STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157554	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	1800 N WABASH AVE STE 100, MARION, IN, 46952

(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
E0000	Initial Comments An unannounced Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.22. Survey Dates: / March 10, 11, 14, 15, 16, 17, 18, 21, 22; 2022 / Facility Number: / 003890 Provider Number: / 157544 / Census: 501 / Angels of Mercy was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.22.	E0000		2022-05-13

N0000	Initial Comments This was a state re-licensure survey for a home health agency completed on March 22, 2022. Dates of Survey: March 10, 11, 14, 15, 16, 17, 18, 21, 22, 2022 Provider ID: 157554 Facility ID: 003890 Unduplicated admissions for past 12 months: 2507 Patient Census: 501	N0000		2022-05-13
G0000	This was an unannounced Federal recertification and State re-licensure survey of a home health agency, completed on March 22, 2022.	G0000		2022-05-13

	The survey was fully extended on 3/16/22 at 3:45pm. Survey Dates: / March 10, 11, 14, 15, 16, 17, 18, 21, 22; 2022 Provider ID: 157554 Facility ID: 003890 Unduplicated admissions for past 12 months: 2507 Active Patient Census: 501 These deficiencies reflect State findings cited in accordance with 410 IAC 17.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in	N0488	During a mandatory staff meeting, Executive Director re-educated clinicians regarding the requirement to provide a notice of patient discharge to the patient at least 15 calendar days before services are stopped, including patients determined to be noncompliant with plan of care, using agency policy 1.003 -	2022-04-28

subsection (i) of this rule does not apply in the following circumstances:

(1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient.

(2) The patient refuses the home health agency's services.

(3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or

(4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.

Based on record review and interview, the home health agency failed to notify the patient of pending discharge due to noncompliance at least 15 days prior to discharge for 1 of 2 discharge records reviewed of a patient discharged for noncompliance (Patient #17).

1. Agency policy titled Patient

"Notice of Non-Coverage, Expedited Determination & Reconsideration for Discharge>"

Unable to correct the deficiency, as patient #17 was discharged.

Patient's that are approaching the end of their episode will be reviewed during case conference at least 15 days in advance to determine if notice should be issued. Case Conference discussion will also include any patients identified with issues of noncompliance and if discharge is necessary, the NOMNC will be issued at least 15 days prior to discharge.

The Executive Director is ultimately responsible for implementing the plan of correction.

Beginning May 2022, Executive Director and/or trained designee will complete medical record audits on 15 discharged records per month to ensure proper discharge notices were issued within the appropriate time frame (at least 15 days prior to discharge date).

For instances of noncompliance, Executive Director will provide one on one remediation with clinician.

Monitoring will continue for 3 months and until 100% compliant for 2 consecutive months.

	Discharge / Transfer Process, numbered 2.1.004 and revised 1/1/2022, indicated, but not limited to, & Procedure: & 3. Revisions to plan for patient s discharge will be communicated to: a. Patient & d. All physicians issuing orders & 8. Patients are notified of discharge as soon as possible prior to discharge &. 2. The clinical record of Patient #17 was reviewed on 2/21/22 and indicated a discharge date of 02/04/22. The record included a plan of care [POC] for the certification period 12/15/2021 02/12/2022 that included diagnoses, but not limited to, Type 1 Diabetes Mellitus, left heel ulcer, cellulitis (infection of the skin layers), depression, anxiety, problems related to living alone, and noncompliance with medical treatments. The POC included orders for the patient to receive skilled nursing and physical therapy services, which included wound care to the patient s left lower leg wound. The record included a skilled nurse visit note, dated 01/27/22, that included documentation that the nurse found the patient with their wound without a dressing; the			

patient reported they missed their most recent wound clinic appointment. The record evidenced the patient signed a Notice of Medicare Non-Coverage (NOMNC) form during the 01/27/2022 visit, which notified the patient that their care was set to end.

The record included a verbal order to discharge the patient, the order was received from the patient s primary physician on 02/04/22; the reason for discharge was non-compliance with treatment plan.

The record included a Client Coordination Note Report, dated 02/04/22 by Branch Director #1, which indicated the nurse notified the patient s wound clinic and physician, who oversaw the wound care services, that the agency discharged the patient effective 02/04/22 due to non-compliance with treatment plan. The note also indicated the branch director left a voicemail for the patient to inform them of the discharge. The record failed to evidence the patient was advised of the potential for discharge, due to noncompliance at least 15 days prior to discharge.

	3. During an interview, on 3/22/22 at 2:55 PM, the Administrator / Clinical Manager relayed that the agency provided a 15 day notice of discharge for noncompliance if the payer source was Medicare and a 7 day notice of discharge if the patient had another payer source.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the home health agency failed to ensure the comprehensive assessment included a complete and thorough assessment of all patient conditions and diseases for 4 of 12 active records reviewed (Patients # 1, 10, 11, and 12). 1. An agency policy #2.1.002 titled Patient Assessment, Initial and Reassessment, last revised 10/1/18, included, but not limited to, upon admission and reassessments, the qualified clinician performs the following assessment activities and collects the following data & current health status & additional assessment needs are determined by patient acuity....	G0528	During a mandatory staff meeting, Executive Director re-educated clinicians regarding the comprehensive assessment to include a complete and thorough assessment of all patient conditions and diseases, using agency policy 2.1.002 - Patient Assessment, Initial and Reassessment. One on one remediation completed with PT#1, RN#5, and RN#6. Unable to correct deficiencies for patient #1 who was discharged 3/16/22 & patient #10 wo was discharged 4/19/22. Patient #12 who is currently in the hospital. Patient #11 - A diagnosis of seizures has been confirmed via H&P and added to the plan of care. A thorough comprehensive assessment was completed on 4/4/22 to include a thorough assessment of the patient's PEG tube including status, appearance, and side of tube. PEG tube was patent with no complications identified. Plan of	2022-04-28

2. The clinical record of Patient #1 was reviewed on 3/15/22, with start of care of 01/22/2022. The plan of care for the certification period 01/22/22 to 3/22/22 included patient diagnoses, but not limited to, heart disease, high blood pressure, heart failure, Type 2 Diabetes with polyneuropathy (decreased sensation in more than one peripheral nerve), Atrial Fibrillation (an irregular heart rhythm), and depression and included physician orders for physical therapy. The record evidenced an initial comprehensive assessment was completed on 01/22/22 by Physical Therapist (PT) #1. The assessment included a ranking system of the patient s current diagnoses and identified the diagnoses which included heart disease with high blood pressure and heart failure and PT#1 rated as 4 - poorly controlled, history of rehospitalizations, the diagnoses of atrial fibrillation was rated as 3 - poorly controlled, patient needs frequent adjustments in treatment and dose monitoring, and the diagnosis of depression was rated as 2 - symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring. The comprehensive assessment failed to evidence a thorough and complete assessment including the presence or absence of symptoms for the patient s poorly or difficultly controlled diagnoses, including heart failure and atrial

Care updated to include PEG tube feedings and maintenance. Order obtained to correct severity status of dysphagia and hemiplegia to a 2 (indicating symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring).

The Executive Director is ultimately responsible for implementing the plan of correction.

Beginning May 2022, Executive Director and/or trained designee will audit 30 medical records monthly to ensure complete and thorough assessments are being completed and documented, including all patient's conditions and diseases. For instances of noncompliance, Executive Director will provide one on one remediation with the clinician.

Monitoring will continue for 3 months and until 100% compliant for 2 consecutive months.

fibrillation. The assessment included a PHQ-2 (screening tool used to assess for two major symptoms of depression) but failed to evidence further assessment for other symptoms of depression.

The comprehensive assessment included a section titled Integumentary [system of organs which make up the outer layer of the body, including skin, hair, and nerves] Assessment. The documentation failed to evidence an assessment of the patient s integumentary system, including an assessment for the presence or absence of wounds.

The comprehensive assessment included a Summary of Therapy Assessment and Need with documentation that stated, Patient saw [primary physician] in late December for a follow up after labs and X-rays for a cough & Patient s cough slightly improved &. The assessment failed to evidence a thorough and complete assessment of the patient s cough (productive or non-productive, worse at night, etc.).

The comprehensive assessment included a medication list which indicated the patient was actively prescribed midodrine (medication given to treat dizziness caused by changing positions) and Flomax (medication given to treat benign prostate hyperplasia, an enlargement of the prostate gland). The assessment failed to evidence diagnoses related to the use of these medications and an assessment of the status and presence or absence of the medication-related conditions.

3. The clinical record of Patient #10 was reviewed on 3/20/22 and indicated a start of care date of 2/23/22. The record included a plan of care for the certification period 02/23/22 to 4/23/22 which indicated patient diagnoses included but was not limited to hypertension (high blood pressure), chronic respiratory failure, and venous insufficiency (condition where the blood in veins does not flow properly). The record included an initial comprehensive assessment completed on 02/23/22 by PT #1. The assessment included a ranking of the status of the patient diagnoses which indicated the

	diagnoses of hypertension, chronic respiratory failure, and venous insufficiency were rated 3 Symptoms poorly controlled, patient needs frequent adjustments in treatment and dose monitoring. The comprehensive assessment failed to evidence a thorough and complete assessment, including the presence or absence of symptoms, for the patient s poorly or difficultly controlled diagnoses, including hypertension, chronic respiratory failure, and venous insufficiency. The assessment indicated the patient had a tracheostomy (trach, tube placed into the windpipe to assist with oxygenation) and wore oxygen continuously via tracheostomy mask. The assessment failed to evidence a complete and thorough assessment of the patient s tracheostomy status and requirements (size of trach tube, appearance of trach site, frequency of changing, etc.). The assessment included a medication list, which indicated the patient was actively prescribed famotidine (medication given to			

treat Gastro Esophageal Reflux Disease, GERD) and Alka-Seltzer (medication given to treat the symptoms of heartburn, upset stomach, and indigestion). The assessment failed to evidence a diagnosis, status, and thorough and complete assessment of the patient s condition which required the above medications.

4. The clinical record of Patient #11 was reviewed on 3/20/22. The plan of care for the certification period 02/07/2022 to 4/07/2022, start of care 6/17/2020, included patient diagnoses that included, but not limited to, COVID-19, dysphagia (difficulty swallowing), hemiplegia (paralysis to one side of the body) post stroke, and history of brain cancer.

The recertification comprehensive assessment was completed on 2/4/22 by RN #6 and included a ranking system of the patient s current diagnoses which indicated the patient s diagnoses of dysphagia and hemiplegia post stroke were 3 Symptoms poorly controlled, patient needs frequent adjustments in

treatment and dose monitoring. The assessment failed to evidence a thorough and complete assessment, including presence or absence of symptoms, for the diagnoses of dysphagia and hemiplegia post stroke.

With the assessment was a Narrative which documented the patient had a PEG tube (percutaneous endoscopic gastrostomy, tube placed through the abdomen into the stomach) to be used for nutrition. The comprehensive assessment failed to evidence a complete and thorough assessment of the status of the patient s PEG tube (appearance of site, size of tube, etc.) and tube feeding (type and frequency of tube feeding, any signs, or symptoms of intolerance, etc.).

The plan of care included a medication list which indicated the patient was currently prescribed three medications, levetiracetam, topiramate, and Vimpat for seizure management. The comprehensive assessment failed to evidence a diagnosis and status assessment of the patient s condition which required the above medications.

5. The clinical record of Patient #12 was reviewed on 3/20/22 and indicated a start of care date of 3/3/22. The record included a plan of care for the certification period 3/3/22 5/1/22 and indicated patient diagnoses included but were not limited to Type 2 Diabetes Mellitus, amputation of left leg below the knee, removal of right first and second toe, and pressure ulcers (wound caused by prolonged pressure on one area of the body) to the right heel and tailbone. The record included a comprehensive assessment completed on 3/3/22 by RN #5. The assessment included a medication list which indicated the patient was actively prescribed miconazole cream to be applied for redness to the patient s abdominal folds. The assessment failed to evidence the presence or absence of redness in the patient s abdominal folds.

An interview was conducted on 3/16/22 at 3:20 PM with Administrator / Clinical Manager and Branch Director #1. During the interview the Administrator /

	Clinical Manager relayed that the comprehensive assessment included an assessment of all active patient conditions and diseases would depend on then number of diagnoses and which diagnoses the agency decided were necessary for them to educate, assess, and observe. He / She also relayed that the diagnoses with focus were at the RN (or other skilled professional) s discretion. The Branch Director #1 relayed the skilled professional assessment of the diagnoses status was a ranking of 1-4, 1 being well controlled and 4 being unstable. 410 IAC 17-14-1(a)(1)(B)			
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 home health agency failed to ensure the patients received all services and interventions as ordered in the plan of care for 1 of	G0572	During a mandatory staff meeting, Executive Director re-educated clinicians to ensure physician's orders are followed, using agency policy 2.1.007 - Plan of Care. It is the visiting clinician's responsibility to review all orders prior to initiating care. Reassessment conducted on Patient #6 by a Registered Nurse on 4/5/22 and the plan of care was reviewed by the physician on 4/8/22 and approved. Calf measurements were no longer necessary. The Executive Director is	2022-04-28

	12 active records reviewed (Patient #6). 1. An agency policy 2.1.007 titled Plan of Care (POC), with last revision date of 01/01/20, included, but not limited to, &purpose: & to ensure that physician s orders are followed &interventions are provided by qualified agency staff as ordered by the physician &. 2. Clinical record of Patient #6 was reviewed on 3/17/22. The plan of care for the certification period 02/09/2022 to 4/09/3033, start of care date 10/12/2021, included the diagnoses, but not limited to, hemiplegia following brain bleed, ischemic cardiomyopathy (condition where the heart is enlarged and not able to work efficiently), anxiety, and pressure ulcer to the sacrum (end of the spinal column below the hip bones). The plan of care included physician orders of skilled nursing visits, once a week for 8 weeks, and included skilled nurse interventions were to include measuring the patient s calves at each visit and to notify the physician of an increase of 2 centimeters or more.		ultimately responsible for implementing the plan of correction. Beginning May 2022, Executive Director or trained designee will audit 30 medical records monthly to ensure physician orders are being followed. For instances of noncompliance, Executive Director will provide one on one remediation with the clinician. Monitoring will continue for 3 months and until 100% compliant for 2 consecutive months.	

	The record included skilled nursing visits that were documented on 02/15/22, 02/24/22, 3/01/22, 3/08/22, and 3/15/22. The nurse visit documentation failed to evidence the calf measurements were obtained during the nurse visits. 3. An interview was conducted on 3/22/22 at 1:07 PM with Administrator / Clinical Manager who confirmed staff should perform all tasks and interventions as ordered in the plan of care. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential;	G0574	During a mandatory staff meeting, Executive Director re-educated clinicians to regarding the requirement of an individualized plan of care for each patient, including but not limited to all pertinent diagnoses, safety precautions, patient-specific goals and discharge plans, all DME and supplies, and complete list of medications, including routes for all meds, using agency policy 2.1.007 - Plan of Care. Patients have been discharged from services: Patient #1 discharged 3/16/22, Patient #8 discharged 4/8/22, Patient #9 discharged 3/11/22, and Patient #10 discharged 4/19/22. Deficiencies unable to be corrected.	2022-04-28

	(vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the agency failed to ensure the plan of care was patient specific, and included all pertinent diagnoses, durable medical equipment (DME), medications and treatments, safety measures appropriate to the patient, patient - specific discharge planning, and patient-specific interventions and measurable goals for 12 of 12 active records reviewed (Patients #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12). 1. An agency policy #2.1.007 titled Plan of Care (POC) , last reviewed 01/01/20, indicated but was not limited to "...the POC includes: &medications and treatments...safety measures to protect against injury...pertinent diagnosis(es) &measurable outcomes and goals...required equipment and supplies &.		For those patient that are still active (Patients #2, #3, #4, #5, #6, #7, #11, and #12), on the next scheduled visit, the qualifying clinician will complete a thorough assessment and ensure plan of care is specific to patient needs, to include pertinent diagnoses, all medications and treatments, DME and supplies, safety measures, patient-specific interventions, specific discharge plan and measurable goals. The Executive Director is ultimately responsible for implementing the plan of correction Beginning May 2022, Executive Director or trained designee will audit 30 medical records per month to ensure complete and individualized plans of care are in place for each patient. For instances of noncompliance, Executive Director will provide one on one remediation with the clinician Monitoring will continue for 3 month and until 100% compliant for 2 consecutive months.	

2. Clinical record of patient #1 was reviewed on 3/15/22. The plan of care [POC] for the certification period 01/22/2022 to 3/22/2022, with start of care [SOC] date of 01/22/2022 included, but not limited to, the diagnoses, heart disease with high blood pressure and heart failure, Type 2 Diabetes with polyneuropathy (decreased sensation in more than one peripheral nerve), Atrial Fibrillation (an irregular heart rhythm), and depression. The POC included a medication list which included, but not limited to, atorvastatin (given to treat high cholesterol), midodrine (given to treat dizziness due to change in position), Flomax (given to treat benign prostatic hyperplasia, a condition of enlarged prostate gland), and Eliquis (given to thin the blood and prevent blood clots). The plan of care failed to evidence diagnoses related to the use of the atorvastatin, midodrine, and Flomax, failed to evidence safety precautions related to the use of Eliquis, and failed to evidence patient-specific and measurable goals.

The plan of care with the discharge plan(s) discharge to care of family / caregiver under supervision of physician, when all goals met. The

POC failed to evidence a patient specific discharge plan.

During a home visit observation, on 3/11/2022 at 10:17 AM, with patient #1 (start of care 1/22/22) and Physical Therapist (PT) #1, a cane and lift chair were noted in the patient s home. The patient also reported the result of their morning blood sugar reading. The POC failed to evidence the cane, lift chair, and diabetic testing supplies.

3. The clinical record of patient #2 was reviewed on 3/15/22. The POC for the certification period 02/15/2022 to 4/15/2022, with SOC of 12/17/21, with diagnoses that included, not limited to, malignant neoplasm of esophagus, Type 2 diabetes mellitus, hypertension, and constipation.

The POC included, but not limited to, the goals &will verbalize / demonstrate understanding of home safety and fall prevention & will verbalize / demonstrate adequate knowledge of integumentary status

	& will understand and demonstrate compliance with treatment regimen for cancer &. The POC failed to evidence patient-specific and measurable goals. The POC included, but not limited to, discharge plans &DC [discharge] Plans: Discharge to care of family / caregiver under supervision of physician when all goals met.... The discharge plan failed patient specific. 4. The clinical record of patient #3 was reviewed on 3/18/22. The POC for the certification period 01/13/2022 to 03/14/2022, with SOC date of 01/13/22, included, but not limited to, the diagnoses intestinal obstruction, emphysema, heart failure, heart failure, chronic kidney disease, and Parkinson s disease. The POC included physician orders for skilled nursing and occupational therapy and included a medication list, which included, not limited to, Breo Ellipta (medication given to treat Chronic Obstructive Pulmonary Disease [COPD], Spiriva (medication given to treat various respiratory disorders, including asthma and COPD, omeprazole (medication given to treat Gastro Esophageal Reflux			

Disease [GERD]), Tums (medication given to treat heartburn), and Senna (medication given to treat constipation). The plan of care failed to evidence diagnoses for these medications and failed to evidence patient specific and measurable goals.

The POC indicated patient s discharge plans included discharge to care of family / caregiver under supervision of physician when all goals met. The POC failed to evidence a patient specific discharge plan.

During a home observation on 3/11/22 at 11:35 AM with patient #3 and Occupational Therapist (OT) #1, it was observed that home oxygen was set up, which included oxygen tanks and tubing, and a nebulizer. The POC failed to evidence these items.

5. The clinical record of patient

The POC for the certification period 3/08/2022 to 5/06/2022, with SOC of 3/13/2021, and included the diagnoses, but not limited to, complications of amputation, Type 2 Diabetes, osteomyelitis, and cellulitis. POC failed to evidence diabetic precautions and patient specific measurable goals.

The plan of care indicated the patient s discharge plans included discharge to care of family / caregiver under supervision of physician when all goals met. The POC failed to evidence a patient specific discharge plan.

6. The clinical record of patient #5 was reviewed on 3/15/22. The POC for the certification period 01/27/2022 to 3/27/2022, with SOC of 01/27/22, included the diagnoses, but not limited to, lymphedema, hypertensive chronic kidney disease, morbid obesity, and history of falling.

	During a home visit observation, on 3/14/22 at 10:31 AM with patient #5 and RN #2, a rollator walker was observed in the patient s home. The POC failed to include use of a rollator walker. The POC included the goals, but not limited to, &will verbalize / demonstrate knowledge in preserving skin integrity & will verbalize / demonstrate understanding of home safety and fall prevention & will be knowledgeable on utilizing the healthcare journal to document health information & will exhibit optimum level of personal hygiene during illness & will have safe and effective personal hygiene this episode &. The POC failed to evidence patient-specific and measurable goals.			

The POC included the discharge plans, &DC [discharge] Plans: Discharge to care of family / caregiver under supervision of physician when all goals met &. The discharge plan failed to be detailed and patient specific.

7. The clinical record of patient #6 was reviewed on 3/17/22. The POC for the certification period 02/09/2022 to 4/09/2022, with SOC of 10/12/2021, included the diagnoses, but not limited to, hemiplegia following brain bleed, ischemic cardiomyopathy (condition where the heart is enlarged and not able to work efficiently), anxiety, and pressure ulcer to the sacrum (end of the spinal column below the hip bones).

The plan of care indicated the patient s discharge plans included discharge to care of family / caregiver under supervision of physician when all goals met. The POC failed to evidence a patient specific discharge plan.

The POC indicated goals which included, but not limited to, & Patient will exhibit optimum level of personal hygiene during illness. Patient will have safe and effective personal hygiene this episode. Patient / caregiver will demonstrate proper use and administration of prescribed medications & Patient / caregiver will verbalize / demonstrate ability to care for myocardial infarction [heart attack] & Patient / caregiver will verbalize / demonstrate adequate knowledge of pneumonia & Patient / caregiver will demonstrate compliance with treatment regimen prescribed for coronary artery disease & Patient s body measurement will remain within physician guidelines &. The POC failed to evidence patient-specific and measurable goals.

8. The clinical record of patient #7 was reviewed on 3/15/22. The POC for the certification period 3/08/2022 to 5/06/2022, with SOC of 01/07/22, and included, the diagnoses, but not limited to, Type 2 diabetes mellitus with chronic kidney disease, COPD, hypertensive chronic kidney disease, and a history of falling. The POC medication list indicated levothyroxine (a medication used to replace thyroid hormone.) The POC failed to include a diagnosis related to this medication and failed to

	evidence patient - specific and measurable goals. The POC indicated & DC [discharge] Plans: Discharge to care of family / caregiver under supervision of physician when all goals met .... The discharge plan failed to be detailed and patient specific. 9. The clinical record of patient #8 was reviewed on 3/21/22. The POC for the certification period 02/09/2022 to 4/09/2022, with SOC of 8/13/21, included the diagnoses, but not limited to, chronic venous hypertension with ulcer and inflammation of right lower extremity, non-pressure chronic ulcer right lower limb, cellulitis right lower limb, lymphedema, asthma, morbid obesity, and a history of falling. The POC included the goals of, but not limited to, &will understand and demonstrate compliance with treatment regimen for hypertension &will verbalize / demonstrate			

understanding of home safety and fall prevention &. The POC failed to evidence patient specific and measurable goals.

The POC indicated &DC [discharge] Plans: Discharge to care of family / caregiver under supervision of physician when all goals met &. The discharge plan failed patient specific.

10. The clinical record of patient #9 was reviewed on 3/20/22. The POC for the certification period 02/01/2022 to 4/01/2022, with SOC 02/06/2022, included the diagnoses, but not limited to, abscess of the back, chronic ulcer of the back, osteomyelitis, heart failure, and COPD. The POC included the goals, but not limited to, Patient / caregiver will verbalize understanding of pharmacologic and nonpharmacologic pan control measures as evidenced by improvement in pain levels & Patient / caregiver will demonstrate proper use and administration of prescribed medications & Patient / caregiver will understand and demonstrate compliance with treatment regimen for heart failure & Patient / caregiver will understand

and demonstrate compliance with treatment regimen for Chronic Obstructive Pulmonary Disease &.

The POC included the discharge plans, discharge to care of family / caregiver under supervision of physician when all goals met. The POC failed to evidence a patient specific discharge plan.

11. The clinical record of patient #10 was reviewed on 3/20/22. The POC for the certification period 02/23/2022 to 4/23/2022, with SOC of 02/23/22, included the diagnoses, but not limited to, hypertension (high blood pressure), chronic respiratory failure, and venous insufficiency (condition where the blood in veins does not flow properly). The POC included a medication list which indicated patient medications included, but were not limited to, albuterol sulfate HFA (medication given as inhaler to treat shortness of breath caused by a multitude of conditions) to be taken every 4 hours as needed for breathing support, famotidine (medication given for GERD), Alka-Seltzer Heartburn + Gas (medication given to treat the symptoms of heartburn, upset stomach, and indigestion) to be

given as needed for antacid, melatonin (medication given to treat insomnia), and oxygen at 5.5 liters per minute through a nasal cannula (tube placed in the nostrils to deliver oxygen).

The record included an initial comprehensive assessment completed on 02/23/22 by PT #1. The assessment evidenced the patient had a tracheostomy (trach, tube placed into the windpipe to assist with getting oxygen in) and the patient received the oxygen through a trach mask. The POC failed to evidence diagnoses for the use of famotidine, Alka-Seltzer, and melatonin and clear directions for administration for the as needed medications albuterol and Alka-Seltzer and failed to evidence the correct route of administration for the patient s oxygen.

The POC indicated the patient s discharge plans included discharge to care of family / caregiver under supervision of physician when all goals met. The POC failed to evidence a patient specific discharge

plan.

12. The clinical record of patient #11 was reviewed on 3/20/22. The POC for the certification period 02/07/2022 to 4/07/2022, with SOC of 6/17/2020, and included the diagnoses, but not limited to, COVID-19, dysphagia (difficulty swallowing), hemiplegia (paralysis to one side of the body) post stroke, and history of brain cancer. The POC included a medication list which indicated the patient was actively prescribed the medications levetiracetam, topiramate, and Vimpat. The POC failed to evidence a diagnosis related to these medications.

The POC indicated the discharge plans discharge to care of family / caregiver under supervision of physician when all goals met. The POC failed to evidence patient specific discharge plan.

	The POC included the orders and interventions, but not limited to, & Skilled Nurse to provide instructions related to the administration of Peptamen 1.5 (type of tube feeding) 1000 [milliliters, mL] over 16 [hours] & Nutritional Requirements: Peptamen 1.5 & 120 [mL] intermittent & Medications: & Peptamen 1.5 & 125 [milliliters per hour over] 16 hours &. The POC failed to evidence patient specific orders for tube feeding, nursing interventions to assess for tube feeding residual (process where the amount of tube feeding remaining in the stomach is measured), and tube feeding residual call parameters. The plan of care indicated goals included but were not limited to Patient / caregiver will verbalize understanding of pharmacologic and nonpharmacologic pain control measures as evidenced by improvement in pain levels from _ to _ & Patient / caregiver will verbalize / demonstrate adequate knowledge of gastrostomy feedings and gastrostomy site care & Patient / caregiver will verbalized understanding of care required secondary to bowel incontinence [inability to control release of stool] & Patient verbalizes tolerance of NG tube [nasogastric tube, placed into the nose and down to the stomach] & Patient/caregiver will demonstrate			

proper use and administration of prescribed medications &. The POC failed to evidence patient-specific and measurable goals.

13. The clinical record of patient #12 was reviewed on 3/20/22. The POC for the certification period 3/03/2022 to 5/01/2022, with SOC of 3/3/22, included the diagnoses, but not limited to, Type 2 Diabetes Mellitus, amputation of left leg below the knee, removal of right first and second toe, and pressure ulcers (wound caused by prolonged pressure on one area of the body) to the right heel and tailbone. The POC included the intervention skilled nurse to instruct caregiver on dementia to include definition, signs and symptoms of different stages, care of the patient. The POC included the medication memantine (medication given to treat dementia). The POC failed to evidence a diagnosis of dementia.

The POC with the discharge plans that included discharge to care of family / caregiver under supervision of physician when all goals met. The POC failed to evidence a patient specific discharge plan.

The POC indicated goals included but were not limited to &. Patient / caregiver will understand and demonstrate compliance with treatment regimen for diabetes & Patient / caregiver will demonstrate compliance with Diabetic ADA diet & Patient / caregiver will understand and demonstrate knowledge compliance with treatment regimen for hypertension [high blood pressure] & Patient / caregiver will demonstrate compliance with treatment regimen prescribed for coronary artery disease & Patient / caregiver will understand and demonstrate compliance with treatment regimen for heart failure & Caregiver will demonstrate ability to manage dementia in the home setting & Patient will tolerate lab draw from vascular access device & Patient will exhibit optimum level of personal hygiene during illness. Patient will have safe and effective personal hygiene this episode & Patient / caregiver will demonstrate proper use of and administration of prescribed medications &. The POC failed to evidence patient specific and measurable goals.

An interview was conducted on

	3/22/22 at 1:07 PM with Administrator / Clinical Manager and Branch Director #1. During the interview, Administrator / Clinical Manager confirmed the POC should include all pertinent diagnoses, all DME / supplies required by the patient, all applicable safety precautions, all medications the patient was taking, clear indications for administration of the PRN (as needed) medications, patient specific discharge planning, measurable and patient-specific goals, and call orders for tube feeding residual only if ordered by the physician. 410 IAC 17-13-1(a)(1)(C) 410 IAC 17 17-13-1(a)(1)(D)(ii) 410 IAC 17-13-1(a)(1)(D)(ix) 410 IAC 17-13-1(a)(1)(D)(x) 410 IAC 17-13-1(a)(1)(D)(xiii)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the home health agency failed to ensure the physician was notified of a change in patient	G0590	During a mandatory staff meeting, Executive Director re-educated clinicians regarding the requirement to notify physician of any changes to the patient's condition using agency policies 2.1.017 Coordination of Care, Admit through Discharge, 2.1.020 Vital Signs, and 2.1.011 Pain Assessment	2022-04-28

	reviewed (Patients #4, 6, 10, 11, and 12). 1. An agency policy 2.1.017 titled Coordination of Care, from Admit through Discharge, last revision date of 8/1/19, indicated, but not limited to, &coordination of services is promoted through routine communication with the patient s physician & when changes occur in the patient s condition or response to treatment & when a missed visit occurs altering the Plan of Care ... when there is a need to change the patient s plan of care &. 2. Agency policy 2.1.020, titled Vital Signs and most recent revision date of 03/01/21, indicated, but not limited to, ...the clinician shall collaborate with the other clinicians and / or Patient Care Manager / Case Manager and notify physician for deviations per physician orders .... 3. Agency policy 2.1.011 titled Pain Assessment, last revised 01/01/2020, indicated, but not limited to, & Policy: The clinician will select one of the following pain assessment tools to assess pain at the present time in the patient and to initiate pain relief measures in the Plan of Care (POC) during each skilled visit. A score of 7 or greater on any of the pain assessment tools below is indicative of severe pain, which will require physician notification and patient appropriate		Patient #10 has been discharged from services on 4/19/22. Deficiencies unable to be corrected. One on one remediation conducted with RN#5. Patient #4 - patient was reassessed on 3/18/22 by an R and physician contacted regarding wound status. New wound care orders received 3/18/22 and again on 4/6/22. Executive Director verified on 4/22/22 that there have been no further changes in wound status that required physician notification.	

	interventions & Procedure: 1. Clinicians assess pain at each comprehensive and subsequent skilled visit & 5. Appropriate documentation is to include the quality, location, response to pain, mitigating factors that relieve or increase pain, and severity &. 4. The clinical record of Patient #4, with start of care [SOC] of 3/13/2021, was reviewed on 3/15/22. The plan of care [POC] for the certification period 3/8/22 5/6/22 included the patient diagnoses, complications of amputation, Type 2 Diabetes, osteomyelitis and cellulitis. The POC included physician orders for skilled nursing visits and interventions to include dressing changes to the patient s left foot amputation wound. The documentation included a skilled nursing visit note, dated 02/05/22, indicated the patient s wound measured 2 centimeters [cm] in length by 5 cm in width and 0 cm in depth, an increase of 0.8 cm in length and 2.7 cm in width from the previous measurement completed on 02/01/22. The documentation also indicated an increase in slough (dead tissue which needs to be removed for wound healing) and necrotic (tissue that has lost blood flow and is now non-viable) tissue observed from the 020/1/22 visit. The clinical record failed to evidence the patient		Patient #6 - One on one remediation conducted with RN#2, RN#8 & PT#2 regarding the requirement to notify the physician of changes to physical status, including falls and changes in vital signs, lung sounds, etc. Executive Director verified on 4/22/22 that documentation is present in the medical record of he occurrence report being completed and physician was notified on 2/8/22 of the fall and there were no changes to the plan of care. Executive Director verified on 4/22/22 that there have been no further incidents of cardiac or respiratory symptoms documented, vital signs have been within parameters, and sacral wound has been healed. Physician order obtained to DC wound care 4/22/22. Patient #11 - One on one remediation conducted with LPN#3 regarding the requirement to notify physician of changes to physical status, including changes in vital signs and respiratory status. On follow up visit 4/13/22, nurse assessed respiratory complications. Patient subsequently was assessed in the Emergency Room and antibiotics initiated. A follow up phone call to the patient was completed on 4/15/22 and there were no change reported by the patient A A follow-up visit was completed	

s physician was notified of the increase in wound size and abnormal wound tissue.

5. The clinical record of Patient #6, with SOC of 10/21/2021, was reviewed on 3/17/22. The POC for the certification period 02/09/22 4/09/22 included the patient diagnoses of hemiplegia following a brain bleed, ischemic cardiomyopathy (condition where the heart is enlarged and not able to work efficiently), anxiety, and pressure ulcer to the sacrum (end of the spinal column below the hip bones). The POC included physician orders for skilled nursing visits once a week for 8 weeks and skilled nurse interventions included to perform and instruct on wound dressing care of the patient s pressure ulcer, on his sacrum, at each visit.

The record included a recertification assessment, completed on 02/08/22, by registered nurse [RN] #2, which indicated the patient had recently fallen (unclear if any injuries sustained from fall), his pulse was weak and thready (difficult to feel), rhonchi (gurgling-like sound which typically indicate fluid or secretion movement in the airways) were heard while listening to lung sounds, the patient was short of breath at rest, and was anxious and irritable. The clinical record failed to evidence the patient s physician was

further changes in condition during clinician visits that would require reporting to physician.

Patient #12 - One on one remediation conducted with RN#5 regarding the requirement to report pain greater than 7, per policy Patient is currently in the hospital and services are on hold.

The Executive Director is ultimately responsible for implementing the plan of correction.

Beginning May 2022, Executive Director or trained designee will audit 30 medical records to ensure physician has been notified of any changes in patients condition. For instances of noncompliance, Executive Director will provide one on one remediation with the clinician.

Monitoring will continue for 3 months and until 100% compliant for 2 consecutive months.

Ongoing clinical note reviews to be performed monthly by Executive Director or trained designee.

notified of the change in patient status.

The record included a skilled nursing visit note, dated 3/8/22, authored by RN #8 which indicated the patient s sacral wound healed. The record failed to evidence the patient s physician was notified of the healed wound and failed to evidence orders were obtained to discontinue the order for wound dressing changes.

The POC included physician orders for physical therapy [PT]. The record included a PT visit note, authored by PT #2 and dated 3/02/22. The documentation revealed the PT noted Patient #6 s blood pressure was 95/52, that the patient reported cough and lethargy, and that the PT
advised the patient to contact his physician if his symptoms worsened but failed to evidence the therapist notified the physician of a change in patient status. (Documented within skilled visit note, dated 03/01/2022 was a blood pressure of 120/80.)

6. The clinical record of Patient #10, with SOC date of 02/23/2022, was reviewed on 3/20/22. The POC for

the certification period 02/23/22 4/23/22 which included diagnoses of, but not limited to, hypertension (high blood pressure), malformation of the heart, chronic respiratory failure, and venous insufficiency (condition where the blood in veins does not flow properly).

A skilled nurse visit note, dated 3/18/22 by Registered Nurse (RN) #5, noted the patient had thick yellow mucus coming from their tracheostomy (hole surgically made in the windpipe to assist with oxygenation), wheezing sounds were noted when listening to the patient s lung sounds, and the patient had started an as needed prescription of levofloxacin for respiratory infection. The note revealed RN #5 noted increased swelling and tightness in patient s lower legs, the right leg more swollen than the left, and that the patient s weight was increased by 3 pounds since admission. The clinical record failed to evidence RN #5 notified the patient s physician of the change in condition.

7. The clinical record of Patient #11, with SOC date of 6/17/2020, was reviewed on 3/20/22. The POC for the certification period 02/07/22 4/07/22 included, but not limited to, the diagnoses of COVID-19, dysphagia (difficulty swallowing),

hemiplegia (paralysis to one side of the body) post stroke, and history of brain cancer. The record evidenced a skilled nurse visit was completed on 3/04/22 by Licensed Practical Nurse #3. The nurse included an assessment of patient s blood pressure to be 92/58 (blood pressures on the two previous visits were 120/80 and 142/68), and the patient exhibited congestion, [location was not documented), shortness of breath with exertion, and lethargy. The record failed to evidence the patient s physician was notified of a change in patient condition.

8.The clinical record of Patient #12, with SOC of 3/03/2022, was reviewed on 3/20/22. The POC for the certification period 3/3/22 5/1/22 included, but not limited to, the diagnoses, Type 2 Diabetes Mellitus, amputation of left leg below the knee, removal of right first and second toe, and pressure ulcers (wound caused by prolonged pressure on one area of the body) to the right heel and tailbone. The POC with physician orders / interventions for a licensed professional to report a pain level greater than 6 (no specific pain scale documented). The comprehensive assessment, completed on 3/3/22 by RN #5, indicated Patient rated their pain as an 8 on a 0 10 numeric pain scale (0 is no pain, 10 is the worst pain),

	described the pain as aching, shooting, stabbing, and that the pain was interfering with the patient s activities and not relieved at an acceptable level. The record evidenced that Patient s Case Manager #1 flagged the elevated pain rating and commented on the assessment on 3/7/22 please fax to doctor. The record failed to evidence the physician was notified of the patient s pain level. 9.During an interview on 3/22/22 at 1:07 PM, the Administrator / Clinical Manager confirmed the physician should be notified for a change in a patient condition.			
G0602	Communication with all physicians 484.60(d)(1) Assure communication with all physicians or allowed practitioners involved in the plan of care. Based on observation, record review, and interview, the home health agency failed to ensure the physician who ordered and signed the home care orders, was notified of a medication change when ordered by another physician, for 1 of 1 home visit observation of patient receiving physical therapy services only (Patient #1). Findings include: Agency policy 2.1.017 titled	G0602	During a mandatory staff meeting, Executive Director re-educated clinicians on the requirement to notify physician who ordered and signed the home care orders when another physician orders a mediation change using agency policy 2.1.017 - Coordination of Care from admit through discharge. Patient #1 has been discharged from services. Unable to correct deficiency. The Executive Director is ultimately responsible for implementing the plan of correction. Beginning May 2022, Executive	2022-04-28

	Coordination of Care, from Admit through Discharge, last revised 8/1/19, indicated, but not limited to, & coordination of services is promoted through routine communication with the patient s physician & when changes occur in the patient s condition or response to treatment & when there is a need to change the patient s plan of care &. During a home visit observation, on 3/11/2022 at 10:17 AM, with Patient #1 (start of care 1/22/22) and Physical Therapist (PT) #1, Patient #1 s family member relayed that the patient s nephrologist recently increased the patient s dose of Flomax (medication given to treat benign prostatic hyperplasia, a condition where the prostate is enlarged), the dose was increased from one pill to two pills every day. The clinical record of Patient #1 was reviewed on 3/15/22. The plan of care for the certification period 01/22/22 3/22/22, revealed the patient s primary care physician was the provider that signed the patient s home care orders. The record failed to evidence the patient s primary care physician was notified of the change in Flomax dose by the nephrologist.		Director or trained designee will audit 30 medical records to ensure physician who ordered and signed home care orders is notified when another physician changes mediations. or instances of noncompliance, Executive Director will provide one one one remediation with the clinician.. Monitoring will continue for 3 months and until 100% complaint for 2 consecutive months.	

	During an interview on 3/22/22 at 1:07 PM, the Administrator / Clinical Manager relayed that the physician who provided the home care orders should be notified when there is a medication order changed by another physician. 410 IAC 17-14-1(a)(1)(G)			
G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control. (d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement.	G0687	100% HR File review was conducted and determined no otheremployees had a temporary exemption. Affected staff member was placed on leave until permanent exemptiongranted. During a mandatory staff meeting, Executive Directoreducated all Business Managers on the requirement of every employee to be fullyvaccinated, unless they receive an approved exemption. Temporary exemptions will be tracked andemployee will be vaccinated or receive a permanent exemption prior to theexpiration date of the temporary exemption.	2022-04-28

	(2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and (ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients; (ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;		Agency policy 9.1.021– COVID 19 Vaccination Policy was updated 3/23/22 and Executive Directoreducated all staff on the policy regarding the requirement of allnon-vaccinated staff to receive an approved exemption and follow additionalrequirements, including but not limited to daily screening procedures andreporting any signs or symptoms of COVID to direct supervisor before reportingto work. The Executive Director is ultimately responsible for implementing theplan of correction. Beginning June 2022, Executive Director or trained designeewill audit 100% of HR files for unvaccinated staff to ensure permanentexemptions have been approved or temporary exemptions have not yet expired. Monitoring willcontinue for 3 months and until 100% compliant for 2 consecutive months.	

(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (d)(1) of this section;

(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;

(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;

(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements;

(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains

(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and

(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;

(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be

CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and

(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Based on record review and interview, the home health agency failed to ensure their policies and procedures included the specific additional precautions in place for the prevention of COVID-19 transmission, for the agency's unvaccinated staff with an approved temporary, religious, or medical exemption to the COVID-19 vaccination for 1 of 1 agency and failed to ensure 1 of 1 approved medical exemption reviewed [employee H] met the federal requirements, with the potential to affect all agency patients and staff.

1. An agency policy 9.1.021 titled COVID-19 Vaccination Policy, last revised 03/01/22, indicated but was not limited to &requires all employees, students, volunteers, and contract workers who are subject to a mandatory vaccination rule, policy, regulation, or law &to be fully vaccinated against COVID-19 unless granted a legally-recognized exemption &staff in a Covered Position &are required to comply with the CMS Vaccination Rule & Covered Positions include all employees (including administrative support staff), volunteers, students,

	and contract workers that work in &Home Health &before, March 15, 2022, all Covered Staff Members &must either (i) provide proof that they are Fully Vaccinated ; (ii) provide proof of a need for a temporary delay due to clinical precautions and considerations as recommended by the CDC; or (iii) have been granted an exemption due to a medical contraindication or disability, or a sincerely held religious belief or religious practice &Covered Staff Members who are not in compliance &may not provide care, treatment, or other services for the company or its patients &Employees who are not in compliance will be placed on unpaid leave of absence for up to 30 days &Individuals who have been granted a medical or religious exemption must comply with all COVID-19 precautions required by the LHC Group COVID-19 Task Force, company policy, state law, or the individual s work location, including without limitation COVID-19 testing (if applicable), social distancing, and PPE requirements. 2. CDC (12/21/21). Summary Document of Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized or Approved in the United States. Retrieved 3/18/22 from www.cdc.gov. The document indicated the CDC recognized			

contraindications to the COVID-19 vaccine was severe allergic reaction & after a previous dose or to component of the COVID-19 vaccine. The CDC document also indicated Antibody testing not recommended for vaccine decision-making &.

3. A log of active employee COVID-19 vaccination status was reviewed on 3/18/22. The log indicated Employee H had a medical exemption for the COVID-19 vaccination.

4. The COVID-19 vaccination medical exemption request for Employee H, dated 11/2021, was reviewed on 3/21/22. The request indicated the reason for medical exemption for the vaccine was the employee "...currently has the antibodies, so there is no need for the COVID vaccine at this time..." The request was approved by the Angels of Mercy corporate office.

5. An interview was conducted on 3/21/22 at 3:52 pm with Administrator/Clinical Manager. During the interview

	Administrator/Clinical Manager confirmed no additional precautions were put into place for staff with medical or religious exemptions to the COVID-19 vaccine. The Administrator/Clinical Manager also confirmed the request and decision making of religious or medical exemption to the COVID-19 vaccine was conducted by the corporate office. 6. A follow up interview was conducted on 3/22/22 at 10:05 AM was conducted with the Administrator/Clinical Manager. During the interview, the Administrator/Clinical Manager confirmed Employee H s medical exemption was input into the vaccine tracking log incorrectly as it was meant to be a temporary exemption for the vaccine. The Administrator/Clinical Manager also confirmed Employee H was not currently vaccinated.			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training.	G0800	During a mandatory staff meeting, Executive Director educated all aides regarding requirement to only provide services as ordered on the home health aide care plan using Home Health Aide job description. Patient #6 - One on one remediation completed with	2022-04-28

Based on observation, record review, and interview, the home health agency failed to ensure the home health aide (HHA) performed tasks only as ordered on the aide care plan for 1 of 1 home health aide visit observed (Patient #6).

1. An agency job description titled Aide Home Health indicated but was not limited to ...the Home Health Aide is responsible for providing patients with in-home personal care...while following the written plan of care...follows current written aide assignment sheet to provide personal care and assistance with activities of daily living (ADLs) ... provides care according to the aide plan of care/assignment sheet ....

2. A home visit observation was conducted on 3/14/22 at 12:00 PM with Patient #6 (start of care 10/12/21) and HHA #1. During the visit, the aide was observed assisting the patient with a full bed bath. During the bath, the aide noted redness to the patient s bilateral inner buttocks and asked the patient if he would

HHA#1 regarding the requirement to provide services only as ordered on the aide care pan. Boudreaux' Butt Paste added to plan of care for use topically as needed for redness or irritation.

The Executive Director is ultimately responsible for implementing the plan of correction.

Beginning May 2022, Executive Director or trained designee will complete 4 home visits per month to ensure home health aide is following aide care plan.

Monitoring will continue for 3 months and until 100% compliant for 2 consecutive months.

like Boudreaux s Butt Paste (medicated ointment applied to treat and prevent diaper rash or skin breakdown) applied to the area. The patient agreed and the cream was applied by the aide.

The clinical record of Patient #6 was reviewed on 3/14/22 and 3/17/22. The record included an Aide Care Plan Report entered and approved by the Administrator / Clinical Manager on 2/9/22. The aide care plan failed to evidence an aide task to apply the medicated ointment to the patient s inner buttocks.

3. An interview was conducted on 3/14/22 at 3:00 PM with Administrator/Clinical Manager and Branch Director #2. During the interview, the Administrator/Clinical Manager confirmed the home health aide should perform tasks only as ordered on aide care plan.

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