the physician on 7/23/2021. The plan of care evidenced the patient s ordered diet was low carbohydrate and the home health aide was to assist with dressing and apply lotion. Review of an agency document titled Home Health Aide Assignment Sheet , dated 6/24/2021 and signed by RN H, evidenced the patient s diet to be a regular diet and failed to evidence the RN provided the HHA written instructions on the patient s diet. This document failed to evidence the home health aide was assigned to assist the patient with dressing and apply lotion. This document had a section subtitled Nails which evidenced hands and feet were checked but failed to evidence if the HHA was to clean, file or soak the patient s nails. During an interview on 8/12/2021 at 11:31 AM, the alternate clinical manager indicated the RN should assign the HHA directions on the HHA care plan as ordered on the plan of care. At 11:33 AM, the alternate clinical manager indicated the RN should have			

	aide was to do with the patient s nails. 4. During an interview on 8/11/2021 at 10:38 AM, former employee A (HHA) indicated she was not informed in writing of the patient care instructions to be provided by the HHA prior to providing care. 5. During an interview on 8/13/2021 at 8:58 AM, HHA G indicated she did not have a copy of the HHA care plan in the patient homes and there was not written patient care instructions for the HHA in the electronic patient record on her application on her phone.			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). 6. Clinical record review on 8/18/2021, for patient #2, start of care 6/24/2021, diagnosis of type 2 diabetes, evidenced an agency document titled Home Health Aide Assignment Sheet which was signed by RN H, on 6/24/2021. This document had an area subtitled Precautions which stated Bleeding & Falls &	G0798	The Agency will educateclinicians to review patient home folders to assure a HHA care plan is in thehome for all patients receiving HHA services. Home Health Aides willbe trained to review the HHA Care Plan in the home folder prior to providingcare to assure the care plan is present and has not changed. If care plan notpresent, or if changes requested by patient, the HHA will contact the office toobtain orders for care. Due to	2021-11-16

	Infections & Total Hip & DM [diabetes mellitus] & O2 [oxygen] & The RN indicated falls and infections as individualized precautions. This document had a list of individualized tasks to be completed for the patient which stated Bath (includes peri, foot and skin care) & which gave the options of a complete or partial assist bathing, and shower, bed bath, sponge bath, or change of clothes. The RN indicated the patient should have a complete assisted shower. Another section subtitled Nails indicated the patient should have the nails on their hands and feet tended to. Another area subtitled Elimination which indicated the patient was incontinent but failed to evidence if the patient had elimination assistive devices, such as a urinal or disposable undergarments. An area subtitled Impairments indicated the patient Tires easily but failed to indicate other impairments including but not limited to, hearing, hearing aids, vision, or glasses. This document failed to evidence the patient had a prosthetic leg. Review failed to evidence the patient was on DM precautions. Review failed to evidence the RN reviewed the care plan to ensure it was complete and appropriate for the patient. Observation evidenced a urinal on the sink in the bathroom. Observation failed to evidence the patient had toenails.		HHA care plan visualization by the HHA, the agency willinstruct RNs to create an NCR copy of a written care plan, leaving a copy inthe home at the time of SOC or when HHA services are initiated. The copy of the form will be scanned into theEMR. Resolution of this issue is expectedby the EMR company 1/2022. The agencywill update the care plan and assure a copy is in the home. The RN Case Managerand Administrator are responsible for assuring home health aide care isdelivered following a written care plan All active clinical records active with home health aideservices were reviewed to assure that a home health aide care plan was evidentin the chart. Patient #1 – This patient remainsactive with the agency and home health aideservices are not active in the patient's care currently. Patient #2 – Thispatient is discharged from the agency as of 9/1/21, and as such the agency isunable to retrospectively impact this episode however training and processeshave been implemented to prevent recurrence.	

G0940	Organization and administration of services 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Organization and Services Administration stated, & Organization, services furnished, administrative control and the lines of authority for the delegation of responsibility for patient care are clearly defined in writing and are readily identifiable &. Pre-survey information received on 8/3/2021 from the Indiana Department of Health indicated employee B was the administrator and employee C was the alternate administrator. Review of an undated agency document titled Organizational Chart indicated employee B was the administrator and employee C was the alternate administrator. This document indicated the organization included medical social worker and speech therapy services if	G0940	The Agency has createdan organizational structure and chart delineating oversight of administrativeand supervisory functions, assuring that these functions are maintainedinternally to the organization and monitors and controls services not directlyfurnished such as therapy services. Staff will be educated to the organizational chart and reportingstructure. The Governing Body hasappointed in writing the Administrator/Alternate Administrator and ClinicalManager/Alternate to their roles which include but are not limited to: 1. Assurethat the organizational structure is set forth, in writing, including lines ofauthority and services furnished (tag G0940) 2. Theadministrator is responsible for all day-to-dayoperations of the agency (see tag G0948), 3. Theadministrator employed qualified personnel(see tag G0952), 4. Authorizationin writing by the governing body andthe administrator a qualified, pre-designated person to assume thesame responsibilities	2021-11-22

	available. Review failed to evidence physical therapists were included in the organizational structure. During an interview at time of entrance on 8/9/2021 at 8:54 AM, employee D identified as the agency administrator and indicated employee E was the agency s alternate administrator. Employee D indicated RN A was the clinical manager and person M was the alternate clinical manager. Employee D indicated RN A was at her home office in New Buffalo, Michigan and indicated she came to the agency 1 or 2 days a week. Employee D indicated RN B was the administrator before employee D assumed the administrator role and was out due to medical reasons since sometime in June when employee D took over as administrator. Review of an agency document titled Employee Information , dated 8/9/2021, indicated physical therapy assistant (PTA) P was a current employee with a start date of 8/2/2021. During an interview on 8/9/2021 at 9:59 AM, RN A, alternate clinical manager, indicated she was the alternate administrator and the alternate clinical manager. The alternate clinical manager indicated the administrator and clinical		and obligationsas the administrator (see tag G0954), 5. toensure the clinical manager provided oversightof patient and personnel assignments (see tag G0960), 6. toensure the clinical manager provided oversightof coordination of patient care (see tag G0962), 7. toensure the clinical manager provided oversight of the development, implementation, and update of the individualizedplan of care (see tag G0968) 8. Toensure all services were provided in accordance with current clinical practice guidelines and accepted professional standards of practice (see tag G0984). The agency hascontracted with consultants to assist the Administrator in quality functions toinclude: 1. Review of the comprehensive assessments atstart of care, recertifications, resumption of care and discharges to assureaccurate, timely, compliant, and comprehensive Plans of Care, providingrecommendations to clinicians for additions, enhancements or changes	

	manager were RN B and indicated RN B was out on medical leave. The alternate clinical manager indicated person M was considered for the alternate clinical manager role but took a role at another agency within the corporation. At 10:02 AM, the alternate clinical manager indicated employee D was the administrator in training and employee E was the office manager. At 10:25 AM, the alternate clinical manager indicated the agency did not provide medical social work and speech therapy services. At 2:23 PM, the alternate clinical manager indicated speech therapy and social work services might have been offered at one time and indicated the organizational chart had not been updated to have those services removed since not currently offered by the agency. The alternate clinical manager indicated the agency utilized physical therapy assistants and should be included on the organizational chart reporting to the physical therapist. At 2:50 PM, the alternate clinical manager indicated she was unsure why employee C was listed with the Indiana Department of Health and listed on the organizational chart as the alternate administrator. The alternate clinical manager stated, [Employee C] swings by here periodically; he s corporate. He doesn t do the day-to-day like		care, 2. Quality review of clinician documentation toassure that clinicians are documenting only to interventions ordered by thephysician and that orders exist for all services provided, 3. Evaluate if clinicians notify physicians ofchange in clinical status appropriately, 4. Participate in development and implementationof QAPI program, and 5. Participate in education and training ofagency staff related to regulations and best practice clinical standards. The consultants collaboratewith the Administrator and provide services based on the request of theAdministrator. The Administrator isresponsible for assuring clinical coordination of care with external careproviders. Ongoing review of thecomprehensive assessments and quality review of the clinical notes will assurecompliance with documentation requirements.	

	me. 17-12-1(a)(1, 2)			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled After Hours Accessibility stated, & A RN [registered nurse] is available 24 hours per day, 7 days per week. Contact can be made by telephone or pager through the on-call system &. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Administrator: Defined stated, & The Governing Body has appointed the Administrator to run the Agency s day-to-day operations &. The administrator failed to ensure the day-to-day operations of the home health agency as evidenced by: The administrator failed to ensure the Emergency Preparedness Plan was maintained for the home health agency. Please see tags associated with federal regulation 42CFR 484.102. The administrator failed to	G0948	TheGoverning Body appoints the Administrator of the agency and is responsible for assuringthat the Administrator fulfills the responsibilities of the role includingendure quality and safe delivery ofhome health care services;coordinates services that reflect the Agency'philosophy and standards of care: plans, develops,implements and evaluates Agency services, programsand activities and responsible for all day-to-day operations of the Agency. TheAdministrator has implemented processes to be in compliance with day-to-dayoperational responsibilities including but not limited to: 1. Assuring24 hour on call availability 7 days per week – directions to answering servicehad been incorrect to hold “non-urgent” calls till AM. This has been changed to all calls beingdirected to on call RN when call comes into service. 2. TheAdministrator has	2021-11-22

	reported Oasis assessment data. Please see tag G0374. The administrator failed to ensure the patient was provided written notice of the patient s rights and responsibilities in advance of furnishing care to the patient. Please see tag G0412. The administrator failed to obtain the patient s or legal representative s signature confirming that he or she has received a copy of the notice of rights and responsibilities. Please see tag G0418. The administrator failed to ensure the patient participated in, was informed about and consented to in advance of treatment with response to the completion of all assessments, the care to be furnished, establishing and revising the plan of care, the disciplines that would furnish the care, the frequency of visits, expected outcomes of care and any changes in care to be furnished. Please see tag G0434. The administrator failed to ensure agency patients received all services ordered in the plan of care. Please see tag G0436. The administrator failed to ensure the physician responsible for the plan of care and the agency agreed the patient met goals and failed to ensure the discharge from the agency was		implemented the Emergency Preparedness Plan as per plan ofcorrection for tags E006, E009, E0017, E0030, E0031, E0037, and E0039. 3. Ensuresaccuracy of OASIS assessment data as referenced in tag GO374. 4. Ensuringpatients receive Patient rights and responsibilities notification, have signedconsents as evidenced in tag G0412 and patient or legal representative confirmin writing that they have received a copy of the notice of rights/responsibilities as per tag G0418. 5. Ensurethe patient participated in, wasinformed about and consented to in advance of treatment withresponse to the completion of allassessments, the care to be furnished,establishing and revising the plan of care,the disciplines that would furnish the care,the frequency of visits, expected outcomes of care and any changes in care to be furnishedas per tag G0434. 6. Ensures agencypatients received all services ordered in theplan of care as per tag G0436. 7. Ensuresthe physician responsible for theplan of care and the agency agreed the patient met goals and ensures	

	appropriate. Please see tag G0458. The administrator failed to ensure the comprehensive assessments were individualized and reflected the patient's status. Please see tag G0528. The administrator failed to ensure the comprehensive assessment medication reconciliation was reviewed by a registered nurse. Please see tag G0536. The administrator failed to update the comprehensive assessment as frequently as the patient s condition warrants due to a major decline in the patient s health status. Please see tag G0544. The administrator failed to ensure the home health agency was meeting all the needs of agency patients. Please see tag G0570. The administrator failed to ensure the plan of care for agency patients was followed, individualized and established by a primary care physician. Please see tag G0572. The administrator failed to ensure the plan of care contained all required elements. Please see tag G0574. The administrator failed to ensure conformance with		appropriate as per tag G0458. 8. 8. Ensures the comprehensive assessments are 9. individualized and reflects the patient's status as 10. per tag G0528. 9. Ensures thecomprehensive assessment medication reconciliation isreviewed by a registered nurse as per tag G0536. 10. Updatesthe comprehensive assessment as frequently as the patient’scondition warrants due to a major decline in the patient’s healthstatus as per tagG0544. 11. Ensures the home health agency is meeting all theneeds of agency patients as per tagG0570. 12. Ensuresthe plan of care for agency patientswas followed, individualized and established by a primarycare physician as per tag G0572. 13. Ensuresthe plan of care contained all required elements as per tag G0574. 14. Ensures conformance	

	physician s orders. Please see tag G0578. The administrator failed to ensure all drugs, treatments, and services were only provided as ordered by a physician or other appropriate healthcare professional. Please see tag G0580. The administrator failed to ensure the clinician receiving verbal orders documented the order, signed, dated and timed the order and failed to ensure the physician signed and dated the verbal order. Please see tag G0584. The administrator failed to ensure the plan of care was reviewed and revised by the primary care physician every 60 days. Please see tag G0588. The administrator failed to ensure the primary care physician was promptly alerted to changes in the patients condition. Please see tag G0590. The administrator failed to revise the plan of care to reflect current health status, medications and nursing needs. Please see tag G0592. The administrator failed to ensure the primary care physician was notified of a patient's discharge from home health agency services. Please		with physician’s orders as per tag G0578 15. Ensuresall drugs, treatments, and serviceswere only provided as ordered by aphysician or other appropriate healthcare professional as per tag G0580. 16. Ensuresthe clinician receiving verbal ordersdocument the order, signed, dated andtimed the order and ensures the physician signed and dated the verbalorder as per tag G0584. 17. Ensures the planof care was reviewed and revisedby the primary care physician every 60 days as per tag G0588. 18. Ensuresthe primary care physician was promptly alertedto changes in thepatient’s condition as per tag G0590. 19. Assuresthe plan of care is revised to reflect currenthealth status, medications and nursing needs as per tag G0592. 20. Ensure the primary carephysician was notified of a patient's discharge from home health agencyservices as per tag G0598.	

	see tag G0598. The administrator failed to ensure communication with all physicians involved in the patients plan of care. Please see tag G0602. The administrator failed to ensure there was coordination of care amongst all agency disciplines and with outside healthcare entities who serviced agency patients. Please see tag G0606. The administrator failed to ensure there was a written visit schedule in all patients homes. Please see tag G0614. The administrator failed to ensure there was a written, current medication schedule in all patients homes. Please see tag G0616. The administrator failed to provide the patient with written instructions for the name and contact information for the clinical manager. Please see tag G0622. The administrator failed to ensure there was a Quality Assessment and Performance Improvement (QAPI) maintained at the home health agency. Please see tag G0640. The administrator failed to ensure the governing body maintained an ongoing QAPI		21. Ensures communicationoccurs with all physicians involved in the patients plan of care as per tagG0602. 22. Ensures coordination ofcare amongst all agency disciplines and with outside healthcare entities whoserviced agency patients as per tag G0606. 23. Ensuresa written visit schedule is in all patients' homes as per tag G0614. 24. Ensures a written,current medication schedule is in all patients homes as per tag G0616 25. Assures patients areprovided with written instructions for the name and contact information for theclinical manager as per tag G0622. 26. Ensures a QualityAssessment and Performance Improvement (QAPI) is maintained at the home healthagency as per tag G0640. 27. Ensures the governingbody maintains an ongoing QAPI program as per tag G0660. 28. Ensures all home healthagency staff followed standard precautions to ensure the prevention andtransmission of infectious and communicable diseases as per tag G0682. 29. Ensure the homehealth	

	program. Please see tag G0660. The administrator failed to ensure all home health agency staff followed standard precautions to ensure the prevention and transmission of infectious and communicable diseases. Please see tag G0682. The administrator failed to ensure the home health agency had documented education on infection control provided to agency staff. Please see tag G0686. The administrator failed to ensure the skilled professionals provided an ongoing assessment of the patient. Please see tag G0706. The administrator failed to ensure skilled professionals provided services as indicated on the plan of care. Please see tag G0710. The administrator failed to ensure skilled professionals provided patient and caregiver education. Please see tag G0714. The administrator failed to ensure skilled professionals created clinical notes and/or accurate complete notes for all services provided to patients. Please see tag G0716. The administrator failed to		agency had documented education on infection control provided to agencystaff as per tag G0686. 30. Ensures the skilledprofessionals provide an ongoing assessment of the patient as per tag G0706. 31. Ensures skilledprofessionals provided services as indicated on the plan of care as per tagG0710. 32. Ensures skilledprofessionals provide patient and caregiver education as per tag G0714. 33. Ensures skilledprofessionals created clinical notes and/or accurate complete notes for allservices provided to patients as per tag G0716. 34. Ensures all home healthaide care plans are completed by a skilled professional and include taskfrequencies as per tag G0798. 35. Ensures apre-designated person is authorized in writing by the administrator andgoverning body to assume the same responsibilities in the administrator’s absence as per tag G0954. 36. Ensures the	

	ensure all home health aide care plans were completed by a skilled professional and included task frequencies. Please see tag G0798. The administrator failed to ensure a pre-designated person was authorized in writing by the administrator and governing body to assume the same responsibilities in the administrator s absence. Please see tag G0954. The administrator failed to ensure the clinical manager provided oversight of patient and personnel assignments. Please see tag G0960. The administrator failed to ensure the clinical manager provided oversight of coordination of patient care. Please see tag G0962. The administrator failed to ensure the clinical manager provided oversight of the development, implementation and update of the individualized plan of care. Please see tag G0968. The administrator failed to ensure all services were provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Please see tag G0984. The administrator failed to		oversight of patient and personnel assignments as per tagG0960 37. Ensures the clinicalmanager provides oversight of coordination of patient care as per tag G0962. 38. Ensures the clinicalmanager provides oversight of the development, implementation and update of theindividualized plan of care as per tag G0968. 39. Ensures all services areprovided in accordance with current clinical practice guidelines and acceptedprofessional standards of practice as per tag G0984. 40. Ensures all clinicalrecords contain a discharge summary that is sent to the primary care physicianas per tag G1022. 41. Ensures all clinicalnotes are clear, complete and appropriately authenticated as per tag G1024. 42. Ensures all clinicalpatient information is safeguarded against unauthorized use as per tag G1028. The agency hascontracted with consultants to assist the Administrator in quality functions toinclude:	

	ensure all clinical records contained a discharge summary that was sent to the primary care physician. Please see tag G1022. The administrator failed to ensure all clinical notes were clear, complete and appropriately authenticated. Please see tag G1024. The administrator failed to ensure all clinical patient information was safeguarded against unauthorized use. Please see tag G1028. A call was placed to the agency, phone number 574-772-3157, on 8/12/2021 at 10:39 PM to which the answering service answered. Caller s contact information and request for a return phone call from the nurse was made to the answering service. No return phone call was received from the agency before 8/13/2021 at 8:13 AM. The administrator failed to ensure a skilled nurse was available 24 hours a day per the agency's policy. During an interview on 8/13/2021 at 9:17 AM, the alternate clinical manager indicated she was unaware of the call made to the agency on 8/12/2021 at 10:39 PM. During an interview on 8/13/2021 at 9:17 AM, the administrator in training D indicated she was		1. Review of the comprehensive assessments atstart of care, recertifications, resumption of care and discharges to assureaccurate, timely, compliant, and comprehensive Plans of Care, providingrecommendations to clinicians for additions, enhancements or changes todocumentation and plan of care, 2. Quality review of clinician documentation toassure that clinicians are documenting only to interventions ordered by thephysician and that orders exist for all services provided, 3. Evaluate if clinicians notify physicians ofchange in clinical status appropriately, 4. Participate in development and implementationof QAPI program, and 5. Participate in education and training ofagency staff related to regulations and best practice clinical standards. The consultantscollaborate with the Administrator and provide services based on the request ofthe Administrator.	

	did not receive a phone call from the answering service and had been notified of the request for a nurse s return phone call when she arrived in the office that morning and received a fax with the message from the answering service of the phone call after hours. 17-12-1(c)(1)		The Administrator isresponsible for assuring clinical coordination of care with external careproviders. The Governing Body willassure the Administrator is aware of the responsibilities of the role andincludes review of the above elements not in compliance at the time of thesurvey as part of the agency's QAPI program untildocumented evidence indicates the Administrator and agency are in compliancewith these regulations. Documentation willexist in the QAPI meeting minutes to assure these elements remain in compliance.	
G0952	Ensure that HHA employs qualified personnel 484.105(b)(1)(iv) (iv) Ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies. 1. Review evidenced an agency policy titled, Personnel Records revised October 2017, stated Policy personnel files will be established and maintained for all staff. All information will be considered confidential and will be made available to authorized	G0952	All personnel files ofclinical and office staff have had 100% review to assure that all the followingelements are included in each file: 1. Signed job descriptionfor all employees 2. Qualifications asidentified in job descriptions	2021-11-18

	Purpose To maintain personnel files on current and former employees... Procedures 1. the personnel record or personal information for an employee will include, but not be limited to, the following: ... Observed competencies: initial during orientation and ongoing (minimally every 3 years) for all patient care staff ... Home Health Aide competency evaluation: initially and annually & Performed appraisal/evaluation forms & Verification of education, certification and/or licensure & Agency employee orientation & Inservice education record & Criminal history check, if required by law & Job description: reviewed and signed by employee & 2. The health record for applicable employees will include: PPD tests or chest x-ray results based on Agency s TB risk assessment & Any other Agency required health requirements & 3. Employee health information must be maintained in files separate from personnel files and in a separate location & 8. Personnel records will be retained for minimally five years after employee leaves the Agency, or according to applicable state law &. 2. Review evidenced an agency policy titled, Job Description revised October 2017, stated Policy Each employee will be furnished with a job description upon employment & Purpose To		3. Criminal History checkcompleted for pertinent individuals 4. Current license,certification or registration as appropriate; licensure verification for alllicensed clinicians 5. Documentation ofonboarding or orientation to job role, responsibilities that is signed by theemployee and the training individual 6. Evaluation conductedminimally annually and is signed by employee and supervisor The organizationalchart for the agency has been validated to confirm the correct structure andidentifies the Administrator/Alternate and DON/Alternate as that reported to theDOH. The Governing Body hasdocumented designation of the Administrator/Alternate Administrator andDirector of Nursing/Alternate. Staffhave been appraised of the organizational chart structure. Personnel medicalinformation to include physical examinations, tuberculosis evaluations	

	outline the responsibilities, requirements and scope of each position & 3. The job description is reviewed by the employee at time of hire/orientation and any time the job description changes &. 3. Review evidenced an agency policy titled, Performance Appraisals/ Evaluations revised October 2017, stated Policy All employees will have a performance appraisal/ evaluation based upon their job description at least every three (3) years, except home health aides who must have performance appraisal/ evaluation every twelve (12) months ... Purpose To review job performance based upon an employee s job description; to clarify duties and responsibilities; to determine the appropriateness of the description and the need for further training ... Procedure & 2. The evaluation must be signed by the employee and supervisor ... Additional [accrediting body] Requirements & 1. Personnel evaluations are completed, shared, reviewed and signed by the designated manager/ supervisor and personnel no less frequently than every twelve (12) months ... 2. Qualified personnel observe and evaluate each direct care staff member performing their job duties at least annually as part of the performance evaluation &.		maintained in separate medical files and treated asconfidential medical records. Themedical records will be maintained in a confidential secure area separate fromthe remainder of the personnel file. The Administrator isresponsible for ensuring ongoing compliance with personnel files. An audit of personnel files will be conductedquarterly for employees with expiring licenses, performance appraisals due andnew employee criminal history checks.	

	4. Review evidenced an agency policy titled, License, Registration or Certification Requirements revised October 2017, stated Policy The employee will be responsible for maintaining a current license for any position requiring such... Purpose To provide a mechanism whereby the Agency assures that all personnel license(s) or certification(s) are kept current and are documented in Agency records & Procedure ... 2. When current licensure, certification and/ or registration are required by law and/ or regulation to practice a profession, the Agency verifies such credentials with the primary source at time of hire and prior to or upon expiration of credentials. Primary source verification will occur through the applicable State Board of practice for: registered nurses, licensed practical nurses, physical therapist... Occupational therapist... If required by state law ... 4. Primary source verification of current licensure, registration and/ or certification may be performed via secure electronic access or by telephone. All such verification will be documented &. 5. Review evidenced an agency policy revised October 2017, titled Employee Orientation which stated Policy Each employee of the Agency will			

	Procedure 1. Orientation for all employees will be coordinated, performed and documented by supervisory staff, peers and/or preceptors & 2. The Orientation Checklist will be used to document orientation for all staff, including contract staff &. 6. Personnel record review on 8/10/2021, for administrator/clinical manager B, date of hire 4/29/1996, evidenced an Registered Nurse (RN) license with an expiration date of 10/31/2021. Review failed to evidence the RN license verified as indicated by the agency policy and required by State law. During an interview on 8/10/2021, at 3:54 PM, alternate clinical manager A stated No when queried if the administrator/clinical manager B s RN license had been verified. The alternate clinical manager indicated there was not documentation in the personnel file, but verification of licensure was performed annually. 7. Personnel review on 8/10/2021, for alternate clinical manager A, date of hire 5/1/2017, failed to evidence documentation of an orientation to the job of clinical manager at time of review. During an interview on 8/10/2021, at 3:26 PM, alternate			

job title was alternate administrator and alternate clinical manager. When queried if there was documented evidence of an orientation to the job, alternate clinical manager A stated No.

8. Personnel record review on 8/10/2021, for alternate administrator C, date of hire unknown, but was identified by the alternate clinical manager as an employee since the change of ownership in January 2020, evidenced a document titled Job Description Administrator which was unsigned. Review failed to evidence an annual evaluation had been performed within the last 12 months, at time of review.

Review evidenced an untitled agency document which stated & Community Home Care Services & Knox, IN & Effective 01-01-2020 The Governing Body has appointed the following: & Administrator is [alternate administrator C] & Alternate administrator is [alternate clinical manager A] &.

Review evidenced an agency document titled Organizational Chart which stated &Assistant Administrator-Nursing- [alternate administrator C] &.

During an interview on 8/10/2021, at 3:41 PM, alternate clinical manager A indicated alternate administrator C was a

	probably listed himself as the alternate administrator of Community Home Care Services until more official plans came through. 9. Personnel record review on 8/10/2021, for office manager E, start date 3/16/2020, evidenced a document from entity G, titled Employee Orientation Checklist which was dated 3/11/2020, incomplete and unsigned at time of review. Review failed to evidence a signed and completed orientation, a signed job description, and an annual evaluation in the employee s file. During an interview on 8/10/2021, at 3:49 PM, alternate clinical manager A stated, Here is an orientation that isn t filled out. The alternate clinical manager indicated they could not locate a signed job description or an annual evaluation in the office manager E s personnel file at time of review. 10. Personnel record review on 8/10/2021, for the administrator in training D, start date 6/1/2020, failed to evidence a signed job description for the administrator role they were hired for.			

During an interview on 8/10/2021, at 3:33 PM, alternate clinical manager A, indicated a signed job description could not be located in the administrator in training D s personnel file at time of review.

11. Personnel record review on 8/11/2021, for home health aide (HHA) G, first patient contact date 7/30/2021, evidenced an agency document titled Functionalized Job Description for the position of Certified Home Health Aide, which was unsigned by the employee. Review failed to evidence a job description for the employee s role as data specialist.

During an interview on 8/11/2021, at 3:56 PM, the alternate clinical manager indicated the job description for HHA G was not signed.

12. Personnel record review on 8/11/2021, for registered nurse (RN) H, start date of 12/16/2019, evidenced an agency document titled Orientation Checklist which was signed by the RN on 4/26/2019. This document had an area for a supervisor s signature which remained blank at time of review. Review failed to evidence an orientation to the job had been completed. Review failed to evidence documentation of a performance evaluation had been performed withing the last 12 months, at time of review.

During an interview on 8/11/2021, at 3:59 PM, the alternate clinical manager A stated, Unfortunately, I am not seeing it when queried if RN H s annual evaluation was in the employee s personnel file.

13. Personnel record review on 8/11/2021, for Occupational Therapist (OT) M, date of hire 6/16/2021, evidenced an agency document titled Orientation Checklist which was undated and signed by the OT. This document had an area for a supervisor s signature which remained blank at time of review. Review failed to evidence an orientation to the job had been completed.

14. Personnel record review on 8/16/2021, for former employee E, licensed practical nurse (LPN), date of hire 2/17/2020, evidenced an untitled document that was verification of licensure which occurred on 5/6/2021. Review failed to evidence license verification was performed prior to first patient contact on 2/18/2020. Review failed to evidence documentation of orientation to the job.

15. Personnel record review on 8/11/2021, for HHA (home health aide) J, first patient contact date 6/14/2021, failed to evidence a signed job description in the employee file, or that a criminal

	performed within 3 days after first patient contact. 16. Personnel record review on 8/11/2021, for licensed practical nurse (LPN) I, first patient contact date 8/4/2021, failed to evidence a criminal history background check was performed within 3 days after first patient contact. 17. During an interview on 8/11/2021, at 3:48 PM, alternate clinical manager A indicated some of the completed background checks were sent to a different home care office by mistake, instead of Community Home Care Services in Knox, IN. 17-12-1(d)(3)			
G0954	Ensures qualified pre-designated person 484.105(b)(2) When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Administrator: Defined stated, & When the Administrator is not available, a qualified, pre-designated person, who is authorized in writing by the	G0954	The organizationalchart for the agency has been validated to confirm the correct structure andidentifies the Administrator and Alternate Administrator and as that reportedto the DOH. The Administrator and AlternateAdministrator have signed job descriptions assuming same responsibilities asthe Administrator in the absence of the Administrator.	2021-11-18

	Body, assumes the same responsibilities and obligations as the Administrator &. Pre-survey information received on 8/3/2021 from the Indiana Department of Health indicated employee B was the administrator and employee C was the alternate administrator. Review on 8/9/2021 of an undated agency document titled Organizational Chart indicated employee B was the administrator and employee C was the alternate administrator. Review on 8/16/2021 of an undated, untitled agency document indicated effective 1/1/2020 the governing body appointed employee C as the administrator and employee A as the alternate administrator. Review failed to evidence the governing body appointed employee B as the administrator and employee C as the alternate administrator as listed with the Indiana Department of Health and on the agency s organizational chart. During an interview on 8/9/2021 at 9:59 AM, the alternate clinical manager, employee A, indicated she was the alternate administrator and the alternate clinical manager. The alternate clinical manager indicated the administrator and clinical manager were employee B and		The Governing Bodyhas documented designation of the Administrator/Alternate Administrator andDirector of Nursing/Alternate. Staffhave been appraised of the organizational chart structure The Administrator isresponsible for maintaining accurate organizational chart and timelynotification of the DOH and CMS for changes in organizational structure. Quarterly QAPImeetings will document any changes to the organizational structure and assuretimely notification of changes has occurred	

	medical leave. At 2:50 PM, the alternate clinical manager indicated she was unsure why employee C was listed with the Indiana Department of Health and listed on the organizational chart as the alternate administrator. The alternate clinical manager stated, [Employee C] swings by here periodically; he s corporate. He doesn t do the day-to-day like me. During an interview on 8/16/2021 at 10:41 AM, the alternate clinical manager, employee A, indicated there was no other written appointment by the governing body and administrator for the alternate administrator. 17-12-1(d)(8)			
G0960	Make patient and personnel assignments, 484.105(c)(1) Making patient and personnel assignments, Review of an agency job description titled Job Description Director of Clinical Services/Clinical Manager , revised October 2017 and obtained 8/18/2021, stated, & Responsibilities & Makes patient and personnel assignments &. Review of an agency document on 8/9/2021 titled Master Employee Schedule for the week of 8/9/2021 indicated registered nurse (RN) L was to	G0960	Agencyhas implemented process related to scheduling – Thescheduler will be responsible for creating the calendar for each patient andeach clinician will access the calendar to assure visits are accurate based onthe Medicare calendar week. Schedulerto review notes in EMR daily and contact each clinician if notes are notsynched to EMR to assure visits for prior day were completed as scheduled.	2021-11-18

	provide a skilled nursing visit to patient #1, start of care 6/18/2021, on 8/11/2021 at 7:00 PM. During an interview on 8/9/2021 3:38 PM when queried about a home visit with RN L at the home of patient #1 on 8/11/2021, administrator in training D indicated RN L was planning to conduct a visit with the patient on 8/10/2021 between 7:30 PM and 8:00 PM. During an interview on 8/10/2021 at 8:59 AM when queried on the status of the home visit with patient #1 for 8/10/2021 with RN L, administrator in training D indicated RN L provided a home visit the night before on 8/9/2021 and indicated RN L had another job and possibly had to change her scheduled visit due to her other job. At 9:50AM, administrator in training D indicated the staff knew which patients they needed to see and had flexibility to change their visits. Administrator in training D indicated staff did not report to the agency when exactly the visits would be scheduled when changes were made but indicated the agency knew the general availability of the staff. During an interview on 8/10/2021 at 11:59 AM, the alternate clinical manager indicated staff scheduled their own visits for the most part and indicated		Visitsmissed will be rescheduled within the Medicare week or Physicians will benotified of any missed visits or variance to the ordered visits. Physicians will be queried as to need to alterPlan of care if there is a clinical impact to the patient. The Administrator is responsible that patient schedules and employeeassignments are managed to assure frequencies are met as ordered The agency has implemented a scheduling processutilizing the new EMR as described in the Plan of Correction. Two processes will ensure that schedules aremaintained as follows: A.) the schedulercontacts clinicians daily to assure visits were completed as scheduled theprior day. If rescheduling is requiredwithin the Medicare week, the scheduler will reschedule and the patient be notifiedof the new visit schedule. If it is notpossible to assure the visit frequency is met as ordered, the physician isnotified of a missed visit. B.) Daily clinical record review and end ofepisode clinical record review assures that patient frequencies are deliveredas ordered. Chart audits are	

	administrator in training D knew more of about the staff s schedules. Alternate clinical manager indicated staff should call and inform the office of schedule changes. 17-14-1(a)(1)(K)		beingconducted to assure ongoing compliance with this regulation.	
G0962	Coordinate patient care 484.105(c)(2) Coordinating patient care, Review of an agency job description titled Job Description Director of Clinical Services/Clinical Manager , revised October 2017 and obtained 8/18/2021, stated, & Responsibilities & coordinates patient care &. Review of an agency policy, revised March 2019 and obtained 8/18/2021, titled Coordination of Patient Care stated, & The Director of Clinical Services provides oversight of all patient care services. & Case conferences are held on an ongoing basis & Documentation of case conferences will be maintained in the patient s medical record &. During an interview on 8/9/2021 at 10:25 AM, the alternate clinical manager indicated there was a weekly case conference call	G0962	The agency clinicalmanager has implemented case conferences to assure interdisciplinary carecoordination and appropriate discharge protocols are followed for pendingdischarge patients. If patient goals arenot met and discharge is pending, physician will be notified and alternatecoordination of care plan developed for post home care. The Administrator isresponsible for the care coordination of patients and assuring discharges areappropriate. Clinical recordreviews will identify any questionable practices and be brought to theattention of the Administrator and Clinical Manager.	2021-11-18

	manager and most of the staff are on to discuss any patient changes. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Occupational Therapy Evaluation , dated 7/28/2021 and electronically signed by occupational therapist (OT) M. The document indicated the patient was to receive 2 OT visits a week for 3 weeks. Review of an agency document titled Discharge/Transfer Summary , dated 8/9/2021 and electronically signed by OT M, indicated the patient was discharged from OT services. Review of the document failed to evidence the OT coordinated the patient s discharge from OT services. During an interview on 8/18/2021 at 12:12 PM, the alternate clinical manager indicated she was unaware OT M discharged the patient from OT services and indicated there were no case conference notes regarding the patient discharge from OT services.			
G0968	Assure implementation of plan of care 484.105(c)(5) Assuring the development, implementation, and	G0968	The agency hascontracted with consultants to assist the Administrator in quality functions	2021-11-18

	updates of the individualized plan of care. Review of an agency job description titled Job Description Director of Clinical Services/Clinical Manager , revised October 2017 and obtained 8/18/2021, stated, & Responsibilities & Assures that patients plans of care are developed, implemented and updated &.		toinclude: 1. Review of the comprehensive assessments atstart of care, recertifications, resumption of care and discharges to assureaccurate, timely, compliant, and comprehensive Plans of Care, providingrecommendations to clinicians for additions, enhancements or changes todocumentation and plan of care. 2. Quality review of clinician documentation toassure that orders exist for all services provided including but not limited tonew/additional wounds identified in clinician documentation and inclusion inplan of care. The Administrator isresponsible for assuring documentation includes orders for all care andcomprehensive assessment of all clinical findings. Ongoing quality reviewof clinical notes will enhance accuracy of the comprehensive assessment andplan of care. Theagency has contracted with consultants to assist the Administrator in qualityfunctions to include the review of the	

	Clinical record review on 8/10/2021 and 8/18/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021 and electronically signed by registered nurse (RN) K. This document indicated the patient s diagnoses included, but were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of the left buttock, quadriplegia (paralysis of all 4 limbs) and chronic embolism (an obstruction of an artery, typically by a blood clot or air bubble) and thrombosis (formation of a blood clot within a blood vessel) of left iliac vein (a vein located in the abdomen). This document indicated the patient had 3 Stage II pressure ulcers consisting of 2 to the left groin and 1 pressure ulcer to the buttocks. Review of a document provided by the alternate clinical manager on 8/13/2021 titled Final Report from wound clinic D, dated 6/23/2021 and electronically signed by physician H, indicated the patient had 2 wounds to the left groin and a wound to the right ischium. Review evidenced an agency		comprehensive assessments at start of care,recertifications, resumption of care and discharges to assure accurate, timely, compliant, and comprehensive Plans of Care,providing recommendations to clinicians for additions, enhancements or changes to documentation and plan of care. In addition, quality review of 100% of cliniciandocumentation has been implemented toassure that orders exist for all services provided including but not limited tonew/additional wounds and changes in patient status have been identifiedin clinician documentation and inclusion in plan of care. Chart auditsare being conducted to assure ongoing compliance with this regulation.	

	document titled Home Health Certification and Plan of Care for certification period 6/18/2021 8/16/2021 which was signed by the alternate clinical manager on 7/15/2021 and by the physician on 8/2/2021. The plan of care stated, & Wound care will be performed by &. and failed to be developed to include the location of the patient s wounds and wound care interventions. Review evidenced agency documents titled Skilled Visit Note , electronically signed by former employee LPN B and dated 7/23/2021, evidenced the skilled nurse assessed a pressure area to the coccyx (the area on the lower back above the buttocks) measuring 0.5 cm in length, 0.5 cm in width and 0.1 cm in depth with a wound treatment of cleanse with normal saline and apply Optifoam (an absorbent foam dressing with an adhesive border). Review failed to evidence the plan of care was updated to include the wound and wound treatment interventions to the coccyx. During an observation of care on 8/13/2021 at 7:19 PM, the patient was observed to have 2 open areas on the left groin. Each open area appeared the length of a large paperclip and as wide as the width of a pen. Both open areas appeared to have a depth of the length of a pinky fingernail.			

	medial, but there are two here. The patient was observed to have 2 open areas to the right ischium (the area of the skin on the lower buttock region that covers the rounded bone of the pelvis). The lateral open area on the right ischium appeared to be the length of a large paperclip, the width of the diameter of a pen and the depth of a tip of a pen. The medial open area of the right ischium appeared to be in the peri wound (the area surrounding the wound) of the lateral open area on the right ischium and have the size of a dime with just the top layer of skin removed and a red wound base. At 7:45 PM, RN H stated, There s a little excoriated [the breakdown of skin due to prolonged exposure to moisture] part here. To me, there s really another wound here. Some may call it one. Review failed to evidence the plan of care was updated to include the second wound to the right ischium and the wound care interventions as provided by the RN. During an interview on 8/18/2021 at 12:43 PM, the alternate clinical manager indicated the plan of care should have been updated to include the second wound and wound treatment interventions to the right ischium. 17-14-1(a)(1)			

G0984	In accordance with current clinical practice 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Review of an undated agency policy, obtained 8/18/2021, titled Integumentary Pressure Ulcer and Wound Assessment stated, & Equipment: Disposable measuring guide & Initial Assessment: & Size: & Length and width are measured as linear distances from wound edge to wound edge. Wound length and width can also be documented by making a tracing of the wound on transparent paper with a permanent marker, tracing on an acetate guide, or photographic documentation. & To measure wound depth, gently insert a sterile, flexible, cotton-tipped applicator into the deepest part of the wound. Then measure the length of the sterile cotton-tipped applicator that was in the wound. & Reassessment: Reassess the wound weekly, according to initial assessment guidelines &. Review on 8/18/2021 of a reference document titled "Recommendations for Wound Assessment & Photo Documentation in Isolation website https://cdn.ymaws.com/member.wocn.org/resource/resmgr/covid19/Recommendations_for_Isolatio	G0984	The agency hascontracted with consultants to assist the Administrator in quality functions toinclude: 1. Review of the comprehensive assessments atstart of care, recertifications, resumption of care and discharges to assureaccurate, timely, compliant, and comprehensive Plans of Care, providingrecommendations to clinicians for additions, enhancements or changes todocumentation and plan of care. Bestpractice and standards of care are included in the review. 2. Quality review of clinician documentation toassure that standards of practice such as wound measurement has been documentedby clinicians in wound care cases. Clinician retrainingregarding utilization of standards of practice such as wound measurements will becompleted. The Administrator isresponsible for assuring documentation includes care includes incorporation ofstandards of practice.	2021-11-18

	measurements: & measure length and width using a disposable measuring tape or stick & Use measuring stick or sterile cotton tipped applicator to probe depth, measure at greatest depth perpendicular to the wound edge &. Review on 8/18/2021 of a reference document titled Wound and Pressure Ulcer Management website https://www.hopkinsmedicine.org/gec/series/wound_care.html stated, & Wound Assessment & An assessment of the wound should be done weekly and be used to drive treatment decisions. Wound assessment includes: location, class/stage, size, base tissues, exudates, odor, edge/perimeter, pain and an evaluation for infection &. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021, evidenced an agency document titled Start of Care (D1) , which was dated 6/18/2021 and electronically signed by registered nurse (RN) K. This document indicated the patient s diagnoses included, but were not limited to, Stage II pressure ulcer (a type of wound which typically develops when soft tissue is compressed between a bony prominence and an exterior surface for an extended period of time resulting in partial thickness skin loss) of		Ongoing quality reviewof clinical notes will enhance accuracy of the documentation to include use ofbest practices in patient care.	

	(paralysis of all 4 limbs). This document indicated the patient had 3 Stage II pressure ulcers consisting of 2 to the left groin and 1 pressure ulcer to the buttocks. One pressure ulcer to the left groin was assessed to be 1 centimeter (cm) in length, 1 cm in width and 0.2 cm in depth. One pressure ulcer to the left groin was assessed to be 1 cm in length, 0.3 cm in width and 0.2 cm in depth. The wound to the buttocks was assessed to be 1 cm in length, 0.5 cm in width, 0.2 cm in depth. Review failed to evidence the wound size of the two pressure ulcers to the left groin and the pressure ulcer to the buttocks were assessed after the start of care assessment on 6/18/2021 until 7/21/2021. During an observation of care on 8/13/2021 at 7:19 PM at the home of patient #1, start of care 8/10/2021, registered nurse (RN) H was observed to have removed the dressing to the patient s left groin and 2 open areas were noted, each appeared the length of a large paperclip and as wide as the width of a pen. Both open areas appeared to have a depth of the length of a pinky fingernail. RN H stated, One is more medial, but there are two here. RN H was observed to place her gloved right thumb along the length of the lateral left groin open area and then pinch her right thumb			

	forefinger. RN H then placed her right thumb over the tag on her nurse bag and stated, The length is from H to I. RN H was then observed to place her gloved right thumb along the width of the lateral left groin open area and then pinch her right thumb with her left thumb and forefinger. RN H placed her right thumb over the tag on her nurse bag and stated, The width is from H to O. RN H was observed placing her gloved right thumb into the lateral left groin open area and was observed pinching her right thumb with her left thumb and forefinger. RN H was observed placing her gloved right thumb over the tag on her nurse bag and stated, The depth is H. At 7:25 PM, RN H placed a retractable tape measure against the tag on her nurse bag and stated, The measurements are just under 1.5 inches, ¾ inch and ½ inch deep. The RN failed to measure the open area according to current clinical practice guidelines and per agency policy. During an interview on 8/18/2021 at 1:21 PM, the alternate clinical manager indicated the RN should have measured the patient s wound using a disposable tape measure or utilizing the wound measurement application available to the nurses by taking a photograph of the wounds.			

G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. 1. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Discharge Summary stated, & A Discharge Summary form will include, but is not limited to: & Patient/family post-discharge instructions & Medications at time of discharge. A Discharge Summary will be sent within 5 business days of patient discharge to the primary care practitioner &. 2. Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced an agency document titled Plan of Care for certification period 4/19/2021 6/17/2021, signed by the alternate clinical manager and signed and dated on 6/30/2021 by the physician. This	G1022	Clinicaland office staff will be re-educated to need to send discharge summary toprimary care practitioner or other health care professional whowill be responsible for providing careand services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or Acompleted transfer summary that is sent within2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or Acompleted transfer summary that is sent within 2 business days of becomingaware of an unplanned transfer, if the patient is still receivingcare in a health carefacility at the time when the HHA becomes aware of the transfer. Clinical record reviewswill be completed of 100% of discharges and transfers to assure discharge andtransfer summaries are sent to the PCP, physicians or receiving facility intimely fashion according to	2021-11-22

	document indicated the patient s primary diagnosis was Type II Diabetes (a chronic condition where the body is impaired in the way it regulates and uses sugar as fuel). The plan of care indicated the patient was to receive skilled nursing services 1 time a week every other week for 9 weeks for a complete body assessment and fall prevention and diabetic care instruction. Review evidenced an agency document titled Discharge Summary , dated 6/14/2021 and signed by former employee RN K, which indicated the date of discharge was 6/14/2021. The document indicated the specific discharge instructions for the patient were to call the home care agency if home care services were needed in the future and failed to evidence patient specific instructions related to the diagnosis and condition were provided. Review failed to evidence the document included the patient medications per agency policy. Review failed to evidence the discharge summary was sent to the physician. During an interview on 8/18/2021 at 11:56 AM, the alternate clinical manager indicated the discharge summary should have been completed and indicated the discharge summary should have been sent to the physician via fax		regulation. The Administrator isresponsible for assuring discharge and transfer summaries are sent to the PCP,physicians or receiving facility in timely fashion according to regulation	

	document. The alternate clinical manager indicated there was no indication the discharge summary was sent to the physician.			
G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. 3. Clinical record review on 8/16/2021, for patient #7, start of care 6/28/2021, diagnosis of an abscess of the genitalia, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 6/28/2021 8/26/2021. This document had an area subtitled 21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) which stated Services for Skilled Nurse: Effective 6/29/2021: SN:	G1022	Clinicaland office staff will be re-educated to need to send discharge summary toprimary care practitioner or other health care professional whowill be responsible for providing careand services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or Acompleted transfer summary that is sent within2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or Acompleted transfer summary that is sent within 2 business days of becomingaware of an unplanned transfer, if the patient is still receivingcare in a health carefacility at the time when the	2021-11-22

	1W6 [once a week, for 6 weeks] & Review evidenced an agency document titled Discharge from Agency (D1) from 7/20/2021 which was signed by RN H. Review failed to evidence the patient received skilled services after the start of care and prior to discharge. Review failed to evidence the physician was notified of the discharge. Review failed to evidence the patient received a discharge notice prior to the discharge assessment. Review failed to evidence a discharge summary was sent to the physician after discharge. During an interview on 8/17/2021, at 2:29 PM, alternate clinical manager A confirmed the clinical record failed to evidence the physician had been notified of discharge. The alternate clinical manager indicated physician notification was not documented in the clinical record. 17-15-1(a)(6)		transfer. Clinical record reviewswill be completed of 100% of discharges and transfers to assure discharge andtransfer summaries are sent to the PCP, physicians or receiving facility intimely fashion according to regulation. The Administrator isresponsible for assuring discharge and transfer summaries are sent to the PCP,physicians or receiving facility in timely fashion according to regulation	
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. 1. Review of an agency policy,	G1024	Agency has worked withEMR vendor to assure that each clinicians credentials are added to theirelectronic signature. Clinical record reviewof visit notes and OASIS documents will	2021-11-22

	revised March 2018, obtained 8/18/2021 titled Medical Record Entries and Authentication stated, & All entries in patient records will be legible, clear, complete and appropriately authenticated, dated and timed. All entries in the medical records will be authenticated by staff signature and title. By authenticating entries in the patient s record, staff is validating the correctness of the information. &. 2. Clinical record review on 8/10/2021 for patient #1, start of care 6/18/2021 evidenced an agency document titled Patient Medications which failed a signature and date to evidence a signature and date of the clinician who reviewed the medications. Review of an agency document titled Start of Care (D1) , dated 6/18/2021 and electronically signed by RN K, failed to evidence the credentials of the clinician. Review of agency documents titled Supplemental Provider Order , dated 8/2/2021, 8/4/2021 and 8/6/2021 and electronically signed by RN L and dated 7/19/2021 and electronically signed by RN K, failed to evidence the credentials of the clinician. Review of an agency document titled Individual Patient		confirm that credentials are added toeach electronic signature. Review of 100% of clinicalnotes will validate that clinician credentials are documented on each clinicalnote. The Administrator is responsible for assuring credentials are identified foreach clinical note	

	Emergency Preparedness Plan , dated 6/18/2021 and signed by RN K, failed to evidence the credentials of the clinician. Review of untitled agency documents identified by the alternate clinical manager as home health aide (HHA) visit notes, dated 6/28/2021, 7/1/2021, 7/5/2021, 7/8/2021, 7/12/2021, 7/15/2021, 7/22/2021 and 7/28/2021 and completed by former employee A (HHA), failed to evidence the credentials of the clinician. Review of agency documents titled Skilled Visit Note , dated 6/22/2021, 6/24/2021,6/29/2021, 7/2/2021, 7/5/2021, 7/7/2021, 7/9/2021, 7/12/2021, 7/15/2021, 7/19/2021 and 7/23/2021 and completed by former employee licensed practical nurse (LPN) B, failed to evidence the credentials of the clinician. Review of an agency document titled Skilled Visit Note , dated 7/12/2021 and electronically signed by former employee LPN B, indicated the patient s last bowel movement was 7/75/21. The review failed to evidence an accurate date of the last bowel movement. During an interview on 8/12/2021 at 1:11 PM, the alternate clinical manager indicated the date documented was a documentation error.			

Review of an agency document titled Skilled Visit Note , dated 7/19/2021 and electronically signed by former employee LPN B, failed to evidence the document was complete to include the patient s temperature.

During an interview on 8/12/2021 at 1:16 PM, the alternate clinical manager indicated the skilled nurse should obtain and document the patient s temperature at every visit.

3. Clinical record review on 8/9/2021 for patient #2, start of care 6/24/2021, evidenced an agency document titled Occupational Therapy [OT] Evaluation , dated 8/2/2021 and electronically signed by OT M, which failed to evidence the credentials of the clinician.

Review of agency documents titled Supplemental Provider Order , signed and dated by OT M on 7/31/2021 and signed and dated 8/4/2021 and 8/8/2021 by RN L, failed to evidence the credentials of the clinician.

Review of an agency document titled Skilled Visit Note , dated 7/7/2021 and electronically signed by former employee LPN B, failed to evidence the credentials of the clinician.

Review evidenced an undated agency document titled Individual

	Preparedness Plan , signed by RN K, which failed to evidence the document included the date signed by the clinician. This document indicated the patient s temperature was 79.7 degrees Fahrenheit. During an interview on 8/12/2021at 11:16 AM, the alternate clinical manager indicated the documented temperature was a mistake and it should have been documented as 97.9 degrees Fahrenheit. 4. Clinical record review on 8/12/2021 for patient #3, start of care 10/8/2020, evidenced an undated agency document titled Individual Patient Emergency Preparedness Plan , signed by RN H, which failed to evidence the document included the date signed by the clinician. Review of an agency document titled Home Health Certification and Plan of Care for certification period 6/5/2021 8/3/202, signed and dated by RN N on 7/6/2021, failed to evidence the credentials of the clinician. Review of an agency document titled Recertification , completed on 6/2/2021 and signed by RN N, failed to evidence the credentials of the clinician. Review of an undated agency document titled Patient Medications failed to evidence a			

	date. Review of an agency document titled Skilled Visit Note , dated 6/14/2021 and electronically signed by RN N, indicated the patient s temperature was 9.8 degrees Fahrenheit. During an interview on 8/16/2021 at 10:58 AM, the alternate clinical manager indicated the documented temperature was an error and probably should have documented as 98.0 degrees Fahrenheit. Review of agency documents titled Supplemental Provider Order , electronically signed by RN N and dated 6/14/2021, 7/28/2021 and 8/4/2021, failed to evidence the credentials of the clinician. Review of an agency document titled Physician s Telephone Order , dated 2/2/2021 and signed by RN O, failed to evidence the credentials of the clinician. Review of agency documents titled Plan of Care failed to evidence a date the documents were signed by RN H for certification period 10/8/2020 12/6/2020 and 12/7/2020 2/4/2021. Review failed to evidence a date the document was signed by RN O for certification period 2/5/2021 4/5/2021. Review failed to evidence a date the document			

	was signed by RN B for certification period 4/6/2021 6/4/2021. 5. Clinical record review on 8/16/2021 for patient #6, start of care 2/18/2021, evidenced agency documents tilted Plan of Care . Review of the documents for certification period 2/18/2021 4/18/2021 and 4/19/2021 6/17/2021 failed to evidence a date the documents were signed by RN A. 6. During an interview on 8/12/2021 at 10:04 AM, the alternate clinical manager indicated the clinical records should include the clinician s credentials. 7. During an interview on 8/18/2021 at 10:47 AM, the alternate clinical manager indicated the date should be included on documents signed by clinicians.			
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed.	G1024	Agency has worked withEMR vendor to assure that each clinicians credentials are added to theirelectronic signature.	2021-11-22

	title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. 8. Clinical record review on 8/16/2021, for patient #4, start of care 7/29/2021, primary diagnosis of fracture of the right shoulder, evidenced an agency document titled "Physical Therapy Evaluation" from 8/2/2021, and was signed by PT [physical therapist] F. Review of this document failed to evidence the title of the clinician who performed the visit. Review evidenced agency documents titled Therapy Visit Note for 8/6/2021 and 8/11/2021, signed by PT F. Review of these documents failed to evidence the credentials of the clinician who performed the visits. Review evidenced an agency document titled "Occupational Therapy Evaluation" from 8/6/2021, and was signed by OT [occupational therapist] M. Review of these documents failed to evidence the credentials of the clinician who performed the visits.		Clinical record reviewof visit notes and OASIS documents will confirm that credentials are added toeach electronic signature. Review of 100% of clinicalnotes will validate that clinician credentials are documented on each clinicalnote. The Administrator is responsible for assuring credentials are identified foreach clinical note	

	Review evidenced an agency document titled "Occupational Therapy Evaluation" from 8/6/2021, and was signed by OT [occupational therapist] M. Review of these documents failed to evidence the credentials of the clinician who performed the visits. Review evidenced an agency document titled "Discharge/Transfer Summary" from 8/11/2021, and was signed by OT M. Review of these documents failed to evidence the credentials of the clinician who performed the visits. Review of an agency document titled "Discharge/Transfer Summary" from 8/11/2021 which was unsigned by a skilled nurse. Review of this document failed to evidence it was signed and dated by the clinician who performed the visit. 9. Clinical record review on 8/16/2021, for patient #5, start of care 2/24/2021, diagnosis of type 2 diabetes with chronic kidney disease, evidenced agency documents titled Skilled Visit Note for 8/5/2021 and 8/11/2021, signed by LPN I. Review of these documents failed to evidence the title of the clinician who performed the visits. Review of an agency document			

	titled Skilled Visit Note for 7/16/2021, signed by RN L. Review of this document failed to evidence the title of the clinician who performed the visit. 10. During an interview on 8/16/2021, at 10:28 AM, alternate clinical manager A indicated the clinician should include their credentials when signing visit note documents. 17-15-1(a)(7)			
G1028	Protection of records 484.110(d) Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164. Review of an agency policy, revised March 2018 and obtained 8/18/2021, titled Patient Confidentiality stated, & All written patient information is stored in the patient s medical record. & Home care records will not be left in unattended areas in the office &. During an observation on 8/9/2021 at 9:47 AM, an agency folder was observed sitting on the conference table in the	G1028	Alloffice and clinical staff will be re-educated to requirement to safeguardclinical records against loss or uauthorized use as per 45 CFR parts 160and 164. PHItraining will be mandatory for all staff. The Administrator isresponsible for maintaining compliance with this regulation conducting weeklyPHI rounds observing for unprotected PHI. Instances ofunprotected PHI will result in employee counseling.	2021-11-18

	training D identified the folder to be a new patient admission folder. Observed inside the folder were documents from hospital L and a document titled Fax Cover Sheet , dated 7/27/2021, stated, & [Patient #4] New Referral D/C [discharge] Today &. Record review of the documents from hospital L inside of the folder evidenced the name, social security number, phone number, address, insurance information, and medical information to include a surgical report, physical therapy evaluation, list of patient medications and laboratory results for patient #4. During an interview on 8/9/2021 at 10:40 AM, the alternate clinical manager indicated the folder was probably left on the conference table for the nurse to pick-up to take to the patient s home for the start of care. The alternate clinical manager indicated the patient information should not have been left inside of the folder and indicated the patient s information was not secured. 17-15-1(c)			
N9999	Final Observations	N9999	All personnel files of unlicensedclinicians have had 100% review to assure that a negative drug screen has beenobtained, reviewed and incorporated into the personnel	2021-11-15

	Based on record review and interview, the agency failed to ensure all unlicensed clinicians submitted a negative drug screen prior to patient contact for 2 of 2 home health aide (HHA) personnel files reviewed. (employee G, J) The findings include: 1. Review of Indiana State regulation number 410 IAC 16-27-2.5 stated "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...(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 ...." 2. Personnel record review on		file prior to assigningpatient contact for the Home Health Aides. The Administrator isresponsible for ensuring ongoing compliance with personnel files. An audit of personnel files will be conductedquarterly for non-licensed employees assuring a negative drug screen is in thepersonnel file prior to employees visiting patients.	

	8/11/2021, for HHA G, first patient contact date on 7/30/2021, failed to evidence a drug screen had been performed at the time of review. 3. Personnel record review on 8/11/2021, for HHA J, first patient contact date on 6/14/2021, failed to evidence a drug screen had been performed at the time of review. During an interview on 8/11/2021, at 1:50 PM, alternate clinical manager A indicated there was not a drug screen on file for HHA J.			

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

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