STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K141	A. BUILDING B. WING	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOGETHER HOMECARE	555 E COUNTY LINE ROAD SUITE 105, GREENWOOD, IN, 46143

(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 visit was for a Federal Recertification and State Re-licensure survey of a Home Health Care Provider. Survey Dates: 3/9/22, 3/10/22, 3/11/22, 3/14/22, 3/15/22, 3/16/22 and 3/17/22. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Based on the Condition-level deficiencies during the 3/17/22 survey, your HHA was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 3/17/22. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training, skills competency and/or competency evaluation program for a period of two years beginning 3/17/22 and continuing through 3/16/24. QR by Area 3 on 4/4/2022	G0000	**Together Homecare(“Together”) submits the following Plan of Correction as required by State and Federallaw. Together’s submission of this Plan of Correction should not be takenas an agreement with or admission of any of the findings contained therein.Together hereby expressly reserves the right to challenge the factual findings,legal conclusions, and allegations contained in the underlying reports.** **Compliance has beenand will be achieved no later than the last completion date identified in thePlan of Correction. Together desires this Plan of Correction to beconsidered our Creditable Allegation of Compliance.**	2022-04-28
G0432	Make complaints to the HHA 484.50(c)(3) Make complaints to the HHA regarding	G0432	G 432 The complaints for the patients	2022-04-14

	treatment or care that is (or fails to be) furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of the HHA; Based on record review and interview, the agency failed to ensure patient complaints were documented in accordance with agency policy, to include documentation of outcomes/resolutions, complete with patient/family response, in 2 (Patients 2 and 6) of 9 clinical records reviewed. Findings include: 1. In an agency policy dated 12/30/21 titled 'Patient/Family Complaint Policy C-381,' stated, "PURPOSE To ensure patient safety and well being by thoroughly documenting and investigating all complaints involving Patient Rights. To provide a mechanism for handling patient/family complaints in a timely and efficient manner. To allow patients to express complaints to someone other than their direct caregiver. To establish a procedure for channeling complaints to the appropriate person for resolution, and to provide response to family...2. Patient complaints will be documented on a patient complaint form and filed with the complaint log in an administrative file. The agency's investigative actions for all complaints will be included with the complaint form. Such investigative actions may include but are not limited to: witness statements/interviews,...patient assessment findings when applicable, Physician progress notes when applicable, evaluation of prior patient satisfaction surveys and/or supervisory visit results, review of prior complaints or incidents related to same patient and/or employee, review of employee administrative file, and any other investigative measures deemed appropriate by the Administrator and/or Director, based on the specific nature of the complaint...3. All complaints will be forwarded to Director of Clinical Services and/or Administrator to ensure that a full investigation is completed and documented appropriately...4. All complaints will be thoroughly investigated and documented, including any complaint regarding treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately...by anyone furnishing services on behalf of the agency, in accordance with with 42CFR 484 and 410 IAC 17...6. Complaints will be addressed by Administrator or Clinical Director of Services, with a response		identified in the surveyreport have been documented according to the Agency’s policy. All Agency patients have been contacted regarding anyunreported or outstanding complaints, and any additional complaints have beendocumented in accordance with Agency policy. All Agency employees responsible for fielding, documentingand investigating complaints have been re-educated on the Agency’s complaintpolicy via an in-service. This education will continue to be presented to allincoming employees during their training process. The Administrator or Director of Clinical Services willaudit the Agency’s Complaint Log weekly for 60 days to ensure the Agency is100% compliant with appropriately documenting all complaints. After 60 days ofcompliance, the Complaint Log will continue to be reviewed during the Agency’squarterly QAPI Program. The Administrator and Director of Clinical Services areresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur. Completed 4/14/22 and ongoing.	

made to the complainant as quickly as possible but within seven (7) calendar days of receipt of complaint...and that the responsible person will report back with a resolution of the complaint. All persons with a complaint will be notified of outcome of agency's investigation."

2. A review of the closed clinical record of Patient #6, with a start of care date of 9/22/21, revealed a Home Health Certification and Plan of Care , dated 9/22/21 for the certification period of 9/22/21 to 11/20/21. The patient was to receive home health aide (HHA) services 4-7 hours per day, 3-5 days per week, while the patient s spouse was at work. The patient was discharged on 12/2/21.

A review of the Scheduled Patient Visits for patient #6, evidenced missed HHA visits for the certification period of 9/22/21 to 11/20/21 were 9/22/21 to 10/4/21, 10/8/21, 10/14/21, 10/15/21, 10/21/21, 10/25/21 to 10/29/21, 11/1/21, 11/2/21, 11/5/21, 11/11/21, 11/12/21, 11/16/21, and 11/17/2.

In a phone interview with Patient #6 on 3/11/21 at 9:28 AM, stated they didn t get all ordered care visits from the agency from day 1, stating they were told there were people to staff, then they wouldn t show up, stating they called the agency many times complaining, asking the agency why they accepted the case when they couldn t staff, with no resolution. When Patient #6 was queried as to the agency asking Patient 6 if they wanted to be transferred to another agency that could staff their case, the patient stated they were never given that option.

In a phone interview on 3/14/22 at 12:46 PM, with case manager E at entity F for patient #6, when queried whether the agency ever reached out to them for assistance in finding another agency, they stated no, I was always reaching out to the agency, asking if they wanted me to find another agency.

A review of the complaint logs from 9/22/21 through the time of discharge on 12/2/21 failed to evidence the agency had documented Patient 6's expressions of dissatisfaction as a complaint.

During an interview on 3/14/22 at 4:04 PM, with

the administrator and clinical manager, when queried about complaints from patients not being documented, there was no explanation offered and no additional complaint records were produced.

IAC 17-12-3(b)(2)(B)

3. Review of the clinical record for Patient 2 revealed a start of care date of 2/20/17, with a certification period of 1/15/22 to 3/15/22, and diagnoses that included but were not limited to Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system, and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for medication administration and enteral feeding administration.

A review of Complaint and Incident logs failed to evidence documentation of complaints related to Patient 2.

In an interview on 3/10/22, Person A stated that concerns regarding the care that Nurse F had provided to Patient 2, were addressed in November, 2021, during a Skilled nursing visit in the home, by the clinical manager, case manager. Person A also stated an additional, but separate visit from the Administrator had been made to the home. Person A stated the visit was related to concerns expressed by Patient 2 with Nurse F's lack of knowledge of the seizure protocol. Person A did not care to elaborate when further queried.

In an interview on 3/11/22, at , with Clinical Manager and Administrator, when queried as to the complaint lodged by Person A (relative of Patient 2), both indicated there was no Complaint Form to review as it had not formally been written up. They indicated Person A had expressed concerns regarding safety and so a joint visit had been made with Nurse F, Nurse K, and the Clinical Manage. During the visit concerns had been addressed, the was nurse re-educated, and follow-up with family all were documented in the 'Nursing Visit' note. The Clinical Manager and Administrator

	written in this note, no additional documents were completed. The agency failed to implement their own policy which required complaints to be documented on an agency complaint form. In a follow-up telephone interview, received a callback from Person A (relative of Patient 2) on 3/17/22 at 11:46 AM who elaborated on concerns related to nursing staff needing re-education on multiple occasions. In particular, Nurse F's lack of knowledge in relation to the patient's seizure protocol. Person A recalled an event in the last year where Nurse F carried the patient into the room where Person A was working from home, and the nurse informed that the patient, "wasn't acting right." Person A indicated Nurse F failed to identify the patient was actively having a seizure, did not seem to know what to do, and was looking to Person A to direct them. Person A instructed Nurse F to lay the patient on the floor, position the patient on his/her side, and Person A provided additional instruction throughout the seizure event. Indicated that Nurse F should have known to take these actions quickly, and without prompting.			
G0436	Receive all services in plan of care 484.50(c)(5) Receive all services outlined in the plan of care. Based on record review and interview, the agency failed to ensure patients received visit frequencies as ordered in the plan of care, for 2 (Patients 6 and 8) in a sample of 9 clinical records reviewed. Findings include: 1. A review of an agency's policy titled, 'Admission Policy C-120', dated 12/30/21, revealed, "POLICY Patients are accepted for treatment in the home on basis of reasonable criteria and under the expectation that the patient's medical, nursing, and social needs can be met adequately by Agency in the patient's	G0436	G 436 Patient #8's legal representative has been contacted for acase conference to discuss staffing and to re-educate them on the ability totransition to another agency who could better staff their Saturday shift everyother weekend. This case conference has been documented in the clinical recordand the patient's AAA Case Manager has been notified. Patient #6 was dischargedin 2021. The Agency has contacted allpatients to address any concerns related to staffing. Any patients whose schedules arehaving consistent staffing issues have been re-educated on the ability of	2022-04-28

	and provide services to all persons without regard...PURPOSE To provide guidelines for accepting patients for home health care services ... SPECIAL INSTRUCTIONS Criteria for Patient Admissions: 4. There must be a reasonable expectation that the patient's medical, nursing, social, or rehabilitation needs can be adequately met in the patient's home. 5. Reasonable expectation shall consider: a. Whether the agency's personnel and resources are adequate...10. Agency Services must be appropriate and available to meet the specific needs and requests of the patient and caregiver." 2. A review of the closed clinical record of patient #6, with a start of care date of 9/22/21, revealed a 'Home Health Certification and Plan of Care', dated 9/22/21 for the certification period of 9/22/21 to 11/20/21. TPatient 6 was to receive home health aide services 4-7 hours per day, 3-5 days per week to assist the patient in/out of bed, chair transfers, hygiene, and grooming, preparation of meals, encourage fluids, and light housekeeping while the patient s spouse was at work. Patient 6 was discharged on 12/2/21. A review of the 'Scheduled Patient Visits,' for patient #6, evidenced missed visits for the certification period of 9/22/21 to 11/20/21, were on 9/22/21 to 10/4/21, 10/8/21, 10/14/21, 10/15/21, 10/21/21, 10/25/21 to 10/29/21, 11/1/21, 11/2/21, 11/5/21, 11/11/21, 11/12/21, 11/16/21, and 11/17/21. The agency failed to provide services to Patient #6 as outlined/ordered in the plan of care. 3. A review of the clinical record of Patient #8, with the start of care date of 3/25/20, revealed a 'Home Health Certification and Plan of Care', dated 1/14/22. The patient was to receive home health aide services 4.5 to 6.5 hours, 2-4 days a week for assistance with transfers, bathing/showering, preparing/serving meals, range of motion exercises, toileting/elimination, encourage stander, light housekeeping, and assist with stairlift as needed. A review of the 'Scheduled Patient Visits,' for Patient #8, evidenced missed care visits for the certification period of 1/14/22 to 3/14/22, which were on the week of 2/7/22 to 2/12/22, the week		theAgency to facilitate a transfer of the patient to another homecare agency who isable to staff their hours, by way of a case conference. Thesecase conferences have been documented in the clinical record, and theinformation has been forwarded to the patient's AAA Case Manager. The Agency will be managed by theAdministrator, who will review all weekly schedules to ensure current patients'care visit needs are met. The Administrator will be responsible for ensuringthat no new patients are admitted unless available caregivers are able tofulfill care visit needs for current Agency patients. The agency's current patients are receiving 100% ofordered care visits. In light of the national healthcareworkforce shortage, the ongoing global pandemic, and a patient's right torefuse care, there are factors beyond the Agency's control that may cause apatient's care visit to be missed. In accordance with the COPs, if the Agencymisses a visit or a treatment or service as required by the plan of care, whichresults in any potential for clinical impact upon the patient, then the Agencywill notify the responsible physician of such missed treatment or service. The Agency will continue to onlyadmit patients for which the Agency has a reasonable expectation, prior to thestart of care, that it can meet the patient's care needs and fulfill orderedcare visits in the patient's	

	of 2/14/22 to 2/19/22, and the week of 3/7/22 to 3/11/22. In a phone interview on 3/14/22 at 10:29 AM, a family member of Patient #8, Person I, stated they thought about changing agencies but talking with their case manager J from entity K, all agencies were having difficulties with staffing. When queried about days requesting services, they stated they had originally requested to have services on Mondays, Wednesdays, Fridays, and Saturdays, and were told by the agency they wouldn t have a problem staffing. In an interview on 3/14/22 at 11:30, with the administrator and clinical director, when asked about not providing services as ordered for Patient #8, the administrator stated Patient 8 had refused some services. When asked to provide documentation of the refused visits, one (1) document was presented which evidenced one care visit was refused on 1/15/22. The agency failed to provide services to Patient #8 as outlined/ordered in the Plan of Care. 410 IAC 17-12-3 (b)(2)(B)		accordance with theConditions of Participation. The Agency identifies a caregiver or caregiverswho can fulfill the patient's ordered care visits prior to accepting a newpatient for services. If the Agency cannot identify a caregiver to fulfill theordered care visits, the patient is not accepted onto service. Each patient receives anindividualized plan of care, as required by Indiana law and the Medicare COPs.The number of ordered care visits for each patient is determined by the patientor his/her representative and the ordering provider, based on the uniqueclinical needs of the patient. The Agency only admits patients for which theAgency has a reasonable expectation, prior to the start of care, that it isable to fulfill the ordered care visits based on the length of the visit,distance and travel requirements, and caregiver qualifications. All currentAgency patients are prioritized when an Agency caregiver becomes available or anew Agency caregiver is hired. If a current patient and a potential new patienthave similar schedules for ordered care visits and live in similar geographicareas, the caregiver will be applied to the current patient's schedule. Agency reviews confirmed	

			all completed patient schedules weekly when payroll isprocessed to verify that ordered care visits have been provided. The Agencyreviews caregiver availability after each orientation to ensure that newcaregivers are matched with current patients before they are identified for newpatients. A hold on new admissions has beenconsidered, and the Agency will hold any new patient admission unless availablecaregivers are able to fulfill care visit needs for current Agency patients.This will continue to ensure that current patient schedules remain thepriority. The Administrator will beresponsible for managing, supervising, and calculating the Agency's ability tomeet the plan of care ordered visits. The objective considerations in makingthis decision will continue to be the type of care required, the geographiclocation of the patient, the initial patient-requested and physician-orderedschedule of care visits, and the availability of a current qualified caregiverwho can provide the care required, who is able to travel to the patient'sgeographic location, and who can fulfill the ordered care visits. The Agencywill continue to only admit patients for whom, at the time of admission, theagency	

			projects that it can meet all ordered care visits, utilizing thecurrent, qualified Agency caregiver(s). If a caregiver assigned to a currentpatient is unable to continue working, whether due to the patient's request fora new caregiver or the caregiver's inability to continue that schedule, theAgency will contact all other active caregivers in or near the patient'sgeographic area until a new caregiver is identified for the patient. If the Agency, patient/patient'srepresentative and the patient's ordering provider determine that the patient'scurrent clinical status and homecare needs warrant a modification to the typeor frequency of services provided, based on an updated comprehensive assessmentof the patient, the plan of care will be modified and sent to the provider forsignature. If the Agency is unable to provide the ordered and needed carevisits, Together Homecare will follow state and federal regulatory requirementsto assist the patient in finding another agency that can meet their care needsand continue to furnish services until an acceptable transfer can beimplemented. The Agency acknowledges thepotential for staffing issues, including ongoing healthcare workforce shortagesand staffing	

			exacerbated by the pandemic. Thisbroader staffing shortage has impacted the Agency's staffing and has led to theissues cited in the survey. Throughout the ongoing public health emergency, theAgency has continued to prioritize efforts to recruit and retain qualifiedcaregivers to staff all ordered care visits for all current patients. We workto properly document and communicate regarding missed visits, and we willcontinue to take aggressive steps to recruit, hire and retain staff, knowingthat this broader staffing shortage is impacting all of healthcare. If a caregiver notifies theAgency that he or she is unable to attend their scheduled shift, the Agencywill take appropriate steps to identify replacement staff and will update thepatient (or patient representative) frequently until the shift is re-staffed,unless the patient or their representative is unwilling to accept a newcaregiver, in which case the refusal will be documented in the medical record. The Agency's efforts to finda replacement caregiver will be documented in the clinical record. If a patientrequires immediate assistance, the Agency's on-call nurse or designatedqualified caregiver will make a visit to the patient's home to provide the carenecessary to ensure the patient remains safe. TheAgency will make every effort to make-up missed shifts within the same workweek, to ensure the patient receives all services as ordered on the plan ofcare. This communication will be documented in the clinical record. Allemployees responsible for	

			staffing and oversight of cases have been re-educatedon the requirement to staff each patient's ordered care visits, as well as theneed to hold a case conference with any patients and/or their legalrepresentatives when scheduling needs cannot be appropriately met, so thattransfer to another Agency can be discussed. All supervising RNswill continue to Educate patients and/or their legal representatives about the right to choose theirprovider and receive all services in the plan of care at allsupervisory and re-certification timepoints, in addition to distributing anddiscussing the Patient Rights and Responsibilities during admission. The Administrator will review 100% of patient schedulesweekly for 60 days to monitor staffing compliance. For any patient who hasongoing staffing issues, the Administrator or designee will hold a caseconference to discuss transfer to another provider. Dischargінga patient after a case conference will continue to be used only as the remedyof last resort. These case conferences will be documented in the clinical recordand will be forwarded to the patient's AAA Case Manager. After 60 days,adherence to the patient-requested schedule, as ordered by the physician, willcontinue to be evaluated	

			record audit as partof the Agency's QAPI Program. The Administrator is responsible for monitoring thesecorrective actions to ensure the deficiency is corrected and will not recur. Completed 4/28/22 and ongoing.	
G0530	Strengths, goals, and care preferences 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview, the agency failed to ensure a complete and accurate assessment of the patients' specific goals, strengths, and care preferences in 5 of 9 records reviewed. (Patients #1, 5, 6, 7, and 8) Findings include: 1. A review of an agency s policy titled, 'Plan of Care C-580,' dated 12/30/21, revealed, "POLICY Home care services are furnished under the supervision and direction of the patient s physician. The Plan of Care is based on a comprehensive assessment and information provided by the & PURPOSE To provide guidelines & to assure that the plan meets state/federal guidelines, and all applicable laws and regulations. SPECIAL INSTRUCTIONS 2. The Plan of Care shall be completed in full to include: & n. Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient & 5 &The plan of care is developed as required by the agency/state guidelines & 2. A review of the clinical record of Patient #1, revealed a SOC (start of care) Comprehensive Assessment dated 11/30/18, for the certification period of 11/30/18 to 1/28/19 which evidenced a subtitle of, Goal Planning and Progress Goals,	G0530	G 530 All RNs responsible for updating the comprehensiveassessment have been re-educated that the comprehensive assessment must includepatient strengths, goals and care preferences. The section for patient goals onthe Agency's comprehensive assessment form has been updated to include carepreferences and patient strengths, and this information will be incorporatedinto each patient's plan of care. All incoming RNs responsible for updating the comprehensiveassessment will receive education on the contents of the comprehensiveassessment, including patient strengths, goals and care preferences, during theorientation and training process. The Director of Clinical Services or RN designee will evaluate100% of comprehensive assessments for 60 days to	2022-04-14

	safe in the home environment, AEB (as evidenced by) no falls, hospitalizations, injuries or ER (emergency room) visits by: End of the certification period. Status of Goal: All goals developed at SOC, all are ongoing goals. The patient will maintain maximum functional independence, AEB (sic as evidenced by) no evidence or report of function decline by: End of the certification period. Status of Goal: All goals developed at SOC, all are ongoing goals. A review of the clinical record of Patient #1, revealed an RCT (Recertification) Comprehensive Assessment dated 1/10/22, for the certification period of 1/13/22 to 3/13/22, which evidenced a subtitle of, Goal Planning and Progress Goals, which identified Goals as Patient would remain safe in the home environment, AEB no falls, hospitalizations, injuries or ER (emergency room) visits by End of the certification period. Status of Goal: All goals developed at SOC, all are ongoing goals. The patient will maintain maximum functional independence, AEB no evidence or report of function decline by: End of the certification period. Status of Goal: All goals developed at SOC, all are ongoing goals. Respiratory health will be maintained AEB no diagnosis of respiratory infection by end of certification period Status of Goal: goal MET, ongoing goal. The comprehensive assessment failed to identify patient-specific goals with measurable outcomes and failed to evidence documentation of the patient's strengths or care preferences. 3. A review of the clinical record of Patient #5, with a start of care date of 4/12/21, revealed a ROC/RCT (Resumption of services/ Recertification) Comprehensive Assessment dated 1/31/22, for the certification period of 2/6/22 to 4/6/22. Assessment type marked as Recertification , which evidenced a subtitle of Goal Planning and Progress , which identified Goals as, Patient will remain safe in the home environment, AEB no falls, hospitalizations, injuries or ER visits by: End of the certification period. Status of Goal: Met; ongoing. The patient will maintain maximum functional independence, AEB no evidence or report of functional decline by: End of certification period Status of Goal: Met; ongoing. Tube feeding will be well-tolerated, AEB absence of vomiting, no feedings held due to excessive residual, and no signs of GI intolerance (diarrhea, constipation, dehydration) by: End of Certification period Status of Goal: Met; ongoing. The patient will		ensure compliance with thisrequirement is maintained. After 60 days, patient strengths, goals and care preferenceswill be reviewed during the quarterly 10% clinical record audit as part of theAgency's QAPI Program to ensure continued compliance. The Director of Clinical Services is responsible formonitoring these corrective actions to ensure the deficiency is corrected andwill not recur. Completed 4/14/22 and ongoing.	

	be free from seizures, AEB no documented or reported seizure activity. By: End of certification period Status of Goal: Met; ongoing. The comprehensive assessment failed to identify patient-specific goals with measurable outcomes and failed to evidence documentation of the patient's strengths or care preferences. 4. A review of the closed clinical record of Patient #6, with a start of care date of 9/22/21, revealed a document titled, ROC/RCT Comprehensive Assessment dated 11/17/21, which evidenced a subtitle Goal Planning and Progress which identified goals as Patient will remain safe in the home environment, AEB no falls, hospitalizations, injuries or ER visits by End of certification period Status of Goal: Goal Met; ongoing. The patient will maintain maximum functional independence, AEB no evidence or report of functional decline by: End of certification period Status of Goal: Goal Met; ongoing. Diabetes symptoms will be well managed, AEB no report of excessive thirst, hunger, urination, dizziness, or fatigue by: End of certification period Status of Goal: Goal Met; ongoing. Skin integrity will be maintained, AEB absence of any new or worsening skin breakdown By: End of certification period Status of Goal: Goal Met; ongoing. The comprehensive assessment failed to identify patient-specific goals with measurable outcomes and failed to evidence documentation of the patient's strengths or care preferences. 5. A review of the clinical record of Patient #7, with a start of care date of 1/27/21, revealed a document titled, ROC/RCT Comprehensive Assessment for the recertification period of 1/22/22 to 3/22/22 which evidenced a subtitle of Goal Planning and Progress , which identified goals as, Patient will remain safe in the home environment, AEB no falls, hospitalizations, injuries or ER visits by End of the certification period. Status of Goal: Goal met. Ongoing goal. The comprehensive assessment failed to identify patient-specific goals with measurable outcomes and failed to evidence documentation of the patient's strengths or care preferences.			

	6. A review of the clinical record of Patient #8, with a start of care date of 3/25/20, revealed a document titled, ROC/RCT Comprehensive Assessment for the recertification period of 1/14/22 to 3/14/22 which evidenced a subtitle of Goal Planning and Progress , which identified goals as, Patient will remain safe in the home environment, AEB no falls, hospitalizations, injuries or ER visits by End of the cert period (60) days. Status of Goal: Goal met; no falls, hospitalizations, injuries, or ER visits. Ongoing goal. The patient will maintain maximum functional independence, AEB no evidence or report of functional decline by: End of the cert period (60) days Status of Goal: Goal MET; no evidence or report of functional decline. Ongoing goal. The comprehensive assessment failed to identify patient-specific goals with measurable outcomes andfailed to evidence documentation of the patient's strengths or care preferences.			
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. Based on record review, interview, and observation, the agency failed to ensure a medication review was performed during the nursing reassessment and failed to ensure an accurate medication administration record was created, in the home, and used as a basis for care in 3 (Patients 2, 3, and 5) in a sample of 9 clinical records reviewed. Findings include: 4. A review of the clinical record of Patient #5,	G0536	G 536 The medication profiles for all agency patients have been re-reviewedto ensure that the medication route for each drug is properly indicated basedon how the medication is administered. All nurses have been re-educated on theimportance of using the MAR as the basis for administering medications, therequirement to document all administrations on the MAR, the need to contact theprovider and Agency for any noted discrepancies or inaccurate information, andthe Agency's policy on medication labeling and preparing medications prior toadministration. Additionally, all nurses responsible for completing thecomprehensive	2022-04-14

	with a start of care date of 4/12/21, revealed a Home Health Certification and Plan of Care , dated 2/2/22, for the certification period of 2/6/22 to 4/6/22. Subtitle 10. Medications/Dose/Route/Frequency/(N)ew (C)hanged included but not limited to Claritin Allergy Children's Oral Syrup 5 mg/5ml / 10 ml / G-tub / Once a day / (C), Hydration Bolus 140 ml / 200 ml / Buccal / 3 times a day Administer water 200 ml per G-tube at 1000, 1400, and 1600. Proper hydration / (C), Nourish Oral Liquid / 461 ml nourish with 200 ML H2O mixed in / Oral / Once a day at 6 PM / (N), and Nourish Oral Liquid / 356 ML Nourish with 180 ML H2O / Oral / Once a day give at noon along with daily Miralax mixed in / (N) . Subtitle 11. ICD-CM Principal Diagnosis Extreme immaturity of newborn, gestational age 24 completed weeks , Subtitle 13 ICD-CM Other Pertinent Diagnoses are but not limited to Delayed Milestone in childhood, dependence on respirator [ventilator] status, Dysphagia, tracheostomy status, gastrostomy status, and Right eye blindness . Subtitle 15. Safety Measures COVID-19 Preventive Measures, Fall Precautions, Standard Precautions, Clear Pathways, Seizure Precautions, and Aspiration Precautions . Subtitle 16. Nutritional Requirements Tube Feeding Nourish 243 ML with 180 ML H2O at 8 AM, 324 ML with 180 ML H2Oat noon, and 405 ML with 200 ML H2O at 6 PM 3 times /daily, ***Aspiration precautions***, NPO . The patient was to receive skilled nursing care 11-13 hours per day 3-5 days per week for medication setup and administration, tracheostomy care, gastrostomy care, check for residual before administering tube feedings, perform full, comprehensive assessment every visit, assist with activities of daily living, and notify physician for any abnormal findings and accompany the patient on appointments/school while the parents were at work. A review of the clinical record revealed a Medication Administration Report dated 2/7/22 to 3/14/22, evidenced on 2/7/22 at 18:15, Nourish 461ML nourish with 200 ML H2O mixed in, was given orally, stop time was 18:30, and signed by RN I. On 2/10/22 at 10:00, Hydration Bolus 140 ML 200 ML was given Buccal, signed by LPN H, at 14:10, a Hydration Bolus 140 ML 200 ml was given Buccal, signed by LPN H, at 15:05, Ondansetron HCL 2.5 ML per Gtube every 6-8 hours as needed for nausea and vomiting was given Buccal, signed by LPN H. On 2/11/22, at 7:04, Ondansetron HCL 2.5 ML per Gtube every 6-8 hours as needed for nausea and vomiting, was given Buccal, signed by LPN H. On 2/14/22, 12:45, Hydration Bolus 140 ML 200 ML was given Buccal by LPN H, 13:30, Nourish 356 ML nourish with 180 ML H20		assessment have been re-educated on properly reviewing themedication list as part of the comprehensive assessment. All future nurses will be educated on proper medicationadministration, documentation and preparation requirements during theonboarding and orientation process. All future nurses responsible forcompleting the comprehensive assessment will receive education on propermedication review and verifying medication information in the med profile andMAR as part of their training and onboarding process. The Director of Clinical Services or designee will auditmedication profiles for all new patients for 60 days to ensure medicationroutes are correctly documented and will audit at least 50% of all completedMARs and 100% of completed MARs for Nurse F weekly for 60 days to ensure medadministration is documented appropriately. After 60 days of 100% compliance,the Director of Clinical Services or designee will review medication profilesand MARs during the 10% quarterly clinical record audit as part of the Agency'sQAPI program. The Director of Clinical Services is responsible formonitoring	

	was given orally, signed by LPN H, at 15:15, Hydration Bolus 140 ML 200 ML was given Buccal signed by LPN H, 16:15 Hydration Bolus 140 ML 200 ML was given Buccal, signed by LPN H, at 18:15 Nourish 461 ML nourish with 200 ML H2O mixed in was given orally, signed by RN I. On 2/15/22 at 10:00, Hydration Bolus 140 ML, 200 ML was given Buccal, signed by RN L, 12:20, Nourish 356 ML Nourish with 180 ML H2O was given orally, signed by RN L, 14:10 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L, 16:10 Hydration Bolus 140 ML, 200 ML given Buccal by RN L, 17:10 Nourish 461 ML nourish with 200 ML H2O mixed in, given orally signed by RN L. On 2/16/22, at11:30, Nourish 356 ML Nourish with 180 ML H2O, given orally signed by RN L, 14:15 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L. On 2/17/22, 10:30 Hydration Bolus 140 ML, 200 ML given Buccal signed by LPN H, 12:20 Nourish 356 ML with 180 ML H2O given orally, signed by LPN H, 14:00 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 16:15 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H. On 2/18/22, 10:00 Hydration Bolus 140 ML, 200 ML given Buccal signed by LPN H, 11:37 Nourish 356 ML Nourish with 180 ML H2O given orally, signed by LPN H, 13:55 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 16:00 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 17:04 Nourish 461 ML Nourish with 200 ML H2O mixed in, given Oral, signed by LPN H. On 2/19/22 15:00, Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 16:47 Nourish 461 ML nourish with 200 ML H2O mixed in, given orally, signed by LPN H, 20:47 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H. On 2/21/22 10:00 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 12:10 Nourish 356 ML Nourish with 180 ML H2O given orally, signed by LPN H, 14:05 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 15:55 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 17:00 Nourish 461 ML with 200 ML H2O mixed in, given orally, signed by LPN H. On 2/22/22 6:30 Nourish 356 ML Nourish with 180 ML H2O, given orally, signed by RN L, 10:15 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L, 14:30 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L. 2/23/22 10:35 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L, 11:30 Nourish 356 ML Nourish with 180 ML H2O, given orally, signed by RN L, 14:45 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L. 2/24/22 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 12:06 Nourish 356 ML with 180 ML H2O, given orally, signed by LPN H, 14:00 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 16:00 Hydration Bolus 140 ML, 200 ML given Buccal,		these corrective actions to ensure the deficiency is corrected andwill not recur. Completed 4/14/22 and ongoing.	

	signed by LPN H, 17:05 Nourish with 461 ML with 200ml H2O, given orally, signed by LPN H. 2/25/22 10:00 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 12:09 Nourish 356 ML with 180 ML H2O, given orally, signed by LPN H, 14:00 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 16:05 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 17:18 Nourish with 461 ML with 200ml H2O, given orally, signed by LPN H. 2/28/22 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 11:50 Nourish 356 ML with 180 ML H2O, given orally, signed by LPN H, 13:45 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H. 3/1/22 10:55 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L, 11:30 Nourish 356 ML with 180 ML H2O, given orally, signed by RN L, 14:15 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L, 17:45 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L. 3/2/22 10:30 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L, Nourish 356 ML with 180 ML H2O, given orally, signed by RN L, 14:25 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L, 17:50 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L. 3/3/22 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 11:42 Nourish 356 ML with 180 ML H2O, given orally, signed by LPN H, 13:45 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H. 3/7/22 10:20 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 13:50 Nourish 356 ML with 180 ML H2O, given orally, signed by LPN H, 15:15 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 17:48 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 18:43 Nourish 461ML with 200 ML H2O, given orally, signed by LPN H. 3/8/22 10:30 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L, 13:15 Nourish 356 ML with 180 ML H2O, given orally, signed by RN L, 14:45 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L, 17:00 Nourish 461ML with 200 ML H2O, given orally, signed by RN L, 17:00 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L. 3/9/22 10:30 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L, 11:30 Nourish 356 ML with 180 ML H2O, given orally, signed by RN L, 17:05 Hydration Bolus 140 ML, 200 ML given Buccal, signed by RN L. 3/10/22 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 11:48 Nourish 356 ML with 180 ML H2O, given orally, signed by LPN H, 13:50 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 15:45 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 18:26 Nourish 461 ML with 200 ML H2O, given orally, signed by LPN H. 3/11/22 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 11:15 Nourish 356 ML with 180 ML H2O, given orally, signed by LPN H, 13:43			

Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H, 15:55 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H. 3/14/22 9:59 Hydration Bolus 140 ML, 200 ML given Buccal, signed by LPN H.

5. In a phone interview on 3/14/22 at 2:18 PM, with employee I, RN when queried about the medication administration with Patient #5, employee I, stated all the nurses know not to give the patient anything by mouth, but was not aware the medication administration form still had orders to administer medication bucally (oral.) and orally. Employee I also stated they used to read through the care plan but not anymore, as the mother would inform the nurses of any changes.

In a phone interview on 3/14/22 at 5:37 PM, employee H, LPN stated they knew the care plan was not accurate (referring to Hydration Bolus and Tube Feedings) but didn t think anything about it, because everyone knows not to give anything by mouth to the patient, and no one really looks at care plan because Mom would tell everyone what to do.

During an interview with Employee G, RN case manager for patient #5, on 3/14/22 at 1:53 PM, stated they hadn t realized the medications routes had been changed. When asked if the Plan of Care was reviewed with the patient s caregiver, stated they don t usually go through them, when there isn t a change.

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

1. Review of an agency policy, titled 'Medication Profile C-700,' dated 12/30/21, stated "POLICY ... the Registered Nurse ... will complete a medication profile for each patient at the time of admission. The medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the patient is taking...PURPOSE...to provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile ...To provide documentation of changes in the medication regimen as they happen, and

support changes needed to the Plan of Care ...To identify the effect of medications and side effects that may lead to falls or other adverse events, so that appropriate interventions can be incorporated in the plan of care to decrease risk of adverse events...SPECIAL INSTRUCTIONS...The Medication Profile shall document: ...C . Medication name ... D. Medication Dosage ... E. Route and frequency of administration...7. The Medication Profile shall be reviewed by a Registered Nurse at least every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the the Medication Profile upon initiation, whenever a change is made and at least every sixty (60) days thereafter ... The original Medication Profile shall be filed in the clinical record. A copy shall be placed the patient's home chart...9. Medication Profiles created through electronic point of care documentation systems will have a copy in the patient record and patient's home if the agency is setting up or managing the medication administration."

A review of an agency policy, titled 'Medication Set Up Policy C-701,' dated 12/30/21, stated, "POLICY ... Together Homecare will set up medications for patients as ordered by the physician...PURPOSE To provide correct doses of medications according to physician's orders...To assist patient who have difficulty (physically or cognitively) setting up and taking prescribed medications...SPECIAL INSTRUCTIONS...1. A medication administration record (MAR) or Medication Profile should be used to set up medications...2. The Plan of Care is the nurse's verbal order until it is signed by the physician at which point it becomes the written order. It is the nurse's responsibility to ensure that it is accurate and without errors...4. The Nurse must always read the pharmacy labels carefully whether he/she is filling the a med-planner or administering the medication. The nurse should then compare the medication labels to the Plan of Care, checklist, and/or MAR before administering the medication...5. The Nurse will clearly document what nursing tasks were performed, what was assessed, and the findings...11. All medications should be stored in the home in a safe and secure location which is out of sight from visitors to the home..."

A review of an agency s policy, titled 'Medication Management C-705', dated 12/30/21 revealed, "POLICY...Together Homecare has a medication management system that supports patient safety and improves quality of care

	variation, errors and misuse of medications. The agency has established a mechanism for identifying and reporting potential and actual errors, and a process to improve systems and performance in the area of medication administration and management. PURPOSE To reduce errors and improve quality of care and promote safety throughout the home care program & PROGRAM SPECIFICS Comprehensive patient assessment performed at the start of care and other defined points in time include review of all medications the patient is taking &and records this in the patient record & Medications in the home are reviewed with the patient/family to determine current medications and patient understanding of the medications actions and side effects. Specific instructions for how and when to take the medications will be reviewed and documented &Medications that are easy to confuse (sound alike or look alike drugs) or chemicals that could be mistaken for medications should be separated and labeled as needed &If medications are being set up by the nurse for self-administration or administration by family or other caregivers, a chart or other form of direction may be left in the home to assure medications are taken at the times ordered, and to assess patient compliance with the schedule...MEDICATION ORDERS 1. Written orders must be legible and clearly documented. A complete medication order must include: a. The full name of the drug. b. Dose and time drug is to be given & MEDICATION ADMINISTRATION 1. When agency staff are administering medications the following steps will be taken: a. Clinician will verify that the medication is the correct one & b. Clinician will verify that the medication or solution is stable based on visual examination &c. Clinician will verify that the dose and the medication are not contraindicated at that time. d. Clinician will verify that the medication is being administered at the correct time, in the correct dose and by the correct route &MONITORING EFFECTS OF MEDICATIONS 1. Together Homecare will develop monitoring parameters and guidelines to assure the medications are appropriate and the patient/caregivers report observations and concerns &2. Patient response to medications will be assessed with each review/reconciliation & FOLLOW UP 1. All medication adverse effects and errors will be documented &2. Staff are educated and encouraged to report all events and near misses, and follow up will be done to identify system or process change needed. 3. Findings will be compiled and reported to the Director of Clinical Services/designee for review and recommendation. A review of an agency s policy, titled 'Medication			

Labels C-707,' dated 12/30/21 revealed, "POLICY Together Homecare staff will check all patient medications to determine that labels are present and legible. PURPOSE To assure that all medications identify the medication and instructions for use. To prevent medication error caused by improper or absent labels &SPECIAL INSTRUCTIONS 1. Together Homecare staff will review patients medications at the time of admission and on an ongoing basis. a. each medication should be labeled with the medication name, strength, dose, and expiration date &

A review of an agency s policy, titled 'Medication Administration C-708,' dated 12/30/21 revealed, POLICY Together Homecare staff will administer medications as ordered by the physician &PURPOSE To assure that medications the patient is taking and/or agency staff are administering have current and accurate orders for safe administration. To Prevent medication errors or adverse effects for patients &SPECIAL INSTRUCTION 1. Together Homecare staff will verify orders for all drugs and treatments before administering them to patients &2. All orders for medications will contain the name of the drug, dosage, frequency, and method of administration &5. Agency staff will check all patient medicines 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 &9. Prior to the administration of any medication by any route, the nurse will verify: a. Medication is correct &b. Medication stability by performing a visual examination &c. Medication has not expired. d. Medication is the correct dose, route, and time &"

2. During a home visit on 3/10/12 at 10:11 AM for Patient 3, Nurse C was observed performing a recertification visit. Nurse C inquired of Person G (relative of Patient 3) if there had been any changes in Patient 3's medication regimen. Person G had difficulty staying awake during the interview and required prompting to stay awake and answer questions, but ultimately indicated that there had been no recent medication changes. Nurse C failed to request to review actual medication containers/bottles to verify the accuracy of, or identify discrepancies between the agency's current medication profile and what was in the home being administered.

In an interview on 3/11/22 at 3:49 PM with the Clinical Manager, when queried as to the reason

Nurse C did not complete a full medication reconciliation/regimen review during the recertification visit, and only inquired verbally about medications from Person G who was unable to stay awake for the interview and was therefore unreliable, the Clinical Manager indicated that nursing staff does not routinely "physically review medications."

3. A review of the clinical record for Patient 2 revealed a start of care date of 2/20/17, with a certification period of 1/15/22 to 3/15/22, and diagnoses which included, but were not limited to: Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system, and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for medication administration and enteral feeding administration via g-tube. The electronic clinical record failed to evidence a Medication Administration Record (MAR), from the start of care (2/20/2017) to 3/11/22.

During a home visit on 3/11/22 at 9:00 AM, for Patient 2, who receives all medications through a gastrostomy tube (g-tube), Nurse F administered 5 separate syringes full of what appeared to be medications, via G-tube, followed by a water flush. The syringes used failed to evidence labels or markings. Nurse F guided the surveyor back to the kitchen where Nurse F had pre-filled all syringes with medication for the entire day. Approximately 30 pre-filled syringes were laying on the kitchen island, loosely grouped together, and were unlabeled/unmarked. There were additional pre-filled syringes on a different counter in the kitchen, also unlabeled/unmarked and placed in a clear gallon-sized baggie labeled '9 am' and similar, adjacent baggies which contained more syringes, were also unmarked/unlabeled. When Nurse F was queried about the medications laid out, Nurse F indicated the patient had medications scheduled to be given approximately every 60-90 minutes throughout the day, and stated he/she prepares all these ahead of time upon arrival at the patient's home, at approximately 7:15 AM every day. When queried as to what document he/she follows to ensure accuracy of medication, Nurse F indicated she had been, "doing this so long," "I just know all the medications" needed. When queried further as to the location of any document that would be utilized to record the

	medications she had just given, Nurse F indicated he/she completes documentation at the end of the day. There was no Medication Administration Record (MAR) present in the kitchen (where meds are stored and prepared), nor in the patient's folder in the living room, to record which medications were given, nor the time and route they had been administered to the patient. When queried about this, Nurse F indicated he/she must have left the MAR in her trunk. Nurse F went to check his/her car, then returned and indicated he/she must have, "left the MAR at home". When queried as to where he/she would be documenting the medications administered today, Nurse F indicated that he/she would check off a box on a sheet titled 'Nursing Note' which was present in the home. Nurse F proceeded to circle with a black pen, an area marked "9 AM meds" and then indicated he/she marks her flushes and feedings on this same document. Times were pre-marked and handwritten. When queried further as to where he/she would record each individual medication administered, Nurse F reiterated, "right here" pointing to space where the column header states 'oral liquid' and has the time handwritten in as, "9 AM, meds, 20 ml." This document failed to evidence each individual medication name, dosage, route, time due, time administered, and how tolerated by the patient. In an interview on 3/11/22 at 9:23 AM with Clinical Manager, when queried as to what she noted to be of concern during the visit with Nurse F at Patient 2's visit, Clinical Manager answered, "[nurse] left the MAR at home." In an interview on 3/11/22 at 4:01 PM, the Clinical Manager indicated she could not locate a MAR for Patient 2. She stated the MAR gets mailed to the patient's home every month. The Clinical Manager stated, "did not know" what was happening in the home, in terms of medication administration and documentation of medication profile and reconciliation. When queried as to what the expectation is from the nursing staff in this matter, the Clinical Manager indicated, "document as you go ... document as you administer" The Clinical Manager stated additionally, she would be taking MAR out to the nurse today. In an interview on 3/16/22 at 11:53 AM, Nurse K indicated that Supervisory Visits of Nurse F only involved observing the administration of enteral feedings through the g-tube. Nurse K indicated she did not observe Nurse F administer medications via g-tube and did not observe			

	Nurse F document the administration of medications. Nurse K stated that pre-filled syringes were not seen during his/her in-person supervisory visits. In a return phone call on 3/17/22 (after exiting the agency) at 11:46 AM, from Person A, inquired if there were concerns with the agency. Person A acknowledged that syringes were pre-drawn and unlabeled. Person A indicated, "having medications labeled is so important." When queried as to an untitled, typed paper found in the kitchen, near several medication bottles, which contained the names and doses of several medications, and dated 9/31/21, Person A acknowledged this sheet and informed that he/she had created this document themselves to ensure accuracy of medications being administered to the patient. Person A indicated having MARS from the agency available in the home was a problem. Stated does not believe Nurse F had left the patient's MAR at the nurse's home. Stated, "that's not accurate." Indicated that MARs are mailed to patients' homes and should be there timely, but are "never mailed on time." Indicated MARs often, "arrive 10 days late, when they should be there the first of the month." Expressed concern documentation was then backdated by default and stated, "that's not right." Indicated would be pleased if MAR could just be delivered to the home timely. Indicated would like MAR to be present so that medications administered could just be checked off "right then." Indicated this has "always been an issue."			
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	G0570	G570 The MAR and medication list for patient 5 identified in thesurvey report have been delivered to the home, and the patient’s nurse has beenre-educated on the requirement to use the MAR as a basis for care and for documentationof all medication administration. The Agency has re-reviewed all medication profiles	2022-04-21

	patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview, the agency failed to ensure services were provided in accordance with the plan of care, failed to ensure each patient received an individualized care plan, failed to ensure visit frequencies were individualized to be specific to the patients' needs, failed to identify patient-specific and measurable outcomes and goals (See G572); the agency failed to ensure that patients received care visits as ordered by the physician in the plan of care (See G 580); and failed to prepare and provide the patient and family with written information containing the patient's medication schedule and instructions to include the medication name, dosage, route, frequency, and which medications would be administered by agency staff (See G616). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 42 CFR 484.60 Care Planning, Coordination of Care, and Quality of Care. A deficient practice citation was also evidenced at this standard as follows: These practices impacted 6 (Patients #1, 2, 5, 6, 7 and 8) out of 9 sampled records reviewed. Findings Include: 1. A review of an agency s policy titled 'Care Plans C-660,' revealed, "POLICY ... Each patient will have a Plan of Care on file that addresses their identified needs and the agency s plan to respond to those needs. The plan is developed with the patient and family & and is based on services needed to achieve specific measurable goals. PURPOSE to assure continuity and consistency between the disciplines & To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals &SPECIAL INSTRUCTIONS 1. Following the initial assessment, a Plan of Care shall be developed with the patient and/or caregiver. The interventions shall correspond to the problems identified, services needed and the patient goals for the episode of care & 3. The		that they are complete and correct. All patients ortheir representatives have been contacted to verify that the complete andcorrect medication profile is present in the patient's home chart and that thecomplete and correct MAR is present in the home chart for skilled patients. Allpatient home charts are 100% compliant. The Agency has verified that a MAR ispresent in the home of every skilled nursing patient. All Agency nurses havebeen re-educated on the requirement to utilize the MAR as a basis for care andto contact the Agency immediately if they are unable to access the electronicMAR and cannot locate a paper MAR in the home. All Agency nurses responsible for creating anddistributing the medication profile and MAR have been re-educated on theimportance of getting the MAR and medication profile to the home timely. A newcontrol has been added to the Agency's comprehensive assessment forms todocument the presence of the paper or electronic MAR and to acknowledge that itis being used for documentation appropriately. The Registered Nursesresponsible for updating the comprehensive assessment have been re-educated onthe requirement to review the medication profile and MAR in the home to verifythat administrations are properly documented, and medication	

	Plan of Care shall include, but not be limited to: &Reasonable, measurable, and realistic goals as determined & c. A list of specific interventions with plans & d. Indicators for measuring goal achievement & 2. A review of an agency s policy titled 'Services Provided C-100,' dated 12/30/21, revealed, & Services shall be available seven (7) days a week, twenty-four(24) hours per day & This will include implementing, revising, and updating the Plan of Care & 3. A review of an agency's policy titled 'Admission Policy C-120,' dated 12/30/21, revealed, "POLICY Patients are accepted for treatment in the home on basis of reasonable criteria and under the expectation that the patient's medical, nursing, and social needs can be met adequately by Agency in the patient's place of residence. Agency shall make available and provide services to all persons without regard...PURPOSE To provide guidelines for accepting patients for home health care services ... SPECIAL INSTRUCTIONS Criteria for Patient Admissions: 4. There must be a reasonable expectation that the patient's medical, nursing, social or rehabilitation needs can be adequately met in the patient's home. 5. Reasonable expectation shall consider: a. Whether the agency's personnel and resources are adequate...10. Agency Services must be appropriate and available to meet the specific needs and requests of the patient and caregiver." 4. A review of an agency s policy titled 'Physician Orders C-635,' dated 12/30/21, revealed, POLICY ... All medications, treatments and services provided to patient must be ordered by a physician &PURPOSE To document verification that orders for services have been obtained from the physician. To assure accurate and complete orders are obtained and verified & 5. Review of an agency policy titled 'Medication Profile C-700,' dated 12/30/21, stated, "POLICY ... the Registered Nurse ... will complete a medication profile for each patient at the time of admission. The medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the patient is taking...PURPOSE...to provide documentation of		lists are current.This education will continue to be provided to all incoming nurses as part ofthe orientation and training process. The Director of Clinical Services or RN designee will audit100% of patient assessments for 60 days to validate continued compliance withthe MAR and med profile monitoring requirements. TheDirector of Clinical Services or RN designee will audit 100% of all completed MARsweekly for 60 days to ensure continued compliance with documentation ofmedication administrations. After 60 days of compliance, the Agency willcomplete a review of MARs for at least 50% of skilled nursing patients eachquarter, in addition to the MARs being reviewed as part of the Agency'squarterly 10% clinical record audit, to ensure compliance is maintained. All RNs responsible for creating and updating the plan ofcare have been re-educated on the requirement to clearly identify patient-specificgoals and measurable outcomes, as well as specific interventions for skillednursing goals. This education will continue to be provided to all incomingnurses responsible for completing the plan of care. The Director of Clinical Services or RN designee will evaluate100% of plans of care for 60 days to ensure patient-specific goals are clearlyidentified and to ensure specific interventions for skilled nursing goals areincorporated in the plan of care. After 60 days, the presence ofpatient-specific goals, as well as interventions for skilled care, will bereviewed and	

	the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile...To provide documentation of changes in the medication regimen as they happen, and support changes needed to the Plan of Care...To identify the effect of medications and side effects that may lead to falls or other adverse events, so that appropriate interventions can be incorporated in the plan of care to decrease risk of adverse events...SPECIAL INSTRUCTIONS...The Medication Profile shall document: ... C. Medication name...D. Medication Dosage ... E. Route and frequency of administration...7. The Medication Profile shall be reviewed by a Registered Nurse at least every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the the Medication Profile upon initiation, whenever a change is made and at least every sixty (60) days thereafter ... The original Medication Profile shall be filed in the clinical record. A copy shall be placed the patient's home chart ... 9. Medication Profiles created through electronic point of care documentation systems will have a copy in the patient record and patient's home if the agency is setting up or managing the medication administration." 6. A review of an agency s policy, titled 'Medication Management C-705,' dated 12/30/21 revealed, "POLICY Together Homecare has a medication management system that supports patient safety and improves quality of care treatment and services by reducing practice variation, errors and misuse of medications. The agency has established a mechanism for identifying and reporting potential and actual errors, and a process to improve systems and performance in the area of medication administration and management. PURPOSE To reduce errors and improve quality of care and promote safety throughout the home care program &PROGRAM SPECIFICS Comprehensive patient assessment performed at the start of care and other defined points in time include review of all medications the patient is taking & and records this in the patient record &Medications in the home are reviewed with the patient/family to determine current medications and patient understanding of the medications actions and side effects. Specific instructions for how and when to take the medications will be reviewed and documented &Medications that are easy to confuse (sound alike or look-alike drugs) or chemicals that could be mistaken for medications should be separated and labeled as needed &If medications are being set up by the		confirmed during the 10% clinical record audit each quarter, aspart of the Agency’s QAPI program. Patient 8’s representative has been contacted to discussstaffing, and to provide re-education on the right to select another homecareprovider who may be better able to staff the patient’s hours. This caseconference has been documented and relayed to the case manager. The Agency will continue to prioritize all efforts to staffall patient shifts according to the plan of care. The Agency has reviewed allcompleted patient schedules and has contacted any patient/patientrepresentative where ongoing scheduling issues have been noted. These patientsor their representatives have been re-educated on the right to choose anotherprovider. All patients will continue to be educated on this right at allre-certification timepoints and upon admission. All employees responsible forstaffing and oversight of cases have been re-educated on the requirement to provideservices as ordered by the physician, as well as the need to hold a caseconference with any patients and/or their legal representatives when schedulingrequirements cannot be appropriately met, to remind patients and/or theirrepresentatives of their right	

	nurse for self-administration or administration by family or other caregivers, a chart or other form of direction may be left in the home to assure medications are taken at the times ordered, and to assess patient compliance with the schedule...MEDICATION ORDERS 1. Written orders must be legible and clearly documented. A complete medication order must include: a. The full name of the drug. b. Dose and time drug is to be given &MEDICATION ADMINISTRATION 1. When agency staff are administering medications the following steps will be taken: a. Clinician will verify that the medication is the correct one &b. Clinician will verify that the medication or solution is stable based on visual examination &c. Clinician will verify that the dose and the medication are not contraindicated at that time. d. Clinician will verify that the medication is being administered at the correct time, in the correct dose and by the correct route &" 7. A review of the clinical record of Patient #1, with a start of care date of 11/30/18, evidenced a plan of care for the certification period of 1/13/22 to 3/13/22, diagnoses included, but not limited to, Polyneuropathy (a condition in which a person's peripheral nerves that run throughout your body are damaged; which affects the nerves in your skin, muscles, and organs which can cause tingling, numbness, pins and needles feeling, difficulty using the arms, legs, hands, or feet, and increased pain [such as burning, stabbing, freezing, or shooting pains]), Osteoarthritis (the protective cartilage that cushions the ends of the bones wears down over time} right knee, Left Artificial hip, and history of Cancer Left Breast. Subtitle 22. Goals/Rehabilitation potential/Discharge Plans Goals: Respiratory health will be maintained AEB (as evidenced by) no diagnosis of respiratory infection. By End of Certification Period Status of Goal: Goal Met. No reported respiratory infection this certification period. Ongoing goal. Due to their continued need for homecare services, this goal remains relevant to their care and progress will continue to be assessed upon supervisory visits, re-certification, and PRN (as needed). Patient will remain safe in home environment AEB no falls, injuries, ER (emergency room) visits, or unscheduled hospitalizations By: End of the certification period (60 days) Status of Goal: Goal Met. No reported falls, injuries, ER visits, or hospitalizations this certification period. Ongoing goal. Due to their continued need for homecare services, this goal remains relevant to their care, and progress will continue to be assessed upon supervisory visits, re-certification, and PRN. Patient will maintain maximum level of independence AEB no		to change agencies at any time. The Administrator will review 100% of completed patientschedules weekly for 60 days to monitor adherence to the physician-orderedfrequency. For any patient who has ongoing staffing issues, the Administratoror designee will hold a case conference to discuss the right to transition toanother provider. These case conferences will be documented in the clinicalrecord and the patient’s Case Manager will be notified. After 60 days, adherence to the patient-requested schedule,as ordered by the physician, will continue to be reviewed during the quarterly10% clinical record audit as part of the Agency’s QAPI Program. The Administrator and Director of Clinical Services areresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur. Completed 4/21/2022 and ongoing.	

functional decline. By: End of the certification period (60days) Status of Goal: Goal Met. No functional decline reported this certification period. Ongoing goal. Due to ... continued need for homecare services, this goal remains relevant to ... care, and progress will continue to be assessed upon supervisory visits, re-certifications, and PRN.

The agency failed to identify patient-specific goals and measurable outcomes and failed to identify specific interventions for the skilled nursing stated goals. There was no measurable objective standard for what "Patient will maintain maximum level of independence as evidenced by (AEB) no functional decline."

8. A review of clinical record for Patient 2 revealed a start of care date of 2/20/17, with a certification period of 1/15/22 to 3/15/22, and diagnoses which included, but were not limited to, Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for medication administration and enteral feeding administration via g-tube.

The electronic clinical record failed to evidence a Medication Administration Record, from the start of care (2/20/2017) to 3/11/22.

During a home visit on 3/11/22 at 9:00 AM, for Patient 2, who received all medications through a gastrostomy tube (g-tube), Nurse F administered 5 separate syringes full of what appeared to be medications, via G-tube, followed by a water flush. The syringes used failed to evidence labels or measurement markings. Nurse F guided the surveyor back to the kitchen where Nurse F had pre-filled syringes with medication for the entire day. Approximately 30 pre-filled syringes were laying on the kitchen island, loosely grouped together, and were unlabeled/unmarked. There were additional pre-filled syringes on another counter in the kitchen, unlabeled/unmarked and placed in a clear gallon-sized baggie labeled '9 am' and similar, adjacent baggies which contained more pre-filled syringes, were also unmarked. When

queried about the medications laid out, Nurse F indicated the patient had medications scheduled to be given approximately every 60-90 minutes throughout the day, and states he/she prepares these ahead of time upon arrival the patient's home, at approximately 7:15 AM every day. When queried as to what document he/she follows to ensure accuracy of medication, Nurse F indicated he/she had been, "doing this so long", "I just know all the medications" needed. When queried further as to the location of any document that would be utilized to record the medications they had just given, Nurse F indicated he/she completes documentation at the end of the day. There was no Medication Administration Record (MAR) present in the kitchen (where meds are stored and prepared), nor in the patient's folder in the living room, to record which specific medications were given, nor what time, nor by which route they had been administered to the patient. When queried about this, Nurse F indicated he/she must have left the MAR in his/her trunk. Nurse F went to check his/her car, then returned and indicated he/she must have, "left the MAR at home". When queried as to where they would be documenting the medications administered today, Nurse F indicated that he/she would check off a box on a sheet titled 'Nursing Note' which was present in the home. Nurse F proceeded to circle with a black ink pen, an area handwritten in as "9 AM, meds, 20ml" and then indicated also marks flushes and feedings on this same document. The times were pre-marked and handwritten. When queried further as to where he/she would record each individual medication administered, Nurse F reiterated, "right here" pointing to the space where the column header stated 'oral liquid' and has the time handwritten in as, "9 AM, meds, 20 ml". This document failed to evidence each individual medication name, dosage, route, time due, time administered, and how the medication was tolerated by the patient. A review of the patient's home folder failed to evidence a handwritten medication profile.

In an interview on 3/11/22 at 9:23 AM with Clinical Manager, when queried as to what she found to be of concern during the home visit with Nurse F for Patient 2, Clinical Manager answered, "[nurse] left the MAR at home."

In an interview on 3/11/22 at 4:01 PM, the Clinical Manager indicated she could not locate a MAR for Patient 2. The clinical manager then stated MAR gets mailed to the patient's home every month. Indicated "did not know" of the medication administration and documentation

	to what the expectation was from the nursing staff in this regard, the Clinical Manager indicated, "document as you go ... document as you administer." Stated additionally that she would be taking MAR out to the patient's home today. In a return phone call on 3/17/22 (after exiting the agency) at 11:46 AM, from Person A, the surveyor inquired if there were concerns with the agency. Person A acknowledged that medication syringes were pre-filled and unlabeled. Indicated that, "having medications labeled is so important". When queried as to the purpose of an untitled, typed paper found in the kitchen, near several medication bottles, which contained the names and doses of several medications, and was dated 9/31/21 Person A acknowledged this sheet and informed that they had created this document themselves to ensure accuracy of medications being administered to the patient. Person A indicated that having agency MARS available in the home has been a problem. Stated does not believe that Nurse F had left the patient's MAR at the nurse's home. Stated, "that's not accurate". Indicated that MARs are mailed to home and should be there timely, but are "never mailed on time." Indicated MARs often, "arrive 10 days late, when they should be there the first of the month". Expressed concern that documentation is then backdated by default and, "that's not right." Expressed would be pleased if MAR could just be delivered to the home timely. Indicated would like MAR to be present so that medications administered could just be checked off "right then." Person A indicated this has, "always been an issue." 9. Review of the clinical record of Patient #5, with a start of care date of 4/12/21, revealed a Home Health Certification and Plan of Care , dated 2/2/22, for the certification period of 2/6/22 to 4/6/22. Subtitle 11. ICD-CM Principal Diagnosis Extreme immaturity of newborn, gestational age 24 completed weeks , Subtitle 13 ICD-CM Other Pertinent Diagnoses are but not limited to Delayed Milestone in childhood, dependence on respirator [ventilator] status, Dysphagia, tracheostomy status, gastrostomy status and Right eye blindness . Subtitle 16. Nutritional Requirements Tube Feeding Nourish 243 ML with 180 ML H2O at 8 AM, 324 ML with 180 ML H2Oat noon, and 405 ML with 200 ML H2O at 6 PM 3 times /daily, ***Aspiration precautions***, NPO . Patient was to receive skilled nursing care 11-13 hours per day 3-5 days per week for medication setup and administration, tracheostomy care, gastrostomy			

	care, check for residual before administering tube feedings, perform full, comprehensive assessment every visit, assist with activities of daily living, and notify physician for any abnormal findings and accompany patient on appointments/school while the parents were at work. Subtitle 22 Goals/Rehabilitation Potential/Discharge Plans Goals: Patient will be free from seizures AEB no documented or reported seizure activity By: End of Certification period, Status of Goal: Goal met: Ongoing, Due to the patient s continued need for home care, this goal remains relevant to their care and will continue to be assess at supervisor visits, re-certifications, and PRN. Respiratory health will be maintained AEB no diagnosis of respiratory infection. By End of certification period, Status of Goals: Goal met: Ongoing, Due to the patient s continued need for home care, this goal remains relevant to their care and will continue to be assess at supervisory visits, re-certifications and PRN. Patient will be free from infections AEB no discolored drainage from stoma and no use of antibiotics to treat stoma infections. By: End of certification period. Status of Goal: Goal met: Ongoing, Due to the Patient s continued need for home care, this goal remains relevant to their care and will continue to be assessed at supervisory visits, re-certifications, and PRN. G-tube feedings will be well-tolerated, AEB absence of vomiting, no feedings held due to excessive residual, and no signs of GI intolerance (diarrhea, constipation, dehydration) By: End of Certification period Status of Goal: Goal met; Ongoing, Due to the patient s continued need for home care, this goal remains relevant to their care and will continue to be assess at supervisory visits, re-certifications, and PRN. Patient will remain safe in home environment AEB no falls, injuries, ER visits, or unscheduled hospitalizations By: End of certification period, Status of Goal: Goal met: Ongoing, Due to the patient s continued need for home care, this goal remains relevant to their care and will continue to be assess at supervisory visits, re-certifications, and PRN. The agency failed to identify patient-specific goals and measurable outcomes and failed to identify specific interventions for the skilled nursing stated goals for the patient. 10. A review of the closed clinical record of Patient #6, with a start of care date of 9/22/21, revealed a Home Health Certification and Plan of Care , dated 9/22/21 for the certification period of 9/22/21 to 11/20/21, which evidenced			

	Left lower extremity paralysis, abdominal hernia, and anemia. The patient was to receive home health aide services 4-7 hours per day, 3-5 days per week to assist the patient in/out of bed, chair transfers, hygiene and grooming, preparation of meals, encourage fluids, and light housekeeping while the patient s spouse was at work. Subtitle 22. Goals/Rehabilitation Potential/Discharge Plans Goals: Skin integrity will be maintained, AEB absence of any new or worsening skin breakdown By: End of certification period Status of Goal: Goal newly established at the start of care, the goal will be assessed during each supervisory visit, re-certifications visits, and PRN. Diabetes symptoms will be well maintained AEB no report of excessive thirst hunger, urination, dizziness, and fatigue. By: End of certification period Status of Goal: Goal new established at start of care, goal will be assessed during each supervisory visit, re-certification visits, and PRN Patient will remain safe in home environment AEB no falls, injuries, ER visits, or unscheduled hospitalizations. By: End of certification period Status of Goals: Goal newly established at start of care, goal will be assessed during each supervisory visit, re-certification visit, and PRN. Patient will maintain maximum level of independence AEB no functional decline. By: End of certification period Status of Goal: Goal newly established at start of care, goal will be assess during each supervisory visit, recertification visit, and PRN. A review of a Home Health Certification and Plan of Care , with a start of care date 9/22/21, dated 11/18/21 for the certification period of 11/21/21 to 1/19/21, which evidenced diagnoses but not limited to Cerebral infarction, Left lower extremity paralysis, abdominal hernia, and anemia. The patient was to receive home health aide services 4-7 hours per day, 3-5 days per week to assist the patient in/out of bed, chair transfers, hygiene and grooming, preparation of meals, encourage fluids, and light housekeeping while the patient s spouse was at work. Subtitle 22. Goals/Rehabilitation Potential/Discharge Plans Goals: Skin integrity will be maintained, AEB absence of any new or worsening skin breakdown By: End of certification period Status of Goal: Goal Met, Ongoing, Due to the patient s continued need for homecare services, this goal remains relevant to their care. Goal will be assessed during each supervisory visit, re-certification visits, and PRN. Diabetes symptoms will be well maintained AEB no report of excessive thirst hunger, urination, dizziness, and fatigue. By: End of certification period Status of Goal: Goal Met: Ongoing, Due to the patient s continued need for homecare services, this goal remains relevant to their care. Goal will			

	be assessed during each supervisory visit, re-certification visits, and PRN Patient will remain safe in home environment AEB no falls, injuries, ER visits, or unscheduled hospitalizations. By: End of certification period Status of Goals: Goal Met: Ongoing, Due to the patient s continued need for homecare services, this goal remains relevant to their care. Goal will be assessed during each supervisory visit, re-certification visit, and PRN. Patient will maintain maximum level of independence AEB no functional decline. By: End of certification period Status of Goal: Goal met: Ongoing, Due to the patient s continued need for homecare services, this goal remains relevant to their care. Goal will be assess during each supervisory visit, recertification visit, and PRN. The Patient was discharged 12/2/21. A review of the Scheduled Patient Visits for patient #6, evidenced missed visits for the certification period of 9/22/21 to 11/20/21, were on 9/22/21 to 10/4/21, 10/8/21, 10/14/21, 10/15/21, 10/21/21, 10/25/21 to 10/29/21, 11/1/21, 11/2/21, 11/5/21, 11/11/21, 11/12/21, 11/16/21, and 11/17/21. A review of the Scheduled Patient Visits, evidenced missed visits for the certification period of 11/21/21 to 1/19/22, were on 11/22/21, 11/24/21, 11/26/21, 11/29/21, and 12/1/21. The agency failed to provide services to Patient #6 as outlined/ordered in the Physician signed plan of care. The agency failed to identify patient-specific goals and measurable outcomes, failed to identify specific interventions for the skilled nursing stated goals for Patient 6, and failed to ensure services were provided as outlined in the Plan of Care. 11. A review of the clinical record of Patient #7, with a start of care date of 1/27/21, revealed a Home Health Certification and Plan of Care , dated 1/27/21 for certification period of 1/27/21 to 3/27/21, with diagnoses, but not limited to, Cerebral infarction due to embolism of an unspecified anterior cerebral artery, Ataxic gait, Polyneuropathy, Other chronic pain, and Chronic obstructive pulmonary disease. The patient was to receive home health aide services			

	assist with ambulation/transfers, assist with shower, skincare, shampoo, oral hygiene, dressing, and light housekeeping. Subtitle 22. Goals/Rehabilitation Potential/Discharge Plans Goals: Diabetes symptoms will be well maintained AEB no report of excessive thirst, hunger, urination, dizziness, and fatigue. By: End of the certification period Status of Goal: Goal established at Start of Care. Progress will be assessed upon supervisory visits, re-certifications, and PRN. Patient will remain safe in home environment AEB no falls, injuries, ER visits, or unscheduled hospitalizations By: End of the certification period Status of Goal: Goal established at Start of Care. Progress will be assessed upon supervisory visits, re-certifications, and PRN. Patient will maintain maximum level of independence AEB no functional decline By: End of the certification period Status of Goal: Goal established at the Start of Care. Progress will be assessed upon supervisory visits, re-certifications, and PRN. A review of the clinical record of Patient #7, with a start of care date of 1/27/21, revealed a Home Health Certification and Plan of Care , dated 1/27/21 for the certification period of 1/22/22 to 3/22/22, with diagnoses but not limited to Cerebral infarction due to embolism of unspecified anterior cerebral artery, Ataxic gait, Polyneuropathy, Other chronic pain, and Chronic obstructive pulmonary disease. The patient was to receive home health aide services 1-3 hours a day, 3-5 days per week for stand by assist with ambulation/transfers, assist with shower, skin care, shampoo, oral hygiene, dressing, and light housekeeping. Subtitle 22. Goals/Rehabilitation Potential/Discharge Plans Goals: Diabetes symptoms will be well maintained AEB no report of excessive thirst, hunger, urination, dizziness, and fatigue. By: End of the certification period Status of Goal: Goal Met. The patient had no reports of uncontrolled diabetic symptoms, Ongoing goal, Due to their continued need for homecare services, this goal remains relevant to their Plan of Care. Progress will be assessed upon supervisory visits, re-certifications, and PRN. Patient will remain safe in home environment AEB no falls, injuries, ER visits, or unscheduled hospitalizations By: End of the certification period Status of Goal: Goal Met, The patient had no reported falls, injuries, ER visits, or hospitalizations this certification period. Ongoing goal, Due to their continued need for homecare services, this goal remains relevant to their Plan of Care. Progress will be assessed upon supervisory visits, re-certifications, and PRN. Patient will maintain maximum level of independence AEB no functional decline By: End of the certification period, Status of Goal:			

	Goal Met. No functional decline reported. Ongoing goal, Due to their continued need for homecare services, this goal remains relevant to their Plan of Care. Progress will be assessed upon supervisory visits, re-certifications, and PRN. The agency failed to identify patient-specific goals and measurable outcomes and failed to identify specific interventions for the skilled nursing stated goals for the Patient 7. 12. A review of the clinical record of Patient #8, with a start of care date of 3/25/20, revealed a Home Health Certification and Plan of Care , dated 1/14/22 with diagnoses but not limited to Tremor, unspecified, Personal history of traumatic brain injury, and aphasia. The patient was to receive home health aide services 4.5 to 6.5 hours, 2-4 days a week for assist with transfers, bathing/showering, preparing/serving meals, range of motion exercises, toileting/elimination, encourage stander, light housekeeping, and assist with stairlift as needed. Subtitle 22 Goals/Rehabilitation Potential/Discharge Plans Goals: Patient will remain safe in home environment AEB no falls, injuries, ER visits, or unscheduled hospitalizations, By: End of the certification period. Status of Goal: Goal Met. No reported falls, injuries, ER visits, or hospitalizations this certification period. Ongoing goal. Due to their continued need for homecare services, this goal remains relevant to their care and progress will be assessed upon supervisory visits, re-certifications, and PRN. Patient will maintain maximum level of independence AEB no functional decline. By: End of the certification period. Status of Goal: Goal Met. No reports of functional decline. Ongoing goal, Due to their continued need for homecare services, this goal remains relevant to their care and progress will be assessed upon supervisory visits, re-certifications, and PRN. A review of the Scheduled Patient Visits, for Patient #8, evidenced missed care visits for the certification period of 1/14/22 to 3/14/22 were the week of 2/7/22 to 2/12/22, the week of 2/14/22 to 2/19/22 and the week of 3/7/22 to 3/11/22. The agency failed to identify patient-specific goals and measurable outcomes, failed to identify specific interventions for the skilled nursing stated goals for Patient 8 and failed to			

	ensure services were provided as outlined in the Plan of Care. The Agency failed to provide services to Patient #8 as outline/ordered, and were signed by the physician in the Plan of Care. During a phone interview on 3/14/22 at 10:29 AM, with a family member of patient #8, person I, stated that they thought about changing agencies but talking with their case manager J from entity K, all agencies are having difficulties with staffing. When queried about days requesting services, they stated they had originally requested to have services on Mondays, Wednesdays, Fridays, and Saturdays, and was told by the agency they wouldn t have a problem staffing. The family member I stated, they do have another family that comes in to assist some on Saturdays. When queried if the agency had ever offered to assist in finding another agency to provide services, they stated no. During an interview with the administrator, when asking about not providing services for patient #8, the administrator stated that the patient had refused some services. When asked to provide documentation of the refused visits, 1 document was presented that 1 visit was refused on 1/15/22. 410 IAC 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 allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure services were provided in accordance with the plan of care, failed to	G0572	G 572 All RNs responsible for creating andupdating the plan of care have been re-educated on the requirement to includepatient-specific goals and measurable outcomes, as well as specificinterventions for skilled nursing goals. The Agency has contacted all patients to address anyconcerns related to staffing. Any patients whose schedules are having consistent staffing issues havebeen re-educated on the ability of the Agency to facilitate	2022-04-28

	ensure each patient received an individualized care plan, failed to ensure the frequency of care visits was specific to patients' needs, and failed to identify patient-specific and measurable outcomes and goals for 5 of 9 records reviewed. (Patients #1, 5, 6, 7, and 8) Findings include: 1. A review of an agency s policy titled, 'Care Plans C-66' , revealed "POLICY Each patient will have a Plan of Care on file that addresses their identified needs and the agency s plan to respond to those needs. The plan is developed with the patient and family &and is based on services needed to achieve specific measurable goals. PURPOSE to assure continuity and consistency between the disciplines &To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals & SPECIAL INSTRUCTIONS 1. Following the initial assessment, a Plan of Care shall be developed with the patient and/or caregiver. The interventions shall correspond to the problems identified, services needed and the patient goals for the episode of care & 3. The Plan of Care shall include, but not be limited to: & Reasonable, measurable, and realistic goals as determined & c. A list of specific interventions with plans & d. Indicators for measuring goal achievement & A review of an agency s policy titled, 'Services Provided C-100,' dated 12/30/21, revealed, & Services shall be available seven (7) days a week, twenty-four(24) hours per day &This will include implementing, revising, and updating the Plan of Care & 2. A review of the clinical record of Patient #1, with a start of care date of 11/30/18, evidenced a plan of care for the certification period of 1/13/22 to 3/13/22, diagnoses included but not limited to Polyneuropathy (a condition in which a person's peripheral nerves that run throughout your body are damaged; which affects the nerves in your skin, muscles, and organs which can cause tingling, numbness, pins, and needles feeling, difficulty using the arms, legs, hands, or feet, and increased pain [such as burning, stabbing, freezing, or shooting pains]), Osteoarthritis (the protective cartilage that cushions the ends of the bones wears down over time} right knee, Left Artificial hip, and history of Cancer Left Breast. Subtitle 22. Goals/Rehabilitation potential/Discharge Plans Goals: Respiratory health will be maintained		homecare agency who is able to staff their hours,by way of a case conference. These case conferences have beendocumented in the clinical record, and the information has been forwarded tothe patient's AAA Case Manager. The Agency will be managed by the Administrator, who will review all weeklyschedules to ensure current patients' care visit needs are met. TheAdministrator will be responsible for ensuring that no new patients areadmitted unless available caregivers are able to fulfill care visit needs forcurrent Agency patients. The agency's currentpatients are receiving 100% of ordered care visits. In light of thenational healthcare workforce shortage, the ongoing global pandemic, anda patient's right to refuse care, there are factors beyond the Agency's controlthat may cause a patient's care visit to be missed. In accordance with theCOPs, if the Agency misses a visit or a treatment or service as required by theplan of care, which results in any potential for clinical impact upon thepatient, then the Agency will notify the responsible physician of such missedtreatment or service. The Agency will continue to only admit patients for which the Agency has areasonable expectation, prior to the start of	

	AEB (as evidenced by) no diagnosis of respiratory infection. By End of Certification Period Status of Goal: Goal Met. No reported respiratory infection during this certification period. Ongoing goal. Due to their continued need for home care services, this goal remains relevant to their care and progress will continue to be assessed upon supervisory visits, re-certification, and PRN (as needed). The patient will remain safe in-home environment AEB no falls, injuries, ER (emergency room) visits, or unscheduled hospitalizations By: End of the certification period (60 days) Status of Goal: Goal Met. No reported falls, injuries, ER visits, or hospitalizations during this certification period. Ongoing goal. Due to their continued need for home care services, this goal remains relevant to their care, and progress will continue to be assessed upon supervisory visits, re-certification, and PRN. The patient will maintain a maximum level of independence AEB with no functional decline. By: End of the certification period (60days) Status of Goal: Goal Met. No functional decline was reported during this certification period. Ongoing goal. Due to her continued need for home care services, this goal remains relevant to her care, and progress will continue to be assessed upon supervisory visits, re-certifications, and PRN. The agency failed to identify patient-specific goals and measurable outcomes and failed to identify specific interventions for the skilled nursing stated goals for Patient1. 3. A review of the clinical record of Patient #5, with a start of care date of 4/12/21, revealed a Home Health Certification and Plan of Care , dated 2/2/22, for the certification period of 2/6/22 to 4/6/22. Subtitle 11. ICD-CM Principal Diagnosis Extreme immaturity of newborn, gestational age 24 completed weeks , Subtitle 13 ICD-CM Other Pertinent Diagnoses are but are not limited to Delayed Milestone in childhood, dependence on respirator [ventilator] status, Dysphagia (difficulty swallowing), tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow direct access to the breathing tube) status, gastrostomy (the construction of an artificial opening from the stomach through the abdominal wall, permitting intake of food or drainage of gastric contents)status, and Right eye blindness . Subtitle 16. Nutritional Requirements Tube Feeding Nourish 243 ML with 180 ML H2O at 8 AM, 324 ML with 180 ML H2Oat noon, and 405 ML with 200 ML H2O at 6 PM 3 times /daily, ***Aspiration precautions***, NPO . The patient was to receive skilled nursing		care, that it can meet thepatient's care needs and fulfill ordered care visits in the patient's place ofresidence, in accordance with the Conditions of Participation. The Agencyidentifies a caregiver or caregivers who can fulfill the patient's ordered carevisits prior to accepting a new patient for services. If the Agency cannotidentify a caregiver to fulfill the ordered care visits, the patient is notaccepted onto service. Each patient receives an individualized plan of care, as required by Indianalaw and the Medicare COPs. The number of ordered care visits for each patientis determined by the patient or his/her representative and the orderingprovider, based on the unique clinical needs of the patient. The Agency onlyadmits patients for which the Agency has a reasonable expectation, prior to thestart of care, that it is able to fulfill the ordered care visits based on thelength of the visit, distance and travel requirements, and caregiverqualifications. All current Agency patients are prioritized when an Agencycaregiver becomes available or a new Agency caregiver is hired. If a currentpatient and a potential new patient have similar schedules for ordered carevisits and live in similar geographic areas, the caregiver will be	

	care 11-13 hours per day 3-5 days per week for medication setup and administration, tracheostomy care, gastrostomy care, check for residual before administering tube feedings, perform full, comprehensive assessment every visit, assist with activities of daily living, and notify physician for any abnormal findings and accompany the patient on appointments/school while the parents were at work. Subtitle 22 Goals/Rehabilitation Potential/Discharge Plans Goals: Patient will be free from seizures AEB no documented or reported seizure activity By End of the Certification period, Status of Goal: Goal met: Ongoing, Due to the patient s continued need for home care, this goal remains relevant to their care and will continue to be assessed at supervisor visits, re-certifications, and PRN. Respiratory health will be maintained AEB no diagnosis of respiratory infection. By the End of the certification period, Status of Goals: Goal met: Ongoing, Due to the patient s continued need for home care, this goal remains relevant to their care and will continue to be assessed at supervisory visits, re-certifications, and PRN. The patient will be free from infections AEB no discolored drainage from the stoma and no use of antibiotics to treat stoma infections. By: End of the certification period. Status of Goal: Goal met: Ongoing, Due to the Patient s continued need for home care, this goal remains relevant to their care and will continue to be assessed at supervisory visits, re-certifications, and PRN. G-tube feedings will be well-tolerated, AEB absence of vomiting, no feedings held due to excessive residual, and no signs of GI intolerance (diarrhea, constipation, dehydration) By: End of Certification period Status of Goal: Goal met; Ongoing, Due to the patient s continued need for home care, this goal remains relevant to their care and will continue to be assessed at supervisory visits, re-certifications, and PRN. The patient will remain safe in-home environment AEB no falls, injuries, ER visits, or unscheduled hospitalizations By: End of the certification period, Status of Goal: Goal met: Ongoing, Due to the patient s continued need for home care, this goal remains relevant to their care and will continue to be assessed at supervisory visits, re-certifications, and PRN. The agency failed to identify patient-specific goals and measurable outcomes and failed to identify specific interventions for the skilled nursing stated goals for the patient. 4. A review of the closed clinical record of Patient #6, with a start of care date of 9/22/21, revealed a Home Health Certification and Plan		applied tothe current patient's schedule. Agency reviews confirmed patient schedules each day and all completedpatient schedules weekly when payroll is processed to verify that ordered carevisits have been provided. The Agency reviews caregiver availability after eachorientation to ensure that new caregivers are matched with current patientsbefore they are identified for new patients. A hold on new admissions has been considered, and the Agency will hold anynew patient admission unless available caregivers are able to fulfill carevisit needs for current Agency patients. This will continue to ensure thatcurrent patient schedules remain the priority. The Administrator will be responsible for managing, supervising, andcalculating the Agency's ability to meet the plan of care ordered visits. Theobjective considerations in making this decision will continue to be the typeof care required, the geographic location of the patient, the initial patient-requestedand physician-ordered schedule of care visits, and the availability of acurrent qualified caregiver who can provide the care required, who is able totravel to the	

	period of 9/22/21 to 11/20/21, which evidenced diagnoses but not limited to Cerebral infarction (a lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), Left lower extremity paralysis (a lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off). The patient was to receive home health aide services 4-7 hours per day, 3-5 days per week to assist the patient in/out of bed, chair transfers, hygiene, and grooming, preparation of meals, encourage fluids, and light housekeeping while the patient s spouse was at work. Subtitle 22. Goals/Rehabilitation Potential/Discharge Plans Goals: Skin integrity will be maintained, AEB absence of any new or worsening skin breakdown By End of certification period Status of Goal: Goal newly established at the start of care, the goal will be assessed during each supervisory visit, re-certifications visits, and PRN. Diabetes symptoms will be well maintained AEB no report of excessive thirst hunger, urination, dizziness, and fatigue. By: End of certification period Status of Goal: Goal new established at the start of care, the goal will be assessed during each supervisory visit, re-certification visits, and PRN Patient will remain safe in-home environment AEB no falls, injuries, ER visits, or unscheduled hospitalizations. By: End of certification period Status of Goals: Goal newly established at the start of care, the goal will be assessed during each supervisory visit, re-certification visit, and PRN. The patient will maintain a maximum level of independence AEB with no functional decline. By: End of certification period Status of Goal: Goal newly established at the start of care, the goal will be assessed during each supervisory visit, recertification visit, and PRN. A review of a 'Home Health Certification and Plan of Care,' with a start of care date of 9/22/21, dated 11/18/21 for the certification period of 11/21/21 to 1/19/21, evidenced diagnoses but not limited to Cerebral infarction (A lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), Left lower extremity paralysis (the loss of muscle function in part of your body). The patient was to receive home health aide services 4-7 hours per day, 3-5 days per week to assist the patient in/out of bed, chair transfers, hygiene, and grooming, preparation of meals, encourage fluids, and light housekeeping while the patient s spouse was at work. Subtitle 22. Goals/Rehabilitation Potential/Discharge Plans Goals: Skin integrity will be maintained, AEB absence of any new or worsening skin breakdown By End of certification period Status of Goal: Goal Met, Ongoing, Due to the patient s continued need for home care services, this goal remains relevant to their care. The goal will be assessed during each supervisory visit, re-certification visit, and PRN. Diabetes		patient’s geographic location, and who can fulfill the orderedcare visits. The Agency will continue to only admit patients for whom, at thetime of admission, the agency projects that it can meet all ordered carevisits, utilizing the current, qualified Agency caregiver(s). If a caregiverassigned to a current patient is unable to continue working, whether due to thepatient’s request for a new caregiver or the caregiver’s inability to continuethat schedule, the Agency will contact all other active caregivers in or nearthe patient’s geographic area until a new caregiver is identified for thepatient. If the Agency,patient/patient’s representative and the patient’s ordering provider determinethat the patient’s current clinical status and homecare needs warrant amodification to the type or frequency of services provided, based on an updatedcomprehensive assessment of the patient, the plan of care will be modified andsent to the provider for signature. If the Agency is unable to provide theordered and needed care visits, Together Homecare will follow state and federalregulatory requirements to assist the patient in finding another agency thatcan meet their care needs and continue to furnish services until an acceptabletransfer can be implemented.	

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. Based on record review and interview, the agency failed to ensure patients received care visits as ordered by the physician in the plan of care, for 2 (Patients #6 and 8) in a sample of 9 clinical records reviewed. Findings include: 1. A review of an agency's policy titled, "Admission Policy C-120," dated 12/30/21, revealed, "POLICY ... Patients are accepted for treatment in the home on basis of reasonable criteria and under the expectation that the patient's medical, nursing, and social needs can be met adequately by Agency in the patient's place of residence. Agency shall make available and provide services to all persons without regard...PURPOSE To provide guidelines for accepting patients for home health care services ... SPECIAL INSTRUCTIONS Criteria for Patient Admissions: 4. There must be a reasonable expectation that the patient's medical, nursing, social, or rehabilitation needs can be adequately met in the patient's home. 5. Reasonable expectation shall consider: a. Whether the agency's personnel and resources are adequate ...10. Agency Services must be appropriate and available to meet the specific needs and requests of the patient and caregiver." A review of an agency s policy titled, Physician Orders C-635, dated 12/30/21, revealed, POLICY ... All medications, treatments, and services provided to the patient must be ordered by a physician & PURPOSE To document verification that orders for services have been obtained from the physician. To assure accurate and complete orders are obtained and verified & 2. A review of the closed clinical record of Patient #6, with a start of care date of 9/22/21, revealed a Home Health Certification and Plan of Care , dated 9/22/21 for the certification period of 9/22/21 to 11/20/21, which evidenced diagnoses but not limited to Cerebral infarction (a lack of adequate blood supply to brain cells	G0580	G 580 The Agency has contacted patient #8’s legal representativeto discuss staffing and to re-educate them on the ability to transition toanother agency who could better staff the patient’s hours. The case conferencehas been documented in the patient’s clinical record and the patient’s AAA CaseManager has been notified so that they can assist the patient in identifyinganother agency who can staff all of patients requested days. The Agency has contacted all patients to address anyconcerns related to staffing. Any patients whose schedules are having consistent staffing issues havebeen re-educated on the ability of the Agency to facilitate a transfer of thepatient to another homecare agency who is able to staff their hours,by way of a case conference. These case conferences have beendocumented in the clinical record, and the information has been forwarded tothe patient’s AAA Case Manager. The Agency will be managed by the Administrator, who will review all weeklyschedules to ensure current patients’ care visit needs are met. TheAdministrator will be responsible for ensuring that no new patients areadmitted unless available caregivers are able to	2022-04-28

	which can cause parts of the brain to die off), Left lower extremity paralysis (the loss of muscle function in part of your body). Patient 6 was to receive home health aide services 4-7 hours per day, 3-5 days per week to assist the patient in/out of bed, chair transfers, hygiene, and grooming, preparation of meals, encourage fluids, and light housekeeping while the patient s spouse was at work. Patient 6 was discharged on 12/2/21. A review of the Scheduled Patient Visits for Patient #6 evidenced missed visits for the certification period of 9/22/21 to 11/20/21, which were on 9/22/21 to 10/4/21, 10/8/21, 10/14/21, 10/15/21, 10/21/21, 10/25/21 to 10/29/21, 11/1/21, 11/2/21, 11/5/21, 11/11/21, 11/12/21, 11/16/21, and 11/17/21. The agency failed to provide services to patient #6 as outlined/ordered in the physician signed plan of care. 3. A review of the clinical record of Patient #8, with the start of care date of 3/25/20, revealed a Home Health Certification and Plan of Care, dated 1/14/22, which evidenced diagnoses, but not limited to, Tremor (shaking movement in one or more parts of your body), unspecified, Personal history of traumatic brain injury, and aphasia (unable to communicate effectively with others). Patient 8's home health aide services were ordered 4.5 to 6.5 hours, 2-4 days a week for assistance with transfers, bathing/showering, preparing/serving meals, range of motion exercises, toileting/elimination, encourage stander, light housekeeping, and assist with stairlift as needed. A review of the Scheduled Patient Visits for Patient #8 evidenced a refused care visit during the certification period of 1/14/22 to 3/14/22, on 1/15/22. The week of 2/20 to 2/26/22 the agency made only 1 care visit. The Agency failed to provide services to Patient #8 as outlined/ordered in the physician signed Plan of Care. 4. During a phone interview on 3/14/22 at 10:29 AM, a family member of Patient #8, family member person I, stated they thought about changing agencies but talking with their case		fulfill care visit needs forcurrent Agency patients. <u>The agency's currentpatients are receiving 100% of ordered care visits.</u> In light of thenational healthcare workforce shortage, the ongoing global pandemic, anda patient's right to refuse care, there are factors beyond the Agency's controlthat may cause a patient's care visit to be missed. In accordance with theCOPs, if the Agency misses a visit or a treatment or service as required by theplan of care, which results in any potential for clinical impact upon thepatient, then the Agency will notify the responsible physician of such missedtreatment or service. The Agency will continue to only admit patients for which the Agency has areasonable expectation, prior to the start of care, that it can meet thepatient's care needs and fulfill ordered care visits in the patient's place ofresidence, in accordance with the Conditions of Participation. The Agencyidentifies a caregiver or caregivers who can fulfill the patient's ordered carevisits prior to accepting a new patient for services. If the Agency cannotidentify a caregiver to fulfill the ordered care visits, the patient is notaccepted onto service. Each patient receives an individualized plan of care, as	

	manager J from entity K (another Home Health Agency,) all agencies were having difficulties with staffing. When queried about days of care visits, stated they had originally requested to have services on Mondays, Wednesdays, Fridays, and Saturdays, and were told by the agency they wouldn t have a problem staffing. Person I stated, they do have another family member who comes in to assist on Saturdays. When queried if the agency had ever offered to assist in finding another agency to provide services, they stated no. When queried how Patient 8's needs were met when the agency did not provide at least 2 care visits per week, responded Patient 8 would not have a bath/shower, had no one to help with safe transfers, had no assistance with meal preparation/serving, and had no assistance with toileting. In an interview on 3/15/22 at 11:30 AM, with the administrator and the clinical director, when queried about not providing services for Patient #8, the administrator stated that the patient had refused some services. When asked to provide documentation of the refused visits, one document was presented that one visit was refused on 1/15/22. 410 IAC 17-13-1(a)		required by Indianalaw and the Medicare COPs. The number of ordered care visits for each patientis determined by the patient or his/her representative and the orderingprovider, based on the unique clinical needs of the patient. The Agency onlyadmits patients for which the Agency has a reasonable expectation, prior to thestart of care, that it is able to fulfill the ordered care visits based on thelength of the visit, distance and travel requirements, and caregiverqualifications. All current Agency patients are prioritized when an Agencycaregiver becomes available or a new Agency caregiver is hired. If a currentpatient and a potential new patient have similar schedules for ordered carevisits and live in similar geographic areas, the caregiver will be applied tothe current patient’s schedule. Agency reviews confirmed patient schedules each day and all completedpatient schedules weekly when payroll is processed to verify that ordered carevisits have been provided. The Agency reviews caregiver availability after eachorientation to ensure that new caregivers are matched with current patientsbefore they are identified for new patients. A hold on new admissions has	

			been considered, and the Agency will hold anynew patient admission unless available caregivers are able to fulfill carevisit needs for current Agency patients. This will continue to ensure thatcurrent patient schedules remain the priority. The Administrator will be responsible for managing, supervising, andcalculating the Agency's ability to meet the plan of care ordered visits. Theobjective considerations in making this decision will continue to be the typeof care required, the geographic location of the patient, the initial patient-requestedand physician-ordered schedule of care visits, and the availability of acurrent qualified caregiver who can provide the care required, who is able totravel to the patient's geographic location, and who can fulfill the orderedcare visits. The Agency will continue to only admit patients for whom, at thetime of admission, the agency projects that it can meet all ordered carevisits, utilizing the current, qualified Agency caregiver(s). If a caregiverassigned to a current patient is unable to continue working, whether due to thepatient's request for a new caregiver or the caregiver's inability to continuethat schedule, the Agency will contact all other	

			patient's geographic area until a new caregiver is identified for thepatient. If the Agency,patient/patient's representative and the patient's ordering provider determinethat the patient's current clinical status and homecare needs warrant amodification to the type or frequency of services provided, based on an updatedcomprehensive assessment of the patient, the plan of care will be modified andsent to the provider for signature. If the Agency is unable to provide theordered and needed care visits, Together Homecare will follow state and federalregulatory requirements to assist the patient in finding another agency thatcan meet their care needs and continue to furnish services until an acceptabletransfer can be implemented. The Agency acknowledges the potential for staffing issues, including ongoinghealthcare workforce shortages and staffing challenges that have beenexacerbated by the pandemic. This broader staffing shortage has impacted theAgency's staffing and has led to the issues cited in the survey. Throughout theongoing public health emergency, the Agency has continued to prioritize effortsto recruit and retain qualified caregivers to staff all	

			patients. We work to properly document and communicate regardingmissed visits, and we will continue to take aggressive steps to recruit, hireand retain staff, knowing that this broader staffing shortage is impacting allof healthcare. If acaregiver notifies the Agency that he or she is unable to attend theirscheduled shift, the Agency will take appropriate steps to identify replacementstaff and will update the patient (or patient representative) frequently untilthe shift is re-staffed, unless the patient or their representative isunwilling to accept a new caregiver, in which case the refusal will bedocumented in the medical record. The Agency's efforts to find a replacementcaregiver will be documented in the clinical record. If a patient requiresimmediate assistance, the Agency's on-call nurse or designated qualifiedcaregiver will make a visit to the patient's home to provide the care necessaryto ensure the patient remains safe. The Agency will make every effort tomake-up missed shifts within the same work week, to ensure the patient receivesall services as ordered on the plan of care. This communication will bedocumented in the clinical record. Allemployees responsible for	

			staffing and oversight of cases have been re-educatedon the requirement to staff each patient's ordered care visits, as well as theneed to hold a case conference with any patients and/or their legalrepresentatives when scheduling needs cannot be appropriately met, so thattransfer to another Agency can be discussed. All supervising RNswill continue to educate patients and/or their legal representatives about the right to choose theirprovider and receive all services in the plan of care at allsupervisory and re-certification timepoints, in addition to distributing anddiscussing the Patient Rights and Responsibilities during admission. The Administrator will review all patient schedules weekly for60 days to monitor staffing. For any patient who has ongoing staffing issues,the Administrator or designee will hold a case conference to discuss patienttransfer to another provider. These case conferences will be documented in theclinical record and will be forwarded to the patient's AAA Case Manager. Dischargeof the patient after a case conference will continue to be used only as aremedy of last resort. After 60 days, the Administrator, Director ofClinical Services or designee will include scheduling and	

			the quarterly clinical record audit as part of the Agency'sQAPI program, to ensure continued compliance. The Administrator is responsible for monitoring thesecorrective actions to ensure the deficiency is corrected and will not recur. Completed 4/28/22 and ongoing.	
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. Based on record review, interview, and observation agency failed to prepare and provide patients and families with written information containing patient medication schedule and instructions, including medication name, dosage, route, frequency and failed to identify which medications would be administered by agency staff in 1 (Patient 3) of 4 home visit observations, in a total sample of 9 clinical records reviewed. Findings include: 1. Review of an agency policy, titled 'Medication Profile C-700,' dated 12/30/21, stated, "POLICY the Registered Nurse...will complete a medication profile for each patient at the time of admission. The medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the patient is taking...PURPOSE...to provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile...To provide documentation of changes in the medication regimen as they happen, and support changes needed to the Plan of Care...To identify the effect of medications and	G0616	G 616 A MAR, which contains the patient's medication schedule andinstructions, has been delivered to the home of patient 2 identified in thesurvey, and its presence in the home has been confirmed by patient 2's parent,as well as patient's 2's nurse. This confirmation has been documented in theclinical record. All medication profiles and MARs were re-reviewed by theAgency to ensure they are complete and correct. All The Agency has contactedall patient families and/or nurses to ensure that a complete and correct MedicationProfile and/or MAR is present in the patient's home. All home charts are 100%compliant with this requirement. The Agency's Medication Administration policyhas been revised to clarify the requirement to use marked volume syringes forany medications where a	2022-04-21

	adverse events, so that appropriate interventions can be incorporated in the plan of care to decrease risk of adverse events...SPECIAL INSTRUCTIONS...The Medication Profile shall document:...C. Medication name...D. Medication Dosage...E. Route and frequency of administration...7. The Medication Profile shall be reviewed by a Registered Nurse at least every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation, whenever a change is made and at least every sixty (60) days thereafter... The original Medication Profile shall be filed in the clinical record. A copy shall be placed the patient's home chart...9. Medication Profiles created through electronic point of care documentation systems will have a copy in the patient record and patient's home if the agency is setting up or managing the medication administration." A review of an agency s policy, titled 'Medication Management C-705,' dated 12/30/21 revealed, "POLICY Together Homecare has a medication management system that supports patient safety and improves quality of care treatment and services by reducing practice variation, errors and misuse of medications. The agency has established a mechanism for identifying and reporting potential and actual errors, and a process to improve systems and performance in the area of medication administration and management. PURPOSE To reduce errors and improve quality of care and promote safety throughout the home care program &PROGRAM SPECIFICS Comprehensive patient assessment performed at the start of care and other defined points in time include review of all medications the patient is taking &and records this in the patient record &Medications in the home are reviewed with the patient/family to determine current medications and patient understanding of the medications actions and side effects. Specific instructions for how and when to take the medications will be reviewed and documented &Medications that are easy to confuse (sound alike or look alike drugs) or chemicals that could be mistaken for medications should be separated and labeled as needed &If medications are being set up by the nurse for self-administration or administration by family or other caregivers, a chart or other form of direction may be left in the home to assure medications are taken at the times ordered, and to assess patient compliance with the schedule...MEDICATION ORDERS 1. Written orders must be legible and clearly documented.		syringe is required to draw or administer themedication. All Agency nurses have been re-educated on the requirementto utilize the MAR as a basis for care and to contact the Agency immediately ifthey are unable to access the electronic MAR and cannot locate a paper MAR inthe home. All Agency nurses have been re-educated on the requirement to useonly marked volume syringes for any medications that require a syringe foradministration. All Agency nurses have been re-educated to validate thepresence of a complete and correct medication profile in the home chart duringassessment. A control has been added to the supervisory section of the Agency'scomprehensive assessment forms to validate that the presence of the MAR and/ormedication profile has been confirmed by the assessing nurse. The Agency willcontinue to provide a MAR and/or medication profile to each patient who isadmitted for services. The Director of Clinical Services or RN designee will audit100% of assessment forms for 60 days to ensure 100% compliance with thisrequirement is maintained. The Director of Clinical Services is responsible formonitoring these corrective actions to	

	A complete medication order must include: a. The full name of the drug. b. Dose and time drug is to be given &MEDICATION ADMINISTRATION 1. When agency staff are administering medications the following steps will be taken: a. Clinician will verify that the medication is the correct one &b. Clinician will verify that the medication or solution is stable based on visual examination &c. Clinician will verify that the dose and the medication are not contraindicated at that time. d. Clinician will verify that the medication is being administered at the correct time, in the correct dose and by the correct route &" 2. A review of the clinical record for Patient 2 reveals a start of care date of 2/20/17 with a certification period of 1/15/22 to 3/15/22 and diagnoses that included but were not limited to Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system, and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for medication administration and enteral feeding administration via g-tube. The electronic clinical record failed to evidence a Medication Administration Record, from the start of care (2/20/2017) to 3/11/22. During a home visit on 3/11/22 at 9:00 AM, for Patient 2, who received all medications through a gastrostomy tube (g-tube), Nurse F administered 5 separate syringes full of what appeared to be medications, via G-tube, followed by a water flush. The syringes used failed to evidence labels or markings. Nurse F guided the surveyor back to the kitchen where Nurse F had pre-filled syringes with medication for the entire day. Approximately 30 pre-filled syringes were laying on the kitchen island, loosely grouped together, and were unlabeled/unmarked. There were additional pre-filled syringes on another counter in the kitchen, unlabeled/unmarked and placed in a clear gallon-sized baggie labeled '9 am' and similar, adjacent baggies which contained more pre-filled syringes, were also unmarked. When queried about the medications laid out, Nurse F indicated the patient had medications scheduled to be given approximately every 60-90 minutes throughout the day and states he/she prepares these ahead of time upon arrival at the patient's home, at approximately 7:15 AM every day. When queried as to what document he/she		ensure the deficiency is corrected andwill not recur. Completed 4/21/22 and ongoing.	

	follows to ensure accuracy of medication, Nurse F indicated he/she had been, "doing this so long", "I just know all the medications" needed. When queried further as to the location of any document that would be utilized to record the medications they had just given, Nurse F indicated he/she completes documentation at the end of the day. There was no Medication Administration Record (MAR) present in the kitchen (where meds are stored and prepared), nor in the patient's folder in the living room, to record which specific medications were given, nor what time, nor by which route they had been administered to the patient. When queried about this, Nurse F indicated he/she must have left the MAR in his/her trunk. Nurse F went to check his/her car, then returned and indicated he/she must have, "left the MAR at home". When queried as to where they would be documenting the medications administered today, Nurse F indicated that he/she would check off a box on a sheet titled 'Nursing Note' which was present in the home. Nurse F proceeded to circle with a black ink pen, an area handwritten in as, "9 AM, meds, 20 ml" and then indicated also marks flushes and feedings on this same document. The times were pre-marked and handwritten. When queried further as to where he/she would record each individual medication administered, Nurse F reiterated, "right here" pointing to the space where the column header states 'oral liquid' and has the time handwritten in as, "9 AM, meds, 20 ml". This document failed to evidence each individual medication name, dosage, route, time due, time administered, and how tolerated by the patient. A review of the patient's home folder failed to evidence a handwritten medication profile. In an interview on 3/11/22 at 9:23 AM with Clinical Manager, when queried as to what she found to be of concern during the home visit with Nurse F for Patient 2, Clinical Manager answered, "[nurse] left the MAR at home". In an interview on 3/11/22 at 4:01 PM, the Clinical Manager indicated she could not locate a Medication Administration Record (MAR) for Patient 2. Then stated the MAR was mailed to the patient's home every month. Indicated, "did not know" of the medication administration and documentation issues happening in the home. When queried as to what the expectation was from the nursing staff in this regard, Clinical Manager indicated, "document as you go ... document as you administer." Stated additionally, she would be taking MAR out to the patient's home today.			

	In a return phone call on 3/17/22 (after exit from the agency) at 11:46 AM, from Person A, this surveyor inquired if there were concerns with the agency. Person A acknowledged that medication syringes were pre-filled and unlabeled. Indicated that, "having medications labeled is so important". When queried as to the purpose of an untitled, typed paper found in the kitchen, near several medication bottles, which contained the names and doses of several medications, and was dated 9/31/21 Person A acknowledged this sheet and informed that they had created this document themselves to ensure accuracy of medications being administered to the patient. Person A indicated that having agency MARS available in the home is a problem. States did not believe that Nurse F had left the patient's MAR at the nurse's home. Stated, "that's not accurate". Indicated that MARs are mailed to home and should be there timely, but are "never mailed on time." Indicated MARs often, "arrive 10 days late, when they should be there the at the first of the month". Expressed concern documentation is then backdated by default and "that's not right." Expressed would be pleased if MAR could just be delivered to the home timely. Indicated would like MAR to be present so that medications administered could just be checked off "right then." Person A indicated this has, "always been an issue".			
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. Based on record review and observation, the agency failed to ensure clinicians followed accepted standards of practice, including the use of standard precautions, to prevent transmission of infections and communicable diseases in 3 of 4 home visits conducted. (Patients #2, 3, and 7) Findings include: 1. A review of an agency s policy titled, 'Handwashing/Hand Hygiene D-330,' dated	G0682	G 682 Allagency employees have been re-educated on infection precautions, including theproper procedure for donning and doffing gloves and performing hand hygiene.All employees have acknowledged receipt and understanding of this information.The Director of Clinical Services and designated supervising RNs have beenre-educated on the importance of monitoring infection precautions and providingadditional education as	2022-04-14

	reduce the risk for infection in patients and staff members thorough hand washing/hand antisepsis is required of all employees & PURPOSE to improve hand-hygiene practices & to reduce transmission of pathogenic microorganisms &SPECIAL INSTRUCTIONS 1. The hand hygiene procedure will be clearly outlined in the agency procedure manual. 2. Appropriate antiseptic cleanser/sanitizer may be used in & 3. Indications for handwashing and hand antisepsis & c. When there is prolonged or intense contact with the patient (bathing the patient). d. Between tasks on the same patient &f. After removing gloves. g. After touching objects that are potentially contaminated &HAND HYGIENE TECHNIQUE & 2. When washing hands with soap and water, et hands first & a. rinse hands with water and dry thoroughly with a disposable towel & After drying hands, use a disposable towel/paper towel to turn the faucet off. (Do NOT turn off the faucet with your bare hands after they have been washed) & A review of an agency s policy titled, 'Standard Precautions for All Health Care Workers D-245,' dated 12/30/21 evidenced POLICY Together Home are employees will exercise standard precautions whenever in the direct care or contact with any patients & SPECIAL INSTRUCTIONS & Gloves should be changed after each patient contact. When gloves are removed, thorough hand washing is required & 2. A review of the clinical record of Patient #7, with the start of care date of 1/27/21, revealed a 'Home Health Certification and Plan of Care' , dated 1/27/21, for the certification period of 1/22/22 to 3/22/22, with diagnoses, but not limited to, Cerebral infarction due to embolism of an unspecified anterior cerebral artery, Ataxic gait, Polyneuropathy, Other chronic pain, and Chronic obstructive pulmonary disease. The patient was to receive home health aide services 1-3 hours a day, 3-5 days per week for stand-by assist with ambulation/transfers, assist with shower, skincare, shampoo, oral hygiene, dressing, and light housekeeping. At a home visit on 3/11/21, scheduled for 10 AM with Patient #7, arrived at 9:45 AM at the patient s door, knocking, with the HHA (home health aide) who answered the door with gloved hands. Employee D, HHA had arrived early, had the patient already sitting at the sink on rollator, in the bathroom, getting ready for a sponge bath. Employee D picked up the patient s alarm		needed during patient visits. Allincoming employees will continue to be educated on the importance of complyingwith proper infection protocol, including proper gloving and handwashing,during orientation. TheDirector of Clinical Services and designated supervising RNs will continue toevaluate adherence to proper infection protocol during all SN visits to ensurecontinued compliance. TheDirector of Clinical Services is responsible for monitoring these correctiveactions to ensure the deficiency is corrected and will not recur. Completed4/14/2022 and ongoing.	

	necklace and placed it around the patient s neck. Turned the water on at sink, assisting patient with washing their face, then pat dry with a towel. The patient continued to wash and dry underarms. Employee D opened the medicine cabinet to retrieve deodorant, gave it to the patient, then returned the deodorant to the cabinet. The patient reached in under the sink to get mouthwash and handed the bottle to employee D to open and pour some into the cap, patient took the cap from employee D, and proceeded to rinse their mouth. Employee D rinsed the cap and placed back on the bottle and placed it back under the sink. The aide then used lotion to apply to both lower extremities. The aide went into the kitchen, removed their gloves and put them in the trash, went back into the bathroom, to wash hands, and used paper towels to dry, donned a clean pair of gloves, proceeded to assist the patient with dressing, escorted the patient to the living room, setting up a table with glasses and water bottle. Employee D opened up the medicine cabinet to retrieve the brush for dentures, emptied the denture cup, put toothpaste on the toothbrush, scrubbed the dentures, put dentures on a paper towel and took it to the patient, applied a small amount of gel to the dentures, and the patient put dentures in. Employee D returned to the bathroom, rinsed out the denture cup, dried with a towel, and put it in the medicine cabinet, sacked up bathroom trash, doffed gloves, washed their hands, and dried their hands with a paper towel. Employee D handed their electronic device for the patient to sign for the visit. The device was not cleaned before or after signing. The HHA failed to remove gloves, perform hand hygiene, and apply new gloves at appropriate intervals throughout personal care when moving from dirty to clean areas.			

3. Review of an agency document titled 'Registered Nurse Job Description,' stated, "Position Summary ... provides services to clients in accordance with the State Nurse Practice Act, Agency Policy and accepted professional standards of practice ... 7. Promotes personal safety and a safe environment for clients and co-workers ... a. Demonstrates knowledge of safety/infection control practices by complying with established policies and procedures," was signed and dated by Nurse F on 1/6/21.

At a home visit on 3/11/22 at 9:00 AM for Patient 2, Nurse F was observed washing her hands in the downstairs bathroom which was explained as dedicated for the nurse's use. Nurse F began washing their hands with soap and water, rubbing vigorously, then proceeded to turn off the faucet with bare hands, turned around to the towel rack behind him/her, and used a cloth towel to dry his/her hands.

In an interview on 3/11/22 at 4:07 PM, the Clinical Manager acknowledged Nurse F's breach in infection control during the home visit for Patient 2, when referring to turning off the faucet bare-handed and using a cloth towel, stated, "I saw that."

4. An undated agency document titled 'Position: Certified Nursing Assistant (CNA) (JD-150,) stated, "Qualifications ... demonstrated ability to read and write and follow a written plan of care ... Essential Functions/Areas of Accountability... Promotes personal safety and a safe environment for clients by observing infection control ..." was signed and dated by Person E on 7/12/19.

An agency document (for Patient #3) titled 'Plan of Care' dated 1/10/22, stated, "15. Safety Measures/Precautions...caregiver to...wear gloves for all direct care."

A home visit occurred on 3/10/22 at 9:00 AM for Patient 3. Upon arrival Home Health Aide E and

	Observed Aide E feeding Patient 3 breakfast from a dish with a utensil, without gloves. Aide E then reached into a box located on the kitchen floor, where boxed protein drinks were stored, prepared the protein drink for the patient, placed and secured a drinking straw with bare hands, in order to assist the patient with drinking. Aide E failed to perform hand hygiene in between tasks and remained without gloves. The home health aide failed to perform hand hygiene at appropriate intervals and failed to don gloves when providing direct care to the patient. In an interview on 3/12/22 with the Clinical Manager, when queried about this practice, indicated Aides do not wear gloves during feedings as this is a "dignity" issue. When queried further as to whether there was a policy in place regarding the same, indicated she was unsure and asked that we, "circle back" later. In a follow-up interview on 3/15/22 at 2:05 PM, the Clinical Manager indicated that after checking, there was no policy in place related to maintaining patient dignity by refraining from wearing gloves during assisted feedings. The agency failed to ensure staff exercised standard practices and failed to follow infection control measures. 410 IAC 17-12-1(m)			
G0700	Skilled professional services 484.75 Condition of participation: Skilled professional services.	G0700	G700 All nurses have been re-educated on the requirement to usethe MAR as the basis for administering medications, the requirement to documentall medication administrations on	2022-04-26

	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. Based on record review, observation, and interview, the agency failed to ensure nursing staff performed and abided by standards of practice in regard to medication administration (G704); failed to develop the plan of care with the patient and/or representative prior to implementation (G708); failed to ensure they provided the services as ordered by the physician (G710); failed to ensure clinical documentation of medication administration included: medication name, medication route, medication dosage, and patient response/tolerance to administration (G716): nursing staff failed to ensure they communicated with the ordering physician in relation to discrepancies upon initial discovery of inaccurate routes of administration of g-tube feedings and hydration boluses as indicated on the Plan of Care (G718). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 42 CFR 484.75 Skilled professional services. A deficient practice citation was also evidenced at this standard as follows: 1. A review of an agency's policy titled 'Admission Policy C-120,' dated 12/30/21, revealed, "POLICY Patients are accepted for treatment in the home...and under the expectation that the patient's medical, nursing, and social needs can be met adequately by Agency in the patient's place of residence ... PURPOSE To provide guidelines for accepting patients for home health care services ... SPECIAL INSTRUCTIONS Criteria for Patient Admissions: 4. There must be a reasonable expectation that the patient's medical, nursing, social or rehabilitation needs can be adequately		contact thephysician to clarify any identified discrepancies on the medication list,including but not limited to incorrect route. The medication profile, MAR, andplan of care for patient 5 identified in the survey have been updated toreflect the physician-ordered route for all medications. All medication listshave been reviewed to ensure the medication profile, MAR and plan of carecontain accurate information. The Agency has confirmed that a complete andcorrect MAR is available for charting in the home for all skilled patients, anda current medication profile is present in all patient homes. The comprehensiveassessment form has been modified to include documentation of review of the MARand acknowledgement that the current medication is present in the home. Allnurses responsible for completing the comprehensive assessment have beenre-educated on the importance of thoroughly reviewing the medication listduring the comprehensive assessment, as well as the new assessment form documentationrequirements. The Agency's Medication Administration policy has been revised to clarify the requirement to use only marked volume syringes for any medications where a syringe is required to draw or administer the medication. The Agency's	

	expectation shall consider: a. Whether the agency's personnel and resources are adequate ... 10. Agency Services must be appropriate and available to meet the specific needs and requests of the patient and caregiver..." 2. A review of an agency policy, titled 'Code of Ethics C-150,' dated 12/30/21, revealed, POLICY Together Homecare has an ethical responsibility to the patients &SPECIAL INSTRUCTIONS & 3. Together Homecare Responsibilities: a. Once a patient is admitted for care, the agency has a responsibility to provide services & If a conflict arises that might result in denial of care, service or payment, the patient s specific needs will dictate the decision regarding discharge/transfer & e. The agency does not compromise patient care &" 3. A review of an agency policy titled 'Care Plans C-660,' revealed "POLICY Each patient will have a Plan of Care on file that addresses their identified needs and the agency s plan to respond to those needs. The plan is developed with the patient and family & and is based on services needed to achieve specific measurable goals. PURPOSE to assure continuity and consistency between the disciplines & To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals &SPECIAL INSTRUCTIONS 1. Following the initial assessment, a Plan of Care shall be developed with the patient and/or caregiver. 4. A review of an agency policy titled 'Clinical Documentation C-680,' dated 12/30/21 stated, "POLICY Together Homecare will document each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for maintaining the patient's care ... PURPOSE To ensure there is an accurate record of the services provided, patient response and ongoing need for patient care ... SPECIAL INSTRUCTIONS 1. All skilled services provided by Nursing will be documented in the clinical record ... 3. Additional information that is pertinent to the patient's care or condition may be documented on a progress note or clinical documentation note." 5. A review of an agency policy titled 'Medication Profile C-700, dated 12/30/21, stated "POLICY the Registered Nurse ... will complete a medication profile for each patient at		Medication Labels policy includes the requirement to properly label a medication that will not be simultaneously administered by the nurse who prepared it. All nurses have been re-educated on the requirement to use only marked volume syringes, as well as the requirements for labeling a medication that will not be simultaneously administered by the nurse who prepared it. All future nurses will continue to be educated on propermedication administration, documentation, and labeling requirements, includingthe use of only marked volume syringes for medications where a syringe isrequired to draw or administer the medication, as well as reportingmedication or other plan of care discrepancies to the physician, during theonboarding and orientation process. All future nurses responsible forcompleting the comprehensive assessment will be educated on the process formedication reviews and the requirement to verify a MAR for skilled patients anda medication profile for unskilled patients as part of the comprehensive assessmentvisit. The Director of Clinical Services or designee will audit 100%of all completed MARs weekly for 60 days to ensure medication administration isdocumented appropriately. The Director of	

	the time of admission. The medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the patient is taking ... PURPOSE ... to provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile...To provide documentation of changes in the medication regimen as they happen, and support changes needed to the Plan of Care...To identify the effect of medications and side effects that may lead to falls or other adverse events, so that appropriate interventions can be incorporated in the plan of care to decrease risk of adverse events...SPECIAL INSTRUCTIONS...The Medication Profile shall document: ... C. Medication name ... D. Medication Dosage ... E. Route and frequency of administration ... 7. The Medication Profile shall be reviewed by a Registered Nurse at least every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation, whenever a change is made and at least every sixty (60) days thereafter ... The original Medication Profile shall be filed in the clinical record. A copy shall be placed the patient's home chart ... 9. Medication Profiles created through electronic point of care documentation systems will have a copy in the patient record and patient's home if the agency is setting up or managing the medication administration. 6. A review of an agency policy titled 'Medication Set Up Policy C-701,' dated 12/30/21, stated, "POLICY Together Homecare will set up medications for patients as ordered by the physician ... PURPOSE To provide correct doses of medications according to physicians orders ...To assist patient who have difficulty (physically or cognitively) setting up and taking prescribed medications...SPECIAL INSTRUCTIONS ... 1. A medication administration record (MAR) or Medication Profile should be used to set up medications ... 2. The Plan of Care is the nurse's verbal order until it is signed by the physician at which point it becomes the written order. It is the nurse's responsibility to ensure that it is accurate and without errors ... 4. The Nurse must always read the pharmacy labels carefully & administering the medication. The nurse should then compare the medication labels to the Plan of Care, checklist, and/or MAR before administering the		Clinical Services or RN designee willaudit 100% of new plans of care and comprehensive assessment forms 60 days toensure compliance is maintained. After 60 days of 100% compliance, the Directorof Clinical Services or designee will review MARs, plans of care, andassessment forms during the 10% quarterly clinical record, and will complete anadditional audit of completed MARs for at least 50% of the Agency's skillednursing patients quarterly, to ensure continued compliance during the Agency'sQAPI review. The patient representative for patient 8 has been contactedto re-educate on the right to choose any homecare agency at any time and tooffer assistance with identifying another provider who could staff therequested, physician-ordered schedule. The case manager for this patient hasbeen contacted, and the case conference has been documented in the clinicalrecord. The Agency has reviewed 100% of patient schedules. For any patientschedule where the Agency has not been able to consistently meetstaffing/scheduling requirements, the Administrator or designee has contactedthe patient or their legal representative to re-educate them on the right tochoose any agency and the ability to communicate with other	

	what nursing tasks were performed, what was assessed, and the findings. 7. A review of an agency s policy titled 'Medication Management C-705,' dated 12/30/21 revealed, POLICY Together Homecare has a medication management system that supports patient safety and improves quality of care treatment and services by reducing practice variation, errors and misuse of medications. The agency has established a mechanism for identifying and reporting potential and actual errors, and a process to improve systems and performance in the area of medication administration and management. PURPOSE To reduce errors and improve quality of care and promote safety throughout the home care program &PROGRAM SPECIFICS Comprehensive patient assessment performed at the start of care and other defined points in time include review of all medications the patient is taking &and records this in the patient record &Medications in the home are reviewed with the patient/family to determine current medications and patient understanding of the medications actions and side effects. Specific instructions for how and when to take the medications will be reviewed and documented &Medications that are easy to confuse (sound alike or look alike drugs) or chemicals that could be mistaken for medications should be separated and labeled as needed &If medications are being set up by the nurse for self-administration or administration by family or other caregivers, a chart or other form of direction may be left in the home to assure medications are taken at the times ordered, and to assess patient compliance with the schedule... MEDICATION ADMINISTRATION 1. When agency staff are administering medications the following steps will be taken: a. Clinician will verify that the medication is the correct one &b. Clinician will verify that the medication or solution is stable based on visual examination &c. Clinician will verify that the dose and the medication are not contraindicated at that time. d. Clinician will verify that the medication is being administered at the correct time, in the correct dose and by the correct route &MONITORING EFFECTS OF MEDICATIONS 1. Together Homecare will develop monitoring parameters and guidelines to assure the medications are appropriate and the patient/caregivers report observations and concerns &2. Patient response to medications will be assessed with each review/reconciliation & FOLLOW UP 1. All medication adverse effects and errors will be documented &2. Staff are educated and encouraged to report all events and near misses, and follow up will be done to identify system or process change needed. 3. Findings will be compiled and		providers who maybe better equipped to staff their physician-ordered schedule. Theseconversations have been communicated to the case managers. All Agency employees responsible for staffing/schedulinghave been re-educated on the requirement to staff the schedule requested by thepatient or their legal representative and ordered by the physician, as well asthe requirement to educate the patient on their ability to exercise theirrights to choose another provider in the event the Agency is unable to fulfillstaffing requirements, and the requirement to documents any such conversationsin the clinical record and in the Complaint Log when applicable. All futureemployees responsible for staffing/scheduling will receive this education aspart of their orientation and training process. The Agency will continue tofacilitate patient transfers to other providers at the request of the patient,their legal representative, and the case manager. The Administrator or designee will review completed patientschedules weekly for 60 days to identify any consistent inability to staffpatients' ordered schedules and to ensure any ongoing inability to staff	

	reported to the Director of Clinical Services/designee for review and recommendation. 8. A review of an agency policy titled 'Visit Notes C-710,' dated 12/30/21 stated, "Together Homecare personnel shall use appropriate visit notes to document ongoing patient assessment, care, and needs when visits are made frequently, when specific services are provided during each visit, or when specific parameters are to be followed. The visit notes will include ... assessment ... response to interventions as applicable, and any additional comments from staff member conducting the visit...SPECIAL INSTRUCTIONS ... 2. The nurse must document each visit on the visit note, whether paper or electronic. The patient assessment, care provided, the patient's response to therapy ... 5. The appropriate areas on the visit note shall be complete the day services are rendered and incorporated into the clinical record within fourteen (14) days of the date ... 6. Findings and/or changes in condition that are not pertinent to the visit note parameters can be documented on the visit note, client loggings, or other Agency-approved documentation method." 9. A review of an agency policy titled Medication Administration C-708, dated 12/30/21 stated, POLICY Together Homecare staff will administer medications as ordered by the physician & PURPOSE To assure that medications the patient is taking and/or agency staff are administering have current and accurate orders for safe administration. To Prevent medication errors or adverse effects for patients & SPECIAL INSTRUCTION 1. Together Homecare staff will verify orders for all drugs and treatments before administering them to patients & 2. All orders for medications will contain the name of the drug, dosage, frequency, and method of administration & 5. Agency staff will check all patient medicines 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 & 9. Prior to the administration of any medication by any route, the nurse will verify: a. Medication is correct & b. Medication stability by performing a visual examination & c. Medication has not expired. d. Medication is the correct dose, route, and time & 10. A review of a professional article from The American Nursing Association (ANA), titled		apatient's ordered schedule is communicated to the patient or their legalrepresentative as well as the case manager and documented in the clinical record.After 60 days of compliance, adherence to patient schedules will continue to beincluded in the quarterly 10% clinical record review, as part of the Agency'sQAPI Program. The Administrator and Director of Clinical Services areresponsible for monitoring these corrective actions to ensure the deficienciesare corrected and will not recur. Completed4/26/22 and ongoing.	

Guidance for Registered Nurses,' dated 2010, stated,

"Principle 5. Documentation... Entries into organization documents or the health record (including but not limited to provider orders) must be:

" Accurate, valid, and complete;

" Authenticated; that is, the information is truthful, the author is identified, and nothing has been added or inserted;

" Dated and time-stamped by the persons who created the entry;

" Legible/readable; and

" Made using standardized terminology, including acronyms and symbols."

Web URL: http://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf

11. A review of the clinical record for Patient 2 revealed a start of care date of 2/20/17, with a certification period of 1/15/22 to 3/15/22, and diagnoses that included, but were not limited to, Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system, and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for medication administration and enteral feeding administration via g-tube.

The electronic clinical record failed to evidence a Medication Administration Record (MAR), from the start of care (2/20/2017) to 3/11/22.

Review of completed paper "Nursing Notes," dated: 1/17/22, 1/18/22, 1/20/22, 1/21/22, 1/22/22, 1/24/22, 1/25/22, 1/26/22, 1/27/22, 1/28/22, 1/31/22, 2/1/22, 2/2/22, 2/3/22, 2/4/22, 2/7/22, 2/8/22, 2/9/22, 2/10/22, 2/11/22, 2/14/22, 2/15/22, 2/16/22, 2/17/22, 2/18/22, 2/22/22, 2/23/22, 2/24/22, 2/25/22, 2/26/22, 2/28/22, 3/1/22, 3/2/22, 3/3/22, 3/4/22, 3/7/22, 3/8/22,

documentation of specific medications administered, accurate documentation of the route delivered, the dosage administered, and how the medication was tolerated by the patient. 'Nursing Notes' for the above dates also failed to evidence a narrative note, progress note, or any documentation that addressed Patient 2's status during the visit.

During a home visit on 3/11/22 at 9:00 AM, for Patient 2, who received all medications through a gastrostomy tube (g-tube), Nurse F administered 5 separate syringes full of what appeared to be medications, via G-tube, followed by a water flush. The syringes used failed to evidence labels or markings. Nurse F guided this surveyor back to the kitchen where Nurse F had pre-filled syringes with medication for the entire day. Approximately 30 pre-filled syringes were laying on the kitchen island, loosely grouped together, and were unlabeled/unmarked. There were additional pre-filled syringes on another counter in the kitchen, unlabeled/unmarked and placed in a clear gallon-sized baggie labeled '9 am' and similar, adjacent baggies which contained more pre-filled syringes, which were also unmarked. When queried about the medications laid out, Nurse F indicated the patient had medications scheduled to be given approximately every 60-90 minutes throughout the day and states he/she prepares these ahead of time upon arrival at the patient's home, at approximately 7:15 AM every day. When queried as to what document he/she follows to ensure accuracy of medication, Nurse F indicated he/she had been, "doing this so long," "I just know all the medications" needed. When queried further as to the location of any document that would be utilized to record the medications they had just given, Nurse F indicated he/she completes documentation at the end of the day. There was no Medication Administration Record (MAR) present in the kitchen (where meds are stored and prepared), nor in the patient's folder in the living room, to record which specific medications were given, nor what time, by which route they had been administered, nor how they had tolerated by the patient. When queried about this, Nurse F indicated he/she must have left the MAR in his/her trunk. Nurse F went to check his/her car, then returned and indicated he/she must have, "left the MAR at home". When queried as to where they would be documenting the medications administered today, Nurse F indicated that he/she would check off a box on a sheet titled 'Nursing Note' which was present in the home. Nurse F proceeded to circle with a black ink pen, an area handwritten in as, "9 AM, meds, 20ml" and then indicated he/she also marks flushes and feedings on this same

document. The times were pre-marked and handwritten in. When queried further as to where he/she would record each individual medication administered, Nurse F reiterated, "right here" pointing to the same space where the column header states 'oral liquid' and has the time handwritten in as, "9 AM, meds, 20 ml." This document failed to evidence each individual medication's name, dosage, route, time due, time administered, and how tolerated by the patient. Additionally, a review of the patient's home folder failed to evidence a handwritten medication profile.

In an interview on 3/11/22 at 9:23 AM, with the Clinical Manager, when queried as to what she found to be of concern during the home visit with Nurse F for Patient 2, Clinical Manager answered, "[nurse] left the MAR at home".

In an interview on 3/11/22 at 4:01 PM, the Clinical Manager indicated she could not locate a MAR for Patient 2. The Clinical Manager stated MAR gets mailed to the patient's home every month. Indicated, "did not know" in relation to medication administration and documentation issues happening in the home. When queried as to what the expectation was from the nursing staff in this regard, the Clinical Manager indicated, "document as you go ... document as you administer," and stated she would be taking MAR out to the Patient 2's home today.

In an interview on 3/16/22 at 11:53 AM, regarding Patient 2, Nurse K indicated Supervisory visits of Nurse F only involved observing the administration of enteral feedings through the g-tube. Nurse K indicated she did not observe Nurse F administer medications via the g-tube and did not observe Nurse F document the administration of medications. Nurse K stated pre-filled syringes had not been seen during supervisory visits.

In an interview (returned phone call) on 3/17/22, (after exit from the agency) at 11:46 AM, with Person A , the surveyor inquired if there were concerns with the agency. Person A acknowledged that medication syringes were pre-filled and unlabeled. Indicated "having medications labeled is so important." When queried as to the purpose of an untitled, typed paper found in the kitchen, near several medication bottles, which contained the names and doses of several medications, and was

	dated 9/31/21 Person A acknowledged this sheet and informed that they had created this document themselves to ensure accuracy of medications being administered to the patient. Person A indicated that having agency MARS available in the home is a problem. Stated did not believe that Nurse F had left the patient's MAR at the nurse's home. Stated, "that's not accurate." Indicated that MARs are mailed to home and should be there timely, but are "never mailed on time." Indicated MARs often, "arrive 10 days late, when they should be there the first of the month." Expressed concern that documentation is then backdated by default and, "that's not right." Expressed would be pleased if MAR could just be delivered to the home timely. Indicated would like MAR to be present so that medications administered could just be checked off "right then." Person A indicated this has "always been an issue." 12. A review of the clinical record of Patient #5, with a start of care date of 4/12/21, revealed a Home Health Certification and Plan of Care , dated 2/2/22, for the certification period of 2/6/22 to 4/6/22. Subtitle 10. Medications/Dose/Route/Frequency/(N)ew (C)hanged included but not limited to Claritin Allergy Children's Oral Syrup 5 mg/5ml / 10 ml / G-tub / Once a day / (C), Hydration Bolus 140 ml / 200 ml / Buccal / 3 times a day Administer water 200 ml per G-tube at 1000, 1400, and 1600. Proper hydration / (C), Nourish Oral Liquid / 461 ml nourish with 200 ML H2O mixed in / Oral / Once a day at 6 PM / (N), and Nourish Oral Liquid / 356 ML Nourish with 180 ML H2O / Oral / Once a day give at noon along with daily MiraLAX mixed in / (N) . Subtitle 11. ICD-CM Principal Diagnosis Extreme immaturity of newborn, gestational age 24 completed weeks , Subtitle 13 ICD-CM Other Pertinent Diagnoses are but not limited to Delayed Milestone in childhood, dependence on respirator [ventilator] status, Dysphagia, tracheostomy status, gastrostomy status and Right eye blindness . Subtitle 15. Safety Measures COVID-19 Preventive Measures, Fall Precautions, Standard Precautions, Clear Pathways, Seizure Precautions, and Aspiration Precautions . Subtitle 16. Nutritional Requirements Tube Feeding Nourish 243 ML with 180 ML H2O at 8 AM, 324 ML with 180 ML H2Oat noon, and 405 ML with 200 ML H2O at 6 PM 3 times /daily, ***Aspiration precautions***, NPO . Patient 5 was to receive skilled nursing care 11-13 hours per day 3-5 days per week for medication setup and administration, tracheostomy care, gastrostomy care, check for residual before administering tube feedings, perform full, comprehensive assessment every visit, assist with activities of daily living, and notify physician			

for any abnormal findings and accompany Patient 5 on appointments/school while the parents were at work.

During a phone interview on 3/14/22 at 9:08 AM, Employee G, RN case manager for Patient #5, stated they hadn t realized the medications routes had gotten changed. When asked if the care plan was reviewed with the patient s caregiver, stated they don t usually go through them, when there isn t a change.

During a phone interview on 3/14/22 at 5:37 PM, employee H, LPN stated they knew the care plan was inaccurate (referring to Hydration Bolus and Tube Feedings) but didn t think anything about it, because everyone knows not to give anything by mouth to the patient, and no one really looks at the Plan of Care because Patient 5's Mom would tell everyone what to do.

During a phone interview on 3/15/22 at 9:36 AM, with nurse M from entity L, when queried if the patient was to be NPO, Nurse M stated the patient did not receive anything orally or buccal.

During a phone interview on 3/16/22 at 12:06 PM, with Patient 5's family member H, when queried about the nurses going over the Plan of Care with them, they stated the nurses had not reviewed the plans of care with them.

The agency failed to ensure the Plan of Care was developed with the patient's representative.

During an interview on 3/14/22 at 1:55 PM with the clinical director, when queried about her expectations of care being delivered, she stated, "The Plan of Care drives the care that's being provided, they are always to use the Plan of Care in the home."

13. A review of the closed clinical record of Patient #6, with a start of care date of 9/22/21, revealed a Home Health Certification and Plan of Care, dated 11/18/21 for the certification period of 11/21/21 to 1/19/21, which evidenced diagnoses but not limited to Cerebral infarction, Left lower extremity paralysis, abdominal hernia, and anemia. Patient 6 was to receive home

per week to assist patient in/out of bed, chair transfers, hygiene and grooming, preparation of meals, encourage fluids, and light housekeeping while the patient s spouse was at work.

A review of the Scheduled Patient Visits, for Patient #6, evidenced missed visits for the certification period of 11/21/21 to 1/19/22, which were on 11/22/21, 11/24/21, 11/26/21, 11/29/21, and 12/1/21.

During a phone interview with Patient #6 on 3/11/21 at 9:28 AM, stated they didn t get ordered care visits from the agency from day one, stated they were told there were people to staff Patient 6's care visit when they came to the agency, but then they wouldn t show up.

The agency failed to provide the physician-ordered services according to the Plan of Care.

14. A review of the clinical record of Patient #8, with a start of care date of 3/25/20, revealed a Home Health Certification and Plan of Care, dated 1/14/22, with diagnoses, but not limited to, Tremor, unspecified, Personal history of traumatic brain injury, and aphasia. The patient was to receive home health aide services 4.5 to 6.5 hours, 2-4 days a week for assist with transfers, bathing/showering, preparing/serving meals, range of motion exercises, toileting/elimination, encourage stander, light housekeeping, and assist with stairlift as needed.

A review of the Scheduled Patient Visits, for Patient #8, evidenced missed care visits for the certification period of 1/14/22 to 3/14/22 were the week of 2/7/22 to 2/12/22, the week of 2/14/22 to 2/19/22, and the week of 3/7/22 to 3/11/22.

During a phone interview on 3/14/22 at 10:29 AM, Patient #8 family member, Person I, stated that they thought about changing agencies but talking with their case manager J from entity K, stated that all agencies were having difficulties with staffing. When queried about days requesting services, they stated they had originally requested to have services on Mondays, Wednesdays, Fridays, and Saturdays,

	Thursdays), and was told by the agency they wouldn t have a problem staffing the ordered visits. During an interview with the administrator, when asked about not providing services for Patient #8, the administrator stated the patient had refused some services. When asked to provide documentation of the refused visits, one (1) document was presented of 1 visit refused on 1/15/22. The agency failed to provide the physician-ordered care visits in accordance with the Plan of Care.			
G0704	Responsibilities of skilled professionals 484.75(b) Standard: Responsibilities of skilled professionals. Skilled professionals must assume responsibility for, but not be restricted to, the following: Based on record review, observation and interview the agency failed to ensure that skilled clinical staff performed and abided by standards of practice in regard to medication administration in 1 (Patient 2) in a sample of 9 clinical records reviewed. Findings include: Review of an agency policy titled 'Medication Profile C-700, dated 12/30/21, stated "POLICY the Registered Nurse...will complete a medication profile for each patient at the time of admission. The medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the patient is taking...SPECIAL INSTRUCTIONS...The Medication Profile shall document:...C. Medication name...D. Medication Dosage...E. Route and frequency of administration...7. The Medication Profile shall be reviewed by a Registered Nurse at least every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation, whenever a change is made and at least every sixty (60) days thereafter... The original Medication Profile shall be filed in the clinical record. A copy shall be placed the patient's home chart...9. Medication Profiles	G0704	G704 All nurses have been re-educated on the importance of usingthe MAR as the basis for administering medications, the requirement to documentall medication administrations on the MAR, and the requirements for medicationlabeling and preparing medications prior to administration. All future nurses will continue to be educated on propermedication administration, documentation, preparation and labeling requirementsduring the onboarding and orientation process. The Director of Clinical Services or RN designee will audit100% of completed MARs weekly for 60 days to ensure continued compliance withdocumentation of medication administrations. After 60 days of restored compliance,the Agency will complete a review of MARs for at	2022-04-21

	created through electronic point of care documentation systems will have a copy in the patient record and patient's home if the agency is setting up or managing the medication administration. Review of an agency policy titled 'Medication Set Up Policy C-701,' dated 12/30/21, stated, "POLICY together Homecare will set up medications for patients as ordered by the physician...PURPOSE To provide correct doses of medications according to physicians orders...To assist patient who have difficulty (physically or cognitively) setting up and taking prescribed medications...SPECIAL INSTRUCTIONS...1. A medication administration record (MAR) or Medication Profile should be used to set up medications...2. The Plan of Care is the nurse's verbal order until it is signed by the physician at which point it becomes the written order. It is the nurse's responsibility to ensure that it is accurate and without errors...4. The Nurse must always read the pharmacy labels carefully & administering the medication. The nurse should then compare the medication labels to the Plan of Care, checklist, and/or MAR before administering the medication...5. The Nurse will clearly document what nursing tasks were performed, what was assessed, and the findings. A review of an agency s policy titled 'Medication Management C-705,' dated 12/30/21 revealed, "POLICY Together Homecare has a medication management system that supports patient safety and improves quality of care treatment and services by reducing practice variation, errors and misuse of medications. The agency has established a mechanism for identifying and reporting potential and actual errors, and a process to improve systems and performance in the area of medication administration and management. PURPOSE To reduce errors and improve quality of care and promote safety throughout the home care program &PROGRAM SPECIFICS Comprehensive patient assessment performed at the start of care and other defined points in time include review of all medications the patient is taking &and records this in the patient record &Medications in the home are reviewed with the patient/family to determine current medications and patient understanding of the medications actions and side effects. Specific instructions for how and when to take the medications will be reviewed and documented &Medications that are easy to confuse (sound alike or look alike drugs) or chemicals that could be mistaken for medications should be separated and labeled as		least 50% of skilled nursingpatients each quarter as part of the quarterly QAPI review, in addition to theMARs being reviewed as part of the Agency’s quarterly 10% clinical recordaudit, to ensure compliance is maintained. The Director of Clinical Services is responsible formonitoring these corrective actions to ensure the deficiency is corrected andwill not recur. Completed 4/21/22 and ongoing.	

	needed &If medications are being set up by the nurse for self-administration or administration by family or other caregivers, a chart or other form of direction may be left in the home to assure medications are taken at the times ordered, and to assess patient compliance with the schedule... MEDICATION ADMINISTRATION 1. When agency staff are administering medications the following steps will be taken: a. Clinician will verify that the medication is the correct one &b. Clinician will verify that the medication or solution is stable based on visual examination &c. Clinician will verify that the dose and the medication are not contraindicated at that time. d. Clinician will verify that the medication is being administered at the correct time, in the correct dose and by the correct route &MONITORING EFFECTS OF MEDICATIONS 1. Together Homecare will develop monitoring parameters and guidelines to assure the medications are appropriate and the patient/caregivers report observations and concerns &2. Patient response to medications will be assessed with each review/reconciliation & FOLLOW UP 1. All medication adverse effects and errors will be documented &2. Staff are educated and encouraged to report all events and near misses, and follow up will be done to identify system or process change needed. 3. Findings will be compiled and reported to the Director of Clinical Services/designee for review and recommendation. A review of an agency s policy titled Medication Administration C-708, dated 12/30/21 stated, POLICY Together Homecare staff will administer medications as ordered by the physician &PURPOSE To assure that medications the patient is taking and/or agency staff are administering have current and accurate orders for safe administration. To Prevent medication errors or adverse effects for patients &SPECIAL INSTRUCTION 1. Together Homecare staff will verify orders for all drugs and treatments before administering them to patients &2. All orders for medications will contain the name of the drug, dosage, frequency, and method of administration &5. Agency staff will check all patient medicines 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 &9. Prior to the administration of any medication by any route, the nurse will verify: a. Medication is correct &b. Medication stability by performing a visual examination &c. Medication has not expired. d. Medication is the correct dose, route, and time &			

A review of a professional article from The American Nursing Association (ANA), titled 'ANA's Principles for Nursing Documentation Guidance for Registered Nurses' dated 2010, stated,

"Principle 5. Documentation...Entries into organization documents or the health record (including but not limited to provider orders) must be:

" Accurate, valid, and complete;

" Authenticated; that is, the information is truthful, the author is identified, and nothing has been added or inserted;

" Dated and time-stamped by the persons who created the entry;

" Legible/readable; and

" Made using standardized terminology, including acronyms and symbols."

Web URL: http://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf

2. Review of the clinical record for Patient 2, revealed a start of care date of 2/20/17, with a certification period of 1/15/22 to 3/15/22, and diagnoses that included but were not limited to Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system, and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for medication administration and enteral feeding administration via g-tube.

The electronic clinical record failed to evidence a Medication Administration Record, from the start of care (2/20/2017) to 3/11/22.

Review of completed paper 'Nursing Notes,' dated: 1/17/22, 1/18/22, 1/20/22, 1/21/22, 1/22/22, 1/24/22, 1/25/22, 1/26/22, 1/27/22,

	2/7/22, 2/8/22, 2/9/22, 2/10/22, 2/11/22, 2/14/22, 2/15/22, 2/16/22, 2/17/22, 2/18/22, 2/22/22, 2/23/22, 2/24/22, 2/25/22, 2/26/22, 2/28/22, 3/1/22, 3/2/22, 3/3/22, 3/4/22, 3/7/22, 3/8/22, 3/9/22, 3/10/22, and 3/11/22, failed to evidence documentation of specific medications administered, accurate route delivered, the dosage administered, and how tolerated by the patient. 'Nursing Notes' for the above dates also failed to evidence a narrative note, progress note, or any documentation that addressed patient status during the visit. During a home visit on 3/11/22 at 9:00 AM, for Patient 2, who received all medications through a gastrostomy tube (g-tube), Nurse F administered 5 separate syringes full of what appeared to be medications, via G-tube, followed by a water flush. The syringes used failed to evidence labels or markings. Nurse F guided the surveyor back to the kitchen where Nurse F had pre-filled syringes with medication for the entire day. Approximately 30 pre-filled syringes were laying on the kitchen island, loosely grouped together, and were unlabeled/unmarked. There were additional pre-filled syringes on another counter in the kitchen, unlabeled/unmarked and placed in a clear gallon-sized baggie labeled '9 am' and similar, adjacent baggies which contained more pre-filled syringes, which were also unmarked. When queried about the medications laid out, Nurse F indicated the patient had medications scheduled to be given approximately every 60-90 minutes throughout the day, and states he/she prepares these ahead of time upon arrival at the patient's home, at approximately 7:15 AM every day. When queried as to what document he/she follows to ensure accuracy of medication, Nurse F indicated he/she had been, "doing this so long", "I just know all the medications" needed. When queried further as to the location of any document that would be utilized to record the medications they had just given, Nurse F indicated he/she completes documentation at the end of the day. There was no Medication Administration Record (MAR) present in the kitchen (where meds are stored and prepared), nor in the patient's folder in the living room, to record which specific medications were given, nor what time, by which route they had been administered, nor how they had tolerated by the patient. When queried about this, Nurse F indicated he/she must have left the MAR in his/her trunk. Nurse F went to check his/her car, then returned and indicated he/she must have, "left the MAR at home". When queried as to where they would be documenting the medications administered today, Nurse F indicated that he/she would check off a box on a sheet titled 'Nursing Note' which was present in			

	the home. Nurse F proceeded to circle with a black ink pen, an area handwritten in as, "9 AM, meds, 20ml" and then indicated he/she also marks flushes and feedings on this same document. The times were pre-marked and handwritten in. When queried further as to where he/she would record each individual medication administered, Nurse F reiterated, "right here" pointing to the same space where the column header states 'oral liquid' and has the time handwritten in as, "9 AM, meds, 20 ml". This document failed to evidence each individual medication name, dosage, route, time due, time administered, and how tolerated by the patient. Additionally, a review of the patient's home folder failed to evidence a handwritten medication profile. In an interview on 3/11/22 at 9:23 AM with the Clinical Manager, when queried as to what she found to be of concern during the home visit with Nurse F for Patient 2, Clinical Manager answered, "[nurse] left the MAR at home". In an interview on 3/11/22 at 4:01 PM, the Clinical Manager indicated she could not locate a MAR for Patient 2. Then stated MAR gets mailed to the patient's home every month. Indicated, "did not know" in relation to medication administration and documentation issues happening in the home. When queried as to what the expectation was from the nursing staff in this regard, Clinical Manager indicated, "document as you go...document as you administer." Stated additionally, that she would be taking MAR out to the patient's home today. In a return phone call on 3/17/22 (after exit from the agency) at 11:46 AM, Person A , a family member, indicated when the surveyor inquired whether there were any concerns with the agency, Person A acknowledged that medication syringes were pre-filled and unlabeled. Indicated that, "having medications labeled is so important." When queried as to the purpose of an untitled, typed paper found in the kitchen, near several medication bottles, which contained the names and doses of several medications, and was dated 9/31/21 Person A acknowledged this sheet and informed that they had created this document themselves to ensure accuracy of medications being administered to the patient. Person A indicated that having agency MARS available in the home was a problem. Stated does not believe that Nurse F had left the patient's MAR at the nurse's home. Stated, "that's not accurate." Indicated that			

	timely, but are "never mailed on time." Indicated MARs often, "arrive 10 days late, when they should be there the first of the month." Expressed concern that documentation is then backdated by default and, "that's not right." Expressed would be pleased if MAR could just be delivered to the home timely. Indicated would like MAR to be present so that medications administered could just be checked off "right then." Person A indicated this has, "always been an issue."			
G0708	Development and evaluation of plan of care 484.75(b)(2) Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); Based on record review and interview, the agency failed to develop the plan of care with the patient and/or representative prior to implementation in 1 of 9 patients reviewed. (Patient #5) 1. A review of an agency s policy titled, 'Care Plans C-660', revealed, "POLICY Each patient will have a Plan of Care on file that addresses their identified needs and the agency s plan to respond to those needs. The plan is developed with the patient and family &and is based on services needed to achieve specific measurable goals. PURPOSE to assure continuity and consistency between the disciplines &To focus the interventions and frequency and duration based on the effectiveness of interventions and progress toward goals &SPECIAL INSTRUCTIONS 1. Following the initial assessment, a Plan of Care shall be developed with the patient and/or caregiver..." 2. A review of the clinical record of Patient #5, with a start of care date of 4/12/21, revealed a 'Home Health Certification and Plan of Care', dated 2/2/22, for the certification period of 2/6/22 to 4/6/22. Subtitle 10. Medications/Dose/Route/Frequency/(N)ew (C)hanged included but not limited to Claritin Allergy Children's Oral Syrup 5 mg/5ml / 10 ml / G-tub / Once a day / (C), Hydration Bolus 140 ml / 200 ml / Buccal / 3 times a day Administer water 200 ml per G-tube at 1000, 1400, and 1600. Proper hydration / (C), Nourish Oral Liquid / 461 ml nourish with 200 ML H2O mixed	G0708	G 708 The medication profile and plan of care for patient 5identified in the survey has been updated to correctly reflect the physician-orderedroutes for each medication. The Agency has completed an additional review of allmedication profiles to ensure that medication information is accuratelydocumented. All medication lists are 100% compliant. All nurses responsible forcompleting the comprehensive assessment have been re-educated on properlyreviewing the plan of care, including the medication list, with the patient ortheir legal representative as part of the comprehensive assessment visit, aswell as the requirement to document this review on the comprehensive assessmentform. An item has been added to the Agency’s comprehensive assessment forms toindicate that the patient or their representative has participated in a reviewof the care plan.	2022-04-14

	Oral Liquid / 356 ML Nourish with 180 ML H2O / Oral / Once a day give at noon along with daily Miralax mixed in / (N) . Subtitle 11. ICD-CM Principal Diagnosis Extreme immaturity of newborn, gestational age 24 completed weeks , Subtitle 13 ICD-CM Other Pertinent Diagnoses are but are not limited to Delayed Milestone in childhood, dependence on respirator [ventilator] status, Dysphagia (difficulty swallowing), tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow direct access to the breathing tube) status, gastrostomy (the construction of an artificial opening from the stomach through the abdominal wall, permitting intake of food or drainage of gastric contents) status, and Right eye blindness . Subtitle 15. Safety Measures COVID-19 Preventive Measures, Fall Precautions, Standard Precautions, Clear Pathways, Seizure Precautions, and Aspiration Precautions . Subtitle 16. Nutritional Requirements Tube Feeding Nourish 243 ML with 180 ML H2O at 8 AM, 324 ML with 180 ML H2Oat noon, and 405 ML with 200 ML H2O at 6 PM 3 times /daily, ***Aspiration precautions***, NPO . The patient was to receive skilled nursing care 11-13 hours per day 3-5 days per week for medication setup and administration, tracheostomy care, gastrostomy care, check for residual before administering tube feedings, perform full, comprehensive assessment every visit, assist with activities of daily living, and notify physician for any abnormal findings and accompany the patient on appointments/school while the parents were at work. During a phone interview on 3/14/22 at 9:08 AM, Employee G, RN case manager for Patient #5, stated they hadn t realized the medications routes had gotten changed. When asked if the care plan was reviewed with the patient s caregiver, stated they don t usually go through them, when there isn t a change. During a phone interview on 3/16/22 at 12:06 PM, with Patient s 5 family member, H, when queried about the nurses going over the Plan of Care with them, they stated the nurses hadn t gone over the Plan of Care with them. The agency failed to ensure the Plan of Care was developed with the patient's representative. 3. During an interview on 3/14/22 at 1:55 PM		The Director of Clinical Services or RN designee will audit 100%of comprehensive assessments for 60 days to ensure compliance with thisrequirement is maintained. After 60 days, the Director of Clinical Services orRN designee will the comprehensive assessment and medication profile during the10% quarterly clinical record audit as part of the Agency’s QAPI program toensure continued compliance. The Director of Clinical Services is responsible formonitoring these corrective actions to ensure the deficiency is corrected andwill not recur. Completed 4/14/22 and ongoing.	

	her expectations of care being delivered, she stated, "The Plan of Care drives the care that's being provided, they are always to use the Plan of Care in the home." 401 IAC 17-14-1(a)(1)(C)			
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; Based on record review and interview, the agency failed to ensure they provided the services ordered by the physician in 2 patient record reviews of 9. (Patients #6 and 8) Findings include: 1. A review of an agency's policy titled, 'Admission Policy C-120,' dated 12/30/21, revealed, "POLICY Patients are accepted for treatment in the home...and under the expectation that the patient's medical, nursing, and social needs can be met adequately by Agency in the patient's place of residence...PURPOSE To provide guidelines for accepting patients for home health care services...SPECIAL INSTRUCTIONS Criteria for Patient Admissions: 4. There must be a reasonable expectation that the patient's medical, nursing, social, or rehabilitation needs can be adequately met in the patient's home. 5. Reasonable expectation shall consider: a. Whether the agency's personnel and resources are adequate...10. Agency Services must be appropriate and available to meet the specific needs and requests of the patient and caregiver..." A review of an agency s policy, titled, 'Code of Ethics C-150,' dated 12/30/21, revealed, POLICY Together Homecare has an ethical responsibility to the patients &SPECIAL INSTRUCTIONS &3. Together Homecare Responsibilities: a. Once a patient is admitted for care, the agency has a responsibility to provide services &If a conflict arises that might result in denial of care, service, or payment, the patient s specific needs will dictate the decision regarding discharge/transfer & e. The agency does not compromise patient care &"	G0710	G 710 Agency has contacted patient #8's legal representative todiscuss staffing and to re-educate them on the ability to transition to anotheragency who could better staff their Saturday shift every other weekend. Thiscase conference has been documented in the clinical record, and the patient'sCase Manager has been notified. The Agency has contacted all patients to address anyconcerns related to staffing. Any patients whose schedules are having consistent staffing issues havebeen re-educated on the ability of the Agency to facilitate a transfer of thepatient to another homecare agency who is able to staff their hours, by way ofa case conference. These case conferences have been documented inthe clinical record, and the information has been forwarded to the patient'sAAA Case Manager. The Agency will be managed by the Administrator, who will review all weeklyschedules to ensure current patients' care visit needs are met. TheAdministrator will be	2022-04-28

	2. A review of the closed clinical record of Patient #6, with a start of care date of 9/22/21, revealed a Home Health Certification and Plan of Care , dated 11/18/21 for the certification period of 11/21/21 to 1/19/21, which evidenced diagnoses but not limited to Cerebral infarction(a lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), and Left lower extremity paralysis (the loss of muscle function in part of your body). The patient was to receive home health aide services 4-7 hours per day, 3-5 days per week to assist the patient in/out of bed, chair transfers, hygiene, and grooming, preparation of meals, encourage fluids, and light housekeeping while the patient s spouse was at work. A review of the Scheduled Patient Visits, for Patient #6, evidenced missed visits for the certification period of 11/21/21 to 1/19/22, which were 11/22/21, 11/24/21, 11/26/21, 11/29/21, and 12/1/21. During a phone interview with Patient #6 on 3/11/21 at 9:28 AM, stated they didn t get care visits furnished as ordered from the agency from day one (1), and stated they were told there were people to staff, but then they wouldn t show up. The agency failed to provide the physician-ordered services in accordance with the Plan of Care. 3. A review of the clinical record of Patient #8, with the start of care date of 3/25/20, revealed a Home Health Certification and Plan of Care , dated 1/14/22 with diagnoses but not limited to Tremor(shaking movement in one or more parts of your body), unspecified, Personal history of traumatic brain injury, and aphasia (unable to communicate effectively with others). The patient was to receive home health aide services 4.5 to 6.5 hours, 2-4 days a week for assistance with transfers, bathing/showering, preparing/serving meals, range of motion exercises, toileting/elimination, encourage stander, light housekeeping, and assist with stairlift as needed.		responsible for ensuring that no new patients areadmitted unless available caregivers are able to fulfill care visit needs forcurrent Agency patients. The agency's currentpatients are receiving 100% of ordered care visits. In light of thenational healthcare workforce shortage, the ongoing global pandemic, anda patient's right to refuse care, there are factors beyond the Agency's controlthat may cause a patient's care visit to be missed. In accordance with theCOPs, if the Agency misses a visit or a treatment or service as required by theplan of care, which results in any potential for clinical impact upon thepatient, then the Agency will notify the responsible physician of such missedtreatment or service.	

	A review of the Scheduled Patient Visits, for Patient 8, evidenced missed care visits for the certification period of 1/14/22 to 3/14/22, which were the week of 2/7/22 to 2/12/22, the week of 2/14/22 to 2/19/22, and the week of 3/7/22 to 3/11/22. During a phone interview on 3/14/22 at 10:29 AM, Patient #8 family member I, stated that they thought about changing agencies but talked with their case manager J from entity K, stated that all agencies are having difficulties with staffing. When queried about days requesting services, they stated they had originally requested to have services on Mondays, Wednesdays, Fridays, and Saturdays, (the patient goes to adult daycare on Tuesdays and Thursdays), and had been told by the agency they wouldn t have a problem staffing. During an interview with the administrator, when asked about not providing services for Patient #8, the administrator stated the patient had refused some services. When asked to provide documentation of the refused visits, 1 document was presented, one (1) visit was refused on 1/15/22. The agency failed to provide the physician-ordered services in accordance with the Plan of Care. 410 IAC 17-14-1(a)(1)(H)		The Agency will continue to only admit patients for which the Agency has areasonable expectation, prior to the start of care, that it can meet thepatient's care needs and fulfill ordered care visits in the patient's place ofresidence, in accordance with the Conditions of Participation. The Agencyidentifies a caregiver or caregivers who can fulfill the patient's ordered carevisits prior to accepting a new patient for services. If the Agency cannotidentify a caregiver to fulfill the ordered care visits, the patient is notaccepted onto service. Each patient receives an individualized plan of care, as required by Indianalaw and the Medicare COPs. The number of ordered care visits for each patientis determined by the patient or his/her representative and the orderingprovider, based on the unique clinical needs of the patient. The Agency onlyadmits patients for which the Agency has a reasonable expectation, prior to thestart of care, that it is able to fulfill the ordered care visits based on thelength of the visit, distance and travel requirements, and caregiverqualifications. All current Agency patients are prioritized when an Agencycaregiver becomes available or a new Agency caregiver is hired. If a	

			new patient have similar schedules for ordered carevisits and live in similar geographic areas, the caregiver will be applied tothe current patient's schedule. Agency reviews confirmed patient schedules each day and all completedpatient schedules weekly when payroll is processed to verify that ordered carevisits have been provided. The Agency reviews caregiver availability after eachorientation to ensure that new caregivers are matched with current patientsbefore they are identified for new patients. A hold on new admissions has been considered, and the Agency will hold anynew patient admission unless available caregivers are able to fulfill carevisit needs for current Agency patients. This will continue to ensure thatcurrent patient schedules remain the priority. The Administrator will be responsible for managing, supervising, andcalculating the Agency's ability to meet the plan of care ordered visits. Theobjective considerations in making this decision will continue to be the typeof care required, the geographic location of the patient, the initial patient-requestedand	

			care visits, and the availability of acurrent qualified caregiver who can provide the care required, who is able totravel to the patient's geographic location, and who can fulfill the orderedcare visits. The Agency will continue to only admit patients for whom, at thetime of admission, the agency projects that it can meet all ordered carevisits, utilizing the current, qualified Agency caregiver(s). If a caregiverassigned to a current patient is unable to continue working, whether due to thepatient's request for a new caregiver or the caregiver's inability to continuethat schedule, the Agency will contact all other active caregivers in or nearthe patient's geographic area until a new caregiver is identified for thepatient. If the Agency,patient/patient's representative and the patient's ordering provider determinethat the patient's current clinical status and homecare needs warrant amodification to the type or frequency of services provided, based on an updatedcomprehensive assessment of the patient, the plan of care will be modified andsent to the provider for signature. If the Agency is unable to provide theordered and needed care visits, Together Homecare will follow state and federalregulatory requirements to assist the patient in finding another agency thatcan meet	

			their care needs and continue to furnish services until an acceptabletransfer can be implemented. The Agency acknowledges the potential for staffing issues, including ongoinghealthcare workforce shortages and staffing challenges that have beenexacerbated by the pandemic. This broader staffing shortage has impacted theAgency's staffing and has led to the issues cited in the survey. Throughout theongoing public health emergency, the Agency has continued to prioritize effortsto recruit and retain qualified caregivers to staff all ordered care visits forall current patients. We work to properly document and communicate regardingmissed visits, and we will continue to take aggressive steps to recruit, hireand retain staff, knowing that this broader staffing shortage is impacting allof healthcare. If acaregiver notifies the Agency that he or she is unable to attend theirscheduled shift, the Agency will take appropriate steps to identify replacementstaff and will update the patient (or patient representative) frequently untilthe shift is re-staffed, unless the patient or their representative isunwilling to accept a new caregiver, in which case the refusal will bedocumented in the	

			efforts to find a replacementcaregiver will be documented in the clinical record. If a patient requiresimmediate assistance, the Agency's on-call nurse or designated qualifiedcaregiver will make a visit to the patient's home to provide the care necessaryto ensure the patient remains safe. The Agency will make every effort tomake-up missed shifts within the same work week, to ensure the patient receivesall services as ordered on the plan of care. This communication will bedocumented in the clinical record.	

			Allemployees responsible for staffing and oversight of cases have been re-educatedon the requirement to staff each patient's ordered care visits, as well as theneed to hold a case conference with any patients and/or their legalrepresentatives when scheduling needs cannot be appropriately met, so thattransfer to another Agency can be discussed. All supervising RNswill continue to Educate patients and/or their legal representatives about the right to choose theirprovider and receive all services in the plan of care at allsupervisory and re-certification timepoints, in addition to distributing anddiscussing the Patient Rights and Responsibilities during admission. The Administrator will review all patient schedules weeklyto monitor staffing. For any patient who has ongoing staffing issues, theAdministrator or designee will hold a case conference to discuss transfer toanother provider. Discharge of the patient after a case conference willcontinue to only be utilized as a remedy of last resort. These case conferenceswill be documented in the clinical record and will be forwarded to thepatient's AAA Case Manager. The Administrator is responsible for monitoring thesecorrective	

			is corrected and will not recur. Completed 4/28/22 and ongoing	
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review, observation, and interview, the agency failed to ensure clinical documentation of medication administration included: medication name, medication route, medication dosage, and patient response/tolerance to administration. Additionally, the agency failed to evidence a medication administration record (MAR) was in place, was incorporated into the patient's clinical record, and was utilized as often as required by nursing staff who administered medications to a patient for a period of four and one-half years in 1 (Patient 2) of 4 home visits observed, out of a total sample of 9 clinical records reviewed. Findings include: 1. Review of an agency policy 'Clinical Documentation C680,' dated 12/30/21, stated, "POLICY Together Homecare will document each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for maintaining the patient's care...PURPOSE To ensure there is an accurate record of the services provided, patient response and ongoing need for patient care...SPECIAL INSTRUCTIONS 1. All skilled services provided by Nursing will be documented in the clinical record...3. Additional information that is pertinent to the patient's care or condition may be documented on a progress note or clinical documentation note." Review of an agency policy, titled	G0716	G 716 The concern voiced after the survey for patient 2 by personA has been documented in the Agency’s complaint log, and the findings have beencommunicated to person A, who has verbalized satisfaction with the outcome. AMAR has been delivered to patient 2’s home, and the patient’s nurse has beenre-educated on the importance of using the MAR to verify and document allmedication administrations. The Agency has contacted all patient families and/or nursesto validate that a current MAR is present in the patient’s home and is beingused to document medication administration. All home charts are 100% compliantwith this requirement. All Agency nurses have been re-educated on the requirementto utilize the MAR as a basis for care and to contact the Agency immediately ifthey are unable to access the electronic MAR and cannot locate a paper MAR inthe home. All Agency nurses responsible for updating the comprehensiveassessment have been re-educated to validate the	2022-04-14

	'Medication Profile C-700,' dated 12/30/21, stated, "POLICY the Registered Nurse...will complete a medication profile for each patient at the time of admission. The medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the patient is taking...PURPOSE...to provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile...To provide documentation of changes in the medication regimen as they happen, and support changes needed to the Plan of Care...To identify the effect of medications and side effects that may lead to falls or other adverse events, so that appropriate interventions can be incorporated in the plan of care to decrease risk of adverse events...SPECIAL INSTRUCTIONS...The Medication Profile shall document:...C. Medication name...D. Medication Dosage...E. Route and frequency of administration...7. The Medication Profile shall be reviewed by a Registered Nurse at least every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation, whenever a change is made and at least every sixty (60) days thereafter... The original Medication Profile shall be filed in the clinical record. A copy shall be placed the patient's home chart...9. Medication Profiles created through electronic point of care documentation systems will have a		presence of a current MAR inthe home chart during assessment. A control has been added to the supervisorysection of the Agency's comprehensive assessment forms to validate that the MARis present in the home and is being used by the nurses to document medicationadministrations. The Agency will continue to provide a MAR and/or medication profileto each patient who is admitted for services. The Director of Clinical Services or RN designee will audit100% of assessment forms for 60 days to ensure 100% compliance with thisrequirement is maintained. The Director of Clinical Services or RN designeewill contact 100% of nurses for newly admitted patients for 60 days to ensure aMAR is present in the home and is being used appropriately. After 60 days ofcompliance, the Agency will complete a review of MARs for at least 50% ofskilled nursing patients each quarter as part of the quarterly QAPI review, inaddition to the MARs being reviewed as part of the Agency's quarterly 10%clinical record audit, to ensure compliance is maintained The Director of Clinical Services is responsible formonitoring these corrective actions to ensure the deficiency is corrected andwill not recur.	

	copy in the patient record and patient's home if the agency is setting up or managing the medication administration. A review of the agency's policy titled 'Medication set up Policy C-701,' dated 12/30/21 stated, "1. A medication administration record (MAR) or Medication Profile should be used to set up medication... 6. The nurse will clearly document what nursing tasks were performed, what was assessed, and the findings ..." A review of an agency s policy, titled 'Medication Management C-705,' dated 12/30/21 revealed, "POLICY Together Homecare has a medication management system that supports patient safety and improves quality of care treatment and services by reducing practice variation, errors and misuse of medications. PURPOSE To reduce errors and improve quality of care and promote safety throughout the home care program &PROGRAM SPECIFICS...Medications that are easy to confuse (sound alike or look alike drugs) or chemicals that could be mistaken for medications should be separated and labeled as needed &If medications are being set up by the nurse for self-administration or administration by family or other caregivers, a chart or other form of direction may be left in the home to assure medications are taken at the times ordered, and to assess patient compliance with the schedule...MEDICATION ORDERS 1. Written orders must be legible and clearly documented. A complete medication order must include: a. The full name of the drug. b. Dose and time drug is to be given		Completed 4/14/22 and ongoing.	

	&MEDICATION ADMINISTRATION 1. When agency staff are administering medications the following steps will be taken: a. Clinician will verify that the medication is the correct one &b. Clinician will verify that the medication or solution is stable based on visual examination &c. Clinician will verify that the dose and the medication are not contraindicated at that time. d. Clinician will verify that the medication is being administered at the correct time, in the correct dose and by the correct route &" A review of an agency policy titled 'Visit Notes C-710,' dated 12/30/21 stated, "Together Homecare personnel shall use appropriate visit notes to document ongoing patient assessment, care, and needs when visits are made frequently, when specific services are provided during each visit, or when specific parameters are to be followed. The visit notes will include...assessment...response to interventions as applicable, and any additional comments from staff member conducting the visit...SPECIAL INSTRUCTIONS...2. The nurse must document each visit on the visit note, whether paper or electronic. The patient assessment, care provided, the patient's response to therapy...5. The appropriate areas on the visit note shall be complete the day services are rendered and incorporated into the clinical record within fourteen (14) days of the date...6. Findings and/or changes in condition that are not pertinent to the visit note parameters can be documented on the visit note, client loggings, or other Agency-approved documentation method."			

	2. Review of the clinical record for Patient 2 revealed a start of care date of 2/20/17, with a certification period of 1/15/22 to 3/15/22, and diagnoses that included but were not limited to Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system, and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for medication administration and enteral feeding administration via g-tube. The electronic clinical record failed to evidence a Medication Administration Record, from the start of care (2/20/2017) to 3/11/22. During a home visit on 3/11/22 at 9:00 AM, for Patient 2, who received all medications through a gastrostomy tube (g-tube), Nurse F administered 5 separate syringes full of what appeared to be medications, via G-tube, followed by a water flush. The syringes used failed to evidence labels or markings. Nurse F guided the surveyor back to the kitchen where Nurse F had pre-filled syringes with medication for the entire day. Approximately 30 pre-filled syringes were laying on the kitchen island, loosely grouped together, and were unlabeled/unmarked. There were additional pre-filled syringes on another counter in the kitchen, unlabeled/unmarked and placed in a clear gallon-sized baggie labeled '9 am' and similar, adjacent baggies which contained more pre-filled syringes, were also unmarked. When			

	queried about the medications laid out, Nurse F, registered nurse (RN) indicated the patient had medications scheduled to be given approximately every 60-90 minutes throughout the day and states he/she prepares these ahead of time upon arrival at the patient's home, at approximately 7:15 AM every day. When queried as to what document he/she follows to ensure accuracy of medication, Nurse F indicated he/she had been, "doing this so long, I just know all the medications" needed. When queried further as to the location of any document that would be utilized to record the medications they had just given, Nurse F indicated he/she completes documentation at the end of the day. There was no Medication Administration Record (MAR) present in the kitchen (where meds are stored and prepared), nor in the patient's folder in the living room, to record which specific medications were given, nor what time, nor by which route they had been administered to the patient. When queried about this, Nurse F indicated he/she must have left the MAR in his/her trunk. Nurse F went to check his/her car, then returned and indicated he/she must have, "left the MAR at home". When queried as to where they would be documenting the medications administered today, Nurse F indicated that he/she would check off a box on a sheet titled 'Nursing Note' which was present in the home. Nurse F proceeded to circle with a black ink pen, an area handwritten in as, "9 AM, meds, 20 ml" and then indicated also marks flushes and feedings on this same document. The times were pre-marked and handwritten. When queried further as to where he/she would record each individual medication administered, Nurse F reiterated, "right here" pointing to			

	space where the column header states 'oral liquid' and has the time handwritten in as, "9 AM, meds, 20 ml". This document failed to evidence each individual medication name, dosage, route, time due, time administered, and how tolerated by the patient. A review of the patient's home folder failed to evidence a handwritten medication profile. In an interview on 3/11/22 at 9:23 AM with the Clinical Manager, when queried as to what she found to be of concern during the home visit with Nurse F, RN, for Patient 2, Clinical Manager answered, "[nurse] left the MAR at home." In an interview on 3/11/22 at 4:01 PM, the Clinical Manager indicated she could not locate a MAR for Patient 2. Then stated MAR gets mailed to the patient's home every month. Indicated, she "did not know" of the medication administration and documentation issues happening in the home. When queried as to what the expectation was from the nursing staff in this regard, Clinical Manager indicated, "document as you go...document as you administer." Stated additionally, she would be taking MAR out to the patient's home today. In an interview on 3/16/22 at 11:53 AM, Nurse K indicated the Supervisory visits of Nurse F only involved observing the administration of enteral feedings through the g-tube. Nurse K indicated she did not observe Nurse F administer medications via g-tube and did not observe Nurse F document			

	administration of medications. Nurse K stated pre-filled syringes were not seen during supervisory visits. In a return phone call on 3/17/22 (after exit from the agency) at 11:46 AM, from Person A, this surveyor inquired if there were concerns with the agency. Person A acknowledged that medication syringes were pre-filled and unlabeled. Indicated that, "having medications labeled is so important". When queried as to the purpose of an untitled, typed paper found in the kitchen, near several medication bottles, which contained the names and doses of several medications, and was dated 9/31/21 Person A acknowledged this sheet and informed that they had created this document themselves to ensure accuracy of medications being administered to the patient. Person A indicated that having agency MARS available in the home is a problem. States did not believe that Nurse F had left the patient's MAR at the nurse's home. Stated, "that's not accurate". Person A also, indicated that MARs are mailed to home and should be there timely, but are "never mailed on time." Indicated the MARs often, "arrive 10 days late, when they should be there the first of the month". Expressed concern that documentation is then backdated by default and, "that's not right." Expressed would be pleased if the MAR could just be delivered to the home timely. Indicated would like the MAR to be present so that medications administered could just be checked off "right then." Person A indicated this has, "always been an issue."			

	410 IAC 17-14-1(a)(1)(E)			
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and interview, nursing staff failed to ensure they communicated discrepancies with the ordering physician upon initial discovery of inaccurate routes of administration of g-tube feedings and hydration boluses as indicated on the Plan of Care in 1 of 9 records reviewed. (Patient 5) Findings include: 1. A review of an agency s policy, titled, Physician Orders C-635, dated 12/30/21 revealed, POLICY All medications, treatments, and services provided to patients must be ordered by a physician & PURPOSE To document verification & To assure accurate and complete orders are obtained &SPECIAL INSTRUCTION & 2. All orders for medications must contain the name of the drug, dosage, route of administration, and directions for use & A review of an agency policy titled 'Medication Management C-705,' dated 12/30/21,revealed, "POLICY Together Homecare has a medication management system that supports patient safety and improves quality of care treatment and services by reducing practice variation, errors and misuse of medications. The agency has established a mechanism for identifying and reporting potential and actual errors, and a process to improve systems and performance in the area of medication administration and management. PURPOSE To reduce errors and improve quality of care and promote safety throughout the home care program & PROGRAM SPECIFICS Comprehensive patient assessment performed at the start of care and other defined points in time include review of all medications the patient is taking &and records this in the patient record &Medications in the	G0718	G 718 The medication profile for patient 5 identified in thesurvey has been corrected to reflect the physician-ordered route foradministration. The Agency has re-reviewed the medication profiles for allagency patients to ensure that the medication route for each drug is properlyindicated based on the physicians' orders. All nurses have been re-educated onthe need to contact the physician and the Agency for any noted discrepancies orinaccurate information noted on the MAR and/or medication profile. All incoming nurses will be educated during their onboardingand orientation process on the requirement to report any medicationdiscrepancies to the patient's physician and Agency immediately for clarification.All future nurses responsible for completing the comprehensive assessment will continueto receive education on proper medication review and verifying medicationinformation in the med profile and MAR as part of their training and onboardingprocess. The Director of Clinical Services or designee will auditmedication profiles for all new patients for 60	2022-04-14

	determine current medications and patient understanding of the medications actions and side effects ... If medications are being set up by the nurse for self-administration or administration by family or other caregivers, a chart or other form of direction may be left in the home to assure medications are taken at the times ordered, and to assess patient compliance with the schedule ... MEDICATION ADMINISTRATION 1. When agency staff are administering medications the following steps will be taken: a. Clinician will verify that the medication is the correct one & d. Clinician will verify that the medication is being administered at the correct time, in the correct dose and by the correct route &MONITORING EFFECTS OF MEDICATIONS 1. Together Homecare will develop monitoring parameters and guidelines to assure the medications are appropriate and the patient/caregivers report observations and concerns &2. Staff are educated and encouraged to report all events and near misses, and follow up will be done to identify system or process change needed. 3. Findings will be compiled and reported to the Director of Clinical Services/designee for review and recommendation. 2. A review of the clinical record of Patient #5, with a start of care date of 4/12/21, revealed a Home Health Certification and Plan of Care , dated 2/2/22, for the certification period of 2/6/22 to 4/6/22. Subtitle 10. Medications/Dose/Route/Frequency/(N)ew (C)hanged included but not limited to: Hydration Bolus 140 ml / 200 ml / Buccal / 3 times a day Administer water 200 ml per G-tube at 1000, 1400, and 1600. Proper hydration / (C), Nourish Oral Liquid / 461 ml nourish with 200 ML H2O mixed in / Oral / Once a day at 6 PM / (N), and Nourish Oral Liquid / 356 ML Nourish with 180 ML H2O / Oral / Once a day give at noon along with daily Miralax mixed in / (N) . Subtitle 11. ICD-CM Principal Diagnosis Extreme immaturity of newborn, gestational age 24 completed weeks , Subtitle 13 ICD-CM Other Pertinent Diagnoses are but not limited to Delayed Milestone in childhood, dependence on respirator [ventilator] status, Dysphagia, tracheostomy status, gastrostomy status, and Right eye blindness . Subtitle 15. Safety Measures COVID-19 Preventive Measures, Fall Precautions, Standard Precautions, Clear Pathways, Seizure Precautions, and Aspiration Precautions . Subtitle 16. Nutritional Requirements Tube Feeding Nourish 243 ML with 180 ML H2O at 8 AM, 324 ML with 180 ML H2Oat noon, and 405 ML with 200 ML H2O at 6 PM 3 times /daily, ***Aspiration precautions***, NPO . The patient was to receive skilled nursing care 11-13 hours per day 3-5 days per week for		days to ensure medicationroutes are correctly documented based on the physician order. After 60 days of100% compliance, the Director of Clinical Services or designee will reviewmedication profiles and MARs during the 10% quarterly clinical record audit aspart of the Agency's QAPI program. The Director of Clinical Services is responsible formonitoring these corrective actions to ensure the deficiency is corrected andwill not recur. Completed 4/14/22 and ongoing.	

	medication setup and administration, tracheostomy care, gastrostomy care, check for residual before administering tube feedings, perform full, comprehensive assessment every visit, assist with activities of daily living, and notify physician for any abnormal findings and accompany the patient on appointments/school while the parents were at work. 3. In a phone interview on 3/14/22 at 5:37 PM, employee H, LPN stated they knew the care plan was inaccurate (referring to Hydration Bolus and Tube Feedings) but didn t think anything about it, because everyone knew not to give anything by mouth to the patient, and no one really looks at the Plan of Care. Mom would tell everyone what to do. In a phone interview on 3/15/22 at 9:36 AM, with nurse M from entity L, when queried if Patient 5 was to be nothing by mouth (NPO,) Nurse M stated the patient does not receive anything orally or buccal. In a phone interview on 3/14/22 at 12:46 PM, Employee G, RN case manager for Patient #5, stated they hadn t realized the medications routes had gotten changed. When queried if the care plan was reviewed with Patient 5's caregiver, stated they don t usually go through them, when there isn t a change. In an interview on 3/14/22 at 4:05 PM, the Clinical Director and Administrator, neither one had a response when they were informed of the errors in the plan of care, the registered nurses' failure to update/correct the plan of care, and their failure to use the plan of care as their directive for furnishing services. The Agency failed to ensure they communicated discrepancies with the ordering physician upon initial discovery of inaccurate routes of administration of g-tube feedings and hydration boluses 410 IAC 17-14-1(a)(1)(G)			

G0942	Governing body 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review and interview, the Governing Body failed to ensure they were fully aware of Federal and State Regulations, failed to ensure governing body meeting minutes were created and maintained showing the exercise of their full legal and fiscal responsibilities, to include the directive to create appropriate seizure protocol/policy for patients served, and failed to ensure the agency had a Gastrostomy (G-Tube) Feeding policy, for 1 of 1 Governing body reviewed. 1. A review of an Agency s policy titled, Governing Body B-100, dated 12/30/21, evidenced, POLICY The Governing Body shall assume full legal authority and responsibility for the operation of Together Homecare &The Governing Body is responsible for ensuring the following: &2. That the HHA-wide quality assessment and performance improvement efforts address priorities for improved quality of care &3. That clear expectations for patient safety are established, implemented, and maintained &PURPOSE &To ensure patients are provided with appropriate, quality services. SPECIAL INSTRUCTIONS The duties and responsibilities of the Governing Body shall include: & 3. Oversee the management and fiscal affairs of the agency. This shall include budget preparation and reviewing &and organization operations & A review of an Agency s policy titled, Agency Budget Planning B140, dated 12/31/21 evidenced, "POLICY Agency, under the direction of the Governing Body, shall prepare an overall plan and budget &PURPOSE To develop an annual operating budget &SPECIAL INSTRUCTIONS 1. Annual Operating Budget: &c. This budget is prepared before the beginning of the fiscal year. d. The budget is	G0942	G 942 The form containing the Governing Body’s meeting minutes hasbeen modified to more thoroughly document the contents of each meeting, showingthe exercise of the Governing Body’s full legal and fiscal responsibilities.The Governing Body completed the review and update of the Agency’s 2022 annualbudget, and confirmation has been documented in Governing Body meeting minutes.The Governing Body has re-reviewed the CMS Conditions of Participation withInterpretive Guidelines, Indiana Home Health Agency Statute and Indiana HomeHealth Agency Rules, along with CHAP Standards of Excellence, to continue toequip the Governing Body to take and exercise full legal authority andresponsibility for the Agency’s overall management and operation. The Governing Body will remain updated on all state andfederal regulations. The Administrator will review all Governing Body MeetingMinutes to ensure continued compliance is maintained. The Agency has protocolsfor gastrostomy feedings and seizure management available for reference andteaching. The Administrator and Governing Body are responsible	2022-04-21

	approved by the Governing body, the Governing Body, and revised as needed. e. The administrator /designee is responsible for reviewing budget expenses and revenue &5. Annual Review of Plan and Budget: a. The overall plan and budget will be reviewed and updated at least annually by the Governing Body of the agency & 2. A review of the agency s document titled, Governing Body Meeting Agenda, dated 1/27/22, revealed & 5. Summary of Decisions the Governing Body is being asked to make this meeting: Item 5.1 Decision title: QAPI Review and Approval Agenda item: 1 & 8. Policy Update: Update 8.1 Information: Approve COVID 19 vaccine policy D-480; Agenda item number: 2. 11. General Business all items as listed below on the agenda. Item 13.1; Description: Actively looking for administrative team mates; Agenda item number 3". No minutes were provided. A review of the agency s document titled, Governing Body Meeting Agenda, dated 8/19/21, revealed & 5. Summary of Decisions the Governing Body is being asked to make this meeting: Item 5.1 Decision title: QAPI Review and Approval Agenda item: 1". No other items were listed on the agenda and no minutes were provided after requested. A review of the agency s document titled, Governing Body Meeting Agenda, dated 11/4/21, revealed & 5. Summary of Decisions the Governing Body is being asked to make this meeting: Item 5.1 Decision title: QAPI Review and Approval Agenda item: 1". No other items were listed on the agenda and no minutes were provided after requested. In an interview on 3/14/22 at 1:55 PM, the Clinical Manager stated there was no official tracking for quality assurance, they used an audit form to review clinical records, really no process, we just check each other's work and stated the charts that get audited with a tool, are 10 percent and are completed quarterly for QAPI s purpose. In an interview on 3/13/22 at 2:05 PM, the Clinical Manager stated there was not a policy for G-tube feedings.		formonitoring these corrective actions to ensure the deficiency is corrected andwill not recur. Completed 4/21/22 and ongoing.	

	In an interview on 3/11/22 at 2:53 PM, the Clinical Manager indicated that the agency had individualized seizure protocols for patients, did not have an agency-wide policy that specified the minimum requirements of a safe seizure protocol for patient care. In an interview on 3/16/22 at 9:44 AM, the Administrator, when queried about the minutes of the Governing Body meetings, stated it was listed on the "Agenda" as to what was discussed at the meetings and there were no minutes created or maintained. In an interview on 3/16/22 at 9:30 AM, with the Administrator, when queried when the Governing Body approved the 2022 budget plan, stated he was not sure and stated it was not listed on the "Agendas" that were provided. 410 IAC 17-12-1(b)			
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; Based on record review and interview, the administrator failed to be responsible for the day-to-day operations of the home health agency in relation to failure to ensure all complaints were recognized and documented with a complete resolution in the complaint log; failure to ensure that patients received care visits as ordered in the plan of care, failure to ensure patients were informed of their right to be transferred to alternate agencies if the agency could not meet their care needs, and failure to initiate transfer, upon agency identification of inability to meet patients' care needs; failure to ensure clinicians followed accepted standards of practice, including the use of standard precautions to prevent transmission of infections and communicable diseases; failure to ensure a complete and accurate assessment of the patient's specific goals, strengths, and care preferences; failure to ensure a medication review was performed during nursing reassessment, and failure to ensure an accurate medication administration record was established and utilized; failure to ensure services were provided per the plan of care,	G0948	G 948 The complaints for the patients identified in the surveyhave been documented according to the Agency’s policy. All Agency patients havebeen contacted regarding any unreported or outstanding complaints, and anyadditional complaints have been documented according to Agency policy.	2022-04-14

	failed to ensure each patient received an individualized care plan, with care visit frequencies specific to the patients' needs, and failed to ensure the nurses identified patient specific and measurable outcomes and goals; failure to prepare and provide patient/family with written information containing patient medication schedule and instructions, including medication name, dosage, route, frequency and which medications would be administered by agency staff; failed to develop the plan of care with the patient and/or representative; failure to ensure the nurses communicated discrepancies with the ordering physician upon initial discovery of inaccurate routes of administration of g-tube feedings and hydration boluses, for 1 of 1 agency administrator. Findings include: 1. Regarding patient complaints, the patients' failure to receive all the ordered services in accordance with the plan of care, and failure to offer to transfer patients to alternate agencies when the agency had sufficient data to determine their inability to meet the patients' needs. The agency failed to ensure patient complaints were written in the complaint log, investigated with a resolution documented, failed to ensure patients received services as outlined in the plan of care, and failed to inform patients of their rights to be transferred to another agency upon identification of the agency s inability to meet the patient s needs and failed to offer to facilitate the transfer. (See G432, G436, G454, G580, and G710) 2. Regarding Infection Prevention The agency failed to ensure all staff followed infection control policies and failed to ensure an effective infection control training/education program was provided and failed to ensure agency staff demonstrated proper infection control practices when providing g-tube feedings and/or personal/hygiene care to patients. (See G682) 3. Regarding patient medications The agency failed to ensure a medication review was performed during the nursing reassessment and failed to ensure an accurate medication		All employees responsible for addressing, documenting andinvestigating complaints have been re-educated on the Agency’s complaint policy.This education will continue to be presented to all incoming employees duringtheir training process. The Administrator or Director of Clinical Services willaudit the Agency’s Complaint Log weekly for 60 days to ensure the Agency is100% compliant with appropriately documenting all complaints. After 60 days ofcompliance, the Complaint Log will continue to be reviewed during the Agency’squarterly QAPI Program. All employees, including those identified in the survey,have been re-educated on infection control measures to ensure patient safety.This education will continue to be provided to all incoming direct careemployees during the orientation and onboarding process. Registered Nursesresponsible for supervision of care have been re-educated on the importance ofaddressing any infection control concerns during home visits. TheDirector of Clinical Services and designated supervising RNs will continue toevaluate adherence to proper infection protocol during all SN visits to	

	utilized in the home and the clinical record; failed to prepare and provide the patient and family with written information containing patient medication schedule and instructions, to include medication name, dosage, route, frequency and which medications would be administered by agency staff; and failed to ensure they adhere to professional documentation standards; failed to ensure documentation in the patients' record was accurate. (See G536, G616, G718, and G1008) 4. Regarding care planning and assessment The agency failed to ensure a complete and accurate assessment of the patient's specific goals, strengths, and care preferences; failed to ensure each patient received an individualized care plan, failed to ensure care visits were specific and individualized to the patients' needs, failed to identify patient-specific and measurable outcomes and goals; and failed to develop the plan of care with the patient and/or representative before implementation. (See G530, G572, and G708) 410 IAC 17-12-1 (c)(1)		ensurecontinued compliance. All patient medication profiles and MARs have been reviewedby the Director of Clinical Services or RN designee to ensure medicationinformation is accurate. All skilled patients have received a current paper MARin the home, in addition to the electronic MAR that is available on the Agency'spoint of care documentation system. The Agency has confirmed that all patientshave a current medication list, including medication name, dosage, route andfrequency available in the home. All nurses have been re-educated on the medicationadministration and documentation requirements. All Registered Nursesresponsible for updating the comprehensive assessment have been re-educated onthe proper procedure for the medication review. An item has been added to theassessment form to document that the presence of the current MAR and medicationprofile. All incoming nurses will be educated during their onboardingand orientation process on the requirement to report any medicationdiscrepancies to the patient's physician and Agency immediately for clarification.All	

			future nurses responsible for completing the comprehensive assessment will continueto receive education on proper medication review and verifying medicationinformation in the med profile and MAR as part of their training and onboardingprocess. The Director of Clinical Services or RN designee will audit100% of assessment forms for 60 days to ensure MARs and medication profiles arereviewed when the comprehensive assessment is updated. The Director of Clinical Services or RN designeewill contact 100% of nurses for newly admitted patients for 60 days to ensure aMAR is present in the home and is being used appropriately. After 60 days ofcompliance, the Agency will complete a review of MARs for at least 50% ofskilled nursing patients each quarter as part of the quarterly QAPI review, inaddition to the MARs being reviewed as part of the Agency's quarterly 10%clinical record audit, to ensure compliance is maintained	

			All patient care plans are complete with patient-specificand measurable goals and outcomes. An item has been added to the Agency's comprehensiveassessment form for the RN to identify the patient's strengths and carepreferences to be incorporated into the plan of care. All Registered Nurses responsible for completing thecomprehensive assessment and creating the plan of care have been re-educated onthe requirement to identify patient-specific and measurable goals and outcomes,as well as patient strengths and care preferences, and to incorporate theseinto the plan of care. The Director of Clinical Services or RN designee will audit100% of comprehensive assessments and plans of care for 60 days to ensurecontinued compliance with these requirements. After 60 days of compliance, theDirector of Clinical Services or designated RN will include a review of goals,strengths and care preferences during the quarterly 10% clinical record audit,as part of the Agency's QAPI Program. The Administrator and Director of Clinical Services have participatedin all re-education efforts. The Administrator and Director of Clinical Servicesare responsible for monitoring these	

			corrective measures to ensure thedeficiencies are corrected and will not recur. Completed 4/14/22 and ongoing.	
G0968	Assure implementation of plan of care 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. Based on record review and interview, the agency failed to ensure the plan of care was developed accurately in 1 of 9 record reviews. (Patient #5) Findings include: 1. A review of an agency s policy titled, 'Plan of Care C-580,' dated 12/30/21, revealed, "POLICY Home care services are furnished under the supervision and direction of the patient s physician. The Plan of Care is based on a comprehensive assessment and information provided by the &PURPOSE To provide guidelines &to assure that the plan meets state/federal guidelines, and all applicable laws and regulations. SPECIAL INSTRUCTIONS .... 5 &The plan of care is developed as required by the agency/state guidelines & 2. A review of the clinical record of Patient #5, with a start of care date of 4/12/21, revealed a Home Health Certification and Plan of Care , dated 2/2/22, for the certification period of 2/6/22 to 4/6/22. Subtitle 10. Medications/Dose/Route/Frequency/(N)ew (C)hanged included but not limited to Claritin Allergy Children's Oral Syrup 5 mg/5ml / 10 ml / G-tub / Once a day / (C), Hydration Bolus 140 ml / 200 ml / Buccal / 3 times a day Administer water 200 ml per G-tube at 1000, 1400, and 1600. Proper hydration / (C), Nourish Oral Liquid / 461 ml nourish with 200 ML H2O mixed in / Oral / Once a day at 6 PM / (N), and Nourish Oral Liquid / 356 ML Nourish with 180 ML H2O / Oral / Once a day give at noon along with daily Miralax mixed in / (N) . Subtitle 11. ICD-CM Principal Diagnosis Extreme immaturity of newborn, gestational age 24 completed weeks , Subtitle 13 ICD-CM Other Pertinent Diagnoses are but are not limited to Delayed Milestone in childhood, dependence on respirator [ventilator]	G0968	G 968 The plan of care for patient 5 identified in the survey hasbeen updated to correctly reflect the physician-ordered routes for eachmedication. The Agency has completed a review of 100% of patient medicationrecords to ensure that medication information is accurately documented in themedication profile and plan of care. All nurses responsible for completing thecomprehensive assessment have been re-educated on properly reviewing the planof care, including the medication list, with the patient or their legalrepresentative as part of the comprehensive assessment visit, along with therequirement to document this review on the comprehensive assessment form. Anitem has been added to the comprehensive assessment form to indicate that thepatient or their representative has participated in a review of the care plan. The Director of Clinical Services or RN designee will audit 100%of comprehensive assessments	2022-04-14

	status, Dysphagia (difficulty swallowing), tracheostomy status, gastrostomy (the construction of an artificial opening from the stomach through the abdominal wall, permitting intake of food or drainage of gastric contents) status, and Right eye blindness . Subtitle 15. Safety Measures COVID-19 Preventive Measures, Fall Precautions, Standard Precautions, Clear Pathways, Seizure Precautions, and Aspiration Precautions . Subtitle 16. Nutritional Requirements Tube Feeding Nourish 243 ML with 180 ML H2O at 8 AM, 324 ML with 180 ML H2Oat noon, and 405 ML with 200 ML H2O at 6 PM 3 times /daily, ***Aspiration precautions***, NPO . The patient was to receive skilled nursing care 11-13 hours per day 3-5 days per week for medication setup and administration, tracheostomy care, gastrostomy care, check for residual before administering tube feedings, perform full, comprehensive assessment every visit, assist with activities of daily living, and notify physician for any abnormal findings and accompany the patient on appointments/school while the parents were at work. 2. During a phone interview on 3/14/22 at 2:18 PM, employee I, registered nurse (RN,) when queried about the medication administration for Patient #5, employee I stated all the nurses know not to give Patient 5 anything by mouth. She stated they used to read through the care plan but not anymore, as the mother would inform them of any changes. In a phone interview on 3/14/22 at 5:37 PM, employee H, a licensed practical nurse (LPN,) stated they knew the care plan was inaccurate (referring to Hydration Bolus and Tube Feedings) but didn t think anything about it, because everyone knew not to give anything by mouth to the patient, and no one looks at it. Mom would tell everyone what to do. In an interview on 3/14/22 at 12:46 PM Employee G, RN case manager for Patient #5, stated they hadn't realized the medications routes had gotten changed. When asked if the care plan was reviewed with the patient s caregiver, stated they don t usually go through them, when there isn t a change. The agency failed to ensure there was an accurate plan of care developed and implemented for Patient 5.		and updated or new plans of care for 60 days toensure compliance with this requirement is maintained. After 60 days, theDirector of Clinical Services or RN designee will the comprehensive assessmentand plan of care during the 10% quarterly clinical record audit as part of theAgency's QAPI program to ensure continued compliance. The Director of Clinical Services is responsible formonitoring these corrective actions to ensure the deficiency is corrected andwill not recur. Completed 4/14/22 and ongoing.	

	410 IAC 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. Based on record review, interview, and observation, the agency failed to ensure the skilled nurses provided home health services in accordance with current clinical practice guidelines in regard to medication administration and documentation for 1 (Patient 2) of 4 home visits, in a total sample of 9 clinical records reviewed. A review of agency policy titled 'Standards of Practice C-110,' dated 12/30/21, stated, "POLICY Together Homecare will provide services that comply with acceptable professional standards for the Home Care industry as well as all state and federal laws and identified agency performance improvement standards ...PURPOSE To identify and define the accepted standards of practice the agency is committed to following on the providing home care services to our patients ... SPECIAL INSTRUCTIONS the agency staff will practice within the guidelines of their stated discipline. 2. All staff will be knowledgeable regarding laws and regulations governing home health care ... 5. The national patient safety goals will be incorporated into standards, performance expectations, orientations, and policy and procedure where applicable. A review of an agency policy titled 'Skilled Nursing Services C-200,' dated 12/30/21, stated, " POLICY Skilled nursing services will be provided by a Registered Nurse ...in accordance with medically approved Plan of Care (physician's orders). In determining whether a service requires the skills of a Nurse, the inherent complexity of the service, condition of the patient, and accepted standards of medical and nursing practice will be considered ...PURPOSE To abide by state/federal guidelines and offer guidelines to the agency staff, physicians, and community for the appropriate utilization of professionally skilled nursing services...SPECIAL INSTRUCTIONS ...1. The registered nurse:...b. Regularly evaluates the patient needs, and coordinates necessary services...d. provides services	G0984	G 984 A MAR has been delivered to the home of patient 2 identifiedin the survey, and its presence in the home has been confirmed by patient 2’sparent, as well as patient’s 2’s nurse. The Agency has contacted all patient families and/or nursesto confirm that a current Med Profile and/or MAR is present in the patient’shome. All home charts are 100% compliant with this requirement. All Agency nurseshave been re-educated on the requirement to use the MAR as the basis foradministering medications, the requirement to document all medicationadministrations on the MAR, and the requirements for medication labeling andpreparing medications prior to administration. All nurses responsible forupdating the comprehensive assessment have been re-educated on the requirementto review the medication list with the patient or their representative, as wellas the medications present in the home, to ensure accuracy during eachcomprehensive assessment. All incoming nurses will continue to be educated on	2022-04-21

	requiring specialized skill...g. prepares clinical notes...3. Skilled nursing activities in the home care setting may include: observation and assessment, teaching and training activities, management and evaluation of a care plan, and routine and complex skilled procedures ...4. The nurse will demonstrate competency in providing such procedures as: ... c. documenting and implementing physician orders ...5. Specialized services such as Pediatric Nursing...and other services as appropriate." A review of an agency policy, titled 'Medication Profile C-700,' dated 12/30/21, stated "POLICY ... the Registered Nurse...will complete a medication profile for each patient at the time of admission. The medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the patient is taking ... PURPOSE ... to provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile...To provide documentation of changes in the medication regimen as they happen, and support changes needed to the Plan of Care...To identify the effect of medications and side effects that may lead to falls or other adverse events, so that appropriate interventions can be incorporated in the plan of care to decrease risk of adverse events ... SPECIAL INSTRUCTIONS...The Medication Profile shall document: ... C. Medication name ...D. Medication Dosage...E. Route and frequency of administration...7. The Medication Profile shall be reviewed by a Registered Nurse at least every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation, whenever a change is made and at least every sixty (60) days thereafter... The original Medication Profile shall be filed in the clinical record. A copy shall be placed the patient's home chart...9. Medication Profiles created through electronic point of care documentation systems will have a copy in the patient record and patient's home if the agency is setting up or managing the medication administration. A review of an agency policy, titled 'Medication Set Up Policy C-701,' dated 12/30/21, stated, "POLICY ... together Homecare will set up medications for patients as ordered by the		propermedication administration, documentation, preparation and labeling requirementsduring the onboarding and orientation process. All incoming nurses responsiblefor updating the comprehensive assessment will continue to receive instructionon comparing the medication list with the medications present in the home toensure accuracy. The Director of Clinical Services or designee will audit 100%of all completed MARs for all Agency nurses weekly for 60 days to ensure medadministration is documented appropriately. The Director of Clinical Servicesor RN designee will also audit 100% of comprehensive assessments for 60 days toensure compliance with MAR review and medication review. After 60 days of compliance, the Agency willcomplete a review of MARs for at least 50% of skilled nursing patients eachquarter as part of the quarterly QAPI review, in addition to the MARs beingreviewed as part of the Agency’s quarterly 10% clinical record audit, to ensurecompliance is maintained The Director of Clinical Services is responsible formonitoring these corrective actions to ensure the deficiency is corrected andwill not recur. Completed 4/21/22 and ongoing.	

	of medications according to physicians orders ...T o assist patient who have difficulty (physically or cognitively) setting up and taking prescribed medications ...SPECIAL INSTRUCTIONS ...1. A medication administration record (MAR) or Medication Profile should be used to set up medications ... 2. The Plan of Care is the nurse's verbal order until it is signed by the physician at which point it becomes the written order. It is the nurse's responsibility to ensure that it is accurate and without errors...4. The Nurse must always read the pharmacy labels carefully whether he/she is filling the med-planner or administering the medication. The nurse should then compare the medication labels to the Plan of Care, checklist, and/or MAR before administering the medication ... 5. The Nurse will clearly document what nursing tasks were performed, what was assessed, and the findings ...11. All medications should be stored in the home in a safe and secure location which is out of sight from visitors to the home..." A review of an agency s policy, titled 'Medication Management C-705,' dated 12/30/21 revealed, POLICY...Together Homecare has a medication management system that supports patient safety and improves quality of care treatment and services by reducing practice variation, errors and misuse of medications. The agency has established a mechanism for identifying and reporting potential and actual errors, and a process to improve systems and performance in the area of medication administration and management. PURPOSE To reduce errors and improve quality of care and promote safety throughout the home care program &PROGRAM SPECIFICS Comprehensive patient assessment performed at the start of care and other defined points in time include review of all medications the patient is taking &and records this in the patient record &Medications in the home are reviewed with the patient/family to determine current medications and patient understanding of the medications actions and side effects. Specific instructions for how and when to take the medications will be reviewed and documented &Medications that are easy to confuse (sound alike or look alike drugs) or chemicals that could be mistaken for medications should be separated and labeled as needed &If medications are being set up by the nurse for self-administration or administration by family or other caregivers, a chart or other form of direction may be left in the home to assure medications are taken at the times ordered, and to assess patient compliance with the schedule...MEDICATION ORDERS 1. Written orders must be legible and clearly documented.			

	The full name of the drug. b. Dose and time drug is to be given &MEDICATION ADMINISTRATION 1. When agency staff are administering medications the following steps will be taken: a. Clinician will verify that the medication is the correct one &b. Clinician will verify that the medication or solution is stable based on visual examination &c. Clinician will verify that the dose and the medication are not contraindicated at that time. d. Clinician will verify that the medication is being administered at the correct time, in the correct dose and by the correct route &MONITORING EFFECTS OF MEDICATIONS 1. Together Homecare will develop monitoring parameters and guidelines to assure the medications are appropriate and the patient/caregivers report observations and concerns &2. Patient response to medications will be assessed with each review/reconciliation & FOLLOW UP 1. All medication adverse effects and errors will be documented &2. Staff are educated and encouraged to report all events and near misses, and follow up will be done to identify system or process change needed. 3. Findings will be compiled and reported to the Director of Clinical Services/designee for review and recommendation. A review of an agency s policy, titled 'Medication Labels C-707,' dated 12/30/21, revealed, POLICY Together Homecare staff will check all patient medications to determine that labels are present and legible. PURPOSE To assure that all medications identify the medication and instructions for use. To prevent medication error caused by improper or absent labels & SPECIAL INSTRUCTIONS 1. Together Homecare staff will review patients medications at the time of admission and on an ongoing basis. a. each medication should be labeled with the medication name, strength, dose, and expiration date & A review of an agency s policy, titled 'Medication Administration C-708,' dated 12/30/21 revealed, POLICY Together Homecare staff will administer medications as ordered by the physician &PURPOSE To assure that medications the patient is taking and/or agency staff are administering have current and accurate orders for safe administration. To Prevent medication errors or adverse effects for patients &SPECIAL INSTRUCTION 1. Together Homecare staff will verify orders for all drugs and treatments before administering them to patients &2. All orders for medications will contain the name of the drug, dosage, frequency, and method of administration &5. Agency staff will check all			

	adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicative drug therapy, and noncompliance with drug therapy &9. Prior to the administration of any medication by any route, the nurse will verify: a. Medication is correct &b. Medication stability by performing a visual examination &c. Medication has not expired. d. Medication is the correct dose, route, and time &" 2. During a home visit on 3/10/12 at 10:11 AM, for Patient 3, Nurse C, registered nurse (RN) was observed performing a recertification visit. Nurse C inquired of Person G (relative of Patient 3) if there had been any changes in Patient 3's medication regimen. Person G had difficulty staying awake during the interview, and required prompting to stay awake and answer questions, but ultimately indicated that there had been no recent medication changes. Nurse C failed to request to review actual medication containers/bottles to verify the accuracy of, or identify discrepancies against, the agency's current medication profile. In an interview on 3/11/22 at 3:49 PM with the Clinical Manager, when queried as to the reason Nurse C did not complete a full medication reconciliation/regimen review during the recertification visit, and only inquired verbally about medications from Person G who was unable to stay awake for interview and was thus unreliable, Clinical Manager indicated that nursing staff does not routinely, "physically review medications". 3. Review of clinical record for Patient 2 revealed a start of care date of 2/20/17 with a certification period of 1/15/22 to 3/15/22 and diagnoses which included, but were not limited to: Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system, and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for medication administration and enteral feeding administration via g-tube. The electronic clinical record failed to evidence a Medication Administration Record (MAR), from the start of care (2/20/2017) to 3/11/22.			

During a home visit on 3/11/22 at 9:00 AM, for Patient 2, who received all medications through a gastrostomy tube (g-tube), RN Nurse F administered 5 separate syringes full of what appeared to be medications, via G-tube, followed by a water flush. The syringes used failed to evidence labels or markings. Nurse F, RN, guided the surveyor back to the kitchen where Nurse F had pre-filled all syringes with medication for the entire day. Approximately 30 pre-filled syringes were laying on the kitchen island, loosely grouped together, and were unlabeled/unmarked. There were additional pre-filled syringes on a different counter in the kitchen, also unlabeled/unmarked and placed in a clear gallon-sized baggie labeled '9 am' and similar, adjacent baggies which contained more syringes, were also unmarked/unlabeled.

When Nurse F was queried about the medications laid out, Nurse F indicated Patient 2 had medications scheduled to be given approximately every 60-90 minutes throughout the day, and stated he/she prepared all these ahead of time upon arrival at the patient's home, at approximately 7:15 AM every day. When queried as to what document he/she followed to ensure accuracy of medication, Nurse F indicated she had been, "doing this so long," "I just know all the medications" needed. When queried further as to the location of any document that would be utilized to record the medications she had just given, Nurse F indicated he/she completed documentation at the end of the day.

There was no Medication Administration Record (MAR) present in the kitchen (where meds are stored and prepared,) nor in the patient's folder in the living room, to record which medications were given, nor the time and route they had been administered to Patient 2. When queried about this, Nurse F indicated he/she must have left the MAR in the trunk. Nurse F went to check his/her car, then returned and indicated he/she must have, "left the MAR at home." When queried as to where he/she would be documenting the medications administered today, Nurse F indicated that he/she would check off a box on sheet titled 'Nursing Note' which was present in the home. Nurse F then circled with a black pen an area marked "9 AM meds" and then indicated he/she marked the flushes and feedings on the same document. Times were pre-marked and handwritten. When queried further as to where he/she would record each individual medication administered, Nurse

	F reiterated, "right here" and pointed to the space where the column header stated 'oral liquid' and had the time handwritten in as, "9 AM, meds, 20 ml." A review of the document failed to evidence each individual medication name, dosage, route, time due, time administered, and how tolerated by the patient. In an interview on 3/11/22 at 9:23 AM with Clinical Manager, when queried as to what she noted to be of concern during the visit with Nurse F at Patient 2's visit, Clinical Manager answered, "[nurse] left the MAR at home." In an interview on 3/11/22 at 4:01 PM, the Clinical Manager indicated she could not locate a MAR for Patient 2. Stated MAR gets mailed to the patient's home every month. Stated, "did not know" what was happening in the home, in terms of medication administration and documentation of same. When queried as to what the expectation is from the nursing staff in this matter, Clinical Manager indicated, "document as you go ... document as you administer." Stated additionally, would be taking MAR out to the nurse today. In an interview on 3/16/22 at 11:53 AM, Nurse K, RN case manager, indicated that Supervisory Visits of RN Nurse F only involved observing the administration of enteral feedings through the g-tube. Nurse K indicated she did not observe Nurse F administer medications via g-tube and did not observe Nurse F document administration of medications. Nurse K stated pre-filled syringes were not seen during his/her in-person supervisory visits.			
G0988	Institutional planning 484.105(h) Standard: Institutional planning. The HHA, under the direction of the governing body, prepares an overall plan and a budget that includes an annual operating budget and capital expenditure plan. (1) Annual operating budget. There is an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense	G0988	G 988 The 2022 annual budget has been developed under thedirection of the Governing Body. The Governing Body's review and approval ofthe annual budget has documented in Governing Body Meeting Minutes, which areon file with the Administrator.	2022-04-14

	prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense. (2) Capital expenditure plan. (i) There is a capital expenditure plan for at least a 3-year period, including the operating budget year. The plan includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure of more than $600,000 for items that would under generally accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds $600,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions that are separated in time, but are components of an overall plan or patient care objective, are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds. (ii) If the anticipated source of financing is, in any part, the anticipated payment from title V (Maternal and Child Health Services Block Grant) or title XVIII (Medicare) or title XIX (Medicaid) of the Social Security Act, the plan specifies the following: (A) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. (B) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval in accordance with section 1122 of the Act (42 U.S.C. 1320a-1) and implementing regulations.		A Governing Body Meeting Minutes form has been created tomore clearly identify the contents of the Governing Body meetings, including,but not limited to, the review and update of the Agency’s annual budget. The Administrator will review all Governing Body Meeting Minutesto ensure continued compliance is maintained. The Administrator is responsible for monitoring thiscorrective action to ensure the deficiency is corrected and will not recur. Completed 4/14/22 and ongoing.	

	(C) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it was presented to that agency. (3) Preparation of plan and budget. The overall plan and budget is prepared under the direction of the governing body of the HHA by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the HHA. (4) Annual review of plan and budget. The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (i)(3) of this section under the direction of the governing body of the HHA. Based on record review and interview, the agency failed to ensure the annual budget was developed under the direction of the Governing Body and approved by the Governing Body, for 1 of 1 home health agency Governing Body. Findings include: 1. A review of an Agency s policy titled, 'Agency Budget Planning B140, 'dated 12/31/21 evidenced POLICY Agency, under the direction of the Governing Body, shall prepare an overall plan and budget &PURPOSE To develop an annual operating budget & SPECIAL INSTRUCTIONS 1. Annual Operating Budget: & c. This budget is prepared before the beginning of the fiscal year. d. The budget is approved by the Governing body, and revised as needed. e. The administrator /designee is responsible for reviewing budget expenses and revenue & 5. Annual Review of Plan and Budget: a. The overall plan and budget will be reviewed and updated at least annually by the Governing Body of the agency & 2. A request was made to review the Governing Body Minutes for the past 6 months during the entrance conference on 3/9/22 at 11:20 AM.			

	3. A review of the agency s document titled, 'Governing Body Meeting,' dated 1/27/22, failed to identify approval of the 2022 budget. A review of the agency s document titled, 'Governing Body Meeting,' dated 11/4/21, failed to identify approval of the 2022 budget. A review of the agency s document titled, 'Governing Body Meeting,' dated 8/19/21, failed to identify approval of the 2022 budget. 4. In an interview with the administrator on 3/16/22 at 9:30 AM, when queried as to whom develops the annual budget, the Administrator stated, I do. In an interview on 3/16/22 at 9:44 AM with the Administrator, when queried about minutes for the Governing Body Meetings, he stated the "Agenda" is all there which stated what they discussed. The Governing Body failed to document it had reviewed and approved the 2022 Budget. 410 IAC 17-12-1(b)(3)			
G1008	Clinical records 484.110 Condition of participation: Clinical records.	G1008	G 1008 The medication profile, plan of care and MAR for patient 5,identified in the survey report, have been updated to reflect thephysician-ordered route. The nurses identified in the survey report have beenre-educated on the importance of using the MAR as a basis for care,	2022-04-21

	The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically. Based on record review and interview, the agency failed to ensure they adhered to professional documentation standards; failed to ensure documentation in the patient s records was accurate (See G1008); failed to ensure the clinical record was complete with medication administration record (MAR), where skilled nursing provided frequent medication administration (see G1010); and failed to ensure skilled nursing documented assessments in the clinical record, the patient's response/tolerance after the administration of medications (see G1014). The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received quality care in a safe environment and the agency's failure to comply with the Condition of Participation of Clinical Records, 42 CFR 484.110. In regards to G1008: Based on record review and interview, the agency failed to ensure they adhered to professional documentation standards; failed to ensure documentation in the patient s record was accurate in 4 of 9 clinical records review. (Patients #1, 5, 6, and 8) Findings include: 1. A review of an agency s policy, titled, 'Physician Orders C-635,' dated 12/30/21 revealed, POLICY All medications, treatments, and services provided to patients must be ordered by a physician & PURPOSE To document verification &To assure accurate and complete orders are obtained & SPECIAL INSTRUCTION & 2. All orders for medications must contain the name of the drug, dosage, route of administration, and directions for use &		therequirement to document all medication administrations via the MAR, and theneed to report any identified or potential inaccuracies to the physician forclarification immediately. The Agency has completed a 100% review of medication listsand MARs to ensure all information is accurately documented, including route.The Agency has contacted the patient representatives or nurses for all skilledpatients to ensure the current MAR is available for Agency nurses fordocumentation and care purposes. All agency nurses have been re-educated on theimportance of using the MAR as a basis for care, the requirement to documentall medication administrations via the MAR, and the need to report anyidentified or potential medication inaccuracies to the physician forclarification immediately. All agency nurses have been re-educated on therequirement to include the ordered discipline on the Agency’s verbal orderforms. All agency nurses have been re-educated on the importance of reviewingthe plan of care during the update of the comprehensive assessment, includingthe medications, to ensure accuracy. All incoming nurses will continue to be educated on properdocumentation of medication administration in the	

	2. A review of the clinical record of Patient #1, with a start of care date of 11/30/18, evidenced a 'Home Health Certification and Plan of Care', for the certification period of 1/13/22 to 3/13/22, diagnoses included but are not limited to Polyneuropathy (a condition in which a person's peripheral nerves that run throughout your body are damaged; which affects the nerves in your skin, muscles, and organs which can cause tingling, numbness, pins, and needles feeling, difficulty using the arms, legs, hands, or feet, and increased pain [such as burning, stabbing, freezing, or shooting pains]), Osteoarthritis (the protective cartilage that cushions the ends of the bones wears down over time} right knee, Left Artificial hip, and history of Cancer Left Breast. The patient was to receive HHA (home health aide) services 4.5 to 6.5 hours a day, 3-5 times a week. A review of the clinical record of Patient #1, revealed verbal orders dated 12/3/18 for the start of care, including order for 1 visit a day for 7 days a week. A review of a verbal order dated 1/11/22, revealed the order was for 1 visit a day for 1-2 days a week for 1 week, and then 1 visit a day, 3-5 days a week for 8 weeks, and 1 visit a day for 1 week. The agency failed to ensure the clinical record patient documentation was accurate in Patient 1's clinical record by failing to identify the discipline (HHA) to provide the ordered care visits. 3. A review of the clinical record of Patient #5, with a start of care date of 4/12/21, revealed a 'Home Health Certification and Plan of Care', dated 2/2/22, for the certification period of 2/6/22 to 4/6/22. Subtitle 10. Medications/Dose/Route/Frequency/(N)ew (C)hanged included but not limited to Claritin Allergy Children's Oral Syrup 5 mg/5ml / 10 ml / G-tub / Once a day / (C), Hydration Bolus 140 ml / 200 ml / Buccal / 3 times a day Administer water 200 ml per G-tube at 1000, 1400, and 1600. Proper hydration / (C), Nourish Oral Liquid / 461 ml nourish with 200 ML H2O mixed in / Oral / Once a day at 6 PM / (N), and Nourish Oral Liquid / 356 ML Nourish with 180 ML H2O / Oral / Once a day give at noon along with daily Miralax mixed in / (N) . Subtitle 11. ICD-CM Principal Diagnosis Extreme immaturity of		paper or electronic MAR aswell as the importance of reporting any potential or actual discrepancies tothe physician immediately for clarification. All incoming nurses will beeducated during their training process about the requirements of the verbalorder forms, ensuring a MAR is present as part of the comprehensive assessment,and the importance of ensuring accuracy on the plan of care. The Director of Clinical Services or designee will review100% of verbal order forms for 60 days to ensure continued compliance withincluding discipline. The Director of Clinical Services or designee will 100%of all completed MARs for all Agency nurses weekly for 60 days to ensure medadministration is documented appropriately. The Director of Clinical Servicesor designee will review 100% of comprehensive assessments for skilled patientsfor 60 days to ensure the presence of a MAR is confirmed. After 60 days ofcompliance, the Director of Clinical Services or designee will includemedication documentation, medication accuracy and verbal order forms in thequarterly clinical record audit as part of the Agency's QAPI Program to ensurecontinued compliance. The Director of Clinical Services is responsible for	

	newborn, gestational age 24 completed weeks , Subtitle 13 ICD-CM Other Pertinent Diagnoses are but are not limited to Delayed Milestone in childhood, dependence on respirator [ventilator] status, Dysphagia (difficulty swallowing), tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow direct access to the breathing tube) status, gastrostomy (the construction of an artificial opening from the stomach through the abdominal wall, permitting intake of food or drainage of gastric contents) status, and Right eye blindness . Subtitle 15. Safety Measures COVID-19 Preventive Measures, Fall Precautions, Standard Precautions, Clear Pathways, Seizure Precautions, and Aspiration Precautions . Subtitle 16. Nutritional Requirements Tube Feeding Nourish 243 ML with 180 ML H2O at 8 AM, 324 ML with 180 ML H2Oat noon, and 405 ML with 200 ML H2O at 6 PM 3 times /daily, ***Aspiration precautions***, NPO . The patient was to receive skilled nursing care 11-13 hours per day 3-5 days per week for medication setup and administration, tracheostomy care, gastrostomy care, check for residual before administering tube feedings, perform full, comprehensive assessment every visit, assist with activities of daily living, and notify physician for any abnormal findings and accompany the patient on appointments/school while the parents were at work. A review of the clinical record of Patient #5, revealed a 'Recertification Comprehensive Assessment,' dated 1/31/22, and evidenced Nutrition Requirements: Tube Feeding: Product Nourish Amount 243 ml with 200 ML H2O at 8 AM, 356 ML with 200 H2O at noon, and 461 ML with 200 ML H2O at 6 PM Frequency: TID. Other Nutrition Requirements/Restrictions NPO. The agency failed to ensure Patient 5's documentation was accurate in the patient's clinical record by having failed to identify the correct administration routes of G-tube feedings and the hydration boluses in the Plan of Care. 4. A review of the closed clinical record of Patient #6, with a start of care date of 9/22/21, revealed a 'Home Health Certification and Plan of Care,' dated 11/18/21, for the certification period of 11/21/21 to 1/19/21, which evidenced diagnoses, but not limited to, Cerebral infarction (a lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), Left lower extremity paralysis (the loss of muscle		monitoringthese corrective actions to ensure the deficiency is corrected and will notrecur. Completed 4/21/22 and ongoing.	

function in part of your body). Patient 6 was to receive home health aide services 4-7 hours per day, 3-5 days per week to assist the patient in/out of bed, chair transfers, hygiene, and grooming, preparation of meals, encourage fluids, and light housekeeping while the patient s spouse was at work.

A review of Physician Orders for Patient #6 revealed a document titled, 'Physician Order for Start of Care,' dated 9/22/21, Verbal Order: Discipline, Frequency, and Duration 1 visit per day x 1-3 days/week for 1 week, then 1 visit a day for 3-5 days a week for 8 weeks.

A review of 'Physician Order for Re-Certification of Services', dated 11/18/21, Verbal Order: Discipline, Frequency and Duration 1 visit a day, 3-5 days a week for 8 weeks then 1 visit a day, 1-3 days a week for 1 week .

The agency failed to ensure Patient 6's clinical record documentation was accurate in the patient's clinical record by failing to identify the discipline (HHA) to provide the care visits.

5. A review of the clinical record of Patient #8, with the start of care date of 3/25/20, revealed a 'Home Health Certification and Plan of Care', dated 1/14/22, with diagnoses that included but were not limited to, Tremor (shaking movement in one or more parts of your body), unspecified, Personal history of traumatic brain injury, and aphasia (unable to communicate effectively with others). The patient was to receive home health aide services 4.5 to 6.5 hours, 2-4 days a week for assistance with transfers, bathing/showering, preparing/serving meals, range of motion exercises, toileting/elimination, encourage stander, light housekeeping, and assist with stairlift as needed.

A review of physician orders for Patient #8 revealed an 'Order for Re-Certification of Services,' dated 1/14/22, Verbal Order: Discipline, Frequency, and Duration Assist with ADLs (Activities of Daily living) /IADL(Instrumental activities of daily living) 1 visit a day for 1-2 days a week for 1 week, then 1 visit a day for 2-4 days a week for 8 weeks, then 1 visit a day for 1 day a week for 1 week."

The agency failed to ensure Patient 8's clinical record documentation was accurate in the patient's clinical record by failing to identify the discipline (HHA) to furnish the care visits.

6. In a phone interview on 3/14/22 at 5:37 PM, employee H, LPN (for Patient #5) stated they knew the care plan was inaccurate (referring to Hydration Bolus and Tube Feedings) but didn t think anything about it, because everyone knew not to give anything by mouth to Patient 8, and no one looked at it. Mom would tell everyone what to do.

In a phone interview on 3/14/22 at 1:53 PM, with Employee G, the RN case manager for patient #5, stated they hadn t realized the medications routes had changed.

6. A review of an agency policy 'Clinical Documentation C680' dated 12/30/21, stated, "POLICY ... Together Homecare will document each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for maintaining the patient's care ... PURPOSE To ensure there is an accurate record of the services provided, patient response and ongoing need for patient care...SPECIAL INSTRUCTIONS 1. All skilled services provided by Nursing will be documented in the clinical record ... 3. Additional information that is pertinent to the patient's care or condition may be documented on a progress note or clinical documentation note."

7. A review of an agency policy titled 'Medication Profile C-700,' dated 12/30/21, stated, "POLICY the Registered Nurse ... will complete a medication profile for each patient at the time of admission. The medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the patient is taking...PURPOSE...to provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile...To provide documentation of changes in the medication regimen as they happen, and support changes needed to the Plan of Care...To identify the effect of medications and side effects that may lead to falls or other adverse events, so that appropriate interventions can be incorporated in the plan of

	care to decrease risk of adverse events...SPECIAL INSTRUCTIONS...The Medication Profile shall document:...C. Medication name...D. Medication Dosage...E. Route and frequency of administration...7. The Medication Profile shall be reviewed by a Registered Nurse at least every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation, whenever a change is made and at least every sixty (60) days thereafter... The original Medication Profile shall be filed in the clinical record. A copy shall be placed the patient's home chart...9. Medication Profiles created through electronic point of care documentation systems will have a copy in the patient record and patient's home if the agency is setting up or managing the medication administration. 8. A review of the agency's policy titled 'Medication set up Policy C-701' dated 12/30/21 stated, "1. A medication administration record (MAR) or Medication Profile should be used to set up medication...6. The nurse will clearly document what nursing tasks were performed, what was assessed, and the findings..." 9. A review of an agency policy, titled 'Medication Set Up Policy C-701', dated 12/30/21, stated, "POLICY...together Homecare will set up medications for patients as ordered by the physician...PURPOSE To provide correct doses of medications according to physicians orders...To assist patients who have difficulty (physically or cognitively) setting up and taking prescribed medications...SPECIAL INSTRUCTIONS...1. A medication administration record (MAR) or Medication Profile should be used to set up medications...2. The Plan of Care is the nurse's verbal order until it is signed by the physician at which point it becomes the written order. It is the nurse's responsibility to ensure that it is accurate and without errors...4. The Nurse must always read the pharmacy labels carefully whether he/she is filling a med-planner or administering the medication. The nurse should then compare the medication labels to the Plan of Care, checklist, and/or MAR before administering the medication...5. The Nurse will clearly document what nursing tasks were performed, what was assessed, and the findings..." 10. A review of an agency s policy, titled 'Medication Management C-705', dated 12/30/21			

	revealed, "POLICY...Together Homecare has a medication management system that supports patient safety and improves quality of care treatment and services by reducing practice variation, errors and misuse of medications. The agency has established a mechanism for identifying and reporting potential and actual errors, and a process to improve systems and performance in the area of medication administration and management. PURPOSE To reduce errors and improve quality of care and promote safety throughout the home care program &PROGRAM SPECIFICS Comprehensive patient assessment performed at the start of care and other defined points in time include review of all medications the patient is taking &and records this in the patient record & Specific instructions for how and when to take the medications will be reviewed and documented &If medications are being set up by the nurse for self-administration or administration by family or other caregivers, a chart or other form of direction may be left in the home to assure medications are taken at the times ordered, and to assess patient compliance with the schedule...MEDICATION ORDERS 1. Written orders must be legible and clearly documented. A complete medication order must include: a. The full name of the drug. b. Dose and time drug is to be given &MEDICATION ADMINISTRATION 1. When agency staff are administering medications the following steps will be taken: a. Clinician will verify that the medication is the correct one &c. Clinician will verify that the dose and the medication are not contraindicated at that time. d. Clinician will verify that the medication is being administered at the correct time, in the correct dose and by the correct route &MONITORING EFFECTS OF MEDICATIONS 1. Together Homecare will develop monitoring parameters and guidelines to assure the medications are appropriate and the patient/caregivers report observations and concerns &2. Patient response to medications will be assessed with each review/reconciliation & FOLLOW UP 1. All medication adverse effects and errors will be documented &2. Staff are educated and encouraged to report all events and near misses, and follow up will be done to identify system or process change needed. 3. Findings will be compiled and reported to the Director of Clinical Services/designee for review and recommendation. 11. A review of an agency s policy, titled 'Medication Administration C-708', dated 12/30/21 revealed, POLICY Together Homecare staff will administer medications as ordered by the physician &PURPOSE To assure that			

staff are administering have current and accurate orders for safe administration. To Prevent medication errors or adverse effects for patients &SPECIAL INSTRUCTION 1. Together Homecare staff will verify orders for all drugs and treatments before administering them to patients &2. All orders for medications will contain the name of the drug, dosage, frequency, and method of administration &"

12. A review of an agency policy titled 'Visit Notes C-710', dated 12/30/21 stated, "Together Homecare personnel shall use appropriate visit notes to document ongoing patient assessment, care, and needs when visits are made frequently, when specific services are provided during each visit, or when specific parameters are to be followed. The visit notes will include...assessment...response to interventions as applicable, and any additional comments from staff member conducting the visit...SPECIAL INSTRUCTIONS...2. The nurse must document each visit on the visit note, whether paper or electronic. The patient assessment, care provided, the patient's response to therapy...5. The appropriate areas on the visit note shall be complete the day services are rendered and incorporated into the clinical record within fourteen (14) days of the date...6. Findings and/or changes in condition that are not pertinent to the visit note parameters can be documented on the visit note, client loggings, or other Agency-approved documentation method."

13. Review of the clinical record for Patient 2 revealed a start of care date of 2/20/17 with a certification period of 1/15/22 to 3/15/22 and diagnoses which included but were not limited to Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system, and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for medication administration and enteral feeding administration via g-tube. The electronic clinical record failed to evidence a Medication Administration Record, from the start of care (2/20/2017) to 3/11/22.

During a home visit on 3/11/22 at 9:00 AM, for Patient 2, who received all medications through

	administered 5 separate syringes full of what appeared to be medications, via G-tube, followed by a water flush. The syringes used failed to evidence labels or markings. Nurse F guided the surveyor back to the kitchen where Nurse F had pre-filled syringes with medication for the entire day. Approximately 30 pre-filled syringes were laying on the kitchen island, loosely grouped together, and were unlabeled/unmarked. There were additional pre-filled syringes on another counter in the kitchen, unlabeled/unmarked and placed in a clear gallon-sized baggie labeled '9 am' and similar, adjacent baggies which contained more pre-filled syringes, were also unmarked. When queried about the medications laid out, Nurse F indicated the patient had medications scheduled to be given approximately every 60-90 minutes throughout the day and states he/she prepares these ahead of time upon arrival at the patient's home, at approximately 7:15 AM every day. When queried as to what document he/she follows to ensure accuracy of medication, Nurse F indicated he/she had been, "doing this so long", "I just know all the medications" needed. When queried further as to the location of any document that would be utilized to record the medications they had just given, Nurse F indicated he/she completes documentation at the end of the day. There was no Medication Administration Record (MAR) present in the kitchen (where meds are stored and prepared), nor in the patient's folder in the living room, to record which specific medications were given, nor what time, nor by which route they had been administered to the patient. When queried about this, Nurse F indicated he/she must have left the MAR in his/her trunk. Nurse F went to check his/her car, then returned and indicated he/she must have, "left the MAR at home". When queried as to where they would be documenting the medications administered today, Nurse F indicated that he/she would check off a box on a sheet titled 'Nursing Note' which was present in the home. Nurse F proceeded to circle with a black ink pen, an area handwritten in as, "9 AM, meds, 20 ml" and then indicated also marks flushes and feedings on this same document. The times were pre-marked and handwritten. When queried further as to where he/she would record each individual medication administered, Nurse F reiterated, "right here" pointing to space where the column header states 'oral liquid' and has the time handwritten in as, "9 AM, meds, 20 ml". This document failed to evidence each individual medication name, dosage, route, time due, time administered, and how tolerated by the patient. A review of the patient's home folder failed to evidence a handwritten medication profile.			

	In an interview on 3/11/22 at 9:23 AM with Clinical Manager, when queried as to what she found to be of concern during the home visit with Nurse F for Patient 2, Clinical Manager answered, "[nurse] left the MAR at home". In an interview on 3/11/22 at 4:01 PM, Clinical Manager indicated she could not locate a MAR for Patient 2. Then stated MAR gets mailed to the patient's home every month. Indicated, "did not know" of the medication administration and documentation issues happening in the home. When queried as to what the expectation was from the nursing staff in this regard, Clinical Manager indicated, "document as you go...document as you administer." Stated additionally, that she would be taking MAR out to the patient's home today. In an interview on 3/16/22 at 11:53 AM, regarding Patient 2, Nurse K indicated that Supervisory visits of Nurse F only involved observing the administration of enteral feedings through the g-tube. Nurse K indicated she did not observe Nurse F administer medications via g-tube and did not observe Nurse F document administration of medications. Nurse K stated pre-filled syringes were not seen during supervisory visits. In a return phone call on 3/17/22 (after exit from the agency) at 11:46 AM, from Person A, this surveyor inquired if there were concerns with the agency. Person A acknowledged that medication syringes were pre-filled and unlabeled. Indicated that, "having medications labeled is so important". When queried as to the purpose of an untitled, typed paper found in the kitchen, near several medication bottles, which contained the names and doses of several medications, and was dated 9/31/21 Person A acknowledged this sheet and informed that they had created this document themselves to ensure accuracy of medications being administered to the patient. Person A indicated that having agency MARS available in the home is a problem. States did not believe that Nurse F had left the patient's MAR at the nurse's home. Stated, "that's not accurate". Person A also, indicated that MARs are mailed to home and should be there timely, but are "never mailed on time." Indicated the MARs often, "arrive 10 days late, when they should be there the first of the month". Expressed concern that documentation is then backdated by default and, "that's not right." Expressed would be pleased if the MAR could just be delivered to the home timely.			

	Indicated would like the MAR to be present so that medications administered could just be checked off "right then." Person A indicated this has, "always been an issue".			
G1010	Contents of clinical record 484.110(a) Standard: Contents of clinical record. The record must include: Based on record review, interview, and observation, the agency failed to ensure the clinical record was complete to include the medication administration record (MAR), where skilled nursing provided daily medication administration, for 1 (Patient 2) out of 4 home visits observed, in a total sample of 9 clinical records reviewed. Findings include: Review of an agency policy, titled 'Medication Profile C-700,' dated 12/30/21, stated "POLICY ... the Registered Nurse...will complete a medication profile for each patient at the time of admission. The medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the patient is taking ...PURPOSE ... to provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile ...To provide documentation of changes in the medication regimen as they happen, and support changes needed to the Plan of Care ...To identify the effect of medications and side effects that may lead to falls or other adverse events, so that appropriate interventions can be incorporated in the plan of care to decrease risk of adverse events...SPECIAL INSTRUCTIONS...The Medication Profile shall document:...C. Medication name...D. Medication Dosage...E. Route and frequency of administration...7. The Medication Profile shall be reviewed by a Registered Nurse at least every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation, whenever a change is made and at least every sixty (60) days thereafter... The original	G1010	G 1010 A MAR has been delivered to the home of patient 2, who wasidentified in the survey. Patient 2's parent and the patient's nurse have bothconfirmed its presence in the home. The Agency has contacted all patient families and/or nursesfor skilled patients to ensure that a current MAR is present in the patient's home. All home charts are 100% compliantwith this requirement. All Agency nurses have been re-educated on the requirementto utilize the MAR as a basis for care, to document all medicationadministrations via the paper or electronic MAR, and to contact the Agencyimmediately if they are unable to access the electronic MAR and cannot locate apaper MAR in the home. All Agency nurses responsible for updating thecomprehensive assessment have been re-educated to validate the presence of acurrent MAR in the home chart during assessment. A control has been added tothe supervisory section of the Agency's comprehensive	2022-04-21

	record. A copy shall be placed the patient's home chart...9. Medication Profiles created through electronic point of care documentation systems will have a copy in the patient record and patient's home if the agency is...managing the medication administration." A review of an agency policy, titled 'Medication Set Up Policy C-701,' dated 12/30/21, stated, "POLICY...together Homecare will set up medications for patients as ordered by the physician...PURPOSE To provide correct doses of medications according to physicians orders...To assist patients who have difficulty (physically or cognitively) setting up and taking prescribed medications...SPECIAL INSTRUCTIONS...1. A medication administration record (MAR) or Medication Profile should be used to set up medications ... 2. The Plan of Care is the nurse's verbal order until it is signed by the physician at which point it becomes the written order. It is the nurse's responsibility to ensure that it is accurate and without errors ... 4. The Nurse must always read the pharmacy labels carefully whether he/she is filling a med-planner or administering the medication. The nurse should then compare the medication labels to the Plan of Care, checklist, and/or MAR before administering the medication...5. The Nurse will clearly document what nursing tasks were performed, what was assessed, and the findings ..." A review of an agency s policy, titled 'Medication Management C-705,' dated 12/30/21 revealed, POLICY...Together Homecare has a medication management system that supports patient safety and improves quality of care treatment and services by reducing practice variation, errors and misuse of medications. The agency has established a mechanism for identifying and reporting potential and actual errors, and a process to improve systems and performance in the area of medication administration and management. PURPOSE To reduce errors and improve quality of care and promote safety throughout the home care program &PROGRAM SPECIFICS Comprehensive patient assessment performed at the start of care and other defined points in time include review of all medications the patient is taking &and records this in the patient record & Specific instructions for how and when to take the medications will be reviewed and documented &If medications are being set up by the nurse for self-administration or administration by family or other caregivers, a chart or other form of direction may be left in the home to assure medications are taken at the times ordered, and to assess patient compliance with the schedule...MEDICATION ORDERS 1.		assessment forms tovalidate that the presence of the MAR and/or medication profile has beenconfirmed by the assessing nurse. The Agency will continue to provide a MARand/or medication profile to each patient who is admitted for services, andMARs will continue to be sent to skilled patient homes 2 months at a time. The Director of Clinical Services or designee will review 100%of all completed MARs for all Agency nurses weekly for 60 days to ensure medadministration is documented appropriately. The Director of Clinical Servicesor RN designee will also audit 100% of comprehensive assessments for 60 days toensure compliance with MAR review to ensure continued compliance. After 60 days of compliance, the Agency willcomplete a review of MARs for at least 50% of skilled nursing patients eachquarter as part of the quarterly QAPI review, in addition to the MARs beingreviewed as part of the Agency’s quarterly 10% clinical record audit, tovalidate ongoing compliance. The Director of Clinical Services is responsible formonitoring these corrective actions to ensure the deficiency is corrected andwill not recur.	

	Written orders must be legible and clearly documented. A complete medication order must include: a. The full name of the drug. b. Dose and time drug is to be given &MEDICATION ADMINISTRATION 1. When agency staff are administering medications the following steps will be taken: a. Clinician will verify that the medication is the correct one &c. Clinician will verify that the dose and the medication are not contraindicated at that time. d. Clinician will verify that the medication is being administered at the correct time, in the correct dose and by the correct route &MONITORING EFFECTS OF MEDICATIONS 1. Together Homecare will develop monitoring parameters and guidelines to assure the medications are appropriate and the patient/caregivers report observations and concerns &2. Patient response to medications will be assessed with each review/reconciliation & FOLLOW UP 1. All medication adverse effects and errors will be documented &2. Staff are educated and encouraged to report all events and near misses, and follow up will be done to identify system or process change needed. 3. Findings will be compiled and reported to the Director of Clinical Services/designee for review and recommendation. A review of an agency s policy, titled 'Medication Administration C-708,' dated 12/30/21 revealed, POLICY Together Homecare staff will administer medications as ordered by the physician &PURPOSE To assure that medications the patient is taking and/or agency staff are administering have current and accurate orders for safe administration. To Prevent medication errors or adverse effects for patients & SPECIAL INSTRUCTION 1. Together Homecare staff will verify orders for all drugs and treatments before administering them to patients & 2. All orders for medications will contain the name of the drug, dosage, frequency, and method of administration &" 2. Review of the clinical record for Patient 2 revealed a start of care date of 2/20/17 with a certification period of 1/15/22 to 3/15/22, and diagnoses which included, but were not limited to: Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system, and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for		Completed 4/21/22 and ongoing.	

	medication administration and enteral feeding administration via g-tube. The electronic clinical record failed to evidence a Medication Administration Record (MAR), from the start of care (2/20/2017) to 3/11/22. During a home visit on 3/11/22 at 9:00 AM, for Patient 2, who received all medications through a gastrostomy tube (g-tube), Nurse F administered 5 separate syringes full of what appeared to be medications, via G-tube, followed by a water flush. The syringes used failed to evidence labels or markings. Nurse F guided the surveyor back to the kitchen where Nurse F had pre-filled all syringes with medication for the entire day. Approximately 30 pre-filled syringes were laying on the kitchen island, loosely grouped together, and were unlabeled/unmarked. There were additional pre-filled syringes on a different counter in the kitchen, also unlabeled/unmarked and placed in a clear gallon-sized baggie labeled '9 am' and similar, adjacent baggies which contained more syringes, were also unmarked/unlabeled. When Nurse F was queried about the medications laid out, Nurse F indicated the patient had medications scheduled to be given approximately every 60-90 minutes throughout the day, and stated he/she prepares all these ahead of time upon arrival to the patient's home, at approximately 7:15 AM every day. When queried as to what document he/she follows to ensure accuracy of medication, Nurse F indicated she had been, "doing this so long", "I just know all the medications" needed. When queried further as to the location of any document that would be utilized to record the medications she had just given, Nurse F indicated he/she completes documentation at the end of the day. There was no Medication Administration Record (MAR) present in the kitchen (where meds are stored and prepared), nor in the patient's folder in the living room, to record which medications were given, nor the time and route they had been administered to the patient. When queried about this, Nurse F indicated he/she must have left the MAR in her trunk. Nurse F went to check his/her car, then returned and indicated he/she must have, "left the MAR at home". When queried as to where he/she would be documenting the medications administered today, Nurse F indicated that he/she would check off a box on the sheet titled 'Nursing Note' which was present in the home. Nurse F proceeded to circle with a black pen, an area marked "9 AM meds" and then indicated he/she marks her flushes and feedings on this same document. Times were pre-marked and handwritten. When queried further as to where he/she would record each individual medication administered, Nurse F reiterated, "right here"			

	pointing to space where the column header states 'oral liquid' and has the time handwritten in as, "9 AM, meds, 20 ml". This document failed to evidence each individual medication name, dosage, route, time due, time administered, and how the medication administration was tolerated by the patient. In an interview on 3/11/22 at 9:23 AM, with the linical Manager, when queried as to what she noted to be of concern during the visit with Nurse F at Patient 2's home visit, the Clinical Manager answered, "[nurse] left the MAR at home." In an interview on 3/11/22 at 4:01 PM, the Clinical Manager indicated she could not locate a MAR for Patient 2. The Clinical Manager stated the MAR gets mailed to the patient's home every month. She also stated, "did not know" what was happening in the home in terms of medication administration and documentation of medication administration. When queried as to what the expectation was from the nursing staff in this matter, the Clinical Manager indicated, "document as you go ... document as you administer." The Clinical Manager stated additionally she would be taking a MAR out to the nurse today. In an interview on 3/16/22 at 11:53 AM, Nurse K indicated that Supervisory Visits of RN Nurse F only involved observing the administration of enteral feedings through the g-tube. Nurse K indicated she did not observe Nurse F administer medications via g-tube and did not observe Nurse F document administration of medication.			
G1014	Interventions and patient response 484.110(a)(2) All interventions, including medication administration, treatments, and services, and responses to those interventions; Based on record review, interview, and observation the agency failed to ensure skilled nursing documented assessments in the clinical record, the patient's response/tolerance after administration of medications for 1 (Patient 2) of 4 home visit observations, out of a total sample of 9 clinical records reviewed.	G1014	G 1014	2022-04-21

Findings include:

1. Review of an agency policy 'Clinical Documentation C680,' dated 12/30/21, stated, " POLICY Together Homecare will document each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for maintaining the patient's care ... PURPOSE To ensure there is an accurate record of the services provided, patient response and ongoing need for patient care ... SPECIAL INSTRUCTIONS 1. All skilled services provided by Nursing will be documented in the clinical record...3. Additional information that is pertinent to the patient's care or condition may be documented on a progress note or clinical documentation note."

A review of an agency policy, titled 'Medication Profile C-700,' dated 12/30/21, stated, "POLICY the Registered Nurse...will complete a medication profile for each patient at the time of admission. The medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the patient is taking...PURPOSE...to provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile...To provide documentation of changes in the medication regimen as they happen, and support changes needed to the Plan of Care...To identify the effect of medications and side effects that may lead to falls or

Nurse F, identified in the survey, has been re-educatedabout the requirements to document all medication administrations on the MAR. AMAR has been delivered to patient 2’s home, and the Director of ClinicalServices has verified that Nurse F is using the MAR appropriately fordocumentation.

All Agency nurses have been re-educated on the requirementto utilize the paper or electronic MAR to document all medicationadministrations and to contact the Agency immediately if they are unable toaccess the electronic MAR and cannot locate a paper MAR in the home. The Agencyhas verified that a MAR is available in home for all skilled nursing patients. AllAgency nurses responsible for updating the comprehensive assessment have beenre-educated to validate the presence of a current MAR in the home chart duringassessment. A control has been added to the supervisory section of the Agency’scomprehensive assessment forms to validate that the presence of the MAR and/ormedication profile has been confirmed by the assessing nurse. The Agency willcontinue to provide a MAR and/or medication profile to each patient who isadmitted for services, and MARs will continue to be sent to skilled patienthomes 2 months at a time to ensure they arrive in

	other adverse events, so that appropriate interventions can be incorporated in the plan of care to decrease risk of adverse events...SPECIAL INSTRUCTIONS...The Medication Profile shall document:...C. Medication name...D. Medication Dosage...E. Route and frequency of administration...7. The Medication Profile shall be reviewed by a Registered Nurse at least every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation, whenever a change is made and at least every sixty (60) days thereafter... The original Medication Profile shall be filed in the clinical record. A copy shall be placed the patient's home chart...9. Medication Profiles created through electronic point of care documentation systems will have a copy in the patient record and patient's home if the agency is setting up or managing the medication administration. A review of the agency's policy titled 'Medication set up Policy C-701,' dated 12/30/21 stated, "1. A medication administration record (MAR) or Medication Profile should be used to set up medication...6. The nurse will clearly document what nursing tasks were performed, what was assessed, and the findings..." A review of an agency s policy, titled 'Medication Management C-705,' dated 12/30/21 revealed, "POLICY Together Homecare has a medication management system that supports patient safety and improves quality of care treatment and services by		advance of the first day ofthe month. The Director of Clinical Services or designee will audit 100%of all completed MARs for all Agency nurses weekly for 60 days to ensure medadministration is documented appropriately. The Director of Clinical Servicesor RN designee will also audit 100% of comprehensive assessments for 60 days toensure compliance with MAR review to ensure continued compliance. After 60 daysof compliance, the Agency will complete a review of MARs for at least 50% ofskilled nursing patients each quarter as part of the quarterly QAPI review, inaddition to the MARs being reviewed as part of the Agency’s quarterly 10%clinical record audit, to ensure compliance is maintained. The Director of Clinical Services is responsible formonitoring these corrective actions to ensure the deficiency is corrected andwill not recur. Completed 4/21/22 and ongoing.	

reducing practice variation, errors and misuse of medications. PURPOSE To reduce errors and improve quality of care and promote safety throughout the home care program &PROGRAM SPECIFICS ... Medications that are easy to confuse (sound alike or look-alike drugs) or chemicals that could be mistaken for medications should be separated and labeled as needed &If medications are being set up by the nurse for self-administration or administration by family or other caregivers, a chart or other form of direction may be left in the home to assure medications are taken at the times ordered, and to assess patient compliance with the schedule...MEDICATION ORDERS 1. Written orders must be legible and clearly documented. A complete medication order must include: a. The full name of the drug. b. Dose and time drug is to be given &MEDICATION ADMINISTRATION 1. When agency staff are administering medications the following steps will be taken: a. Clinician will verify that the medication is the correct one &b. Clinician will verify that the medication or solution is stable based on visual examination &c. Clinician will verify that the dose and the medication are not contraindicated at that time. d. Clinician will verify that the medication is being administered at the correct time, in the correct dose and by the correct route &"

A review of an agency policy titled 'Visit Notes C-710,' dated 12/30/21 stated, "Together Homecare personnel shall use appropriate visit notes to document ongoing patient assessment, care, and needs when visits are made frequently, when specific services are provided during each visit, or when specific

parameters are to be followed. The visit notes will include ... assessment ... response to interventions as applicable, and any additional comments from staff member conducting the visit...SPECIAL INSTRUCTIONS ... 2. The nurse must document each visit on the visit note, whether paper or electronic. The patient assessment, care provided, the patient's response to therapy ... 5. The appropriate areas on the visit note shall be complete the day services are rendered and incorporated into the clinical record within fourteen (14) days of the date...6. Findings and/or changes in condition that are not pertinent to the visit note parameters can be documented on the visit note, client loggings, or other Agency-approved documentation method."

2. Review of the clinical record for Patient 2 revealed a start of care date of 2/20/17, with a certification period of 1/15/22 to 3/15/22, and diagnoses that included, but were not limited to, Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system, and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for medication administration and enteral feeding administration via g-tube. The electronic clinical record failed to evidence a Medication Administration Record, from the start of care (2/20/2017) to 3/11/22.

During a home visit on 3/11/22 at 9:00 AM, for Patient 2, who received all medications through a gastrostomy tube (g-tube), Nurse F administered 5 separate syringes full of what appeared to be medications, via G-tube, followed by a water flush. The syringes used failed to evidence labels or markings. Nurse F guided the surveyor back to the kitchen where Nurse F had pre-filled syringes with medication for the entire day. Approximately 30 pre-filled syringes were laying on the kitchen island, loosely grouped together, and were unlabeled/unmarked. There were additional pre-filled syringes on another counter in the kitchen, unlabeled/unmarked and placed in a clear gallon-sized baggie labeled '9 am' and similar, adjacent baggies which contained more pre-filled syringes, were also unmarked. When queried about the medications laid out, Nurse F indicated the patient had medications scheduled to be given approximately every 60-90 minutes throughout the day and states he/she prepares these ahead of time upon arrival at the patient's home, at approximately 7:15 AM every day. When queried as to what document he/she follows to ensure accuracy of medication, Nurse F indicated he/she had been, "doing this so long", "I just know all the medications" needed. When queried further as to the location of any document that would be utilized to record the medications they had just given, Nurse F indicated he/she completes documentation at the end of the day. There was no Medication Administration Record (MAR) present in the kitchen (where meds are stored and prepared), nor in the patient's folder in the living room, to record which specific medications were given, nor what time, nor by

which route they had been administered to the patient. When queried about this, Nurse F indicated he/she must have left the MAR in his/her trunk. Nurse F went to check his/her car, then returned and indicated he/she must have, "left the MAR at home". When queried as to where they would be documenting the medications administered today, Nurse F indicated that he/she would check off a box on a sheet titled 'Nursing Note' which was present in the home. Nurse F proceeded to circle with a black ink pen, an area handwritten in as, "9 AM, meds, 20 ml" and then indicated also marks flushes and feedings on this same document. The times were pre-marked and handwritten. When queried further as to where he/she would record each individual medication administered, Nurse F reiterated, "right here" pointing to space where the column header states 'oral liquid' and has the time handwritten in as, "9 AM, meds, 20 ml." This document failed to evidence each individual medication name, dosage, route, time due, time administered, and how tolerated by the patient. A review of the patient's home folder failed to evidence a handwritten medication profile or a generated medication profile or an administration record.

In an interview on 3/11/22 at 9:23 AM, with the Clinical Manager, when queried as to what she found to be of concern during the home visit with Nurse F for Patient 2, Clinical Manager answered, "[nurse] left the MAR at home."

In an interview on 3/11/22 at 4:01 PM, the Clinical Manager indicated she

could not locate a MAR for Patient 2. Then stated MAR gets mailed to the patient's home every month. Indicated, "did not know" of the medication administration and documentation issues happening in the home. When queried as to what the expectation was from the nursing staff in this regard, Clinical Manager indicated, "document as you go...document as you administer." Stated additionally, that she would be taking MAR out to the patient's home today.

In an interview on 3/16/22 at 11:53 AM, Nurse K indicated Supervisory visits of RN Nurse F only involved observing the administration of enteral feedings through the g-tube. Nurse K indicated she did not observe Nurse F administer medications via g-tube and did not observe Nurse F document administration of medications. Nurse K stated pre-filled syringes were not seen during supervisory visits.

In a return phone call on 3/17/22 (after exit from the agency) at 11:46 AM, with Person A, the surveyor inquired if there were concerns with the agency. Person A acknowledged that medication syringes were pre-filled and unlabeled. Indicated that, "having medications labeled is so important." When queried as to the purpose of an untitled, typed paper found in the kitchen, near several medication bottles, which contained the names and doses of several medications, and was dated 9/31/21 Person A acknowledged this sheet and informed that they had created this document themselves to ensure accuracy of medications being administered to the patient. Person A

	indicated that having agency MARS available in the home was a problem. Stated did not believe that Nurse F had left the patient's MAR at the nurse's home. Stated, "that's not accurate". Person A also, indicated that MARs were mailed to the home and should be there timely, but are "never mailed on time." Indicated the MARs often, "arrive 10 days late, when they should be there the first of the month." Expressed concern that documentation is then backdated by default and, "that's not right." Expressed would be pleased if the MAR could just be delivered to the home timely. Indicated would like the MAR to be present in the home on time so that medications administered could just be checked off "right then." Person A indicated this had, "always been an issue".			

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