STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K070	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TMG HOME HEALTH CARE INC	224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This survey was for a Federal Home Health Recertification survey with survey dates of 8/7/18 - 8/16/18. A complaint was investigated during this survey. The survey was fully extended on 8/8/18. Survey dates: 8/7/18 - 8/16/18 Complaint #: IN00245734: Complaint was substantiated. Federal deficiencies related to the complaint were cited. Unrelated deficiencies were also cited. Facility ID: 011556 Provider #: 15K070 Medicaid #: 201022100 Census: 7 unduplicated skilled patients for past year 16 active patients 4 discharged patients in past 6 months TMG Home Health Care Inc is precluded from its own home health training and competency evaluation for a period of two years beginning 8/17/18 - 8/17/2020 due to being found out of compliance with the Conditions of Participation CFR 484.50 Patient Rights; 484.60 Care Planning, Coordination, Quality of Care; 484.65 Quality Assessment / performance improvement; 484.70 Infection prevention and control; 484.75 Skilled Professional Services; 484.105 Organization and Administration of Services; and 484: 110 Clinical Records.	G 000		
G 406	Patient rights	G 406		

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

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 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.

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G 406	Continued From page 1 CFR(s): 484.50 The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. This CONDITION is not met as evidenced by: Based on record review and interview, the agency failed to ensure patient and/ or patient representatives received an accurate notice of the Patient Bill of Rights, Authorization, Agreement, and Acknowledgement Forms, and Notice of Privacy Rights before the initiation of treatment (See G 410); failed to ensure the patients / patient representatives received the home health agency administrator's name, business address, and business phone number in order to receive complaints (see G 414); failed to ensure written notice of the patient's rights and responsibilities was provided within 4 business days of the initial assessment (see G 422); failed to ensure the patient / patient representative had the right to be informed of the HHA's policy for transfer and discharge see G 452); failed to ensure the home health agency arranged a safe and appropriate transfer to another care entities when the needs of the patient exceeded the HHA's capabilities (See G 454); failed to ensure the patient's physician and the legal representative was informed in advance of a discharge (See G 464); failed to investigate the complaint made by a patient's legal representative (See G 478); and failed to document the existence of a complaint made by the patient's legal representative and the resolution (See G 484).	G 406		

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G 406	Continued From page 2 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 484.50 Patient Rights.	G 406		
G 410	Information to patient CFR(s): 484.50(a)(1) Provide the patient and the patient's legal representative (if any), the following information during the initial evaluation visit, in advance of furnishing care to the patient: This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure patient and/ or patient representatives was provided an accurate notice of the Patient Bill of Rights, Authorization, Agreement, and Acknowledgement Forms, and Notice of Privacy Rights before the initiation of treatment in 5 of 9 clinical records reviewed. (#1, 2, 4, 5, 7) The findings include: 1. The policy titled "Patient Rights" dated 7/12/18 stated, "The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: The home health agency shall provide the patient with a written notified of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment." 2. During the entrance conference on 8/7/18 at 10:40 AM, the owner of the agency indicated the	G 410		

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G 410	Continued From page 3	G 410		

agency was not accredited by any accrediting organizations.

3. Review of the agency document titled "Patient Bill of Rights" stated, "The patient bill of rights includes, but is not limited to, the right to be fully informed in advance about service / care to be provided, including the disciplines that furnish care and the frequency of visits as any modifications to the service / care plan ... receive information about the services covered under the Medicare home health or hospice benefit. Participate in the development and periodic revision of the plan of care. Informed consent and to refuse care or treatment after the consequences of refusing care or treatment are fully presented. Be informed, both orally and in writing, in advance of care being provided, of the changes, including payment ... Have one's property and person treated with respect consideration, and recognition of patient dignity and individuality. Be able to identify visiting staff members through proper identification. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source ... voice grievances ... be informed of patient rights under state law to formulate advance care directives to include, determining the existence of advance care directives ..." Included on this document was how to complain with contact information to two accrediting bodies: Company A and Company B including a Spanish translation. The home health agency was not part of these accrediting bodies. This form was dated in the individual clinical records as received.

4. Review of the agency document titled "Authorization, Agreement, and

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G 410	Continued From page 4	G 410		

Acknowledgement Form" (included dates of signing with each patient), included contact information for two accrediting bodies' information including how to complain and the contact information including fax number, mailing address, phone number, email information, and translation of this in Spanish. The agency was not part of these two accreditation bodies (Company A and Company B). This was further evidenced by the following:

5. Review of the agency document titled "Notice of Privacy Rights" stated, "This notice describes how medical information about you may be disclosed and how you can get access to this information ... 10. Individuals may complain to the organization and to the Secretary of the US Department of Health and Human Services if they believe their privacy rights have been violated. Complaints should be directed to [former employee, Person A, past administrator] at the organization at the following telephone # [out of state phone number] ... 11. For further information, individuals should contact [Person A] at the organization at the following number [out of state phone number]. 12. This Notice is in effect as of October 1, 2013 .... "

6. A review of clinical record #1, start of care 12/8/17, failed to evidence that the patient / patient representative received an accurate Patient Bill of Rights, Authorization/ Agreement/ Acknowledgement, and Notice of Privacy Rights documents before the initiation of treatment. The patient/ patient representative signed these documents on 1/19/18 with Employee A, Registered Nurse (RN), which was approximately one month after the patient started care with the agency.

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7. A review of clinical record #2, start of care 12/4/17, failed to evidence that the patient / patient representative received an accurate Patient Bill of Rights, Authorization/ Agreement/ Acknowledgement, and Notice of Privacy Rights documents before the initiation of treatment. The patient signed the documents on 12/26/17 with the administrator / director of nursing, which was approximately 22 days after the patient started care with the agency.

8. A review of clinical record #3, a start of care on 12/13/17, failed to evidence that the patient received an accurate Patient Bill of Rights and Notice of Privacy Rights document. The patient signed the documents on 12/13/17 with Employee A.

9. A review of clinical record #4, a start of care of 11/16/17, failed to evidence that the patient received accurate Patient Bill of Rights, Authorization/ Agreement/ Acknowledgment, and Notice of Privacy Rights documents before the initiation of treatment. The patient signed the documents on 11/21/17 with Employee A, which was approximately 5 days after the patient started care with the agency.

10. A review of clinical record #5, a start of care of 12/15/17, failed to evidenced that the patient/ patient representative received accurate Patient Bill of Rights, Authorization/ Agreement/ Acknowledgement, and Notice of Privacy Rights document before the initiation of treatment. The patient's representative signed the documents on 12/19/17 with Employee A, which was approximately 4 days after the patient started care with the agency.

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G 410	Continued From page 6	G 410		

11. A review of clinical record #6, a start of care of 1/18/18, failed to evidence that the patient received accurate Patient Bill of Rights Authorization, Agreement, and Acknowledgement documents. The patient signed the documents on 1/18/18 with Employee A.

12. A review of clinical record #7, a start of care of 2/23/18, failed to evidenced that the patient received accurate Patient Bill of Rights document before the initiation of treatment. The patient signed the document on Paper on 2/27/18 with was 4 days after the patient started care with the agency.

13. A review of clinical record #8, a start of care of 4/19/16, failed to evidenced that the patient received accurate Patient Bill of Rights document. The patient's legal representative signed the document on 4/19/16 with the past administrator.

14. A review of clinical record #9, a start of care of 6/27/18, failed to evidenced that the patient/ patient representative received accurate Patient Bill of Rights and Notice of Privacy Rights documents. The patient's representative signed these documents on 6/27/18 with the administrator/ director of nursing.

15. During a phone call on 8/14/18 at 1:48 PM, the complaint line for Accrediting organization, Company A, was called. A receptionist answered and identified this as the complaint line for Company A.

16. During a phone call on 8/14/18 at 1:50 PM, the complaint line for the accrediting organization, Company B, was called. This number was

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G 410	Continued From page 7 identified as a nonworking number by a voice recording. 17. During an interview on 8/14/18 at 3:39 PM, the administrator / director of nursing and the owner indicated not having the accrediting organizations involved in the agency. 18. The number on the documents for Person A was called on 8/15/18 at 11:20 AM. Person B identified self as employee of an agency in Florida and indicated Person A was not available.	G 410		
G 414	HHA administrator contact information CFR(s): 484.50(a)(1)(ii) Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the patients / patient representatives received the home health agency administrator's name, business address, and business phone number in order to receive complaints for 8 of 9 clinical records reviewed (#1 - 7, #9). The findings include: 1. The agency policy "Patient Rights" dated 7/12/18 stated, "The patient has the right to exercise his / her rights as a patient of the home health agency: 1. The patient's family or legal representative may exercise patient 's rights as permitted by law ... the patient has the right to voice grievances regarding treatment or care furnished ... a. the home health agency shall	G 414		

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investigate complaints made to the patient or patient's legal representative regarding treatment or care that is [or fails to be] furnished or regarding the lack of respect for the patient's property by anyone furnished or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency and shall document both existence of the complaint and the resolution of the complaint." This policy did not evidence the administrator's name or contact information.

2. The agency policy titled "Nondiscrimination Policy" revised 7/6/18 stated, "In case of questions concerning this policy or in the event of a desire to file a complaint alleging violations of the above please contact: [administrator's name, RN / administrator In writing: 224 W Jefferson Blvd, Suite 200, South Bend, Indiana 46601 or by phone [574] 233 - 9564 [24 hour hotline].

3. A review of the undated Home Care Admission Packet failed to show the administrator's name or contact information. This was presented to the agency patients at admission.

On 8/7/18 at 1:30 PM, the administrator / director of nursing indicated the above packet was given to the patient's upon admission.

4. A review of clinical record #1, start of care 12/8/17, failed to evidence that the patient / patient representative received the current administrator's name, business address, and business phone number in order to receive complaints.

5. A review of clinical record #2, start of care 12/4/17, failed to evidence that the patient /

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patient representative received the current administrator's name, business address, and business phone number in order to receive complaints.

6. A review of clinical record #3, start of care 12/13/17, failed to evidence that the patient / patient representative received the current administrator's name, business address, and business phone number in order to receive complaints.

7. A review of clinical record #4, start of care11/16/17, failed to evidence that the patient / patient representative received the current administrator's name, business address, and business phone number in order to receive complaints.

8. A review of clinical record #5, start of care12/15/17, failed to evidence that the patient / patient representative received the current administrator's name, business address, and business phone number in order to receive complaints.

9. A review of clinical record #6, start of care 1/18/18, failed to evidence that the patient / patient representative received the current administrator's name, business address, and business phone number in order to receive complaints.

10. A review of clinical record #7, start of care of 2/23/18, failed to evidence that the patient / patient representative received the current administrator's name, business address, and business phone number in order to receive complaints.

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G 414	Continued From page 10 11. A review of clinical record #9, a start of care of 6/27/18, failed to evidence that the patient / patient representative received the current administrator's name, business address, and business phone number in order to receive complaints.	G 414		
G 422	Written notice within 4 business days CFR(s): 484.50(a)(4) This ELEMENT is not met as evidenced by: Based on record review, the agency failed to ensure written notice of the patient's rights and responsibilities was provided within 4 business days of the initial assessment for 3 of 9 records reviewed (#1, #2, #4). The findings include: 1. The policy titled "Patient Rights" dated 7/12/18 stated, "The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows: The home health agency shall provide the patient with a written notified of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment." 2. A review of 3 of 9 clinical records reviewed failed to evidence the patients/ patient representative had received the rights within 4 days days of the initial evaluation visit. 3. A review of clinical record #1, start of care	G 422		

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G 422	Continued From page 11 12/8/17, evidenced the patient's representative did not sign the Patient Bill of Rights until 1/19/18 with Employee A, Registered Nurse (RN). The agency failed to ensure the patient representative received an accurate Patient Bill or Rights within 4 day business days of the initial evaluation visit. 4. A review of clinical record #2, start of care 12/4/17, evidenced the patient did not sign the Patient Bill of Rights until 12/26/17 and the document was not signed by the patient and the administrator / director of nursing until 12/26/17. The agency failed to ensure the patient received an accurate Patient Bill or Rights within 4 day business days of the initial evaluation visit. 5. A review of the clinical record #4 with a start of care of 11/16/17, evidenced the patient did not sign the Patient Bill of Rights document until 11/21/17 with Employee A. The agency failed to ensure the patient received an accurate Patient Bill or Rights within 4 day business days of the initial evaluation visit.	G 422		
G 428	Property and person treated with respect CFR(s): 484.50(c)(1) Have his or her property and person treated with respect; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the patient was treated with dignity for 1 of 1 licensed practical nurse visits observed (patient #2 with Employee B, LPN, who completed a home health aide visit). The findings include: 1. The agency policy titled "Patient Rights" dated	G 428		

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G 428	Continued From page 12 7/12/18 stated, "The patient has the right to exercise his / her rights as a patient of the home health agency as follows ... The patient has the right to be ... treated with dignity." 2. During a home visit observation on 8/14/18 at 4:10 PM, Employee B, Licensed Practical Nurse, was observed to give a bed bath to patient #2. During the bath, Employee B did not close the window blinds and had the patient uncovered. At times during the bath, the patient's peri area and other exposed parts of the body were exposed and not covered with a towel or blanket. At 4:15 PM, the patient covered self with covering. During the bath, the window blinds were open for approximately 15 minutes while the patient was undressed. 3. During an interview on 8/14/18 at 4:45 PM, the administrator / director of nursing indicated the blinds had been open during the bath and this did not provide privacy for the patient.	G 428		
G 452	Transfer and discharge CFR(s): 484.50(d) The patient and representative (if any), have a right to be informed of the HHA's policies for transfer and discharge. The HHA may only transfer or discharge the patient from the HHA if: This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the patient / patient representative had the right to be informed of the HHA's policy for transfer and discharge for 9 of 9 records reviewed #1 - #9) of patients who received care. The findings include:	G 452		

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G 452	Continued From page 13 1. A review of the agency policy titled "2/17 Discharge / Transfer Policy" dated 2015 stated, "The agency will maintain a process for the ongoing assessment of each patient's continuing care and discharge planning process ..." 2. A review of record #1 failed to evidence the patient had received the transfer and discharge policy. 3. A review of record #2 failed to evidence the patient had received the transfer and discharge policy. 4. A review of record #3 failed to evidence the patient had received the transfer and discharge policy. 5. A review of record #4 failed to evidence the patient had received the transfer and discharge policy. 6. A review of record #5 failed to evidence the patient had received the transfer and discharge policy. 7. A review of record #6 evidenced the record had the agency discharge / transfer of patient policy in it. This document was not signed by the caregiver or patient. 8. A review of record #7 failed to evidence the patient had received the transfer and discharge policy. 9. A review of record #8 failed to evidence the patient had received the transfer and discharge policy.	G 452		

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TMG HOME HEALTH CARE INC	224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601

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G 452	Continued From page 14 10. A review of record #9 failed to evidence the patient had received the transfer and discharge policy.	G 452		
G 454	HHA can no longer meet the patient's needs CFR(s): 484.50(d)(1) The transfer or discharge is necessary for the patient's welfare because the HHA and the physician who is responsible for the home health plan of care agree that the HHA can no longer meet the patient's needs, based on the patient's acuity. The HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHA's capabilities; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the home health agency arranged a safe and appropriate transfer to another care entities when the needs of the patient exceeded the HHA's capabilities for 2 of 3 closed records reviewed (#6 and #8). The findings included: 1. The policy titled "2.17 Discharge / Transfer Policy" dated 2015 stated, "Discharge planning shall begin at the time of admission with patients being advised as to the expected duration of treatment. Re- evaluation by the RN and additional planning with the patient shall occur through out the course of care and shall include the documentation of specific plans and expected date of discharge ... 1. At the visit before the discharge, the patient and the physician will be notified of discharge ..." 2. A review of closed record #6, start of care	G 454		

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G 454	Continued From page 15 1/18/18 and discharge of 4/17/18 evidenced the patient was discharged due to patient's request / transfer 4/17/18. The patient was transferred to other home care on 4/17/18. The discharge summary on this Discharge assessment document dated 4/17/18 evidenced the patient had received home health aide services 8 hours a day X 5 days a week for assistance with Activities of Daily Living and Instrumental Activities of Daily Living, housekeeping, meal preparation, and safety. Skilled nurse services included services 3 hours a day X 5 days / week for straight catheterization of bladder, bowel program, and medication and health monitoring. The clinical record evidenced the patient transferred to another home care without the name of the home care in the record. This was further evidenced by the following: During an interview on 8/14/18 at 12:30 PM, the administrator / director of nursing indicated patient #6 requested a transfer and refused to cooperate with the agency staff. There was no documentation of this refusal of care except for the request to be transferred. A family member of this patient cared for patient after the patient transferred / discharged. The care for the patient was written out of for the patient and the new caregiver. A copy of this document was not kept for the clinical record. Concerning the lack of home health aide visits, the administrator / director of nursing indicated another home health agency providing home health aide visits refused to relinquish the prior authorization for the home health aide visits. This agency did not complete the home health aide visits. During an interview via phone on 8/15/18 at 8:15 AM, patient #6 indicated being given two week	G 454		

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G 454	Continued From page 16	G 454		

notice of discharge. Patient #6 indicated Employee N had found employment elsewhere and so the agency could not meet his / her needs any longer. The administrator / director of nursing had lined up a nurse for the patient but indicated this did not work out due to conflict with the nurse's family. The patient indicated a informal caregiver ended up taking over the care.

During an interview on 8/16/18 at 11 AM with Employee N, Licensed Practical Nurse, indicated the patient discharged due to needing more care with a full time agency.

3. A review of a clinical record #8, start of care 4/25/16, diagnosis of physical abuse complicating pregnancy, generalized epilepsy and attention - deficit hyperactivity disorder, failed to evidenced a complaint that was investigated by the agency administrator or other staff. Review of the closed record, failed to evidence that the agency failed to inform the patient's legal representative in advance notice of their intentions to disharge the patient and assist them with finding another agency to provide services so that there be no disuption of care as evidenced by the following:

A review of the record evidenced a "Comprehensive Adult Assessment" dated 8/14/17, with time in of 3:42 PM and time out of 5 PM. This note evidenced a visit was completed by Employee H, RN, and signed on this date. Under discharge plans, Employee H checked box "other" and stated, "When services are no longer needed or can be provided by another source."

A review of the record evidenced home health visits completed on 8/18/17, 8/19/17, 8/21/17, 8/22/17, 8/23/18, 8/24/17, 8/25/17, 8/26/17,

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G 454	Continued From page 17 8/28/17, 8/29/17, 8/30/17, 8/31/17, 9/1/17, 9/2/17, 9/5/17, 9/6/17, 9/7/17, 9/8/17, 9/9/17, 9/11/17, 9/12/17, 9/13/17, 9/14/17, 9/15/17, 9/18/17, 9/19/17, 9/20/17, 9/21/17, 9/22/17. A supervisory nurse visit was completed on 8/18/17. A review of the record evidenced a home health aide visit with no tasks completed on 10/2/17. The note was signed by Employee K, Home Health Aide. A note on this note under patient's signature stated, "Power of attorney verbalized [illegible words after this.]" This was electronically signed by Employee K on 10/19/17. Review of the clinical record, the only communication about the discharge in the notes was dated 9/28/17 from Employee L, RN, which stated, "Please complete note on 8/14/17. Need to use that note to discharge patient as of 923/17." This review occurred 8/14/18 - 8/18/18. The only communication about the discharge in the notes was dated 9/28/17 from Employee L, RN, which stated, "Please complete note on 8/14/17. Need to use that note to discharge patient as of 9/23/17." This review occurred 8/14/18 - 8/16/18. During an interview on 8/14/18 at 3:20 PM, the owner of the agency indicated the patient representative for patient #8 refused to sign the visit notes. The patient representative wanted all of the records that he / she signed and would not sign without receiving copies. The patient was grabbing aides inappropriately. The owner stated, "[Patient #8] was abusive and would grab ... aides." The owner indicated talking to the past administrator and told the past administrator that the patient representative needed to sign the visit	G 454		

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G 454	Continued From page 18 notes. She stated, "I told [the patient representative] we would not service [him / her] if she would not sign the visit notes." During an interview on 8/14/18 at 3:45 PM, the administrator/ director of nursing indicated the discharge oasis and summary were not found in the record. During an interview on 8/15/18 at 9:40 AM, the patient representative of patient #8 indicated refusing to sign the agency visit notes because the agency refused to give him / her copies and complaining to the agency and case manager and the agency discharging the patient because of her / his refusal to sign the visit notes. The patient representative also indicated complaining to the agency when the aide did not show up or called in sick. A new aide, Employee K, HHA, was assigned after the complaint. The patient representative recalled complaining to the owner and administrator due to Employee K's smoking and the smell of the smoke in the home. During an interview on 8/15/18 at 10:18 AM, Person C, the case manager for patient #8, indicated billing concerns with the agency. She indicated there was a complaint filed and the administrator and owner of the agency were aware of the complaint. A letter dated September 26, 2017 stated, "[Patient #8] ... Date of Service: 5/26/17 - 11/24/17, To Whom It May Concern: This letter is to confirm that [Patient #8] has been discharged from our agency as of September 23, 2017 due to noncompliance of caregiver to inform [agency] of changes of [patient #8] physician; also caregiver's refusal to sign in order to be compliant	G 454		

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G 454	Continued From page 19 with home health aide services. If you have any further questions or concerns regarding this matter please contact our office. Thank you. [past administrator, director of nursing] RN BSN, administrator."	G 454		
G 464	Advise the patient of discharge for cause CFR(s): 484.50(d)(5)(i) Advise the patient, representative (if any), the physician(s) issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the patient's physician and the legal representative was informed in advance of a discharge for 1 of 3 closed records reviewed in a sample of 9. (#8) Findings include: A review of a clinical record #8, start of care 4/25/16, diagnosis of physical abuse complicating pregnancy, generalized epilepsy and attention - deficit hyperactivity disorder, failed to evidenced a complaint that was investigated by the agency administrator or other staff. Review of the closed record, failed to evidence that the agency failed to inform the patient's physician and legal representative in advance notice of their intentions to disharge the patient as evidenced by the following: A review of the record evidenced a	G 464		

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G 464	Continued From page 20 "Comprehensive Adult Assessment" dated 8/14/17, with time in of 3:42 PM and time out of 5 PM. This note evidenced a visit was completed by Employee H, RN, and signed on this date. Under discharge plans, Employee H checked box "other" and stated, "When services are no longer needed or can be provided by another source." A review of the record evidenced home health visits completed on 8/18/17, 8/19/17, 8/21/17, 8/22/17, 8/23/18, 8/24/17, 8/25/17, 8/26/17, 8/28/17, 8/29/17, 8/30/17, 8/31/17, 9/1/17, 9/2/17, 9/5/17, 9/6/17, 9/7/17, 9/8/17, 9/9/17, 9/11/17, 9/12/17, 9/13/17, 9/14/17, 9/15/17, 9/18/17, 9/19/17, 9/20/17, 9/21/17, 9/22/17. A supervisory nurse visit was completed on 8/18/17. A review of the record evidenced a home health aide visit with no tasks completed on 10/2/17. The note was signed by Employee K, Home Health Aide. A note on this note under patient's signature stated, "Power of attorney verbalized [illegible words after this.]" This was electronically signed by Employee K on 10/19/17. Review of the clinical record, the only communication about the discharge in the notes was dated 9/28/17 from Employee L, RN, which stated, "Please complete note on 8/14/17. Need to use that note to discharge patient as of 923/17." This review occurred 8/14/18 - 8/18/18. The only communication about the discharge in the notes was dated 9/28/17 from Employee L, RN, which stated, "Please complete note on 8/14/17. Need to use that note to discharge patient as of 9/23/17." This review occurred 8/14/18 - 8/16/18.	G 464		

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During an interview on 8/14/18 at 3:20 PM, the owner of the agency indicated the patient representative for patient #8 refused to sign the visit notes. The patient representative wanted all of the records that he / she signed and would not sign without receiving copies. The patient was grabbing aides inappropriately. The owner stated, "[Patient #8] was abusive and would grab ... aides." The owner indicated talking to the past administrator and told the past administrator that the patient representative needed to sign the visit notes. She stated, "I told [the patient representative] we would not service [him / her] if she would not sign the visit notes."

During an interview on 8/14/18 at 3:45 PM, the administrator/ director of nursing indicated the discharge oasis and summary were not found in the record.

During an interview on 8/15/18 at 9:40 AM, the patient representative of patient #8 indicated refusing to sign the agency visit notes because the agency refused to give him / her copies and complaining to the agency and case manager and the agency discharging the patient because of her / his refusal to sign the visit notes. The patient representative also indicated complaining to the agency when the aide did not show up or called in sick. A new aide, Employee K, HHA, was assigned after the complaint. The patient representative recalled complaining to the owner and administrator due to Employee K's smoking and the smell of the smoke in the home.

During an interview on 8/15/18 at 10:18 AM, Person C, the case manager for patient #8, indicated billing concerns with the agency. She indicated there was a complaint filed and the

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G 464	Continued From page 22 administrator and owner of the agency were aware of the complaint. A letter dated September 26, 2017 stated, "[Patient #8] ... Date of Service: 5/26/17 - 11/24/17, To Whom It May Concern: This letter is to confirm that [Patient #8] has been discharged from our agency as of September 23, 2017 due to noncompliance of caregiver to inform [agency] of changes of [patient #8] physician; also caregiver's refusal to sign in order to be compliant with home health aide services. If you have any further questions or concerns regarding this matter please contact our office. Thank you. [past administrator, director of nursing] RN BSN, administrator."	G 464		
G 478	Investigate complaints made by patient CFR(s): 484.50(e)(1)(i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics: This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the agency failed to investigate the complaint made by a patient's legal representative for 1 of 3 closed records reviewed (#8). The findings include: A policy titled "Patient Rights" revised 7/12/18 stated, "The patient or the patient's legal representative has the right to be informed of the patient's right through effective means of communication. The home health agency must protect and promote the exercise of these rights	G 478		

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as follows ... The patient has the right to exercise his / her rights as a patient of the home health agency as follows ... the patient has the right to voice grievances regarding treatment or care that is or fails to be furnished ... the patient has the right to be informed about the care to be furnished as follows: a. The home health agency shall advise the patient in advance of the disciplines that will furnish care and the frequency of visits proposed to be furnished ... the home health agency shall investigate complaints made to the patient or the patient's representative regarding treatment or care that is or fails to be furnished ... and shall document both existence of the complaint and the resolution of the complaint."

During the entrance conference on 8/7/18 at 10:55 AM, in regargs to documentation of complaints, the owner of the agency stated, "Mostly they are not documented but [the complaints] get into the personnel files."

On 8/7/18 at 4 PM, it was observed there was no complaint log available at the agency and no investigated complaints for 2016 - 2018. During this time, the administrator/ director of nursing and the owner indicated the complaint log was missing. The owner indicated the complaint log may have been taken by the past office coordinator, Employee J.

A review of a clinical record #8, start of care 4/25/16, failed to evidenced a complaint that was investigated by the agency administrator or other staff. The only communication about the discharge in the notes was dated 9/28/17 from Employee L, RN, which stated, "Please complete note on 8/14/17. Need to use that note to

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G 478	Continued From page 24 discharge patient as of 923/17." This review occurred 8/14/18 - 8/18/18. During an interview on 8/14/18 at 3:20 PM, the owner of the agency indicated the patient representative for patient #8 refused to sign the visit notes. The patient representative wanted all of the records that he/ she signed and would not sign without receiving copies. The patient was grabbing aides inappropriately. The owner stated, "[Patient #8] was abusive and would grab ... aides." The owner indicated talking to the past administrator and told the past administrator that the patient representative needed to sign the visit notes. She stated, "I told [the patient representative] we would not service [him/ her] if she would not sign the visit notes." During a phone call to patient #8's representative on 8/15/18 at 9:40 AM, it was found that a complaint had been filed in September 2017, that was not present in the complaint log. There was no evidence that this complaint had been investigated or resolved. The patient's representative indicated he/ she refused to sign the agency visit notes because the agency refused to give him/ her copies. The patient representative indicated he complained to the agency and to the case manager. The patient representative indicated the agency was discharging the patient because of his/ her refusal to sign the visit notes. The patient representative also indicated he/ she complained to the agency when the aide did not show up or called in sick. A new aide, Employee K, HHA, was assigned after the complaint. The patient representative also recalled complaining to the owner and administrator due to Employee K's smoking and the smell of the smoke in the home.	G 478		

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During an interview on 8/15/18 at 10:18 AM, Person C, a former case manager for patient #8, indicated there was billing concerns with the agency. Person C indicated there was a complaint filed and the administrator and owner of the agency were aware of the complaint.

A letter dated September 26, 2017 stated, "[Patient #8] ... Date of Service: 5/26/17 - 11/24/17, To Whom It May Concern: This letter is to confirm that [Patient #8] has been discharged from our agency as of September 23, 2017 due to noncompliance of caregiver to inform [agency] of changes of [patient #8] physician; also caregiver's refusal to sign in order to be compliant with home health aide services. If you have any further questions or concerns regarding this matter please contact our office. Thank you. [past administrator, director of nursing] RN BSN, administrator."

A letter dated 10/3/17, was presented by Person C, to the department. This letter was addressed to the past administrator of the agency concerning care to be received from 5/26/17 - 10/23/17. The letter stated, "[Past Administrator], 224 W. Jefferson Blvd, Ste #200, South Bend ... To Whom It May Concern: Re [patient #8] Service from 5/26/17 - 10/23/17 To Whom It May Concern: This letter is in reply to your letter I received. I never refused to sign state regulated paper work. You and [the owner] refused to give me paper work to read and sign. You said that everything had to be done electronically. You also said when you visited on 5/26/17 that you would give copies of the paperwork I signed on your tablet. You never did. You said that [the owner] no[sic] that was between [agency] and the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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state. [Employee K, HHA] said that [his/ her] phone was shut off because she could not afford to pay the bill on it. [He/ she] used my land line to punch in and out every day ... I told you at that time that I would not sign any thing that I was not allowed to read first. You also said that your tablet would not work in my house. I repeated, get me the paperwork to read and I will sign it. As far as the [patient #8's] physician is concerned, I just recently changed doctors for [patient #8]. [Employee K] knew it, [he/ she] went to [his/ her] appointment with us. I have not seen or talk to you since we changed doctors." Thank you. Signed by the Guardian for patient #8. Cc. Person C, Case Manager.

G 484 Document complaint and resolution
CFR(s): 484.50(e)(1)(ii)

Document both the existence of the complaint and the resolution of the complaint; and
This ELEMENT is not met as evidenced by:
Based on observation, record review, and interview, the agency failed to document the existence of a complaint made by the patient's legal representative and the resolution for 1 of 3 closed records reviewed (#8).

The findings include:

A policy titled "Patient Rights" revised 7/12/18 stated, "The patient or the patient's legal representative has the right to be informed of the patient's right through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows ... The patient has the right to exercise his / her rights as a patient of the home health agency as follows ... the patient has the right to

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voice grievances regarding treatment or care that is or fails to be furnished ... the patient has the right to be informed about the care to be furnished as follows: a. The home health agency shall advise the patient in advance of the disciplines that will furnish care and the frequency of visits proposed to be furnished ... the home health agency shall investigate complaints made to the patient or the patient's representative regarding treatment or care that is or fails to be furnished ... and shall document both existence of the complaint and the resolution of the complaint."

During the entrance conference on 8/7/18 at 10:55 AM, in regargs to documentation of complaints, the owner of the agency stated, "Mostly they are not documented but [the complaints] get into the personnel files."

On 8/7/18 at 4 PM, it was observed there was no complaint log available at the agency and no investigated complaints for 2016 - 2018. During this time, the administrator/ director of nursing and the owner indicated the complaint log was missing. The owner indicated the complaint log may have been taken by the past office coordinator, Employee J.

A review of a clinical record #8, start of care 4/25/16, failed to evidenced a complaint that was investigated by the agency administrator or other staff. The only communication about the discharge in the notes was dated 9/28/17 from Employee L, RN, which stated, "Please complete note on 8/14/17. Need to use that note to discharge patient as of 923/17." This review occurred 8/14/18 - 8/18/18.

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During an interview on 8/14/18 at 3:20 PM, the owner of the agency indicated the patient representative for patient #8 refused to sign the visit notes. The patient representative wanted all of the records that he/ she signed and would not sign without receiving copies. The patient was grabbing aides inappropriately. The owner stated, "[Patient #8] was abusive and would grab ... aides." The owner indicated talking to the past administrator and told the past administrator that the patient representative needed to sign the visit notes. She stated, "I told [the patient representative] we would not service [him/ her] if she would not sign the visit notes."

During a phone call to patient #8's representative on 8/15/18 at 9:40 AM, it was found that a complaint had been filed in September 2017, that was not present in the complaint log. There was no evidence that this complaint had been investigated or resolved. The patient's representative indicated he/ she refused to sign the agency visit notes because the agency refused to give him/ her copies. The patient representative indicated he complained to the agency and to the case manager. The patient representative indicated the agency was discharging the patient because of his/ her refusal to sign the visit notes. The patient representative also indicated he/ she complained to the agency when the aide did not show up or called in sick. A new aide, Employee K, HHA, was assigned after the complaint. The patient representative also recalled complaining to the owner and administrator due to Employee K's smoking and the smell of the smoke in the home.

During an interview on 8/15/18 at 10:18 AM, Person C, a former case manager for patient #8,

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indicated there was billing concerns with the agency. Person C indicated there was a complaint filed and the administrator and owner of the agency were aware of the complaint.

A letter dated September 26, 2017 stated, "[Patient #8] ... Date of Service: 5/26/17 - 11/24/17, To Whom It May Concern: This letter is to confirm that [Patient #8] has been discharged from our agency as of September 23, 2017 due to noncompliance of caregiver to inform [agency] of changes of [patient #8] physician; also caregiver's refusal to sign in order to be compliant with home health aide services. If you have any further questions or concerns regarding this matter please contact our office. Thank you. [past administrator, director of nursing] RN BSN, administrator."

A letter dated 10/3/17, was presented by Person C, to the department. This letter was addressed to the past administrator of the agency concerning care to be received from 5/26/17 - 10/23/17. The letter stated, "[Past Administrator], 224 W. Jefferson Blvd, Ste #200, South Bend ... To Whom It May Concern: Re [patient #8] Service from 5/26/17 - 10/23/17 To Whom It May Concern: This letter is in reply to your letter I received. I never refused to sign state regulated paper work. You and [the owner] refused to give me paper work to read and sign. You said that everything had to be done electronically. You also said when you visited on 5/26/17 that you would give copies of the paperwork I signed on your tablet. You never did. You said that [the owner] no[sic] that was between [agency] and the state. [Employee K, HHA] said that [his/ her] phone was shut off because she could not afford to pay the bill on it. [He/ she] used my land line to

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G 484	Continued From page 30 punch in and out every day ... I told you at that time that I would not sign any thing that I was not allowed to read first. You also said that your tablet would not work in my house. I repeated, get me the paperwork to read and I will sign it. As far as the [patient #8's] physician is concerned, I just recently changed doctors for [patient #8]. [Employee K] knew it, [he/ she] went to [his/ her] appointment with us. I have not seen or talk to you since we changed doctors." Thank you. Signed by the Guardian for patient #8. Cc. Person C, Case Manager.	G 484		
G 530	Strengths, goals, and care preferences CFR(s): 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; This ELEMENT is not met as evidenced by: Based on record review, the home health agency failed to ensure the goals were patient specific and based on the comprehensive assessment findings in 2 of 6 active clinical records reviewed (#2 and #9). The findings include: 1. The agency policy titled "Comprehensive Assessment" dated 7/11/18 stated, "Plan of care will be developed from the comprehensive assessment plan with information from client, family, and physician." 2. The agency policy titled "2.8 Care Plan" dated 2015 stated, "4. Determine of the nature of the	G 530		

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G 530	Continued From page 31 home care services needed. To determine this ... Based upon the goals to be achieved, what actions must be taken to achieve them?" 3. Clinical record review on 8/13/18 and 8/16/18 for patient #2, start of care 12/4/17, included a document titled "Home Health Certification and Plan of Care" for the certification period of 6/2/18 - 7/31/18, with a primary diagnosis of pressure ulcer of sacral region stage 2, signed by administrator/ director of nursing on 5/31/18. The physician signed this document on 6/7/18. This document had an area subtitled "Goals / Rehabilitation potential/ discharge plans was blank. The following comprehensive re-assessment findings dated 7/31/18, did not lead to the addition of goals on the plan of care: A review of the "Recertification Follow up Assessment" including OASIS elements with plan of care / 485 information dated 7/31/18, evidenced the following: The patient had a Stage II sacrum / coccyx pressure ulcer, skin turgor poor; the patient had chronic pain issues with above knee amputation sites that were presently at a "3" level (0 -10), with aching, throbbing and with the back with present level "2" and worst pain gets at a "9"; the patient had a chronic productive cough described as a smoker's cough and COPD (chronic obstructive pulmonary disease) due to smoking; elimination status evidenced the patient had a urinary catheter due to neurogenic bladder due to paralysis below the waist level; the catheter was described as a Suprapubic catheter 26 French 10 cc ml (cubic centimeter milliliter) with amber colored urine with sediment, bowel incontinence with removal of feces with digital stimulation and digital removal of feces 1 to 3 times a week; laxative use;	G 530		

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G 530	Continued From page 32 needed prompting when stressed or unfamiliar in the situation; paranoid behaviors was noted - trusted no one to set up medications but [him / her] self; impaired decision making as evidenced by trying to do self disimpaction of stool without assistance; spasms: abdomen, back, bladder; needs assist with transfers, ADLs [activities of daily living], IADLs [instrumental activities of daily living] and assistance with leaving the home, specialized transportation; bilateral amputations above the knees; wheel chair bound; needed assistance for transfers from bed to chair, used regular w / c [wheelchair] in apartment and electric w / c when out in the community with assistance and for safety; and patient was at risk for falls. The sections were blank about the patient's report about their progress towards their personal goals and the HHA measurable goals. Potential goals were listed as SN (skilled nurse) gastrointestinal goals, SN genitourinary goals: will be free of S / S (signs / symptoms) of UTI (urinary tract infection) SN Integumentary Goals including healing of wounds and safe effective wound care teaching / education / understanding of patient. 4. Clinical record review on 8/16/18 for patient #9, start of care 6/27/18, included a document titled "Home Health Certification and Plan of Care" for the certification period of 6/2718 - 8/25/18, with a primary diagnosis of quadriplegia C - 5 - C-7, signed by administrator / director of nursing on 6/28/18. The physician signed this document on 7/11/18. This document had an area subtitled "Goals/ Rehabilitation potential/ discharge plans that was blank. The following comprehensive re-assessment findings dated 6/27/18, did not lead to the addition of goals on the plan of care:	G 530		

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G 530	Continued From page 33 A review of the "Comprehensive Adult Assessment" including SOC / ROC OASIS elements with plan of care / 485 information dated 6/27/18, signed by administrator / director of nursing and patient caregiver on this date evidenced the following: Cardiac pacemaker in left chest; tracheostomy with history of adult respiratory distress syndrome, Intermittent treatments: albuterol updrafts; Enteral feedings - access device. Gastrostomy, bolus, 240 cc every 4 hours and 200 cc every 4 hours water; dressing site wash with soap and water, pat dry; suprapubic catheter placement due to urinary incontinence and past skin issues; type 26 French / 10 CC balloon with date of last changed on 6/7/18; colostomy and suprapubic catheter - wash with soap and water, rinse well, pat dry; quadriplegia with spasticity; history of a traumatic brain injury date 12/6/16; needed full assistance with all activities of daily living, all IADLs; quadriplegia , fracture C 5 neck fracture; hand grips weak; needs assistance with all activities, transfers, toileting, and gastrostomy feedings. The document stated, "Potential Goals: SN Patient Centered Goal: Maintain current health status start effective date: 6/27/18; SN Respiratory Goals: Pt / Pcg [patient caregiver] will demonstrate proper suction technique ... proper use of respiratory treatments ... demonstrate trach care start effective date 6/27/18, SN Cardiovascular goals: Pt / PCG will state understanding of measures to manage to manage disease and identify S / S to report; SN Gastrointestinal goals: Enteral feeding tube site will remain intact without S / S infection. Start effective: 6/27/18, pt. will be able to tolerate feedings without complications. Start effective date 6/27/18."	G 530		

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G 544	Update of the comprehensive assessment CFR(s): 484.55(d) The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure the Registered Nurse accurately identify and assess a second wound on a patient for 1 of 1 active records reviewed (#2) of patients with wounds in a sample of 9. The findings include: A review of clinical record #2, failed to evidence an accurate assessment of a wound for patient #2. This was further evidenced by the following: A review of a visit note on 7/30/18, completed by Employee B, Licensed Practical Nurse, evidenced the patient had two wounds. One wound indicated a location on the sacrum. The other wound indicated it was to the right of the ischial process. A review of the Recertification follow up assessment dated 7/31/18, completed by the administrator / director of nursing, evidenced two wounds that were noted during this visit. The first wound indicated it was located at the coccyx/ sacrum/ buttock area which measured 4.5 centimeters, width of 5.3 centimeters, and depth of 4 centimeters. The second wound was not measured and was evidenced to be in the coccyx area.	G 544		

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G 544	Continued From page 35 During an interview on 8/16/18 at 11:55 AM, when asked if the second wound was on the sacral area or ischium as noted on the assessment, the administrator / director of nursing stated, "My error."	G 544		
G 550	At discharge CFR(s): 484.55(d)(3) At discharge. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the Registered Nurse completed a discharge assessment with the patient's progress in meeting the care plan goals for 1 of 3 closed records reviewed (#8) in a sample of 9. The findings include: The policy titled "2.17 Discharge/ Transfer Policy" dated 2015 stated, "The agency will maintain a process for the ongoing assessment of each patient's continuing care and discharge planning needs ... at the visit before this discharge, the patient and the physician will be notified of the discharge ... all patients will receive discharge instructions regarding his/ her ongoing care ... prior to discharge the patient, the attending physician shall be notified. A written discharge summary which shall be prepared within 30 days of discharge will be made available to the physician with a copy maintained in the record. The discharge summary will include: A. The reason for discharge B. The patient's physical and psychosocial status at the time of discharge. C. A summary of the care and services provided. D. Patient's progress toward desired goals. E. Instructions and referrals provided to the patient."	G 550		

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A review of clinical record #8, diagnosis of physical abuse complicating pregnancy, start of care 4/25/16 included a plan of care for the certification period of 8/18/17 - 10/16/17. The clinical record failed to evidence a discharge assessment or discharge summary had been completed after a discharge was requested by the agency due to the caregiver's refusal to sign staff visit notes. The discharge plans on the plan of care did not evidence goals the patient was to progress to. This was further evidenced by the following:

The home health certification and plan of care for the certification period of 8/18/17 - 10/16/17, included under the goals/ rehabilitation potential/ discharge plans this statement, "When services are no longer needed or can be provided by another source." There were no other goals on this plan of care.

A review of the record evidenced a "Comprehensive Adult Assessment" dated 8/14/17, with time in of 3:42 PM and time out of 5 PM. This note evidenced a visit was completed by Employee H, RN, and signed on this date. Under discharge plans, Employee H checked box "other" and stated, "When services are no longer needed or can be provided by another source."

A review of the record evidenced home health visits completed on 8/18/17, 8/19/17, 8/21/17, 8/22/17, 8/23/18, 8/24/17, 8/25/17, 8/26/17, 8/28/17, 8/29/17, 8/30/17, 8/31/17, 9/1/17, 9/2/17, 9/5/17, 9/6/17, 9/7/17, 9/8/17, 9/9/17, 9/11/17, 9/12/17, 9/13/17, 9/14/17, 9/15/17, 9/18/17, 9/19/17, 9/20/17, 9/21/17, 9/22/17. A supervisory nurse visit was completed on 8/18/17.

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G 550	Continued From page 37 A review of the record evidenced a home health aide visit with no tasks completed on 10/2/17. The note was signed by Employee K, Home Health Aide. A note on this note under patient's signature stated, "Power of attorney verbalized [illegible words after this.]" This was electronically signed by Employee K on 10/19/17. The only communication about the discharge in the notes was dated 9/28/17 from Employee L, RN, which stated, "Please complete note on 8/14/17. Need to use that note to discharge patient as of 9/23/17." This review occurred 8/14/18 - 8/16/18. During an interview on 8/14/18 at 3:45 PM, the administrator/ director of nursing indicated the patient went to a group home. The administrator/ director of nursing indicated the discharge oasis and summary were not found in the record.	G 550		
G 570	Care planning, coordination, quality of care CFR(s): 484.60 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	G 570		

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G 570	Continued From page 38 individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This CONDITION is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure visits were provided per the plan of care and failed to ensure treatment and services were not provided absent of a physicians order (See G 572); failed to ensure the plans of care contained frequency and duration of visits specific to the certification period, failed to ensure the plan of care contained all required elements including the tasks to be provided and the goals to achieve (see G 574); failed to ensure all patient care orders were recorded on the plan of care (see G 576); failed to promptly notify the physician of changes in the patient's condition (see G 590); failed to ensure the clinical record contained documentation that the patient's physician and the legal representative was informed in advance of a discharge (See G 598); failed to ensure communication with all physicians involved in the plan of care (see G 602); and failed to ensure the Registered Nurse coordinated the patient's care with a DME (durable medical equipment) company (see G 608). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 484.60 Condition: Care Planning, Coordination, Quality of Care.	G 570		
G 572	Plan of care CFR(s): 484.60(a)(1)	G 572		

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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 refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.
This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the agency failed to ensure visits were provided per the plan of care for 3 of 6 active records (#2, #4, #9) and failed to ensure treatment and services were not provided absent of a physicians order for 5 of 6 active records reviewed (#1, #2, #3, #4, #9).

The findings include:

1. The agency policy titled "2.21 Physician's Plan of Treatment" dated 2015 stated, "A physician prepares a plan of treatment and it is made available to the agency. 2. Physician's orders are established and documented for the health care services the agency provides to those patients who a. Are being actively treated by a physician for a diagnosed health care problem b. have a health care need or change in physical status requiring medical intervention c. are admitted to service with the agency."

2. The agency policy titled "2.26 Service Policies Nursing Service" stated, "Nursing services shall mean the services provided by nurses within the

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practice of the profession of nursing ... The provision of nursing services includes the performance, direction or supervision of health care tasks pursuant to a plan of care and consistent with an existing medical regimen."

3. The agency policy titled "2.23 Services provided ... Registered Nurses provide quality nursing care by the visit or the shift. The highly trained professionals follow the physician's orders, monitor and instruct the patient regarding their care ... The licensed practical nurse provides assigned care under the direction of a RN. 3. All RN's are licensed in Indiana and follow all regulations and standards of practice required by the state. 4. All LPNs are licensed in Indiana and follow all regulations and standards of practice required by the state ... Home health aides ... these services are provided in accordance with the plan of care."

4. A review of clinical record #1, included a plan of care for the certification period of 6/6/18 - 8/4/18, evidence the home health aide conducted care and services absent of a physician order during the certification period of 6/6/18 - 8/4/18, as evidenced by the following:

A review of a Recertification Follow - up assessment including OASIS elements with Plan of Care / 485 information dated 6/1/18 with time in of 7 AM and time out of 10 AM, was completed and was electronically signed on 6/5/18 by the administrator / director of nursing. The services to be provided were written as supervisory visits, recertification, and HHA (home health aide) 7 days a week for 26 weeks.

A verbal order for SN and Aide services was

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completed 6/1/18 by the administrator / director of nursing. The order only contained RN duties and did not evidence frequency, duration of home health aide visits, and the tasks to be completed.

The plan of care for the certification period of 6/6/18 - 8/4/18, failed to evidence home health aide orders. This order was electronically signed by the administrator / director of nursing on 6/5/18.

A HHA visit note dated 6/7/18 and signed by Employee B, LPN, evidenced the patient had 6 hours of care including a bath, personal care, hair care, check pressure areas, nail hygiene, assist with medications, and ambulation assist.

A HHA visit note dated 6/9/18 and signed by Employee B, evidenced the patient had 7 hours of care including a bath, personal care, hair care, check pressure areas, nail hygiene, assist with medications, and ambulation assist.

A HHA visit note dated 6/11/18 and signed by Employee C, HHA, evidenced the patient had 5 hours of care including a bath, assist with bath, personal care, hair care, assist with medications, ambulation assist, and mobility assist.

A HHA visit note dated 6/13/18, signed by Employee B, evidenced the patient had 6 hours of care including personal care, check pressure areas, oral care, assist with medications, meal preparation, and wash clothes.

HHA visit notes dated 6/14/18, 6/20/18, and 7/19/18, signed by Employee C, evidenced the patient had 5 hours of care including a bath and personal care.

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HHA visit notes dated 6/15/18, 7/13/18, 7/26/18, 7/27/18, and 7/31/18, signed by Employee B, HHA, evidenced the patient had 6 hours of care including a bath and personal care.

A HHA visit note dated 6/18/18, signed by Employee B, evidenced the patient had 4 hours of care including a bath and personal care.

HHA visit notes dated 7/6/18, 7/9/18, 7/12/18, and 7/17/18, signed by Employee C, evidenced the patient had 6 hours of care including a bath and personal care.

A HHA visit note dated 7/16/18, signed by Employee D, HHA, evidenced the patient had 6 hours of care including a bath and personal care.

A HHA visit note dated 7/18/18, signed by Employee D, evidenced the patient had 6 hours of care including a bath and personal care.

A HHA visit note dated 8/2/18, signed by Employee B, evidenced the patient received 8 hours of personal care and a bath and other care.

5. A review of clinical record #2, with a start of care 12/4/17, principal diagnosis of pressure ulcer of sacral region, failed to evidence skilled nurse and home health aide visits were provided per the physician ordered plan of care and the record evidenced SN and HHA conducted care and services absent of a physician's order as evidenced by:

A review of a Home Health Certification and Plan of Care for the certification period of 6/2/18 - 7/31/18, evidenced skilled nursing orders for 3

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hours a day, 3 days a week, for 26 weeks and HHA orders 6 hours a day, 7 days a week, 9 weeks. The plan of care failed to evidence the tasks that would be completed by the staff. This document was electronically signed by the administrator / director of nursing on 5/31/18 and electronically signed by the physician on 6/7/18.

A review of home health aide visits notes evidenced visits occurred on 6/2/18 (Week 1), 6/10/18, 6/13/18, 6/14/18, 6/15/18, 6/16/18 (week 3), 6/17/18, 6/18/18, 6/19/18, 6/21/18, 6/22/18, 6/23/18 (week 4), no visits between 6/14/18 to 6/30/18 (week 5), no visits between 7/1/18 to 7/7/18 (week 6), no visits between 7/8/18 to 7/12/18 and 7/14/18, but 1 visit on 7/13/18 (week 7), no visits between 7/15/18 to 7/17/18, 7/19/18, and 7/21/18 but two visits on 7/18/18 and 7/20/18 (week 8), no visits from 7/22/19 to 7/24/18, 7/26/18, and 7/28/18 but two visits on 7/25/18 and 7/27/18 (week 9). The agency failed to ensure home health aide visits were provided 7 days a week.

A review of a skilled nurse visit note dated 6/5/18, 6/9/18, 6/12/18, and 6/16/18, evidenced Employee B visited the patient for 2 hours each day. Tasks completed were nursing assessment, vital signs, dressing change for wounds on sacral, coccyx area and right elbow area. Suprapubic catheter assessed.

A review of a physician order dated 6/18/18, completed by the physician, evidenced wound care orders to cleanse all wounds, pack the right sacrum wound with absorptive silver and cover with mepilex border; the peri anal area was to be clean and dry, and the right elbow was to be protected.

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G 572	Continued From page 44 A review of a physician order dated 6/20/18, and completed by the administrator / director of nursing, evidenced the home health aide was to visit 5 hours a day, 7 days a week, for 26 weeks and skilled nursing 2 hours a day, 3 days / week, for 26 weeks per new PA (prior authorization). The order failed to be specific to the remaining certification period between 6/20/18 to 7/31/18 and failed to include the tasks to be provided by the skilled nurse and home health aide A review of a skilled nurse visit note dated 6/21/18, 6/27/18, 6/29/18, 7/2/18, 7/6/18, 7/9/18, evidenced Employee B visited the patient. Tasks completed absent of a physician's order were nursing assessment, vital signs, and suprapubic catheter monitoring. Employee B visited the patient for 2 hourson 6/29, 7/2, 7/9/18 and less than 2 hours on 7/6/18. A review of a skilled nurse visit note dated 6/25/18, evidenced Employee B visited the patient. Tasks completed absent of a physicians order were nursing assessment, vital signs, and suprapubic catheter monitoring. The suprapubic catheter was changed using a 26 French / 30 cc (cubic centimeter) bulb. A review of a skilled nurse visit note dated 7/18/18, evidenced Employee B visited the patient for 2 hours. Tasks completed absent of a physician's order were nursing assessment, vital signs, and suprapubic catheter monitoring. The note failed to evidence if dressing changes had been conducted. A review of a skilled nurse visit note dated 7/20/18, evidenced Employee B visited the	G 572		

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patient for 2 hours. Tasks completed absent of a physician's order were nursing assessment, vital signs, the wound on the sacral area was measured, and suprapubic catheter monitoring. The note failed to evidence if dressing changes had been conducted.

A review of a skilled nurse visit note dated 7/23/18, evidenced Employee B visited the patient for 1.5 hours. Tasks completed absent of a physicians order were nursing assessment, vital signs, the wound on the sacral area was measure, and suprapubic catheter monitoring.

A review of a physician order dated 7/23/18, included orders for the right sacrum for dressing order of absorptive silver and mepilex border with cleanses two times a week. Only 1 visit was conducted during this week (7/22/18 to 7/28/18).

A review of a skilled nurse visit note dated 7/27/18, 7/30/18, evidenced Employee B visited the patient for 2 hours. Tasks completed absent of a physician's order were nursing assessment, vital signs, the wound on the sacral area was measured, and suprapubic catheter monitoring was completed. The note failed to evidence if dressing changes had been conducted.

A review of a physician order dated 7/31/18, signed by the administrator / director of nursing, evidenced HHA was to visit the patient 5 hours a day, 7 days a week, for 26 weeks for assistance with ADLs' and IADLs, housekeeping, laundry, grocery shopping, errands and meal prep. The skilled nurse was to visit 2 hours daily, 3 days a week for wound care, nursing assessment, medication monitoring, catheter care and changes and coordination of care.

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A Recertification follow up assessment including OASIS elements with plan of care / 485 information dated 7/31/18 and completed by the administrator / director of nursing on 7/31/18. The wounds were measured. The wounds were cleansed with sterile saline and then packed with colloidal silver and nystatin cream and dressed with mepilex border. The document stated,"The wound was contaminated with fecal matter, areas were thoroughly washed with soap and water, prior to dressing change to decrease contamination." The deviation of treatment was conducted absent of a physician's order.

6. A review of clinical record #3, with a start of care 12/13/17, and principal diagnosis of essential hypertension, evidenced the skilled nurse conducted care and services absent of a physician's order as evidenced by:

Review of the plan of care for the certification period of 6/11/18 - 8/9/18, failed to evidence the agency was to set up the patient's medications or checking blood sugar results.

Review of A skilled nursing visit note completed by Employee B dated 6/16/18, evidenced the nurse set up the patient's medications. A note stated, "Medications dispensed as ordered."

Review of a skilled nursing visit note completed by Employee B dated 6/23/18 and 6/30/18, evidenced the nurse set up the patient's medications for the next week.

During an interview on 8/16/18 at 12 noon, the administrator / director of nursing indicated the medication set up was not on the plan of care.

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7. A review of clinical record #4, with a start of care 11/16/17, and principal diagnosis of Quadriplegia, failed to evidence skilled nurse visits were provided per the physician ordered plan of care and the record evidenced SN conducted care and services absent of a physician's order as evidenced by:

A review of the Home Health Certification and Plan of Care for the certification period of 7/14/18 - 9/11/18 evidenced the skilled nurse was to visit 5 hours day , for 7 days a week. There were no additional tasks written on this document except under Medications: Renadicin 30 cc ml daily irrigation.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/14/18 and completed by Employee M, RN, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment including suprapubic catheter assessment and irrigation, repositioning every 2 hours, pain assessment, skin assessment, trach care, and trach change with fenestrated size 4 uncuffed trach, wound care on right buttock was measured and cleansed with soap and water, patted dry, and dressing applied, patient education with discussion about proper hydration, medications were administered, bladder irrigation completed, shower given, suprapubic and trach dressing removed and new dressings placed.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/15/18 and completed by Employee

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M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, repositioning every 2 hours, pain assessment, skin assessment, trach care, patient education with discussion about proper nutrition and increased protein to promote wound healing, medications were set up, bladder irrigation completed, shower given, trach care, trach collar changed, new dressing placed and suprapubic dressing care completed.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/16/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, repositioning every 2 hours, pain assessment, skin assessment and wound care, trach care, patient education safety while sitting in wheelchair, and medications provided.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/17/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation,

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pain assessment, skin assessment and wound care, trach care, and medications provided.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/18/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, medications set up, and bowel program was completed.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/19/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, medications set up, and trach collar replaced.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/20/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment, trach care,

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G 572	Continued From page 50 and medication administration. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/21/18 and completed by Employee B, evidenced the nurse had completed approximately 3 hour visit from 8:49 AM - 12 PM. Tasks completed absent of a physician's order were a physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter, pain assessment, skin assessment, trach care, and medication administration. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/21/18 and completed by Employee B, evidenced the nurse had completed a 1 hour visit from 6:41 PM - 7:51 PM. Tasks completed absent of a physician's order were a physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter, pain assessment, skin assessment, trach care, and medication administration. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/22/18 and completed by Employee B, evidenced the nurse had completed a 1:45 hour visit from 7 AM - 8:45 AM. Tasks completed absent of a physician's order were a physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter, pain assessment, skin assessment, trach care,	G 572		

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G 572	Continued From page 51 medication administration, and digital stimulation. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/22/18 and completed by Employee B, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter, pain assessment, skin assessment, and trach care. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/23/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, and medications set up and administration. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/27/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, medications set up, and trach collar replaced.	G 572		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A review of an Adult Extended Hour Nursing Flow Sheet dated 7/28/18 and completed by Employee M, evidenced the nurse completed a 5 1 / 2 hour visit from 8 am - 1:30 PM. Tasks completed absent of a physician's order: Assessments, Suprapubic catheter change with a 26 French 10 cc catheter, and trach care.

During an interview on 8/16/18 at 12:05 PM, the administrator / director of nursing indicated the record lacked a complete plan of care. The record was lacking orders for the care received.

8. During an observation of the home visit on 8/13/18 at 9:10 AM, patient #9 was observed to be in a hospital bed with an air mattress. The administrator / director of nursing was observed to assess the patient by taking vital signs and then give the patient a nebulizer treatment with albuterol. The CPT vest treatment was started at approximately 9:25 AM. The CPT treatment was completed at approximately 9:50 AM. Also completed was a nebulizer treatment with the medication albuterol, suctioning of the tracheostomy with a 14 French suction tube and cough assist.

A review of clinical record #9, with a start of care 6/27/18, and principal diagnosis of Quadriplegia, failed to evidence skilled nurse and home health aide visits were provided per the physician ordered plan of care and the record evidenced skilled nursing provided care and services absent of a physician's order as evidenced by:

A review of the Home Health Certification and Plan of Care for the certification period of 6/27/18 - 8/25/18, evidenced the skilled nurse was to visit 60 hours a month. There were no additional tasks

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G 572	Continued From page 53 written on this document. A review of the Comprehensive Adult Assessment evidenced a start of care on 6/27/18. This document evidenced a visit from the administrator / director of nursing. The document indicated the patient had a colostomy, suprapubic catheter, and a feeding tube. The document indicated orders for the enteral feedings were boluses 240 CC every 4 hours, performed by family. Tasks performed absent of a physicians order were: A physical assessment, feeding tube site was washed with soap and water and patted dry, suprapubic catheter washed with soap and water, rinsed well, and patted dry. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/2/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a 8 hour visit from 8 AM - 4 PM. Tasks completed absent of a physician's order were: A physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with a note: humidification, CPT vest treatment completed, gastrointestinal assessment (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20 (Catheter site is 24 French, 10 cc balloon); reposition every 2 hours; pain assessment; skin assessment; trach ties changed and inner cannula changed; oral and tracheal suctioning completed; and intake recorded. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/9/18 and completed by the administrator / director of nursing, evidenced the	G 572		

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nurse had completed a 8 hour visit from 8 AM - 4 PM. Tasks completed absent of a physician's order were: A physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with note concerning humidification, CPT vest X 1/2 hour; Gastrointestinal assessment and appliance change (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20, Catheter site is 24 French, 10 cc balloon; reposition every 2 hours; pain assessment; skin assessment; trach ties changed and inner cannula changed; full and passive range of motion completed on upper and lower extremities; leg bag applied to suprapubic catheter draining urine; cough assist with tracheal suctioning; and position changes every 15 minutes.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/16/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a 6 hour visit from 8 AM - 2 PM. Tasks completed absent of a physician's order were: A physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with note concerning humidification, CPT vest X 1/2 hour; gastrointestinal assessment (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20; reposition every 2 hours; pain assessment; skin assessment; trach ties changed and inner cannula changed; humidification removed from tracheotomy #6 Shiley, uncuffed trach, midline secured with Dale straps; pacimuir valve in place to aid with

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G 572	Continued From page 55 speaking; CPT vest placed on for 15 minute intervals at 14 pressure; range of motion on upper and lower extremities; and feeding of Isosource 240 cc followed by 200 cc of water for flush. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/30/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a visit from 8 AM - 3:15 PM. Tasks completed absent of a physician's order were: A trach ties change and inner cannula change, cough assist used, suctioned trach, gastric tube feeding given bolus as ordered flushed with 240 cc water, and bed bath given. A review of an Adult Extended Hour Nursing Flow Sheet dated 8/6/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a visit from 8 AM - 4 PM. Tasks completed absent of a physician's order were: Trach ties changed and inner cannula changed; suctioned trach, gastric tube feeding given bolused as ordered, flushed with water; and partial bed bath given. During an interview on 8/13/18 at 10 AM, the administrator / director of nursing indicated the plan of care was not complete.	G 572		
G 574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) (2) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status;	G 574		

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G 574	Continued From page 56 (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the plans of care contained frequency and duration of visits specific to the certification period, failed to ensure the plan of care contained all required elements including the tasks to be provided and the goals to achieve for 5 of 6 active records reviewed (#1 - #4, #9) in a sample of 9. The findings include: 1. A review of the policy titled "2.21 Physician's Plan of Treatment" stated, "A physician prepares a plan of treatment and it is made available to the	G 574		

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agency. 2. Physician's orders are established and documented for the health care services the agency provides to those patients who a. are being actively treated by a physician ... b. have a health care need or change in physical status for a diagnosed health care problem c. are admitted to service with the agency ... 4. A physician's plan of treatment must be signed and dated by the attending physician and in the chart within 30 days after the admission to the agency and must include ... the type and frequency of services provided ... specific orders and frequency of visits ... necessary medical equipment."

2. A review of clinical record #1, the plan of care for the certification period of 6/6/18 - 8/4/18 failed to evidence home health aide frequency, duration of visits specific to the certification period and failed to evidence the tasks to be provided by the home health aide. This was evidenced by the following:

A review of a document titled "Recertification Follow - up assessment" that included OASIS elements with Plan of Care / 485 information dated 6/1/18, with time in of 7 AM and time out of 10 AM, was completed and was electronically signed on 6/5/18 by the administrator / director of nursing. The document indicated the services to be provided were supervisory visits, recertification, and the HHA (home health aide) visits 7 days a week for 26 weeks.

A verbal order dated 6/1/18, completed by the administrator / director of nursing, evidenced an order for only RN duties and did not evidence frequency and duration of home health aide visits as well as the tasks to be provided.

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The plan of care for the certification period of 6/6/18 - 8/4/18, failed to evidence the frequency and duration of home health aide visits specific to the certification period and the tasks to be provided by the home health aide. This plan of care was electronically signed by the administrator / director of nursing on 6/5/18.

Review of HHA visit notes dated 6/7, 6/9, 6/11, 6/13, 6/14, 6/15, 6/18, 6/20, 7/6, 7/9, 7/12, 7/13, 7/16, 7/17, 7/18, 7/19, 7/27, 7/31, and 8/2/18 indicated specific ADL's/ personal care including assistance with medications, meal preps, and washing clothes were provided by a licensed practical nurse and home health aide from 4 to 8 hours on these days.

3. A review of clinical record #2, the plan of care for the certification period of 6/6/18 - 8/4/18 failed to contain all the required elements, failed to evidence skilled nursing and home health aide frequency and duration of visits specific to the certification period, and the tasks to be provided by skilled nursing and the home health aide. This was evidenced by the following:

A physician order dated 4/30/18, and completed by the physician, evidenced wound care orders to cleanse all wounds, pack the right sacrum wound with absorptive silver and cover with mepilex border; the peri anal area was to be clean and dry, and the right elbow was to be protected.

A verbal order dated 5/30/18, evidenced the patient was to have skilled nursing and aide services. There was no frequency and duration of the visits or tasks for the staff to complete.

A physician order dated 5/31/18, and completed

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G 574	Continued From page 59 by the administrator / director of nursing, evidenced the skilled nurse was to visit 3 hours a day, 3 days a week, for 26 weeks for wound care, medication monitoring, health monitoring, suprapubic catheter changes and care and bowel program 3 times a week by digital disimpaction. The home health aide was to visit for assistance with ADLs and IADLs, supervision, meal preparation, housekeeping, laundry, grocery shopping, errands, assistance with appointments, and arranging specialized transportation. The order failed to include a duration and frequency of skilled nursing and home health aide visits specific to the 6/2/18 to 7/31/18 certification period. A review of a Home Health Certification and Plan of Care for the certification period of 6/2/18 - 7/31/18, evidenced skilled nursing orders for 3 hours a day, 3 days a week, for 26 weeks and HHA orders 6 hours a day, 7 days a week, 9 weeks. The plan of care failed to evidence the tasks that would be completed by the staff as indicated on the 5/31/18 physician's order and failed to evidence goals, rehabilitation potential, and discharge plans, and the mental status, DME (durable medical equipment) and supplies, safety measures, activities permitted, and allergies sections were all blank. This document was electronically signed by the administrator / director of nursing on 5/31/18 and electronically signed by the physician on 6/7/18. A review of home health aide visit notes dated 6/2, 6/3, 6/4, 6/5, 6/6, 6/7, 6/8, 6/9, 6/10, 6/13, 6/14, 6/15, 6/16, 6/17, 6/18, 6/19, 6/21, 6/22, 6/23, 7/13, 7/18, 7/20, 7/25, and 7/27/18, indicated HHAs completed tasks such as bathing, personal care, hair care, catheter care, record	G 574		

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G 574	Continued From page 60 output / input, inspect / reinforce dressing, ambulation assist and other tasks. A review of skilled nurse visit notes evidenced visits occurred on 6/5, 6/9, 6/12, 6/16, 6/21, 6/25, 6/27, 6/29, 7/2, 7/6, 7/9, 7/18, 7/20, 7/23, 7/27, and 7/30/18, and indicated nursing assessments, vital signs, dressing change for wounds on sacral, coccyx area and right elbow area, wound measurements, suprapubic catheter assessments, suprapubic catheter was changed using a 26 French / 30 cc (cubic centimeter) bulb. A review of the "Recertification Follow - up assessment" including OASIS elements with plan of care / 485 dated 7/31/18 and completed by the administrator / director of nursing on 7/31/18, indicated the wounds were measured. A review of a Home Health Certification and Plan of Care for the certification period of 8/1/18 - 9/29/18 was completed by administrator/ director of nursing on 7/31/18. This plan of care was not complete and failed to include the DME/ supplies, safety measures, and goals. The orders evidenced a SN frequency and duration 2 hours a day 3 days a week for 26 weeks and HHA orders for 5 hours a day, 7 days a week for 26 weeks. A review of skilled nurse visit noted dated 8/1, 8/4, 8/6, and 8/9/18, indicated nursing assessments, vital signs, dressing change for wounds on sacral, coccyx area and right elbow area, wound measurements, suprapubic catheter assessments, and catheter was irrigated with 60 cc of normal saline. 4. A review of clinical record #3 with a start of	G 574		

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care 12/13/17 and principal diagnosis of essential hypertension, the plan of care for the certification period of 6/11/18 - 8/9/18 failed to evidence the skilled nurse was to set up the patient's medications. This was evidenced by the following:

Review of A skilled nursing visit notes, completed by Employee B dated 6/16, 6/23, and 6/3018, evidenced the nurse set up the patient's medications for the following week. A note on 6/16/18 stated, "Medications dispensed as ordered."

During an interview on 8/16/18 at 12 noon, the administrator / director of nursing indicated the medication set up was not on the plan of care.

5. A review of clinical record #4 with a start of care 11/16/17 and principal diagnosis of Quadriplegia, the plan of care for the certification period of 7/14/18 - 911/18 failed to evidence the tasks to be completed by the skilled nurse. This was evidenced by the following:

A review of the Home Health Certification and Plan of Care for the certification period of 7/14/18 - 9/11/18 evidenced the skilled nurse was to visit 5 hours day/ 7 days a week. There were no additional tasks written on this document except under Medications: Renadicin 30 cc ml daily irrigation.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/14, 7/15, 7/16, 7/17, 7/18, 7/19, 7/20, 7/21 (x2 visits), 7/22 (x2 visits), 7/23, 7/27, and 7/28/18, indicated physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular

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assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment including suprapubic catheter assessment and irrigation, repositioning every 2 hours, pain assessment, skin assessment, trach care, and trach change with fenestrated size 4 uncuffed trach, wound care on right buttock was measured and cleansed with soap and water, patted dry, with dressing applied, patient education with discussion, medications were administered, bladder irrigated, shower given, suprapubic and trach care, trach collar changed and new dressings placed, bowel program was being completed and suprapubic catheter change with a 26 French 10 cc catheter was completed.

During an interview on 8/16/18 at 12:05 PM, the administrator / director of nursing indicated the record lacked a complete plan of care. The record was lacking orders for the care received.

6. During an observation of the home visit on 8/13/18 at 9:10 AM, patient #9 was observed to be in a hospital bed with an air mattress. The administrator / director of nursing was observed to assess the patient by taking vital signs and then give the patient a nebulizer treatment with albuterol. The CPT vest treatment was started at approximately 9:25 AM. The CPT treatment was completed at approximately 9:50 AM. Also completed was a nebulizer treatment with the medication albuterol. Suctioning of the tracheostomy with a 14 French suction tube and cough assist.

A review of clinical record #9 with a start of care 6/27/18 and principal diagnosis of Quadriplegia, evidenced the Comprehensive Adult Assessment dated 6/27/18. The document indicated the

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G 574	Continued From page 63 administrator / director of nursing conducted the admission and indicated a physical assessment was completed, the patient had colostomy, suprapubic catheter, and a feeding tube. The document indicated orders for the enteral feedings was a bolus 240 CC every 4 hours to be performed by family. The document indicated the site was washed with soap and water and patted dry and the suprapubic catheter was washed with soap and water, rinsed well, patted dry. Review of the plan of care for the certification period of 6/27/18 - 8/25/18, evidenced the skilled nurse was to visit 60 hours a month. The plan of care failed to contain all the required elements such a as safety measures, DME and supplies, nutritional requirements, and goals/ rehabilitation potential / discharge plans box were blank, failed to include size of suprapubic catheter, colostomy care, gastric tube care and failed to evidence the tasks to be provided by skilled nursing. This was evidenced by the following: A review of an Adult Extended Hour Nursing Flow Sheet dated 7/2,7/9, 7/30, and 8/6/18, evidenced the administrator/ director of nursing conducted a physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with a note: humidification, CPT vest treatment completed, gastrointestinal assessment (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20; reposition every 2 hours; pain assessment; skin assessment; trach ties changed and inner cannula changed; oral and tracheal suctioning completed; intake recorded; leg bag applied to suprapubic catheter draining	G 574		

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G 574	Continued From page 64 urine; full and passive range of motion completed on upper and lower extremities; bed bath given; A review of an Adult Extended Hour Nursing Flow Sheet dated 7/16/18 and completed by the administrator / director of nursing, indicated a physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with note concerning humidification, CPT vest X 1/2 hour; Gastrointestinal assessment (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20; reposition every 2 hours; pain assessment; skin assessment; Trach ties changed and inner cannula changed; Humidification removed from tracheotomy #6 Shiley, uncuffed trach, midline secured with Dale straps; Pacimuir valve in place to aid with speaking; CPT vest placed on for 15 minute intervals at 14 pressure. Range of motion on upper and lower extremities; Feeding of Isosource 240 cc followed by 200 cc of water for flush. During an interview on 8/13/18 at 10 AM, the administrator / director of nursing indicated the plan of care was not complete.	G 574		
G 576	All orders recorded in plan of care CFR(s): 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. This ELEMENT is not met as evidenced by: Based on record review, the agency failed to ensure all patient care orders were recorded on the plan of care for 2 of 6 active records reviewed	G 576		

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TMG HOME HEALTH CARE INC	**224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 576	Continued From page 65	G 576		

(#1, #2).

The findings included:

1. A review of clinical record #1, failed to evidence all patient care orders were recorded on the updated plan of care. This was further evidenced by the following:

A review of a document titled "Recertification Follow - up assessment" including OASIS elements with Plan of Care / 485 information dated 6/1/18, was completed by the administrator / director of nursing and electronically signed on 6/5/18 by the administrator / director of nursing. The document indicated the services to be provided were supervisory visits, recertification, and HHA (home health aide) for 7 days a week for 26 weeks. The documented reason for Recertification of services stated, "Awake and alert, oriented to place and person. Follows instructions. Becomes paranoid at times believing that someone is out to get [him / her]. Lung sounds essentially clear bilaterally, becomes short of breath with activity. Uses walker when inside the home and for short distances. Uses manual w / c for distances. Needs supervision and assistance with all activities, ADLs [activities of daily living], IADLs [Instrumental Activities of Daily Living]. Medication reminders, meal preparation with reminders to eat, reminders and assistance with toileting and changing adult incontinence diaper. Housekeeping, laundry, and errands." The document indicated a verbal order was obtained on 6/1/18.

A verbal order for SN and Aide services was completed 6/1/18 by the administrator / director of

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G 576	Continued From page 66 nursing. The RN was to incorporate with following comprehensive assessment inclusive of vital signs with SPO2 (oxygen) saturation, neuro / emotional; integumentary; cardiopulmonary; nutrition/ elimination/ hydration assessments and pain management was adequate. The RN would review the plan of care and medications for effectiveness and make needed revisions, check for drug interactions and complete, medication reconciliation if indicated, assess for fall risk, fire safety, home safety, DME supplies and or needs. There was no order for frequency and duration of home health aide visits and tasks to be completed on this verbal order. The plan of care electronically signed by the administrator / director of nursing on 6/5/18, for the certification period of 6/6/18 - 8/4/18, failed to include the 6/1/18 order on the updated plan of care. 2. A review of clinical record #2, failed to evidence that all the following patient care orders were recorded on the plan of care for the certification period of 6/2/18 - 7/31/18 as evidenced by the following: A physician's order dated 4/30/18 completed by the physician, evidenced wound care orders for the right sacrum area to be absorptive silver and pack into the wound and then cover with mepilex border. The peri anal area was to be clean and dry. Also the right elbow was to be protected. The areas were to be cleansed. A physician's order dated 5/31/18 and completed by the administrator / director of nursing, evidenced the skilled nurse was to visit 3 hours a day for 3 days a week for 26 weeks for wound care, medication monitoring, health monitoring, suprapubic catheter changes and care. Bowel	G 576		

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G 576	Continued From page 67 program 3 times a week by digital disimpaction. The home health aide was to visit for assist with ADLs and IADLs, supervision, meal preparation, housekeeping, laundry, grocery shopping, errands, assistance with appointments, and arranging specialized transportation. A physician's order dated 6/18/18 completed by the physician evidenced wound care orders for the right sacrum to be cleansed, pack absorptive silver into the wound and then cover with mepilex border. The peri anal area was to be clean and dry. Also the right elbow was to be protected. A physician's order dated 6/20/18 and completed by the administrator / director of nursing, evidenced the home health aide was to visit 5 hours a day, 7 days a week, for 26 weeks and skilled nurse 2 hours a day, 3 days/ week, for 26 weeks per new PA (prior authorization). A physician's order dated 7/23/18 included orders for the right sacrum for dressing order of absorptive silver and mepilex border with cleanses two times a week.	G 576		
G 590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to promptly notify the physician of changes in the patient's condition in 1 of 6 active clinical records reviewed (#1) with home health	G 590		

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G 590	Continued From page 68 aide services ordered by the agency. The findings include: 1. A review of a policy dated 7/6/18 titled "Home Health Aide Documentation" stated, "Home Health Aides are to document care / services provided on the visit record and be in concurrence with care plan. Purpose 1. Provides documentation of care / services provided during the home health aide visit. 2. Provides documentation of the home health aide's observations during the visits and evidence of client's progress or demise. Special instruction: 1. The home health aide is responsible for reporting any changes in the client's condition to the supervising nurse, such as the following but not limited to a). increased pain, reddened area to skin, foul smelling urine, falls, fatigue, edema. 2. The original documentation is to be completed and filed in the chart within 14 days of the visit." 2. A review of clinical record #1, start of care 12/8/17 included a certification period of 6/6/18 - 8/4/18, with orders for skilled nursing. The clinical record and the following documents failed to evidence the agency staff alerted the physician to patient #1's change of condition and concerns including rash and diarrhea: A review of a Recertification Follow - up assessment including OASIS elements with Plan of Care / 485 information dated 6/1/18, evidenced this assessment was completed by the administrator / director of nursing and electronically signed on 6/5/18 by the administrator / director of nursing. This assessment document assessment evidenced the patient had a rash in the buttocks and rectal	G 590		

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G 590	Continued From page 69 area due to diarrhea. There was no notice of physician notification of this change of condition on this document. A HHA visit note dated 6/7/18 and signed by Employee B, HHA, evidenced the following statement, "Groin rash has odor. Perianal rash improving. A HHA visit note dated 6/9/18 and signed by Employee B, HHA, evidenced the following statement, "Rash has improved. Pain when moving ... bowels." A HHA visit note dated 6/13/18 and signed by Employee B, HHA, evidenced the following statement, "Assistance with pericare. Applied protective cream to perianal area ... see improvement on perianal rash." A HHA visit note dated 6/18/18 and signed by Employee B, HHA, evidenced the following statement, "Note redness on perianal area." A HHA visit note dated 7/13/18 and signed by Employee B, HHA, evidenced the following statement, "Perianal not irritated at this time." A HHA visit note dated 7/26/18 and signed by Employee B, HHA, evidenced the following statement, "No pressure wounds. Perianal irritation noted." A HHA visit note dated 7/27/18 and signed by Employee B, HHA, evidenced the following statement, "Note peri area irritation worse. Extra assistance with protective barrier." A HHA visit note dated 7/31/18 and signed by	G 590		

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G 590	Continued From page 70 Employee B, HHA, evidenced the patient had mild perianal irritation. A HHA visit note dated 8/2/18 and signed by Employee B, HHA, evidenced the patient had no perianal irritation at this time. During an interview on 8/16/18 at 10:15 AM, the administrator / director of nursing indicated that Budreau butt cream had been used and this was not in the record or reported to the Registered Nurse by Employee B or other staff.	G 590		
G 598	Discharge plans communication CFR(s): 484.60(c)(3)(ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the clinical record contained documentation that the patient's physician and the legal representative was informed in advance of a discharge for 1 of 3 closed records reviewed in a sample of 9. (#8) Findings include: A review of a clinical record #8, start of care 4/25/16, diagnosis of physical abuse complicating pregnancy, generalized epilepsy and attention - deficit hyperactivity disorder, failed to evidenced a complaint that was investigated by the agency	G 598		

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G 598	Continued From page 71 administrator or other staff. Review of the closed record, failed to evidence that the agency failed to inform the patient's physician and legal representative in advance notice of their intentions to disharge the patient as evidenced by the following: A review of the record evidenced a "Comprehensive Adult Assessment" dated 8/14/17, with time in of 3:42 PM and time out of 5 PM. This note evidenced a visit was completed by Employee H, RN, and signed on this date. Under discharge plans, Employee H checked box "other" and stated, "When services are no longer needed or can be provided by another source." A review of the record evidenced home health visits completed on 8/18/17, 8/19/17, 8/21/17, 8/22/17, 8/23/18, 8/24/17, 8/25/17, 8/26/17, 8/28/17, 8/29/17, 8/30/17, 8/31/17, 9/1/17, 9/2/17, 9/5/17, 9/6/17, 9/7/17, 9/8/17, 9/9/17, 9/11/17, 9/12/17, 9/13/17, 9/14/17, 9/15/17, 9/18/17, 9/19/17, 9/20/17, 9/21/17, 9/22/17. A supervisory nurse visit was completed on 8/18/17. A review of the record evidenced a home health aide visit with no tasks completed on 10/2/17. The note was signed by Employee K, Home Health Aide. A note on this note under patient's signature stated, "Power of attorney verbalized [illegible words after this.]" This was electronically signed by Employee K on 10/19/17. Review of the clinical record, the only communication about the discharge in the notes was dated 9/28/17 from Employee L, RN, which stated, "Please complete note on 8/14/17. Need to use that note to discharge patient as of 923/17." This review occurred 8/14/18 - 8/18/18.	G 598		

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G 598	Continued From page 72	G 598		

The only communication about the discharge in the notes was dated 9/28/17 from Employee L, RN, which stated, "Please complete note on 8/14/17. Need to use that note to discharge patient as of 9/23/17." This review occurred 8/14/18 - 8/16/18.

During an interview on 8/14/18 at 3:20 PM, the owner of the agency indicated the patient representative for patient #8 refused to sign the visit notes. The patient representative wanted all of the records that he / she signed and would not sign without receiving copies. The patient was grabbing aides inappropriately. The owner stated, "[Patient #8] was abusive and would grab ... aides." The owner indicated talking to the past administrator and told the past administrator that the patient representative needed to sign the visit notes. She stated, "I told [the patient representative] we would not service [him / her] if she would not sign the visit notes."

During an interview on 8/14/18 at 3:45 PM, the administrator/ director of nursing indicated the discharge oasis and summary were not found in the record.

During an interview on 8/15/18 at 9:40 AM, the patient representative of patient #8 indicated refusing to sign the agency visit notes because the agency refused to give him / her copies and complaining to the agency and case manager and the agency discharging the patient because of her / his refusal to sign the visit notes. The patient representative also indicated complaining to the agency when the aide did not show up or called in sick. A new aide, Employee K, HHA, was assigned after the complaint. The patient

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G 598	Continued From page 73	G 598		

representative recalled complaining to the owner and administrator due to Employee K's smoking and the smell of the smoke in the home.

During an interview on 8/15/18 at 10:18 AM, Person C, the case manager for patient #8, indicated billing concerns with the agency. She indicated there was a complaint filed and the administrator and owner of the agency were aware of the complaint.

A letter dated September 26, 2017 stated, "[Patient #8] ... Date of Service: 5/26/17 - 11/24/17, To Whom It May Concern: This letter is to confirm that [Patient #8] has been discharged from our agency as of September 23, 2017 due to noncompliance of caregiver to inform [agency] of changes of [patient #8] physician; also caregiver's refusal to sign in order to be compliant with home health aide services. If you have any further questions or concerns regarding this matter please contact our office. Thank you. [past administrator, director of nursing] RN BSN, administrator."

G 602	Communication with all physicians CFR(s): 484.60(d)(1)	G 602		

Assure communication with all physicians involved in the plan of care.
This ELEMENT is not met as evidenced by:
Based on record review and interview, the agency failed to ensure communication with all physicians involved in the plan of care for 1 of 2 active records reviewed (#2) with a patient with wound care.

The findings include:

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G 602	Continued From page 74 The agency policy titled "Service Policies Nursing Service" dated 2015 stated, "Professional Nursing Functions In keeping with professional standards and depending upon each patient / family need, all or a selection of the following nursing functions may be performed ... coordination of services, including referral to other services as needed." The agency policy titled "Coordination of Services" dated 2015 stated, "To coordinate services in order to provide comprehensive home care, and assure continuity of care ... the staff professional nurse is responsible for the following: a. the professional coordination of all home care services b. ensuring that the established plan of care is carried out c. the ongoing evaluation and assessment of the patient's home care needs. d. Maintaining channels of communication between / among all active caregivers and documents same on patient record e. Scheduling and participation in case conferences." A review of clinical record #2 on 8/16/18, start of care 12/4/17 and principal diagnosis of pressure ulcer of sacral region, failed to evidence documentation that the home health agency coordinated care with the physician ordering wound care (Physician A) for this patient and the patient's attending physician, Physician B. This was further evidenced by the following: A review of a physician order dated 4/30/18, completed by Physician A, evidenced wound care orders for the right sacrum area to be cleansed and pack the wound with absorptive silver and then cover with mepilex border. The peri anal area was to be clean and dry. Also the right	G 602		

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G 602	Continued From page 75 elbow was to be protected. The clinical record failed to evidence that this order was coordinated with the patient's attending physician (B). A review of a Home Health Certification and Plan of Care for the certification period of 6/2/18 - 7/31/18 evidenced SN orders for the frequency and duration of 3 hours a day / 3 days a week for 26 weeks and HHA 6 hours a day, for 7 days a week, for 9 weeks. This plan of care failed to evidence any wound care orders. This document was signed by the patient's attending physician, Physician B, electronically on 6/7/18 and signed by the administrator / director of nursing on 5/31/18. This plan of care failed to evidence that the patient was receiving services from the wound clinic and the agency may accept orders from Physician A at the wound clinic. A review of a physician order written by Physician A, dated 7/23/18, included orders for the right sacrum for dressing order of absorptive silver and mepilex border with cleanses two times a week. The clinical record failed to evidence that this order was coordinated with the patient's attending physician (B). A review of a Home Health Certification and Plan of Care for the certification period of 8/1/18 - 9/29/18 was completed by administrator / director of nursing on 7/31/18. This plan of care was not complete. The patient's attending physician name, Physician B, and contact information was evidenced on this document. This document was signed by the administrator / director of nursing on 7/31/18. This plan of care failed to evidence that the patient was receiving services from the wound clinic and the agency may accept orders from Physician A at the wound	G 602		

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G 602	Continued From page 76 clinic. During an interview on 8/16/18 at 10:15 AM, the administrator/ director of nursing indicated the coordination of care was lacking.	G 602		
G 608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the Registered Nurse coordinated the patient's care with a DME (durable medical equipment) company in 1 of 1 active clinical records reviewed (#2) of a patient with a wound in a sample of 9. The findings included: The agency policy titled "Service Policies Nursing Service" dated 2015 stated, "Professional Nursing Functions In keeping with professional standards and depending upon each patient / family need, all or a selection of the following nursing functions may be performed ... coordination of services, including referral to other services as needed." The agency policy titled "Coordination of Services" dated 2015 stated, "To coordinate services in order to provide comprehensive home care, and assure continuity of care ... the staff professional nurse is responsible for the following: a. the professional coordination of all	G 608		

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G 608	Continued From page 77 home care services b. ensuring that the established plan of care is carried out c. the ongoing evaluation and assessment of the patient's home care needs. d. Maintaining channels of communication between / among all active caregivers and documents same on patient record e. Scheduling and participation in case conferences." During a home visit observation on 8/14/18 at 4:10 PM, patient #2's hospital bed with an air mattress was evidenced to not be in working order. The bed was bowing upward in the middle of the bed area where the patient's lower back region would rest. The patient was observed to have pressure ulcers in the sacral region and right hip region. Employee B, licensed practical nurse, observed to care for this patient and did not engage the patient in discussion about how to contact the durable medical equipment company. The company's contact information was written on the bed. During this time, patient #2 indicated discussing this with the agency staff in the past for a period of several months. During a review of clinical record #2 on 8/16/18, there was no evidence of communication notes with the patient's durable medical equipment company. The phone number of this DME company was in the record and found on the Recertification follow up assessment dated 7/31/18. There was no evidence in the record of the problems with the hospital bed, communication with the DME company, or involvement with the patient about the bed concern.	G 608		
G 640	Quality assessment/performance improvement CFR(s): 484.65	G 640		

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G 640	Continued From page 78 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. This CONDITION is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure the quality assurance program was capable of showing measurable improvement and must measure, analyze and track quality indicators, including adverse patient events, and other aspects of performance that enable the agency to assess processes of care, HHA services, and operations (see G 642); failed to ensure the quality assurance program utilized quality indicator data, including measures derived from OASIS and other relevant data, to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement (see G 644); failed to ensure the quality assurance program must include program activities (see G 646); failed to ensure the quality assurance program focused on high risk, high volume, or	G 640		

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G 640	Continued From page 79 problem prone areas (see G 648); failed to ensure the quality assurance program considered the incidence, prevalence and severity of problems (see G 650); failed to ensure the quality assurance program led to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patient (see G 652); failed to ensure performance improvement activities tracked adverse patient events, analyzed their causes, and implemented preventive actions (see G 654); failed to ensure actions aimed at performance improvement occurred and were sustained (see G 658); and failed to ensure the governing body was involved with the ongoing quality assurance program (see G 660). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation: 484: 65 Condition: Quality Assessment / Performance Improvement.	G 640		
G 642	Program scope CFR(s): 484.65(a)(1),(2) Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations.	G 642		

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G 642	Continued From page 80	G 642		

This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the agency failed to ensure the quality assurance program was capable of showing measurable improvement and must measure, analyze and track quality indicators, including adverse patient events, and other aspects of performance that enable the agency to assess processes of care, HHA services, and operations for 1 of 1 quality assurance program reviewed.

The findings include:

The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was signed by the administrator / director of nursing.

The agency policy titled "Committees" dated 2015 stated, "As part of the agency's quality assurance program, a committee of professional personnel reviews the results of quality assurance data collection activities at least quarterly. Written minutes of meetings are maintained at the agency's office."

During the Entrance conference on 8/7/18 at 11:10 AM, the administrator/ director of nursing indicated the quality assurance program monitored the changes in patient. The focus areas were wound care and infection tracking. She stated, "We follow the guidelines and go by the plans of care." She indicated a concern with the staff keeping up with the charting/ documentation.

During an interview on 8/7/18 at 4 PM, the quality assurance/ performance program was requested.

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G 642	Continued From page 81	G 642		

The administrator/ director of nursing indicated the program was missing and could not be found. During this time, the owner indicated the quality assurance binder may have been taken by a past employee, a past office coordinator, who was seen on security monitors taking items from the office. She indicated having a lawyer involved with this concern.

During an interview on 8/15/18 at 2:10 PM, the administrator/ director of nursing indicated the quality assurance had not occurred and that she had been in the role of administrator since June 2018.

During an observation on 8/15/18 at 3 PM, the owner was observed coming out of a back room with binders including the quality assurance binder and infection control binder.

A review of documents in the quality assurance binder evidenced no documentation of meetings since 2014. This was further evidenced by the following documents from this binder:

1. A skilled nurse visit note for Patient #3 for 1/10/14 was kept in the quality assurance book. There were other skilled nursing visit notes dated 1/12/14, 1/24/14, 1/31/14, 2/2/14, 2/13/14, 2/20/14, 3/4/14, 3/11/14, and 3/18/14. The note dated 3/18/14 evidenced a note at the top of the page which stated, "Before Corrections."

2. Also noted were the Infection Control Quarterly Report dated 1st Quarter January 1 - March 31, 2013 with notes related to dates of 1/8/13 "Prophylactic on admission Tobramycin 300 mg / 5 ml INH every 12 hours ongoing ... This document proceeded to list dates through

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G 642	Continued From page 82 3/29/13. A note at the bottom of the page stated, "No trends noted. Continue to educate clients on universal precautions." 3. Also noted were the Infection Control Quarterly Report dated 2nd Quarter April 1st to June 30, 2013 with notes related to dates of 4/27/13, "UTI Keflex 500 mg every 6 hours X 10 days. Resolved 5/1/13. More notes listed other dates and antibiotics. A note at the bottom of the page stated, "No trends noted. Infection Control measures to instruct to clients." 4. Also noted was the Infection Control quarterly Report for the 3rd Quarter of July 1 - September 31, 2013 and 4th Quarter 2013.	G 642		
G 644	Program data CFR(s): 484.65(b)(1),(2),(3) Program data. The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. The HHA must use the data collected to monitor the effectiveness and safety of services and quality of care; and identify opportunities for improvement. The frequency and detail of the data collection must be approved by the HHA's governing body. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure the quality assurance program utilized quality indicator data, including measures derived from OASIS and other relevant data, to monitor the effectiveness	G 644		

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G 644	Continued From page 83	G 644		

and safety of services and quality of care and identify opportunities for improvement for 1 of 1 quality assurance program reviewed.

The findings include:

The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was signed by the administrator / director of nursing.

The agency policy titled "Committees" dated 2015 stated, "As part of the agency's quality assurance program, a committee of professional personnel reviews the results of quality assurance data collection activities at least quarterly. Written minutes of meetings are maintained at the agency's office."

During the Entrance conference on 8/7/18 at 11:10 AM, the administrator / director of nursing indicated the quality assurance program monitored the changes in patient. The focus areas were wound care and infection tracking. She stated, "We follow the guidelines and go by the plans of care." She indicated a concern with the staff keeping up with the charting / documentation.

During an interview on 8/7/18 at 4 PM, the quality assurance / performance program was requested. The administrator / director of nursing indicated the program was missing and could not be found. During this time, the owner indicated the quality assurance binder may have been taken by a past employee, a past office coordinator, who was seen on security monitors taking items from the office. She indicated

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G 644	Continued From page 84	G 644		

having a lawyer involved with this concern.

During an interview on 8/15/18 at 2:10 PM, the administrator / director of nursing indicated the quality assurance program meetings had not occurred and that she had been in the role of administrator since June 2018.

During an observation on 8/15/18 at 3 PM, the owner was observed coming out of a back room with binders including the quality assurance binder and infection control binder.

A review of documents in the quality assurance binder evidenced no documentation of meetings since 2014. This was further evidenced by the following documents from this binder:

1. A skilled nurse visit note for Patient #3 for 1/10/14 was kept in the quality assurance book. There were other skilled nursing visit notes dated 1/12/14, 1/24/14, 1/31/14, 2/2/14, 2/13/14, 2/20/14, 3/4/14, 3/11/14, and 3/18/14. The note dated 3/18/14 evidenced a note at the top of the page which stated, "Before Corrections."

2. Also noted were the Infection Control Quarterly Report dated 1st Quarter January 1 - March 31, 2013 with notes related to dates of 1/8/13 "Prophylactic on admission Tobramycin 300 mg / 5 ml INH every 12 hours ongoing ... This document proceeded to list dates through 3/29/13. A note at the bottom of the page stated, "No trends noted. Continue to educate clients on universal precautions."

3. Also noted were the Infection Control Quarterly Report dated 2nd Quarter April 1st to June 30, 2013 with notes related to dates of

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G 644	Continued From page 85 4/27/13 "UTI Keflex 500 mg every 6 hours X 10 days. Resolved 5/1/13. More notes listed other dates and antibiotics. A note at the bottom of the page stated, "No trends noted. Infection Control measures to instruct to clients." 4. Also noted was the Infection Control quarterly Report for the 3rd Quarter of July 1 - September 31, 2013 and 4th Quarter 2013.	G 644		
G 646	Program activities CFR(s): 484.65(c) Program activities This STANDARD is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure the quality assurance program must include program activities for 1 of 1 agency reviewed. The findings include: The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was signed by the administrator / director of nursing. The agency policy titled "Committees" dated 2015 stated, "As part of the agency's quality assurance program, a committee of professional personnel reviews the results of quality assurance data collection activities at least quarterly. Written minutes of meetings are maintained at the agency's office." During the Entrance conference on 8/7/18 at 11:10 AM, the administrator / director of nursing indicated the quality assurance program	G 646		

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G 646		G 646		

Continued From page 86
monitored the changes in patient. The focus areas were wound care and infection tracking. She stated, "We follow the guidelines and go by the plans of care." She indicated a concern with the staff keeping up with the charting / documentation.

During an interview on 8/7/18 at 4 PM, the quality assurance / performance program was requested. The administrator / director of nursing indicated the program was missing and could not be found. During this time, the owner indicated the quality assurance binder may have been taken by a past employee, a past office coordinator, who was seen on security monitors taking items from the office. She indicated having a lawyer involved with this concern.

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G 646	Continued From page 87 dated 3/18/14 evidenced a note at the top of the page which stated, "Before Corrections." 2. Also noted were the Infection Control Quarterly Report dated 1st Quarter January 1 - March 31, 2013 with notes related to dates of 1/8/13 "Prophylactic on admission Tobramycin 300 mg / 5 ml INH every 12 hours ongoing ... This document proceeded to list dates through 3/29/13. A note at the bottom of the page stated, "No trends noted. Continue to educate clients on universal precautions." 3. Also noted were the Infection Control Quarterly Report dated 2nd Quarter April 1st to June 30, 2013 with notes related to dates of 4/27/13 "UTI Keflex 500 mg every 6 hours X 10 days. Resolved 5/1/13. More notes listed other dates and antibiotics. A note at the bottom of the page stated, "No trends noted. Infection Control measures to instruct to clients." 4. Also noted was the Infection Control quarterly Report for the 3rd Quarter of July 1 - September 31, 2013 and 4th Quarter 2013.	G 646		
G 648	High risk, high volume, or problem-prone area CFR(s): 484.65(c)(1)(i) The HHA's performance improvement activities must focus on high risk, high volume, or problem-prone areas; This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure the quality assurance program focused on high risk, high volume, or problem prone areas for 1 of 1 agency.	G 648		

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G 648	Continued From page 88	G 648		

Continued From page 88

The findings include:

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During an interview on 8/15/18 at 2:10 PM, the administrator / director of nursing indicated the

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G 648	Continued From page 89	G 648		

quality assurance program meetings had not occurred and that she had been in the role of administrator since June 2018.

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G 648	Continued From page 90 measures to instruct to clients." 4. Also noted was the Infection Control quarterly Report for the 3rd Quarter of July 1 - September 31, 2013 and 4th Quarter 2013.	G 648		
G 650	Incidence, prevalence, severity of problems CFR(s): 484.65(c)(1)(ii) The HHA's performance improvement activities must consider incidence, prevalence, and severity of problems in those areas; and This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure the quality assurance program considered the incidence, prevalence and severity of problems for 1 of 1 agency. The findings include: The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was signed by the administrator / director of nursing. The agency policy titled "Committees" dated 2015 stated, "As part of the agency's quality assurance program, a committee of professional personnel reviews the results of quality assurance data collection activities at least quarterly. Written minutes of meetings are maintained at the agency's office." During the Entrance conference on 8/7/18 at 11:10 AM, the administrator / director of nursing indicated the quality assurance program monitored the changes in patient. The focus	G 650		

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G 650	Continued From page 91	G 650		

areas were wound care and infection tracking. She stated, "We follow the guidelines and go by the plans of care." She indicated a concern with the staff keeping up with the charting / documentation.

During an interview on 8/7/18 at 4 PM, the quality assurance / performance program was requested. The administrator / director of nursing indicated the program was missing and could not be found. During this time, the owner indicated the quality assurance binder may have been taken by a past employee, a past office coordinator, who was seen on security monitors taking items from the office. She indicated having a lawyer involved with this concern.

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During an observation on 8/15/18 at 3 PM, the owner was observed coming out of a back room with binders including the quality assurance binder and infection control binder.

A review of documents in the quality assurance binder evidenced no documentation of meetings since 2014. This was further evidenced by the following documents from this binder:

1. A skilled nurse visit note for Patient #3 for 1/10/14 was kept in the quality assurance book. There were other skilled nursing visit notes dated 1/12/14, 1/24/14, 1/31/14, 2/2/14, 2/13/14, 2/20/14, 3/4/14, 3/11/14, and 3/18/14. The note dated 3/18/14 evidenced a note at the top of the

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page which stated, "Before Corrections."

2. Also noted were the Infection Control Quarterly Report dated 1st Quarter January 1 - March 31, 2013 with notes related to dates of 1/8/13 "Prophylactic on admission Tobramycin 300 mg / 5 ml INH every 12 hours ongoing ... This document proceeded to list dates through 3/29/13. A note at the bottom of the page stated, "No trends noted. Continue to educate clients on universal precautions."

3. Also noted were the Infection Control Quarterly Report dated 2nd Quarter April 1st to June 30, 2013 with notes related to dates of 4/27/13 "UTI Keflex 500 mg every 6 hours X 10 days. Resolved 5/1/13. More notes listed other dates and antibiotics. A note at the bottom of the page stated, "No trends noted. Infection Control measures to instruct to clients."

4. Also noted was the Infection Control quarterly Report for the 3rd Quarter of July 1 - September 31, 2013 and 4th Quarter 2013.

G 650

G 652 Activities lead to an immediate correction
CFR(s): 484.65(c)(1)(iii)

The HHA's performance improvement activities must lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.
This ELEMENT is not met as evidenced by:
Based on observation, record review and interview, the agency failed to ensure the quality assurance program led to an immediate correction of any identified problem that directly or potentially threaten the health and safety of

G 652

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patients for 1 of 1 agency.

The findings include:

The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was signed by the administrator / director of nursing.

The agency policy titled "Committees" dated 2015 stated, "As part of the agency's quality assurance program, a committee of professional personnel reviews the results of quality assurance data collection activities at least quarterly. Written minutes of meetings are maintained at the agency's office."

During the Entrance conference on 8/7/18 at 11:10 AM, the administrator / director of nursing indicated the quality assurance program monitored the changes in patient. The focus areas were wound care and infection tracking. She stated, "We follow the guidelines and go by the plans of care." She indicated a concern with the staff keeping up with the charting / documentation.

During an interview on 8/7/18 at 4 PM, the quality assurance / performance program was requested. The administrator / director of nursing indicated the program was missing and could not be found. During this time, the owner indicated the quality assurance binder may have been taken by a past employee, a past office coordinator, who was seen on security monitors taking items from the office. She indicated having a lawyer involved with this concern.

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Continued From page 94
During an interview on 8/15/18 at 2:10 PM, the administrator / director of nursing indicated the quality assurance program meetings had not occurred and that she had been in the role of administrator since June 2018.

During an observation on 8/15/18 at 3 PM, the owner was observed coming out of a back room with binders including the quality assurance binder and infection control binder.

A review of documents in the quality assurance binder evidenced no documentation of meetings since 2014. This was further evidenced by the following documents from this binder:

1. A skilled nurse visit note for Patient #3 for 1/10/14 was kept in the quality assurance book. There were other skilled nursing visit notes dated 1/12/14, 1/24/14, 1/31/14, 2/2/14, 2/13/14, 2/20/14, 3/4/14, 3/11/14, and 3/18/14. The note dated 3/18/14 evidenced a note at the top of the page which stated, "Before Corrections."

2. Also noted were the Infection Control Quarterly Report dated 1st Quarter January 1 - March 31, 2013 with notes related to dates of 1/8/13 "Prophylactic on admission Tobramycin 300 mg / 5 ml INH every 12 hours ongoing ... This document proceeded to list dates through 3/29/13. A note at the bottom of the page stated, "No trends noted. Continue to educate clients on universal precautions."

3. Also noted were the Infection Control Quarterly Report dated 2nd Quarter April 1st to June 30, 2013 with notes related to dates of 4/27/13 "UTI Keflex 500 mg every 6 hours X 10 days. Resolved 5/1/13. More notes listed other

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G 652	Continued From page 95 dates and antibiotics. A note at the bottom of the page stated, "No trends noted. Infection Control measures to instruct to clients." 4. Also noted was the Infection Control quarterly Report for the 3rd Quarter of July 1 - September 31, 2013 and 4th Quarter 2013.	G 652		
G 654	Track adverse patient events CFR(s): 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. This STANDARD is not met as evidenced by: During observation, record review and interview, the agency failed to ensure Performance improvement activities tracked adverse patient events, analyzed their causes, and implemented preventive actions for 1 of 1 agency. The findings include: The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was signed by the administrator / director of nursing. The agency policy titled "Committees" dated 2015 stated, "As part of the agency's quality assurance program, a committee of professional personnel reviews the results of quality assurance data collection activities at least quarterly. Written minutes of meetings are maintained at the agency's office." During the Entrance conference on 8/7/18 at 11:10 AM, the administrator / director of nursing	G 654		

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G 654	Continued From page 96	G 654		

indicated the quality assurance program monitored the changes in patient. The focus areas were wound care and infection tracking. She stated, "We follow the guidelines and go by the plans of care." She indicated a concern with the staff keeping up with the charting / documentation.

During an interview on 8/7/18 at 4 PM, the quality assurance / performance program was requested. The administrator / director of nursing indicated the program was missing and could not be found. During this time, the owner indicated the quality assurance binder may have been taken by a past employee, a past office coordinator, who was seen on security monitors taking items from the office. She indicated having a lawyer involved with this concern.

During an interview on 8/15/18 at 2:10 PM, the administrator / director of nursing indicated the quality assurance program meetings had not occurred and that she had been in the role of administrator since June 2018.

During an observation on 8/15/18 at 3 PM, the owner was observed coming out of a back room with binders including the quality assurance binder and infection control binder.

A review of documents in the quality assurance binder evidenced no documentation of meetings since 2014. This was further evidenced by the following documents from this binder:

1. A skilled nurse visit note for Patient #3 for 1/10/14 was kept in the quality assurance book. There were other skilled nursing visit notes dated 1/12/14, 1/24/14, 1/31/14, 2/2/14, 2/13/14,

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2/20/14, 3/4/14, 3/11/14, and 3/18/14. The note dated 3/18/14 evidenced a note at the top of the page which stated, "Before Corrections."

2. Also noted were the Infection Control Quarterly Report dated 1st Quarter January 1 - March 31, 2013 with notes related to dates of 1/8/13 "Prophylactic on admission Tobramycin 300 mg / 5 ml INH every 12 hours ongoing ... This document proceeded to list dates through 3/29/13. A note at the bottom of the page stated, "No trends noted. Continue to educate clients on universal precautions."

3. Also noted were the Infection Control Quarterly Report dated 2nd Quarter April 1st to June 30, 2013 with notes related to dates of 4/27/13 "UTI Keflex 500 mg every 6 hours X 10 days. Resolved 5/1/13. More notes listed other dates and antibiotics. A note at the bottom of the page stated, "No trends noted. Infection Control measures to instruct to clients."

4. Also noted was the Infection Control quarterly Report for the 3rd Quarter of July 1 - September 31, 2013 and 4th Quarter 2013.

G 656

Improvements are sustained
CFR(s): 484.65(c)(3)

The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained.
This ELEMENT is not met as evidenced by:
Based on observation, record review and interview, the agency failed to ensure actions aimed at performance improvement occurred and

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G 656		G 656		

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were sustained for 1 of 1 agency reviewed.

The findings include:

The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was signed by the administrator / director of nursing.

The agency policy titled "Committees" dated 2015 stated, "As part of the agency's quality assurance program, a committee of professional personnel reviews the results of quality assurance data collection activities at least quarterly. Written minutes of meetings are maintained at the agency's office."

During the Entrance conference on 8/7/18 at 11:10 AM, the administrator / director of nursing indicated the quality assurance program monitored the changes in patient. The focus areas were wound care and infection tracking. She stated, "We follow the guidelines and go by the plans of care." She indicated a concern with the staff keeping up with the charting / documentation.

During an interview on 8/7/18 at 4 PM, the quality assurance / performance program was requested. The administrator / director of nursing indicated the program was missing and could not be found. During this time, the owner indicated the quality assurance binder may have been taken by a past employee, a past office coordinator, who was seen on security monitors taking items from the office. She indicated having a lawyer involved with this concern.

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G 656		G 656		

Continued From page 99
During an interview on 8/15/18 at 2:10 PM, the administrator / director of nursing indicated the quality assurance program meetings had not occurred and that she had been in the role of administrator since June 2018.

During an observation on 8/15/18 at 3 PM, the owner was observed coming out of a back room with binders including the quality assurance binder and infection control binder.

A review of documents in the quality assurance binder evidenced no documentation of meetings since 2014. This was further evidenced by the following documents from this binder:

1. A skilled nurse visit note for Patient #3 for 1/10/14 was kept in the quality assurance book. There were other skilled nursing visit notes dated 1/12/14, 1/24/14, 1/31/14, 2/2/14, 2/13/14, 2/20/14, 3/4/14, 3/11/14, and 3/18/14. The note dated 3/18/14 evidenced a note at the top of the page which stated, "Before Corrections."

2. Also noted were the Infection Control Quarterly Report dated 1st Quarter January 1 - March 31, 2013 with notes related to dates of 1/8/13 "Prophylactic on admission Tobramycin 300 mg / 5 ml INH every 12 hours ongoing ... This document proceeded to list dates through 3/29/13. A note at the bottom of the page stated, "No trends noted. Continue to educate clients on universal precautions."

3. Also noted were the Infection Control Quarterly Report dated 2nd Quarter April 1st to June 30, 2013 with notes related to dates of 4/27/13 "UTI Keflex 500 mg every 6 hours X 10 days. Resolved 5/1/13. More notes listed other

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G 656	Continued From page 100 dates and antibiotics. A note at the bottom of the page stated, "No trends noted. Infection Control measures to instruct to clients." 4. Also noted was the Infection Control quarterly Report for the 3rd Quarter of July 1 - September 31, 2013 and 4th Quarter 2013.	G 656		
G 658	Performance improvement projects CFR(s): 484.65(d)(1)(2) Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure the quality assurance program tracked adverse events and had distinct projects and noted measurable progress for 1 of 1 agency reviewed. The findings include: The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was signed by the administrator / director of nursing. The agency policy titled "Committees" dated 2015 stated, "As part of the agency's quality assurance	G 658		

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G 658	Continued From page 101	G 658		

program, a committee of professional personnel reviews the results of quality assurance data collection activities at least quarterly. Written minutes of meetings are maintained at the agency's office."

During the Entrance conference on 8/7/18 at 11:10 AM, the administrator / director of nursing indicated the quality assurance program monitored the changes in patient. The focus areas were wound care and infection tracking. She stated, "We follow the guidelines and go by the plans of care." She indicated a concern with the staff keeping up with the charting / documentation.

During an interview on 8/7/18 at 4 PM, the quality assurance / performance program was requested. The administrator / director of nursing indicated the program was missing and could not be found. During this time, the owner indicated the quality assurance binder may have been taken by a past employee, a past office coordinator, who was seen on security monitors taking items from the office. She indicated having a lawyer involved with this concern.

During an interview on 8/15/18 at 2:10 PM, the administrator / director of nursing indicated the quality assurance program meetings had not occurred and that she had been in the role of administrator since June 2018.

During an observation on 8/15/18 at 3 PM, the owner was observed coming out of a back room with binders including the quality assurance binder and infection control binder.

A review of documents in the quality assurance

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G 658	Continued From page 102 binder evidenced no documentation of meetings since 2014. This was further evidenced by the following documents from this binder: 1. A skilled nurse visit note for Patient #3 for 1/10/14 was kept in the quality assurance book. There were other skilled nursing visit notes dated 1/12/14, 1/24/14, 1/31/14, 2/2/14, 2/13/14, 2/20/14, 3/4/14, 3/11/14, and 3/18/14. The note dated 3/18/14 evidenced a note at the top of the page which stated, "Before Corrections." 2. Also noted were the Infection Control Quarterly Report dated 1st Quarter January 1 - March 31, 2013 with notes related to dates of 1/8/13 "Prophylactic on admission Tobramycin 300 mg / 5 ml INH every 12 hours ongoing ... This document proceeded to list dates through 3/29/13. A note at the bottom of the page stated, "No trends noted. Continue to educate clients on universal precautions." 3. Also noted were the Infection Control Quarterly Report dated 2nd Quarter April 1st to June 30, 2013 with notes related to dates of 4/27/13 "UTI Keflex 500 mg every 6 hours X 10 days. Resolved 5/1/13. More notes listed other dates and antibiotics. A note at the bottom of the page stated, "No trends noted. Infection Control measures to instruct to clients." 4. Also noted was the Infection Control quarterly Report for the 3rd Quarter of July 1 - September 31, 2013 and 4th Quarter 2013.	G 658		
G 660	Executive responsibilities for QAPI CFR(s): 484.65(e)(1)(2)(3)(4) Executive responsibilities. The HHA's governing	G 660		

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body is responsible for ensuring the following:

(1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained;
(2) That the HHA-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness;
(3) That clear expectations for patient safety are established, implemented, and maintained; and
(4) That any findings of fraud or waste are appropriately addressed.
This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the agency failed to ensure the governing body was involved with the ongoing quality assurance program for 1 of 1 agency.

The findings include:

The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was signed by the administrator / director of nursing.

The agency policy titled "Committees" dated 2015 stated, "As part of the agency's quality assurance program, a committee of professional personnel reviews the results of quality assurance data collection activities at least quarterly. Written minutes of meetings are maintained at the agency's office."

During the Entrance conference on 8/7/18 at 11:10 AM, the administrator / director of nursing indicated the quality assurance program

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monitored the changes in patient. The focus areas were wound care and infection tracking. She stated, "We follow the guidelines and go by the plans of care." She indicated a concern with the staff keeping up with the charting / documentation.

During an interview on 8/7/18 at 4 PM, the quality assurance / performance program was requested. The administrator / director of nursing indicated the program was missing and could not be found. During this time, the owner indicated the quality assurance binder may have been taken by a past employee, a past office coordinator, who was seen on security monitors taking items from the office. She indicated having a lawyer involved with this concern.

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During an observation on 8/15/18 at 3 PM, the owner was observed coming out of a back room with binders including the quality assurance binder and infection control binder.

A review of documents in the quality assurance binder evidenced no documentation of meetings since 2014. This was further evidenced by the following documents from this binder:

1. A skilled nurse visit note for Patient #3 for 1/10/14 was kept in the quality assurance book. There were other skilled nursing visit notes dated 1/12/14, 1/24/14, 1/31/14, 2/2/14, 2/13/14, 2/20/14, 3/4/14, 3/11/14, and 3/18/14. The note

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 660	Continued From page 105 dated 3/18/14 evidenced a note at the top of the page which stated, "Before Corrections." 2. Also noted were the Infection Control Quarterly Report dated 1st Quarter January 1 - March 31, 2013 with notes related to dates of 1/8/13 "Prophylactic on admission Tobramycin 300 mg / 5 ml INH every 12 hours ongoing ... This document proceeded to list dates through 3/29/13. A note at the bottom of the page stated, "No trends noted. Continue to educate clients on universal precautions." 3. Also noted were the Infection Control Quarterly Report dated 2nd Quarter April 1st to June 30, 2013 with notes related to dates of 4/27/13 "UTI Keflex 500 mg every 6 hours X 10 days. Resolved 5/1/13. More notes listed other dates and antibiotics. A note at the bottom of the page stated, "No trends noted. Infection Control measures to instruct to clients." 4. Also noted was the Infection Control quarterly Report for the 3rd Quarter of July 1 - September 31, 2013 and 4th Quarter 2013.	G 660		
G 680	Infection prevention and control CFR(s): 484.70 Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to follow infection control guidelines (see G 682) and failed to maintain a coordinated agency-wide program	G 680		

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G 680	Continued From page 106 for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement program (see G 684). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation: 484.70 Condition of participation: Infection prevention and control.	G 680		
G 682	Prevention CFR(s): 484.70(a) Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to follow infection control guidelines in 1 of 1 home visits (#2) with a Licensed Practical Nurse(#B). The findings include: The undated agency policy titled "Handwashing procedure" stated, "To prevent cross contamination and spread of infectious organisms ... Equipment 1. Paper Towels 2. Lotion 3. Liquid Soap 4. Alcohol - based hand sanitizer or wipes 5. Antiseptic hand scrub .. and an impermeable plastic trash bag Procedure 1. Take alcohol based hand sanitizer from bag. 2. Pour small amount of sanitizer into palm and spread over hands and fingers and rub thoroughly until dry. 3.	G 682		

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G 682	Continued From page 107 If caring for patient with a drug - resistant bacteria ... a. Take equipment to wash hands [liquid soap, paper towels, lotion to the sink area in bathroom b. Use one paper towel on which to place the other items. The second and third towels are used for washing and drying the hands before and after care has been given. c. Wet hands and forearms. Then lather, using vigorous friction, starting at the fingertips, ad working toward the forearm for no less than 15 seconds. d. Do not touch the sink. e. Rinse ... Avoid using cloth towels or bars of soap for these are a haven of bacteria. f. Dry hands from the fingers toward the forearm. G. Turn off water faucet with a dry paper towel; then discard the towel into trash bag." During a home visit observation on 8/14/18 at 4:10 PM, Employee B, Licensed Practical Nurse, was observed to give a bed bath to patient #2. After the patient's bath, Employee B removed her gloves and washed her hands with the patient's bar soap kept by the bathroom sink. She then dried her hands with paper towels. The paper towels were found on the patient's box where a household pet would sit. This area was covered with pet hair. During an interview on 8/15/18 at 4 PM, the administrator / director of nursing and owner indicated using bar soap was not in the agency policy and handwashing soap in bottles was supplied to all direct care staff.	G 682		
G 684	Infection control CFR(s): 484.70(b)(1)(2) Control. The HHA must maintain a coordinated	G 684		

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G 684	Continued From page 108 agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. This STANDARD is not met as evidenced by: During observation, record review, and interview, the agency failed to maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases as part of the HHA's quality assessment and performance improvement program for 1 of 1 agency. The findings include: The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was signed by the administrator / director of nursing. The agency policy titled "Committees" dated 2015 stated, "As part of the agency's quality assurance program, a committee of professional personnel reviews the results of quality assurance data collection activities at least quarterly. Written minutes of meetings are maintained at the agency's office." During the Entrance conference on 8/7/18 at	G 684		

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G 684		G 684		

Continued From page 109
11:10 AM, the administrator / director of nursing indicated the quality assurance program monitored the changes in patient. The focus areas were wound care and infection tracking. She stated, "We follow the guidelines and go by the plans of care." She indicated a concern with the staff keeping up with the charting / documentation.

During an interview on 8/7/18 at 4 PM, the quality assurance / performance program was requested. The administrator / director of nursing indicated the program was missing and could not be found. During this time, the owner indicated the quality assurance binder may have been taken by a past employee, a past office coordinator, who was seen on security monitors taking items from the office. She indicated having a lawyer involved with this concern.

During an interview on 8/15/18 at 2:10 PM, the administrator / director of nursing indicated the quality assurance program meetings had not occurred and that she had been in the role of administrator since June 2018. She indicated that she had started logging infections in the agency.

A document titled "Infection Control" revised 8/8/18 stated, "Infection Control Distribution: Administration, Approved by [the administrator / director of nursing] Policy and Procedures Revised 8/8/18 2/7/18 [patient #3] pneumonia 2/21/18 resolved , 5/5/18 [patient #3] UTI resolved 6/5/18, 7/14/18 [patient #10] pneumonia 7/27/18 resolved; 8/10/18 [patient #11] sinus infection." There was no other information on this document including what physician orders were written for this infection."

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G 684	Continued From page 110	G 684		

During an observation on 8/15/18 at 3 PM, the owner was observed coming out of a back room with binders including the quality assurance binder and infection control binder.

A review of documents in the quality assurance binder evidenced no documentation of meetings since 2014. This was further evidenced by the following documents from this binder:

1. A skilled nurse visit note for Patient #3 for 1/10/14 was kept in the quality assurance book. There were other skilled nursing visit notes dated 1/12/14, 1/24/14, 1/31/14, 2/2/14, 2/13/14, 2/20/14, 3/4/14, 3/11/14, and 3/18/14. The note dated 3/18/14 evidenced a note at the top of the page which stated, "Before Corrections."

2. Also noted were the Infection Control Quarterly Report dated 1st Quarter January 1 - March 31, 2013 with notes related to dates of 1/8/13 "Prophylactic on admission Tobramycin 300 mg / 5 ml INH every 12 hours ongoing ... This document proceeded to list dates through 3/29/13. A note at the bottom of the page stated, "No trends noted. Continue to educate clients on universal precautions."

3. Also noted were the Infection Control Quarterly Report dated 2nd Quarter April 1st to June 30, 2013 with notes related to dates of 4/27/13 "UTI Keflex 500 mg every 6 hours X 10 days. Resolved 5/1/13. More notes listed other dates and antibiotics. A note at the bottom of the page stated, "No trends noted. Infection Control measures to instruct to clients."

4. Also noted was the Infection Control

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G 684	Continued From page 111 quarterly Report for the 3rd Quarter of July 1 - September 31, 2013 and 4th Quarter 2013.	G 684		
G 700	Skilled professional services CFR(s): 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician 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. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the Registered Nurse failed to ensure the plans of care contained frequency and duration of visits specific to the certification period, failed to ensure the plan of care contained all required elements including the tasks to be provided, and the goals to achieve (see G 708); failed to ensure visits were provided per the plan of care and failed to ensure treatment and services were not provided absent of a physicians order (see G 710); failed to ensure the attending physician was notified in a change in a patient's condition and failed to ensure coordination between the wound clinic physician and the attending physician (see G 718); and failed to ensure skilled professional services participated in a quality assurance program (see G 720). The cumulative effect of these systemic problems	G 700		

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G 700	Continued From page 112 resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation: 484: 75 Condition: Skilled Professional Services.	G 700		
G 708	Development and evaluation of plan of care CFR(s): 484.75(b)(2) Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the Registerd Nurse failed to ensure the plans of care contained frequency and duration of visits specific to the certification period, failed to ensure the plan of care contained all required elements including the tasks to be provided, and the goals to achieve for 5 of 6 active records reviewed (#1 - #4, #9) in a sample of 9. The findings include: 1. A review of the policy titled "2.21 Physician's Plan of Treatment" stated, "A physician prepares a plan of treatment and it is made available to the agency. 2. Physician's orders are established and documented for the health care services the agency provides to those patients who a. are being actively treated by a physician ... b. have a health care need or change in physical status for a diagnosed health care problem c. are admitted to service with the agency ... 4. A physician's plan of treatment must be signed and dated by the attending physician and in the chart within 30 days after the admission to the agency and must include ... the type and frequency of services	G 708		

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G 708	Continued From page 113 provided ... specific orders and frequency of visits ... necessary medical equipment." 2. A review of clinical record #1, the plan of care for the certification period of 6/6/18 - 8/4/18 failed to evidence home health aide frequency, duration of visits specific to the certification period and failed to evidence the tasks to be provided by the home health aide. This was evidenced by the following: A review of a document titled "Recertification Follow - up assessment" that included OASIS elements with Plan of Care / 485 information dated 6/1/18, with time in of 7 AM and time out of 10 AM, was completed and was electronically signed on 6/5/18 by the administrator / director of nursing. The document indicated the services to be provided were supervisory visits, recertification, and the HHA (home health aide) visits 7 days a week for 26 weeks. A verbal order dated 6/1/18, completed by the administrator / director of nursing, evidenced an order for only RN duties and did not evidence frequency and duration of home health aide visits as well as the tasks to be provided. The plan of care for the certification period of 6/6/18 - 8/4/18, failed to evidence the frequency and duration of home health aide visits specific to the certification period and the tasks to be provided by the home health aide. This plan of care was electronically signed by the administrator / director of nursing on 6/5/18. Review of HHA visit notes dated 6/7, 6/9, 6/11, 6/13, 6/14, 6/15, 6/18, 6/20, 7/6, 7/9, 7/12, 7/13, 7/16, 7/17, 7/18, 7/19, 7/27, 7/31, and 8/2/18	G 708		

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G 708	Continued From page 114	G 708		

indicated specific ADL's/ personal care including assistance with medications, meal preps, and washing clothes were provided by a licensed practical nurse and home health aide from 4 to 8 hours on these days.

3. A review of clinical record #2, the plan of care for the certification period of 6/6/18 - 8/4/18 failed to contain all the required elements, failed to evidence skilled nursing and home health aide frequency and duration of visits specific to the certification period, and the tasks to be provided by skilled nursing and the home health aide. This was evidenced by the following:

A physician order dated 4/30/18, and completed by the physician, evidenced wound care orders to cleanse all wounds, pack the right sacrum wound with absorptive silver and cover with mepilex border; the peri anal area was to be clean and dry, and the right elbow was to be protected.

A verbal order dated 5/30/18, evidenced the patient was to have skilled nursing and aide services. There was no frequency and duration of the visits or tasks for the staff to complete.

A physician order dated 5/31/18, and completed by the administrator / director of nursing, evidenced the skilled nurse was to visit 3 hours a day, 3 days a week, for 26 weeks for wound care, medication monitoring, health monitoring, suprapubic catheter changes and care and bowel program 3 times a week by digital disimpaction. The home health aide was to visit for assistance with ADLs and IADLs, supervision, meal preparation, housekeeping, laundry, grocery shopping, errands, assistance with appointments, and arranging specialized transportation. The

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G 708	Continued From page 115	G 708		

order failed to include a duration and frequency of skilled nursing and home health aide visits specific to the 6/2/18 to 7/31/18 certification period.

A review of a Home Health Certification and Plan of Care for the certification period of 6/2/18 - 7/31/18, evidenced skilled nursing orders for 3 hours a day, 3 days a week, for 26 weeks and HHA orders 6 hours a day, 7 days a week, 9 weeks. The plan of care failed to evidence the tasks that would be completed by the staff as indicated on the 5/31/18 physician's order and failed to evidence goals, rehabilitation potential, and discharge plans, and the mental status, DME (durable medical equipment) and supplies, safety measures, activities permitted, and allergies sections were all blank. This document was electronically signed by the administrator / director of nursing on 5/31/18 and electronically signed by the physician on 6/7/18.

A review of home health aide visit notes dated 6/2, 6/3, 6/4, 6/5, 6/6, 6/7, 6/8, 6/9, 6/10, 6/13, 6/14, 6/15, 6/16, 6/17, 6/18, 6/19, 6/21, 6/22, 6/23, 7/13, 7/18, 7/20, 7/25, and 7/27/18, indicated HHAs completed tasks such as bathing, personal care, hair care, catheter care, record output / input, inspect / reinforce dressing, ambulation assist and other tasks.

A review of skilled nurse visit notes evidenced visits occurred on 6/5, 6/9, 6/12, 6/16, 6/21, 6/25, 6/27, 6/29, 7/2, 7/6, 7/9, 7/18, 7/20, 7/23, 7/27, and 7/30/18, and indicated nursing assessments, vital signs, dressing change for wounds on sacral, coccyx area and right elbow area, wound measurements, suprapubic catheter assessments, suprapubic catheter was changed

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G 708	Continued From page 116 using a 26 French / 30 cc (cubic centimeter) bulb. A review of the "Recertification Follow - up assessment" including OASIS elements with plan of care / 485 dated 7/31/18 and completed by the administrator / director of nursing on 7/31/18, indicated the wounds were measured. A review of a Home Health Certification and Plan of Care for the certification period of 8/1/18 - 9/29/18 was completed by administrator/ director of nursing on 7/31/18. This plan of care was not complete and failed to include the DME/ supplies, safety measures, and goals. The orders evidenced a SN frequency and duration 2 hours a day 3 days a week for 26 weeks and HHA orders for 5 hours a day, 7 days a week for 26 weeks. A review of skilled nurse visit noted dated 8/1, 8/4, 8/6, and 8/9/18, indicated nursing assessments, vital signs, dressing change for wounds on sacral, coccyx area and right elbow area, wound measurements, suprapubic catheter assessments, and catheter was irrigated with 60 cc of normal saline. 4. A review of clinical record #3 with a start of care 12/13/17 and principal diagnosis of essential hypertension, the plan of care for the certification period of 6/11/18 - 8/9/18 failed to evidence the skilled nurse was to set up the patient's medications. This was evidenced by the following: Review of A skilled nursing visit notes, completed by Employee B dated 6/16, 6/23, and 6/3018, evidenced the nurse set up the patient's medications for the following week. A note on	G 708		

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6/16/18 stated, "Medications dispensed as ordered."

During an interview on 8/16/18 at 12 noon, the administrator / director of nursing indicated the medication set up was not on the plan of care.

5. A review of clinical record #4 with a start of care 11/16/17 and principal diagnosis of Quadriplegia, the plan of care for the certification period of 7/14/18 - 911/18 failed to evidence the tasks to be completed by the skilled nurse. This was evidenced by the following:

A review of the Home Health Certification and Plan of Care for the certification period of 7/14/18 - 9/11/18 evidenced the skilled nurse was to visit 5 hours day/ 7 days a week. There were no additional tasks written on this document except under Medications: Renadicin 30 cc ml daily irrigation.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/14, 7/15, 7/16, 7/17, 7/18, 7/19, 7/20, 7/21 (x2 visits), 7/22 (x2 visits), 7/23, 7/27, and 7/28/18, indicated physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment including suprapubic catheter assessment and irrigation, repositioning every 2 hours, pain assessment, skin assessment, trach care, and trach change with fenestrated size 4 uncuffed trach, wound care on right buttock was measured and cleansed with soap and water, patted dry, with dressing applied, patient education with discussion, medications were administered, bladder irrigated, shower given,

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G 708	Continued From page 118 suprapubic and trach care, trach collar changed and new dressings placed, bowel program was being completed and suprapubic catheter change with a 26 French 10 cc catheter was completed. During an interview on 8/16/18 at 12:05 PM, the administrator / director of nursing indicated the record lacked a complete plan of care. The record was lacking orders for the care received. 6. During an observation of the home visit on 8/13/18 at 9:10 AM, patient #9 was observed to be in a hospital bed with an air mattress. The administrator / director of nursing was observed to assess the patient by taking vital signs and then give the patient a nebulizer treatment with albuterol. The CPT vest treatment was started at approximately 9:25 AM. The CPT treatment was completed at approximately 9:50 AM. Also completed was a nebulizer treatment with the medication albuterol. Suctioning of the tracheostomy with a 14 French suction tube and cough assist. A review of clinical record #9 with a start of care 6/27/18 and principal diagnosis of Quadriplegia, evidenced the Comprehensive Adult Assessment dated 6/27/18. The document indicated the administrator / director of nursing conducted the admission and indicated a physical assessment was completed, the patient had colostomy, suprapubic catheter, and a feeding tube. The document indicated orders for the enteral feedings was a bolus 240 CC every 4 hours to be performed by family. The document indicated the site was washed with soap and water and patted dry and the suprapubic catheter was washed with soap and water, rinsed well, patted dry.	G 708		

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Review of the plan of care for the certification period of 6/27/18 - 8/25/18, evidenced the skilled nurse was to visit 60 hours a month. The plan of care failed to contain all the required elements such a as safety measures, DME and supplies, nutritional requirements, and goals/ rehabilitation potential / discharge plans box were blank, failed to include size of suprapubic catheter, colostomy care, gastric tube care and failed to evidence the tasks to be provided by skilled nursing. This was evidenced by the following:

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/2,7/9, 7/30, and 8/6/18, evidenced the administrator/ director of nursing conducted a physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with a note: humidification, CPT vest treatment completed, gastrointestinal assessment (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20; reposition every 2 hours; pain assessment; skin assessment; trach ties changed and inner cannula changed; oral and tracheal suctioning completed; intake recorded; leg bag applied to suprapubic catheter draining urine; full and passive range of motion completed on upper and lower extremities; bed bath given;

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/16/18 and completed by the administrator / director of nursing, indicated a physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with note concerning humidification, CPT vest X 1/2 hour;

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G 708	Continued From page 120 Gastrointestinal assessment (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20; reposition every 2 hours; pain assessment; skin assessment; Trach ties changed and inner cannula changed; Humidification removed from tracheotomy #6 Shiley, uncuffed trach, midline secured with Dale straps; Pacimuir valve in place to aid with speaking; CPT vest placed on for 15 minute intervals at 14 pressure. Range of motion on upper and lower extremities; Feeding of Isosource 240 cc followed by 200 cc of water for flush. During an interview on 8/13/18 at 10 AM, the administrator / director of nursing indicated the plan of care was not complete.	G 708		
G 710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician as indicated in the plan of care; This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the skilled nurses failed to ensure visits were provided per the plan of care for 3 of 6 active records (#2, #4, #9) and failed to ensure treatment and services were not provided absent of a physicians order for 4 of 6 active records reviewed (#2, #3, #4, #9). The findings include: 1. The agency policy titled "2.21 Physician's Plan of Treatment" dated 2015 stated, "A physician prepares a plan of treatment and it is made available to the agency. 2. Physician's orders	G 710		

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are established and documented for the health care services the agency provides to those patients who a. Are being actively treated by a physician for a diagnosed health care problem b. have a health care need or change in physical status requiring medical intervention c. are admitted to service with the agency."

2. The agency policy titled "2.26 Service Policies Nursing Service" stated, "Nursing services shall mean the services provided by nurses within the practice of the profession of nursing ... The provision of nursing services includes the performance, direction or supervision of health care tasks pursuant to a plan of care and consistent with an existing medical regimen."

3. The agency policy titled "2.23 Services provided ... Registered Nurses provide quality nursing care by the visit or the shift. The highly trained professionals follow the physician's orders, monitor and instruct the patient regarding their care ... The licensed practical nurse provides assigned care under the direction of a RN. 3. All RN's are licensed in Indiana and follow all regulations and standards of practice required by the state. 4. All LPNs are licensed in Indiana and follow all regulations and standards of practice required by the state ... Home health aides ... these services are provided in accordance with the plan of care."

4. A review of clinical record #2, with a start of care 12/4/17, principal diagnosis of pressure ulcer of sacral region, failed to evidence skilled nurse were provided per the physician ordered plan of care and the record evidenced SN conducted care and services absent of a physician's order as evidenced by:

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A review of a Home Health Certification and Plan of Care for the certification period of 6/2/18 - 7/31/18, evidenced skilled nursing orders for 3 hours a day, 3 days a week, for 26 weeks. The plan of care failed to evidence the tasks that would be completed by the staff. This document was electronically signed by the administrator / director of nursing on 5/31/18 and electronically signed by the physician on 6/7/18.

A review of a skilled nurse visit note dated 6/5/18, 6/9/18, 6/12/18, and 6/16/18, evidenced Employee B visited the patient for 2 hours each day. Tasks completed were nursing assessment, vital signs, dressing change for wounds on sacral, coccyx area and right elbow area. Suprapubic catheter assessed.

A review of a physician order dated 6/18/18, completed by the physician, evidenced wound care orders to cleanse all wounds, pack the right sacrum wound with absorptive silver and cover with mepilex border; the peri anal area was to be clean and dry, and the right elbow was to be protected.

A review of a physician order dated 6/20/18, and completed by the administrator / director of nursing, evidenced the home health aide was to visit 5 hours a day, 7 days a week, for 26 weeks and skilled nursing 2 hours a day, 3 days / week, for 26 weeks per new PA (prior authorization). The order failed to be specific to the remaining certification period between 6/20/18 to 7/31/18 and failed to include the tasks to be provided by the skilled nurse.

A review of a skilled nurse visit note dated

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G 710	Continued From page 123 6/21/18, 6/27/18, 6/29/18, 7/2/18, 7/6/18, 7/9/18, evidenced Employee B visited the patient. Tasks completed absent of a physician's order were nursing assessment, vital signs, and suprapubic catheter monitoring. Employee B visited the patient for 2 hourson 6/29, 7/2, 7/9/18 and less than 2 hours on 7/6/18. A review of a skilled nurse visit note dated 6/25/18, evidenced Employee B visited the patient. Tasks completed absent of a physicians order were nursing assessment, vital signs, and suprapubic catheter monitoring. The suprapubic catheter was changed using a 26 French / 30 cc (cubic centimeter) bulb. A review of a skilled nurse visit note dated 7/18/18, evidenced Employee B visited the patient for 2 hours. Tasks completed absent of a physician's order were nursing assessment, vital signs, and suprapubic catheter monitoring. The note failed to evidence if dressing changes had been conducted. A review of a skilled nurse visit note dated 7/20/18, evidenced Employee B visited the patient for 2 hours. Tasks completed absent of a physician's order were nursing assessment, vital signs, the wound on the sacral area was measured, and suprapubic catheter monitoring. The note failed to evidence if dressing changes had been conducted. A review of a skilled nurse visit note dated 7/23/18, evidenced Employee B visited the patient for 1.5 hours. Tasks completed absent of a physicians order were nursing assessment, vital signs, the wound on the sacral area was measure, and suprapubic catheter monitoring.	G 710		

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A review of a physician order dated 7/23/18, included orders for the right sacrum for dressing order of absorptive silver and mepilex border with cleanses two times a week. Only 1 visit was conducted during this week (7/22/18 to 7/28/18).

A review of a skilled nurse visit note dated 7/27/18, 7/30/18, evidenced Employee B visited the patient for 2 hours. Tasks completed absent of a physician's order were nursing assessment, vital signs, the wound on the sacral area was measured, and suprapubic catheter monitoring was completed. The note failed to evidence if dressing changes had been conducted.

A review of a physician order dated 7/31/18, signed by the administrator / director of nursing, evidenced HHA was to visit the patient 5 hours a day, 7 days a week, for 26 weeks for assistance with ADLs' and IADLs, housekeeping, laundry, grocery shopping, errands and meal prep. The skilled nurse was to visit 2 hours daily, 3 days a week for wound care, nursing assessment, medication monitoring, catheter care and changes and coordination of care.

A Recertification follow up assessment including OASIS elements with plan of care / 485 information dated 7/31/18 and completed by the administrator / director of nursing on 7/31/18. The wounds were measured. The wounds were cleansed with sterile saline and then packed with colloidal silver and nystatin cream and dressed with mepilex border. The document stated,"The wound was contaminated with fecal matter, areas were thoroughly washed with soap and water, prior to dressing change to decrease contamination." The deviation of treatment was

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G 710	Continued From page 125 conducted absent of a physician's order. 5. A review of clinical record #3, with a start of care 12/13/17, and principal diagnosis of essential hypertension, evidenced the skilled nurse conducted care and services absent of a physician's order as evidenced by: Review of the plan of care for the certification period of 6/11/18 - 8/9/18, failed to evidence the agency was to set up the patient's medications or checking blood sugar results. Review of A skilled nursing visit note completed by Employee B dated 6/16/18, evidenced the nurse set up the patient's medications. A note stated, "Medications dispensed as ordered." Review of a skilled nursing visit note completed by Employee B dated 6/23/18 and 6/30/18, evidenced the nurse set up the patient's medications for the next week. During an interview on 8/16/18 at 12 noon, the administrator / director of nursing indicated the medication set up was not on the plan of care. 6. A review of clinical record #4, with a start of care 11/16/17, and principal diagnosis of Quadriplegia, failed to evidence skilled nurse visits were provided per the physician ordered plan of care and the record evidenced SN conducted care and services absent of a physician's order as evidenced by: A review of the Home Health Certification and Plan of Care for the certification period of 7/14/18 - 9/11/18 evidenced the skilled nurse was to visit 5 hours day , for 7 days a week. There were no	G 710		

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G 710	Continued From page 126 additional tasks written on this document except under Medications: Renadicin 30 cc ml daily irrigation. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/14/18 and completed by Employee M, RN, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment including suprapubic catheter assessment and irrigation, repositioning every 2 hours, pain assessment, skin assessment, trach care, and trach change with fenestrated size 4 uncuffed trach, wound care on right buttock was measured and cleansed with soap and water, patted dry, and dressing applied, patient education with discussion about proper hydration, medications were administered, bladder irrigation completed, shower given, suprapubic and trach dressing removed and new dressings placed. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/15/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, repositioning every 2 hours, pain assessment, skin assessment, trach care, patient education with discussion about proper nutrition and increased protein to promote wound healing, medications were set up, bladder irrigation completed, shower given, trach care, trach collar	G 710		

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G 710	Continued From page 127 changed, new dressing placed and suprapubic dressing care completed. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/16/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, repositioning every 2 hours, pain assessment, skin assessment and wound care, trach care, patient education safety while sitting in wheelchair, and medications provided. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/17/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, and medications provided. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/18/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound	G 710		

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G 710	Continued From page 128 care, trach care, medications set up, and bowel program was completed. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/19/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, medications set up, and trach collar replaced. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/20/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment, trach care, and medication administration. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/21/18 and completed by Employee B, evidenced the nurse had completed approximately 3 hour visit from 8:49 AM - 12 PM. Tasks completed absent of a physician's order were a physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter, pain assessment, skin assessment, trach care,	G 710		

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G 710	Continued From page 129 and medication administration. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/21/18 and completed by Employee B, evidenced the nurse had completed a 1 hour visit from 6:41 PM - 7:51 PM. Tasks completed absent of a physician's order were a physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter, pain assessment, skin assessment, trach care, and medication administration. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/22/18 and completed by Employee B, evidenced the nurse had completed a 1:45 hour visit from 7 AM - 8:45 AM. Tasks completed absent of a physician's order were a physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter, pain assessment, skin assessment, trach care, medication administration, and digital stimulation. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/22/18 and completed by Employee B, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter, pain assessment, skin assessment, and trach care.	G 710		

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A review of an Adult Extended Hour Nursing Flow Sheet dated 7/23/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, and medications set up and administration.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/27/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, medications set up, and trach collar replaced.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/28/18 and completed by Employee M, evidenced the nurse completed a 5 1 / 2 hour visit from 8 am - 1:30 PM. Tasks completed absent of a physician's order: Assessments, Suprapubic catheter change with a 26 French 10 cc catheter, and trach care.

During an interview on 8/16/18 at 12:05 PM, the administrator / director of nursing indicated the record lacked a complete plan of care. The record was lacking orders for the care received.

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7. During an observation of the home visit on 8/13/18 at 9:10 AM, patient #9 was observed to be in a hospital bed with an air mattress. The administrator / director of nursing was observed to assess the patient by taking vital signs and then give the patient a nebulizer treatment with albuterol. The CPT vest treatment was started at approximately 9:25 AM. The CPT treatment was completed at approximately 9:50 AM. Also completed was a nebulizer treatment with the medication albuterol, suctioning of the tracheostomy with a 14 French suction tube and cough assist.

A review of clinical record #9, with a start of care 6/27/18, and principal diagnosis of Quadriplegia, failed to evidence skilled nurse and home health aide visits were provided per the physician ordered plan of care and the record evidenced skilled nursing provided care and services absent of a physician's order as evidenced by:

A review of the Home Health Certification and Plan of Care for the certification period of 6/27/18 - 8/25/18, evidenced the skilled nurse was to visit 60 hours a month. There were no additional tasks written on this document.

A review of the Comprehensive Adult Assessment evidenced a start of care on 6/27/18. This document evidenced a visit from the administrator / director of nursing. The document indicated the patient had a colostomy, suprapubic catheter, and a feeding tube. The document indicated orders for the enteral feedings were boluses 240 CC every 4 hours, performed by family. Tasks performed absent of a physicians order were: A physical assessment, feeding tube site was washed with soap and water and patted

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dry, suprapubic catheter washed with soap and water, rinsed well, and patted dry.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/2/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a 8 hour visit from 8 AM - 4 PM. Tasks completed absent of a physician's order were: A physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with a note: humidification, CPT vest treatment completed, gastrointestinal assessment (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20 (Catheter site is 24 French, 10 cc balloon); reposition every 2 hours; pain assessment; skin assessment; trach ties changed and inner cannula changed; oral and tracheal suctioning completed; and intake recorded.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/9/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a 8 hour visit from 8 AM - 4 PM. Tasks completed absent of a physician's order were: A physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with note concerning humidification, CPT vest X 1/2 hour; Gastrointestinal assessment and appliance change (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20, Catheter site is 24 French, 10 cc balloon; reposition every 2 hours; pain assessment; skin assessment; trach

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G 710	Continued From page 133 ties changed and inner cannula changed; full and passive range of motion completed on upper and lower extremities; leg bag applied to suprapubic catheter draining urine; cough assist with tracheal suctioning; and position changes every 15 minutes. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/16/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a 6 hour visit from 8 AM - 2 PM. Tasks completed absent of a physician's order were: A physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with note concerning humidification, CPT vest X 1/2 hour; gastrointestinal assessment (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20; reposition every 2 hours; pain assessment; skin assessment; trach ties changed and inner cannula changed; humidification removed from tracheotomy #6 Shiley, uncuffed trach, midline secured with Dale straps; pacimuir valve in place to aid with speaking; CPT vest placed on for 15 minute intervals at 14 pressure; range of motion on upper and lower extremities; and feeding of Isosource 240 cc followed by 200 cc of water for flush. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/30/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a visit from 8 AM - 3:15 PM. Tasks completed absent of a physician's order were: A trach ties change and inner cannula change, cough assist used, suctioned trach,	G 710		

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G 710	Continued From page 134 gastric tube feeding given bolus as ordered flushed with 240 cc water, and bed bath given. A review of an Adult Extended Hour Nursing Flow Sheet dated 8/6/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a visit from 8 AM - 4 PM. Tasks completed absent of a physician's order were: Trach ties changed and inner cannula changed; suctioned trach, gastric tube feeding given bolused as ordered, flushed with water; and partial bed bath given. During an interview on 8/13/18 at 10 AM, the administrator / director of nursing indicated the plan of care was not complete.	G 710		
G 718	Communication with physicians CFR(s): 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; This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the Registered Nurse failed to ensure the attending physician was notified in a change in a patient's condition and failed to ensure coordination between the wound clinic physician and the attending physician 2 of 2 active clinical records reviewed (#2) of a patient with skin impairments in a sample of 9. The findings included: 1. The agency policy titled "Service Policies Nursing Service" dated 2015 stated, "Professional Nursing Functions In keeping with	G 718		

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professional standards and depending upon each patient / family need, all or a selection of the following nursing functions may be performed ... coordination of services, including referral to other services as needed."

2. The agency policy titled "Coordination of Services" dated 2015 stated, "To coordinate services in order to provide comprehensive home care, and assure continuity of care ... the staff professional nurse is responsible for the following: a. the professional coordination of all home care services b. ensuring that the established plan of care is carried out c. the ongoing evaluation and assessment of the patient's home care needs. d. Maintaining channels of communication between / among all active caregivers and documents same on patient record e. Scheduling and participation in case conferences."

3. A review of clinical record #1, start of care 12/8/17 included a certification period of 6/6/18 - 8/4/18, with orders for skilled nursing. The clinical record and the following documents failed to evidence the agency staff alerted the physician to patient #1's change of condition and concerns including rash and diarrhea:

A review of a Recertification Follow - up assessment including OASIS elements with Plan of Care / 485 information dated 6/1/18, evidenced this assessment was completed by the administrator / director of nursing and electronically signed on 6/5/18 by the administrator / director of nursing. This assessment document assessment evidenced the patient had a rash in the buttocks and rectal area due to diarrhea. There was no notice of

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G 718	Continued From page 136 physician notification of this change of condition on this document. A HHA visit note dated 6/7/18 and signed by Employee B, HHA, evidenced the following statement, "Groin rash has odor. Perianal rash improving. A HHA visit note dated 6/9/18 and signed by Employee B, HHA, evidenced the following statement, "Rash has improved. Pain when moving ... bowels." A HHA visit note dated 6/13/18 and signed by Employee B, HHA, evidenced the following statement, "Assistance with pericare. Applied protective cream to perianal area ... see improvement on perianal rash." A HHA visit note dated 6/18/18 and signed by Employee B, HHA, evidenced the following statement, "Note redness on perianal area." A HHA visit note dated 7/13/18 and signed by Employee B, HHA, evidenced the following statement, "Perianal not irritated at this time." A HHA visit note dated 7/26/18 and signed by Employee B, HHA, evidenced the following statement, "No pressure wounds. Perianal irritation noted." A HHA visit note dated 7/27/18 and signed by Employee B, HHA, evidenced the following statement, "Note peri area irritation worse. Extra assistance with protective barrier." A HHA visit note dated 7/31/18 and signed by Employee B, HHA, evidenced the patient had	G 718		

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G 718	Continued From page 137 mild perianal irritation. A HHA visit note dated 8/2/18 and signed by Employee B, HHA, evidenced the patient had no perianal irritation at this time. During an interview on 8/16/18 at 10:15 AM, the administrator / director of nursing indicated that Budreau butt cream had been used and this was not in the record or reported to the Registered Nurse by Employee B or other staff. 4. A review of clinical record #2 on 8/16/18, start of care 12/4/17 and principal diagnosis of pressure ulcer of sacral region, failed to evidence documentation that the home health agency coordinated care with the physician ordering wound care (Physician A) for this patient and the patient's attending physician, Physician B. This was further evidenced by the following: A review of a physician order dated 4/30/18, completed by Physician A, evidenced wound care orders for the right sacrum area to be cleansed and pack the wound with absorptive silver and then cover with mepilex border. The peri anal area was to be clean and dry. Also the right elbow was to be protected. The clinical record failed to evidence that this order was coordinated with the patient's attending physician (B). A review of a Home Health Certification and Plan of Care for the certification period of 6/2/18 - 7/31/18 evidenced SN orders for the frequency and duration of 3 hours a day / 3 days a week for 26 weeks and HHA 6 hours a day, for 7 days a week, for 9 weeks. This plan of care failed to evidence any wound care orders. This document was signed by the patient's attending physician,	G 718		

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G 718	Continued From page 138 Physician B, electronically on 6/7/18 and signed by the administrator / director of nursing on 5/31/18. This plan of care failed to evidence that the patient was receiving services from the wound clinic and the agency may accept orders from Physician A at the wound clinic. A review of a physician order written by Physician A, dated 7/23/18, included orders for the right sacrum for dressing order of absorptive silver and mepilex border with cleanses two times a week. The clinical record failed to evidence that this order was coordinated with the patient's attending physician (B). A review of a Home Health Certification and Plan of Care for the certification period of 8/1/18 - 9/29/18 was completed by administrator / director of nursing on 7/31/18. This plan of care was not complete. The patient's attending physician name, Physician B, and contact information was evidenced on this document. This document was signed by the administrator / director of nursing on 7/31/18. This plan of care failed to evidence that the patient was receiving services from the wound clinic and the agency may accept orders from Physician A at the wound clinic. During an interview on 8/16/18 at 10:15 AM, the administrator/ director of nursing indicated the coordination of care was lacking.	G 718		
G 720	Participate in the HHA's QAPI program; CFR(s): 484.75(b)(8) Participation in the HHA's QAPI program; and This ELEMENT is not met as evidenced by: Based on observation, record review and	G 720		

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interview, the agency failed to ensure the skilled professional services participated in a quality assurance program for 1 of 1 agency reviewed.

The findings include:

The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was signed by the administrator / director of nursing.

The agency policy titled "Committees" dated 2015 stated, "As part of the agency's quality assurance program, a committee of professional personnel reviews the results of quality assurance data collection activities at least quarterly. Written minutes of meetings are maintained at the agency's office."

During the Entrance conference on 8/7/18 at 11:10 AM, the administrator / director of nursing indicated the quality assurance program monitored the changes in patient. The focus areas were wound care and infection tracking. She stated, "We follow the guidelines and go by the plans of care." She indicated a concern with the staff keeping up with the charting / documentation.

During an interview on 8/7/18 at 4 PM, the quality assurance / performance program was requested. The administrator / director of nursing indicated the program was missing and could not be found. During this time, the owner indicated the quality assurance binder may have been taken by a past employee, a past office coordinator, who was seen on security monitors taking items from the office. She indicated

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G 720	Continued From page 140 having a lawyer involved with this concern. During an interview on 8/15/18 at 2:10 PM, the administrator / director of nursing indicated the quality assurance had not occurred and that she had been in the role of administrator since June 2018. During an observation on 8/15/18 at 3 PM, the owner was observed coming out of a back room with binders including the quality assurance binder and infection control binder. A review of documents in the quality assurance binder evidenced no documentation of meetings since 2014.	G 720		
G 800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is not met as evidenced by: Based on record review and interview, the home health aide failed to ensure visits were provided per the plan of care for 1 of 4 active records (#2) reviewed, failed to ensure services were not provided absent of a physicians order for 2 of 4 active records (#1, #2) reviewed and failed to ensure the home health aide did not provide services beyond their scope of practice for 1 of 2 active record reviewed (#5) with home health aide only services in a sample of 9. (Employee I) The findings include:	G 800		

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1. A review of the policy titled "2.21 Physician's Plan of Treatment" stated, "A physician prepares a plan of treatment and it is made available to the agency. 2. Physician's orders are established and documented for the health care services the agency provides to those patients who a. are being actively treated by a physician ... b. have a health care need or change in physical status for a diagnosed health care problem c. are admitted to service with the agency ... 4. A physician's plan of treatment must be signed and dated by the attending physician and in the chart within 30 days after the admission to the agency and must include ... the type and frequency of services provided ... specific orders and frequency of visits ... necessary medical equipment."

2. The policy titled "2.2 Home Health Aide Service" dated 2015 stated, "Duties of a home health aide a. The nurse or therapist is to demonstrate or observe the skills involved before they are performed by an HHA, if the HHA does not have documented training or experience in performing the tasks prescribed in the plan of care. It is the legal responsibility of the nurse / therapist responsible for supervision of the HHA to assure that the HHA is competent to render safe care in any given patient situation ... the following patient care procedures are generally not to be performed until they have been demonstrated / observed in each patient situation ... apply simple, non - sterile dressings."

3. A review of clinical record #1, included a plan of care for the certification period of 6/6/18 - 8/4/18, evidence the home health aide conducted care and services absent of a physician order during the certification period of 6/6/18 - 8/4/18,

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as evidenced by the following:

A review of a Recertification Follow - up assessment including OASIS elements with Plan of Care / 485 information dated 6/1/18 with time in of 7 AM and time out of 10 AM, was completed and was electronically signed on 6/5/18 by the administrator / director of nursing. The services to be provided were written as supervisory visits, recertification, and HHA (home health aide) 7 days a week for 26 weeks.

A verbal order for SN and Aide services was completed 6/1/18 by the administrator / director of nursing. The order only contained RN duties and did not evidence frequency, duration of home health aide visits, and the tasks to be completed.

The plan of care for the certification period of 6/6/18 - 8/4/18, failed to evidence home health aide orders. This order was electronically signed by the administrator / director of nursing on 6/5/18.

A HHA visit note dated 6/7/18 and signed by Employee B, LPN, evidenced the patient had 6 hours of care including a bath, personal care, hair care, check pressure areas, nail hygiene, assist with medications, and ambulation assist.

A HHA visit note dated 6/9/18 and signed by Employee B, evidenced the patient had 7 hours of care including a bath, personal care, hair care, check pressure areas, nail hygiene, assist with medications, and ambulation assist.

A HHA visit note dated 6/11/18 and signed by Employee C, HHA, evidenced the patient had 5 hours of care including a bath, assist with bath,

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G 800	Continued From page 143 personal care, hair care, assist with medications, ambulation assist, and mobility assist. A HHA visit note dated 6/13/18, signed by Employee B, evidenced the patient had 6 hours of care including personal care, check pressure areas, oral care, assist with medications, meal preparation, and wash clothes. HHA visit notes dated 6/14/18, 6/20/18, and 7/19/18, signed by Employee C, evidenced the patient had 5 hours of care including a bath and personal care. HHA visit notes dated 6/15/18, 7/13/18, 7/26/18, 7/27/18, and 7/31/18, signed by Employee B, HHA, evidenced the patient had 6 hours of care including a bath and personal care. A HHA visit note dated 6/18/18, signed by Employee B, evidenced the patient had 4 hours of care including a bath and personal care. HHA visit notes dated 7/6/18, 7/9/18, 7/12/18, and 7/17/18, signed by Employee C, evidenced the patient had 6 hours of care including a bath and personal care. A HHA visit note dated 7/16/18, signed by Employee D, HHA, evidenced the patient had 6 hours of care including a bath and personal care. A HHA visit note dated 7/18/18, signed by Employee D, evidenced the patient had 6 hours of care including a bath and personal care. A HHA visit note dated 8/2/18, signed by Employee B, evidenced the patient received 8 hours of personal care and a bath and other care.	G 800		

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4. A review of clinical record #2, with a start of care 12/4/17, principal diagnosis of pressure ulcer of sacral region, failed to evidence home health aide visits were provided per the physician ordered plan of care and the record evidenced HHA conducted care and services absent of a physician's order as evidenced by:

A review of a Home Health Certification and Plan of Care for the certification period of 6/2/18 - 7/31/18, evidenced HHA orders 6 hours a day, 7 days a week, 9 weeks. The plan of care failed to evidence the tasks that would be completed by the staff. This document was electronically signed by the administrator / director of nursing on 5/31/18 and electronically signed by the physician on 6/7/18.

A review of home health aide visits notes evidenced visits occurred on 6/2/18 (Week 1), 6/10/18, 6/13/18, 6/14/18, 6/15/18, 6/16/18 (week 3), 6/17/18, 6/18/18, 6/19/18, 6/21/18, 6/22/18, 6/23/18 (week 4), no visits between 6/14/18 to 6/30/18 (week 5), no visits between 7/1/18 to 7/7/18 (week 6), no visits between 7/8/18 to 7/12/18 and 7/14/18, but 1 visit on 7/13/18 (week 7), no visits between 7/15/18 to 7/17/18, 7/19/18, and 7/21/18 but two visits on 7/18/18 and 7/20/18 (week 8), no visits from 7/22/19 to 7/24/18, 7/26/18, and 7/28/18 but two visits on 7/25/18 and 7/27/18 (week 9). The agency failed to ensure home health aide visits were provided 7 days a week.

5. The personnel file document of Employee I, Home Health Aide, dated 9/26/17 and signed by this employee stated, "Must have successfully completed a HHA competency evaluation training

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G 800	Continued From page 145 program which conforms to state requirements." During a review of record #5 on 8/16/18, it was evidenced that the home health aide, Employee I, was completing dressing changes for a peg tube on patient #5. Employee I was not competencied on this task. This was further evidenced by the following: 1. A review of a document titled "Personnel Care Assistant Skills check list" for Employee I, Home Health Aide, evidenced this employee was not competent to change a peg tube dressing. This check list was dated 9/17/17. This competency check list was completed by past employee, Employee H, RN. 2. A review of HHA visit notes dated 6/13/18, 6/14/18, 6/15/18, 6/18/18, 6/19/18 6/20/18, 6/21/18, 6/22/18, 6/25/18, 6/26/18, 6/27/18, 6/28/18, 6/29/18, 7/2/18, 7/3/18, 7/5/18, 7/6/18, 7/7/18, 7/9/18, 7/10/18, 7/11/18, 7/12/18, 7/13/18, 7/16/18, 7/17/18, 7/18/18, 7/19/18, 7/20/18, 7/23/18, 7/24/18, 7/25/18, 7/26/18, 7/27/18, 7/30/18, 8/1/18, 8/2/18 completed by Employee I evidenced the bandage on the G Tube was changed at each visit. During an interview on 8/16/18 at 12:35 PM, the administrator/ director of nursing indicated that Employee I was not competent in the task of dressing changes.	G 800		
G 804	Aides are members of interdisciplinary team CFR(s): 484.80(g)(4) Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a registered nurse or other	G 804		

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G 804	Continued From page 146 appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures. This ELEMENT is not met as evidenced by: Based on record review and interview, the home health aide failed to notify the case manager of changes in the patient's condition in 1 of 3 active clinical records reviewed (#1) with home health aide only services in a sample of 9. The findings include: A review of a policy dated 7/6/18 titled "Home Health Aide Documentation" stated, "Home Health Aides are to document care / services provided on the visit record and be in concurrence with care plan. Purpose 1. Provides documentation of care / services provided during the home health aide visit. 2. Provides documentation of the home health aide's observations during the visits and evidence of client's progress or demise. Special instruction: 1. The home health aide is responsible for reporting any changes in the client's condition to the supervising nurse, such as the following but not limited to a). increased pain, reddened area to skin, foul smelling urine, falls, fatigue, edema. 2. The original documentation is to be completed and filed in the chart within 14 days of the visit." A review of clinical record #1, start of care 12/8/17 included a certification period of 6/6/18 - 8/4/18, failed to evidence the home health aide alerted the case manager to patient #1's change of condition and concerns including rash and diarrhea. The following notes failed to evidence communication documentation that the case manager was aware of these changes found in the record.	G 804		

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A HHA visit note dated 6/7/18 and signed by Employee B, HHA, evidenced the following statement, "Groin rash has odor. Perianal rash improving.

A HHA visit note dated 6/9/18 and signed by Employee B, HHA, evidenced the following statement, "Rash has improved. Pain when moving ... bowels."

A HHA visit note dated 6/13/18 and signed by Employee B, HHA, evidenced the following statement, "Assistance with pericare. Applied protective cream to perianal area ... see improvement on perianal rash."

A HHA visit note dated 6/18/18 and signed by Employee B, HHA, evidenced the following statement, "Note redness on perianal area."

A HHA visit note dated 7/13/18 and signed by Employee B, HHA, evidenced the following statement, "Perianal not irritated at this time."

A HHA visit note dated 7/26/18 and signed by Employee B, HHA, evidenced the following statement, "No pressure wounds. Perianal irritation noted."

A HHA visit note dated 7/27/18 and signed by Employee B, HHA, evidenced the following statement, "Note peri area irritation worse. Extra assistance with protective barrier."

A HHA visit note dated 7/31/18 and signed by Employee B, HHA, evidenced the patient had mild perianal irritation.

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G 804	Continued From page 148 A HHA visit note dated 8/2/18 and signed by Employee B, HHA, evidenced the patient had no perianal irritation at this time. During an interview on 8/16/18 at 10:15 AM, the administrator / director of nursing indicated that Budreau butt cream had been used and this was not in the record or reported to the Registered Nurse by Employee B or other staff.	G 804		
G 808	Onsite supervisory visit every 14 days CFR(s): 484.80(h)(1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit. This ELEMENT is not met as evidenced by: Based on record review and interview, the Registered Nurse failed to ensure aide supervisory visit were conducted no less frequently every 14 days for 1 of 2 records with skilled nursing and home health aide services (#3) in a sample of 9 The findings include The agency policy "Home Health Supervision" revised 7/13/18 stated, "The agency shall provide home health aide services under the direction and supervision of a Registered Professional Nurse when personal services are indicated and	G 808		

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G 808	Continued From page 149 ordered by the physician. The frequency of supervision will be in response to Medicare / Medicaid regulations, agency policy and other state or federal requirements ... 3. Direct supervision of home health aide services will be completed at least every 60 days or per regulations." A review of clinical record #3, evidenced the patient was receiving skilled nursing and home health aide services. The clinical record failed to evidence timely supervision of a home health aide within every 14 days. A skilled nurse supervisory visit was completed at a Recertification assessment visit on 6/8/18 and then the next supervisory visit was documented on 8/8/18 for a visit that was completed on 7/12/18. During an interview on 8/16/18 at 12:30 PM, the administrator/ director of nursing stated, "I was in the neighborhood" in reference to the 8/7/18 supervisory visit note.	G 808		
G 940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and	G 940		

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G 940	Continued From page 150 controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. This CONDITION is not met as evidenced by: Based on record review, interview, and observation, the agency failed to ensure the governing body was involved with the ongoing quality assurance program (see G 942); the administrator failed to organize and direct the agency's ongoing functions (see G 948); the Clinical Manager failed to ensure a system was in place for tracking referrals to ensure patients are assessed within 48 hours (see G 964); and the Clinical Manager failed to ensure visits were provided per the plan of care, failed to ensure treatment and services were not provided absent of a physicians order, failed to ensure the plans of care contained frequency and duration of visits specific to the certification period, and failed to ensure the plan of care contained all required elements including the tasks to be provided and the goals to achieve. (see G 968). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation: 484.105 Condition: Organization and Administration of Services.	G 940		
G 942	Governing body CFR(s): 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of	G 942		

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G 942	Continued From page 151	G 942		

the agency's budget and its operational plans, and its quality assessment and performance improvement program.
This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the agency failed to ensure the governing body was involved with the ongoing quality assurance program for 1 of 1 agency.

The findings include:

The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was signed by the administrator/ director of nursing.

The agency policy titled "Committees" dated 2015 stated, "As part of the agency's quality assurance program, a committee of professional personnel reviews the results of quality assurance data collection activities at least quarterly. Written minutes of meetings are maintained at the agency's office."

During the Entrance conference on 8/7/18 at 11:10 AM, the administrator/ director of nursing indicated the quality assurance program monitored the changes in patient. The focus areas were wound care and infection tracking. She stated, "We follow the guidelines and go by the plans of care." She indicated a concern with the staff keeping up with the charting/ documentation.

During an interview on 8/7/18 at 4 PM, the quality assurance/ performance program was requested. The administrator / director of nursing indicated the program was missing and could not be found.

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G 942	Continued From page 152 During this time, the owner indicated the quality assurance binder may have been taken by a past employee, a past office coordinator, who was seen on security monitors taking items from the office. She indicated having a lawyer involved with this concern. During an interview on 8/15/18 at 2:10 PM, the administrator/ director of nursing indicated the quality assurance program meetings had not occurred and that she had been in the role of administrator since June 2018. During an observation on 8/15/18 at 3 PM, the owner was observed coming out of a back room with binders including the quality assurance binder and infection control binder. A review of documents in the quality assurance binder evidenced no documentation of meetings since 2014.	G 942		
G 948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the administrator failed to organize and direct the agency's ongoing functions for 1 of 1 agency. The findings include: The agency policy titled "Administration Delegation Policy" dated 7/6/18 stated, "The administration shall be responsible for all operations on a day to day basis. This was	G 948		

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G 948	Continued From page 153	G 948		

signed by the administrator / director of nursing.

Regarding closed office on a Monday on 8/6/18

During an observation on 8/6/18 at 10:34 AM, it was observed the office door was locked and no one answered the knock. The lights were off inside the office. A sign on the door evidenced the agency was closed on Mondays.

A review of state department documents evidenced the agency was open Monday and Tuesdays from 9:00 - 4:00 PM, closed Wednesdays, and open Thursdays and Fridays from 10 AM - 4 PM.

A review of a letter dated June 1, 2018 stated, "To Whom It May Concern: TMG Home Health Care Inc. has changed the hours of operation: Monday closed, Tuesday - Friday - 9 AM - 4 PM. This was signed by the administrator / director of nursing.

During an interview on 8/7/18 at 10:35 AM, the owner indicated a letter was sent to the state about 2 weeks ago with the administrative changes and the changes of hours.

On 8/7/18, the Indiana State Department of Health database was reviewed and it was confirmed that the department had not received any documents/ letter indicating the change in hours of operation.

Regarding Patient Rights

The administrator failed to ensure patient and/ or patient representatives received an accurate notice of the Patient Bill of Rights, Authorization,

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G 948	Continued From page 154 Agreement, and Acknowledgement Forms, and Notice of Privacy Rights before the initiation of treatment. (See G 410) The administrator failed to ensure the patients / patient representatives received the home health agency administrator's name, business address, and business phone number in order to receive complaints. (see G 414) The administrator failed to ensure written notice of the patient's rights and responsibilities was provided within 4 business days of the initial assessment. (see G 422) The administrator failed to ensure the patient / patient representative had the right to be informed of the HHA's policy for transfer and discharge. (see G 452) The administrator failed to ensure the home health agency arranged a safe and appropriate transfer to another care entities when the needs of the patient exceeded the HHA's capabilities. (see G 454) The administrator failed to ensure the patient's physician and the legal representative was informed in advance of a discharge. (see G 464) The administrator failed to investigate the complaint made by a patient's legal representative. (see G 478) The administrator failed to document the existence of a complaint made by the patient's legal representative and the resolution. (see G 484)	G 948		

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G 948	Continued From page 155 In regards to Comprehensive Assessments The administrator failed to ensure the goals were patient specific and based on the comprehensive assessment findings. (see G 530) The administrator failed to ensure the Registered Nurse accurately identify and assess a second wound on a patient. (see G 544 and G 706) The administrator failed to ensure the Registered Nurse completed a comprehensive assessment and discharge summary with the patient's progress in meeting the care plan goals. (see G 550) In regards to Care planning, Coordination, and Quality of Care and Skilled Professional Services The administrator failed to ensure visits were provided per the plan of care and failed to ensure treatment and services were not provided absent of a physicians order. (see G 572 and G 708) The administrator failed to ensure the plans of care contained frequency and duration of visits specific to the certification period, failed to ensure the plan of care contained all required elements including the tasks to be provided and the goals to achieve. (see G 574 and G 710) The administrator failed to ensure all patient care orders were recorded on the plan of care. (see G 576) The administartor failed to promptly notify the physician of changes in the patient's condition. (see G 590 and G 718)	G 948		

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G 948	Continued From page 156 The administrator failed to ensure the clinical record contained documentation that the patient's physician and the legal representative was informed in advance of a discharge. (see G 598) The administrator failed to ensure communication with all physicians involved in the plan of care. (see G 602 and G718) The administrator failed to ensure the Registered Nurse coordinated the patient's care with a DME (durable medical equipment) company. (see G 608) In regards to Quality Assessment/ Performance Improvement and Skilled Professional Services The administrator failed to ensure the quality assurance program was capable of showing measurable improvement and must measure, analyze and track quality indicators, including adverse patient events, and other aspects of performance that enable the agency to assess processes of care, HHA services, and operations. (see G 642) The administrator failed to ensure the quality assurance program utilized quality indicator data, including measures derived from OASIS and other relevant data, to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement. (see G 644) The administrator failed to ensure the quality assurance program must include program activities. (see G 646) The administrator failed to ensure the quality	G 948		

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G 948	Continued From page 157	G 948		

assurance program focused on high risk, high volume, or problem prone areas. (see G 648)

The administrator failed to ensure the quality assurance program considered the incidence, prevalence and severity of problems. (see G 650)

The administrator failed to ensure the quality assurance program led to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patient. (see G 652)

The administrator failed to ensure Performance improvement activities tracked adverse patient events, analyzed their causes, and implemented preventive actions. (see G 654)

The administrator failed to ensure actions aimed at performance improvement occurred and were sustained. (see G 658)

The administrator failed to ensure the governing body was involved with the ongoing quality assurance program. (see G 660)

The administrator failed to ensure skilled professional services participated in a quality assurance program. (see G 720)

In regards to Infection Prevention and Control

The administrator failed to follow infection control guidelines. (see G 682)

The administrator failed to maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable

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G 948	Continued From page 158 diseases that is an integral part of the HHA's quality assessment and performance improvement program. (see G 684) In regards to Home Health Aide Services The administrator failed to ensure home health aide visits were provided per the plan of care, failed to ensure home health aide services were not provided absent of a physicians order, and failed to ensure the home health aide did not provide services beyond their scope of practice. (see G 800) The administrator failed to ensure home health aides notify the case manager of changes in the patient's condition. (see G 804) The administrator failed to ensure the Registered Nurse aide supervisory visit were conducted no less frequently every 14 days. (see G 808) In regards to Clinical Records The administrator failed to ensure the goals were patient specific and based on the comprehensive assessment findings. (see G1016 The administrator failed to ensure the Registered Nurse completed a discharge assessment and discharge summary with the patient's progress in meeting the care plan goals. (see G 1022) The administrator failed to ensure clinical records were completed and signed the date services were rendered. (see G 1024)	G 948		
G 964	Coordinate referrals; CFR(s): 484.105(c)(3)	G 964		

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Coordinating referrals;
This ELEMENT is not met as evidenced by:
Based on record review and interview, the Clinical Manager failed to ensure a system was in place for tracking referrals to ensure patients are assessed within 48 hours for 5 of 6 active patients whose clinical records were reviewed (#1 - #4, #9) in a sample of 9.

The findings include:

1. Review of the policy titled "2.7 Guidelines for Assessment" dated 2015 stated, " ... 2. The initial assessment will be made within 48 hours .... "

2. Review of the clinical record of patient #1, start of care date of 12/8/17, failed to evidence a physician order start of care and/ or referral documentation to determine if the initial assessment/ start of care was conducted within the 48 hours.

3. Review of the clinical record of patient #2, start of care date of 12/4/17, failed to evidence a physician order start of care and/ or referral documentation to determine if the initial assessment/ start of care was conducted within the 48 hours.

4. Review of the clinical record of patient #3, start of care date of 12/13/17, failed to evidence a physician order start of care and/ or referral documentation to determine if the initial assessment/ start of care was conducted within the 48 hours.

5. Review of the clinical record of patient #4,

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G 964	Continued From page 160 start of care date of 11/16/17, failed to evidence a physician order start of care and/ or referral documentation to determine if the initial assessment/ start of care was conducted within the 48 hours. During an interview on 8/16/18 at 12:06 PM, the administrator / director of nursing when questioned about the referral stated, "Word of mouth through [name of other home health agency]." 6. Review of the clinical record of patient #9 start of care date of 6/27/18, failed to evidence a physician order start of care and/ or referral documentation to determine if the initial assessment/ start of care was conducted within the 48 hours.	G 964		
G 968	Assure implementation of plan of care CFR(s): 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. This ELEMENT is not met as evidenced by: Based on record review and interview, the Clinical Manager failed to ensure visits were provided per the plan of care for 3 of 6 active records (#2, #4, #9), failed to ensure treatment and services were not provided absent of a physicians order for 5 of 6 active records reviewed (#1, #2, #3, #4, #9), failed to ensure the plans of care contained frequency and duration of visits specific to the certification period, and failed to ensure the plan of care contained all required elements including the tasks to be provided and the goals to achieve for 5 of 6 active records reviewed (#1 - #4, #9) in a sample of 9.	G 968		

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The findings include:

1. A review of the policy titled "2.21 Physician's Plan of Treatment" stated, "A physician prepares a plan of treatment and it is made available to the agency. 2. Physician's orders are established and documented for the health care services the agency provides to those patients who a. are being actively treated by a physician ... b. have a health care need or change in physical status for a diagnosed health care problem c. are admitted to service with the agency ... 4. A physician's plan of treatment must be signed and dated by the attending physician and in the chart within 30 days after the admission to the agency and must include ... the type and frequency of services provided ... specific orders and frequency of visits ... necessary medical equipment."

2. The agency policy titled "2.26 Service Policies Nursing Service" stated, "Nursing services shall mean the services provided by nurses within the practice of the profession of nursing ... The provision of nursing services includes the performance, direction or supervision of health care tasks pursuant to a plan of care and consistent with an existing medical regimen."

3. The agency policy titled "2.23 Services provided ... Registered Nurses provide quality nursing care by the visit or the shift. The highly trained professionals follow the physician's orders, monitor and instruct the patient regarding their care ... The licensed practical nurse provides assigned care under the direction of a RN. 3. All RN's are licensed in Indiana and follow all regulations and standards of practice required by the state. 4. All LPNs are licensed in Indiana and

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follow all regulations and standards of practice required by the state ... Home health aides ... these services are provided in accordance with the plan of care."

In regards to the Plan of Care

4. A review of clinical record #1, included a plan of care for the certification period of 6/6/18 - 8/4/18, evidence the home health aide conducted care and services absent of a physician order during the certification period of 6/6/18 - 8/4/18, as evidenced by the following:

A review of a Recertification Follow - up assessment including OASIS elements with Plan of Care / 485 information dated 6/1/18 with time in of 7 AM and time out of 10 AM, was completed and was electronically signed on 6/5/18 by the administrator / director of nursing. The services to be provided were written as supervisory visits, recertification, and HHA (home health aide) 7 days a week for 26 weeks.

A verbal order for SN and Aide services was completed 6/1/18 by the administrator / director of nursing. The order only contained RN duties and did not evidence frequency, duration of home health aide visits, and the tasks to be completed.

The plan of care for the certification period of 6/6/18 - 8/4/18, failed to evidence home health aide orders. This order was electronically signed by the administrator / director of nursing on 6/5/18.

A HHA visit note dated 6/7/18 and signed by Employee B, LPN, evidenced the patient had 6 hours of care including a bath, personal care, hair

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care, check pressure areas, nail hygiene, assist with medications, and ambulation assist.

A HHA visit note dated 6/9/18 and signed by Employee B, evidenced the patient had 7 hours of care including a bath, personal care, hair care, check pressure areas, nail hygiene, assist with medications, and ambulation assist.

A HHA visit note dated 6/11/18 and signed by Employee C, HHA, evidenced the patient had 5 hours of care including a bath, assist with bath, personal care, hair care, assist with medications, ambulation assist, and mobility assist.

A HHA visit note dated 6/13/18, signed by Employee B, evidenced the patient had 6 hours of care including personal care, check pressure areas, oral care, assist with medications, meal preparation, and wash clothes.

HHA visit notes dated 6/14/18, 6/20/18, and 7/19/18, signed by Employee C, evidenced the patient had 5 hours of care including a bath and personal care.

HHA visit notes dated 6/15/18, 7/13/18, 7/26/18, 7/27/18, and 7/31/18, signed by Employee B, HHA, evidenced the patient had 6 hours of care including a bath and personal care.

A HHA visit note dated 6/18/18, signed by Employee B, evidenced the patient had 4 hours of care including a bath and personal care.

HHA visit notes dated 7/6/18, 7/9/18, 7/12/18, and 7/17/18, signed by Employee C, evidenced the patient had 6 hours of care including a bath and personal care.

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A HHA visit note dated 7/16/18, signed by Employee D, HHA, evidenced the patient had 6 hours of care including a bath and personal care.

A HHA visit note dated 7/18/18, signed by Employee D, evidenced the patient had 6 hours of care including a bath and personal care.

A HHA visit note dated 8/2/18, signed by Employee B, evidenced the patient received 8 hours of personal care and a bath and other care.

5. A review of clinical record #2, with a start of care 12/4/17, principal diagnosis of pressure ulcer of sacral region, failed to evidence skilled nurse and home health aide visits were provided per the physician ordered plan of care and the record evidenced SN and HHA conducted care and services absent of a physician's order as evidenced by:

A review of a Home Health Certification and Plan of Care for the certification period of 6/2/18 - 7/31/18, evidenced skilled nursing orders for 3 hours a day, 3 days a week, for 26 weeks and HHA orders 6 hours a day, 7 days a week, 9 weeks. The plan of care failed to evidence the tasks that would be completed by the staff. This document was electronically signed by the administrator / director of nursing on 5/31/18 and electronically signed by the physician on 6/7/18.

A review of home health aide visits notes evidenced visits occurred on 6/2/18 (Week 1), 6/10/18, 6/13/18, 6/14/18, 6/15/18, 6/16/18 (week 3), 6/17/18, 6/18/18, 6/19/18, 6/21/18, 6/22/18, 6/23/18 (week 4), no visits between 6/14/18 to 6/30/18 (week 5), no visits between 7/1/18 to

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G 968	Continued From page 165 7/7/18 (week 6), no visits between 7/8/18 to 7/12/18 and 7/14/18, but 1 visit on 7/13/18 (week 7), no visits between 7/15/18 to 7/17/18, 7/19/18, and 7/21/18 but two visits on 7/18/18 and 7/20/18 (week 8), no visits from 7/22/19 to 7/24/18, 7/26/18, and 7/28/18 but two visits on 7/25/18 and 7/27/18 (week 9). The agency failed to ensure home health aide visits were provided 7 days a week. A review of a skilled nurse visit note dated 6/5/18, 6/9/18, 6/12/18, and 6/16/18, evidenced Employee B visited the patient for 2 hours each day. Tasks completed were nursing assessment, vital signs, dressing change for wounds on sacral, coccyx area and right elbow area. Suprapubic catheter assessed. A review of a physician order dated 6/18/18, completed by the physician, evidenced wound care orders to cleanse all wounds, pack the right sacrum wound with absorptive silver and cover with mepilex border; the peri anal area was to be clean and dry, and the right elbow was to be protected. A review of a physician order dated 6/20/18, and completed by the administrator / director of nursing, evidenced the home health aide was to visit 5 hours a day, 7 days a week, for 26 weeks and skilled nursing 2 hours a day, 3 days / week, for 26 weeks per new PA (prior authorization). The order failed to be specific to the remaining certification period between 6/20/18 to 7/31/18 and failed to include the tasks to be provided by the skilled nurse and home health aide A review of a skilled nurse visit note dated 6/21/18, 6/27/18, 6/29/18, 7/2/18, 7/6/18, 7/9/18,	G 968		

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G 968	Continued From page 166 evidenced Employee B visited the patient. Tasks completed absent of a physician's order were nursing assessment, vital signs, and suprapubic catheter monitoring. Employee B visited the patient for 2 hourson 6/29, 7/2, 7/9/18 and less than 2 hours on 7/6/18. A review of a skilled nurse visit note dated 6/25/18, evidenced Employee B visited the patient. Tasks completed absent of a physicians order were nursing assessment, vital signs, and suprapubic catheter monitoring. The suprapubic catheter was changed using a 26 French / 30 cc (cubic centimeter) bulb. A review of a skilled nurse visit note dated 7/18/18, evidenced Employee B visited the patient for 2 hours. Tasks completed absent of a physician's order were nursing assessment, vital signs, and suprapubic catheter monitoring. The note failed to evidence if dressing changes had been conducted. A review of a skilled nurse visit note dated 7/20/18, evidenced Employee B visited the patient for 2 hours. Tasks completed absent of a physician's order were nursing assessment, vital signs, the wound on the sacral area was measured, and suprapubic catheter monitoring. The note failed to evidence if dressing changes had been conducted. A review of a skilled nurse visit note dated 7/23/18, evidenced Employee B visited the patient for 1.5 hours. Tasks completed absent of a physicians order were nursing assessment, vital signs, the wound on the sacral area was measure, and suprapubic catheter monitoring.	G 968		

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A review of a physician order dated 7/23/18, included orders for the right sacrum for dressing order of absorptive silver and mepilex border with cleanses two times a week. Only 1 visit was conducted during this week (7/22/18 to 7/28/18).

A review of a skilled nurse visit note dated 7/27/18, 7/30/18, evidenced Employee B visited the patient for 2 hours. Tasks completed absent of a physician's order were nursing assessment, vital signs, the wound on the sacral area was measured, and suprapubic catheter monitoring was completed. The note failed to evidence if dressing changes had been conducted.

A review of a physician order dated 7/31/18, signed by the administrator / director of nursing, evidenced HHA was to visit the patient 5 hours a day, 7 days a week, for 26 weeks for assistance with ADLs' and IADLs, housekeeping, laundry, grocery shopping, errands and meal prep. The skilled nurse was to visit 2 hours daily, 3 days a week for wound care, nursing assessment, medication monitoring, catheter care and changes and coordination of care.

A Recertification follow up assessment including OASIS elements with plan of care / 485 information dated 7/31/18 and completed by the administrator / director of nursing on 7/31/18. The wounds were measured. The wounds were cleansed with sterile saline and then packed with colloidal silver and nystatin cream and dressed with mepilex border. The document stated,"The wound was contaminated with fecal matter, areas were thoroughly washed with soap and water, prior to dressing change to decrease contamination." The deviation of treatment was conducted absent of a physician's order.

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G 968	Continued From page 168 6. A review of clinical record #3, with a start of care 12/13/17, and principal diagnosis of essential hypertension, evidenced the skilled nurse conducted care and services absent of a physician's order as evidenced by: Review of the plan of care for the certification period of 6/11/18 - 8/9/18, failed to evidence the agency was to set up the patient's medications or checking blood sugar results. Review of A skilled nursing visit note completed by Employee B dated 6/16/18, evidenced the nurse set up the patient's medications. A note stated, "Medications dispensed as ordered." Review of a skilled nursing visit note completed by Employee B dated 6/23/18 and 6/30/18, evidenced the nurse set up the patient's medications for the next week. During an interview on 8/16/18 at 12 noon, the administrator / director of nursing indicated the medication set up was not on the plan of care. 7. A review of clinical record #4, with a start of care 11/16/17, and principal diagnosis of Quadriplegia, failed to evidence skilled nurse visits were provided per the physician ordered plan of care and the record evidenced SN conducted care and services absent of a physician's order as evidenced by: A review of the Home Health Certification and Plan of Care for the certification period of 7/14/18 - 9/11/18 evidenced the skilled nurse was to visit 5 hours day , for 7 days a week. There were no additional tasks written on this document except	G 968		

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G 968	Continued From page 169 under Medications: Renadicin 30 cc ml daily irrigation. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/14/18 and completed by Employee M, RN, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment including suprapubic catheter assessment and irrigation, repositioning every 2 hours, pain assessment, skin assessment, trach care, and trach change with fenestrated size 4 uncuffed trach, wound care on right buttock was measured and cleansed with soap and water, patted dry, and dressing applied, patient education with discussion about proper hydration, medications were administered, bladder irrigation completed, shower given, suprapubic and trach dressing removed and new dressings placed. A review of an Adult Extended Hour Nursing Flow Sheet dated 7/15/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, repositioning every 2 hours, pain assessment, skin assessment, trach care, patient education with discussion about proper nutrition and increased protein to promote wound healing, medications were set up, bladder irrigation completed, shower given, trach care, trach collar changed, new dressing placed and suprapubic	G 968		

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dressing care completed.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/16/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, repositioning every 2 hours, pain assessment, skin assessment and wound care, trach care, patient education safety while sitting in wheelchair, and medications provided.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/17/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, and medications provided.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/18/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, medications set up, and bowel

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program was completed.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/19/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, medications set up, and trach collar replaced.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/20/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment, trach care, and medication administration.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/21/18 and completed by Employee B, evidenced the nurse had completed approximately 3 hour visit from 8:49 AM - 12 PM. Tasks completed absent of a physician's order were a physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter, pain assessment, skin assessment, trach care, and medication administration.

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A review of an Adult Extended Hour Nursing Flow Sheet dated 7/21/18 and completed by Employee B, evidenced the nurse had completed a 1 hour visit from 6:41 PM - 7:51 PM. Tasks completed absent of a physician's order were a physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter, pain assessment, skin assessment, trach care, and medication administration.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/22/18 and completed by Employee B, evidenced the nurse had completed a 1:45 hour visit from 7 AM - 8:45 AM. Tasks completed absent of a physician's order were a physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter, pain assessment, skin assessment, trach care, medication administration, and digital stimulation.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/22/18 and completed by Employee B, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter, pain assessment, skin assessment, and trach care.

A review of an Adult Extended Hour Nursing Flow

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Sheet dated 7/23/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, and medications set up and administration.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/27/18 and completed by Employee M, indicated tasks were completed absent of a physician's order: A physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment of suprapubic catheter and irrigation, pain assessment, skin assessment and wound care, trach care, medications set up, and trach collar replaced.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/28/18 and completed by Employee M, evidenced the nurse completed a 5 1 / 2 hour visit from 8 am - 1:30 PM. Tasks completed absent of a physician's order: Assessments, Suprapubic catheter change with a 26 French 10 cc catheter, and trach care.

During an interview on 8/16/18 at 12:05 PM, the administrator / director of nursing indicated the record lacked a complete plan of care. The record was lacking orders for the care received.

8. During an observation of the home visit on

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8/13/18 at 9:10 AM, patient #9 was observed to be in a hospital bed with an air mattress. The administrator / director of nursing was observed to assess the patient by taking vital signs and then give the patient a nebulizer treatment with albuterol. The CPT vest treatment was started at approximately 9:25 AM. The CPT treatment was completed at approximately 9:50 AM. Also completed was a nebulizer treatment with the medication albuterol, suctioning of the tracheostomy with a 14 French suction tube and cough assist.

A review of clinical record #9, with a start of care 6/27/18, and principal diagnosis of Quadriplegia, failed to evidence skilled nurse and home health aide visits were provided per the physician ordered plan of care and the record evidenced skilled nursing provided care and services absent of a physician's order as evidenced by:

A review of the Home Health Certification and Plan of Care for the certification period of 6/27/18 - 8/25/18, evidenced the skilled nurse was to visit 60 hours a month. There were no additional tasks written on this document.

A review of the Comprehensive Adult Assessment evidenced a start of care on 6/27/18. This document evidenced a visit from the administrator / director of nursing. The document indicated the patient had a colostomy, suprapubic catheter, and a feeding tube. The document indicated orders for the enteral feedings were boluses 240 CC every 4 hours, performed by family. Tasks performed absent of a physicians order were: A physical assessment, feeding tube site was washed with soap and water and patted dry, suprapubic catheter washed with soap and

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water, rinsed well, and patted dry.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/2/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a 8 hour visit from 8 AM - 4 PM. Tasks completed absent of a physician's order were: A physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with a note: humidification, CPT vest treatment completed, gastrointestinal assessment (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20 (Catheter site is 24 French, 10 cc balloon); reposition every 2 hours; pain assessment; skin assessment; trach ties changed and inner cannula changed; oral and tracheal suctioning completed; and intake recorded.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/9/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a 8 hour visit from 8 AM - 4 PM. Tasks completed absent of a physician's order were: A physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with note concerning humidification, CPT vest X 1/2 hour; Gastrointestinal assessment and appliance change (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20, Catheter site is 24 French, 10 cc balloon; reposition every 2 hours; pain assessment; skin assessment; trach ties changed and inner cannula changed; full and

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passive range of motion completed on upper and lower extremities; leg bag applied to suprapubic catheter draining urine; cough assist with tracheal suctioning; and position changes every 15 minutes.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/16/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a 6 hour visit from 8 AM - 2 PM. Tasks completed absent of a physician's order were: A physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with note concerning humidification, CPT vest X 1/2 hour; gastrointestinal assessment (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20; reposition every 2 hours; pain assessment; skin assessment; trach ties changed and inner cannula changed; humidification removed from tracheotomy #6 Shiley, uncuffed trach, midline secured with Dale straps; pacimuir valve in place to aid with speaking; CPT vest placed on for 15 minute intervals at 14 pressure; range of motion on upper and lower extremities; and feeding of Isosource 240 cc followed by 200 cc of water for flush.

A review of an Adult Extended Hour Nursing Flow Sheet dated 7/30/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a visit from 8 AM - 3:15 PM. Tasks completed absent of a physician's order were: A trach ties change and inner cannula change, cough assist used, suctioned trach, gastric tube feeding given bolus as ordered

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flushed with 240 cc water, and bed bath given.

A review of an Adult Extended Hour Nursing Flow Sheet dated 8/6/18 and completed by the administrator / director of nursing, evidenced the nurse had completed a visit from 8 AM - 4 PM. Tasks completed absent of a physician's order were: Trach ties changed and inner cannula changed; suctioned trach, gastric tube feeding given bolused as ordered, flushed with water; and partial bed bath given.

During an interview on 8/13/18 at 10 AM, the administrator / director of nursing indicated the plan of care was not complete.

In regards to the Plan of Care include the required elements

9. A review of clinical record #1, the plan of care for the certification period of 6/6/18 - 8/4/18 failed to evidence home health aide frequency, duration of visits specific to the certification period and failed to evidence the tasks to be provided by the home health aide. This was evidenced by the following:

A review of a document titled "Recertification Follow - up assessment" that included OASIS elements with Plan of Care / 485 information dated 6/1/18, with time in of 7 AM and time out of 10 AM, was completed and was electronically signed on 6/5/18 by the administrator / director of nursing. The document indicated the services to be provided were supervisory visits, recertification, and the HHA (home health aide) visits 7 days a week for 26 weeks.

A verbal order dated 6/1/18, completed by the

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administrator / director of nursing, evidenced an order for only RN duties and did not evidence frequency and duration of home health aide visits as well as the tasks to be provided.

The plan of care for the certification period of 6/6/18 - 8/4/18, failed to evidence the frequency and duration of home health aide visits specific to the certification period and the tasks to be provided by the home health aide. This plan of care was electronically signed by the administrator / director of nursing on 6/5/18.

Review of HHA visit notes dated 6/7, 6/9, 6/11, 6/13, 6/14, 6/15, 6/18, 6/20, 7/6, 7/9, 7/12, 7/13, 7/16, 7/17, 7/18, 7/19, 7/27, 7/31, and 8/2/18 indicated specific ADL's/ personal care including assistance with medications, meal preps, and washing clothes were provided by a licensed practical nurse and home health aide from 4 to 8 hours on these days.

10. A review of clinical record #2, the plan of care for the certification period of 6/6/18 - 8/4/18 failed to contain all the required elements, failed to evidence skilled nursing and home health aide frequency and duration of visits specific to the certification period, and the tasks to be provided by skilled nursing and the home health aide. This was evidenced by the following:

A physician order dated 4/30/18, and completed by the physician, evidenced wound care orders to cleanse all wounds, pack the right sacrum wound with absorptive silver and cover with mepilex border; the peri anal area was to be clean and dry, and the right elbow was to be protected.

A verbal order dated 5/30/18, evidenced the

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patient was to have skilled nursing and aide services. There was no frequency and duration of the visits or tasks for the staff to complete.

A physician order dated 5/31/18, and completed by the administrator / director of nursing, evidenced the skilled nurse was to visit 3 hours a day, 3 days a week, for 26 weeks for wound care, medication monitoring, health monitoring, suprapubic catheter changes and care and bowel program 3 times a week by digital disimpaction. The home health aide was to visit for assistance with ADLs and IADLs, supervision, meal preparation, housekeeping, laundry, grocery shopping, errands, assistance with appointments, and arranging specialized transportation. The order failed to include a duration and frequency of skilled nursing and home health aide visits specific to the 6/2/18 to 7/31/18 certification period.

A review of a Home Health Certification and Plan of Care for the certification period of 6/2/18 - 7/31/18, evidenced skilled nursing orders for 3 hours a day, 3 days a week, for 26 weeks and HHA orders 6 hours a day, 7 days a week, 9 weeks. The plan of care failed to evidence the tasks that would be completed by the staff as indicated on the 5/31/18 physician's order and failed to evidence goals, rehabilitation potential, and discharge plans, and the mental status, DME (durable medical equipment) and supplies, safety measures, activities permitted, and allergies sections were all blank. This document was electronically signed by the administrator / director of nursing on 5/31/18 and electronically signed by the physician on 6/7/18.

A review of home health aide visit notes dated

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G 968	Continued From page 180 6/2, 6/3, 6/4, 6/5, 6/6, 6/7, 6/8, 6/9, 6/10, 6/13, 6/14, 6/15, 6/16, 6/17, 6/18, 6/19, 6/21, 6/22, 6/23, 7/13, 7/18, 7/20, 7/25, and 7/27/18, indicated HHAs completed tasks such as bathing, personal care, hair care, catheter care, record output / input, inspect / reinforce dressing, ambulation assist and other tasks. A review of skilled nurse visit notes evidenced visits occurred on 6/5, 6/9, 6/12, 6/16, 6/21, 6/25, 6/27, 6/29, 7/2, 7/6, 7/9, 7/18, 7/20, 7/23, 7/27, and 7/30/18, and indicated nursing assessments, vital signs, dressing change for wounds on sacral, coccyx area and right elbow area, wound measurements, suprapubic catheter assessments, suprapubic catheter was changed using a 26 French / 30 cc (cubic centimeter) bulb. A review of the "Recertification Follow - up assessment" including OASIS elements with plan of care / 485 dated 7/31/18 and completed by the administrator / director of nursing on 7/31/18, indicated the wounds were measured. A review of a Home Health Certification and Plan of Care for the certification period of 8/1/18 - 9/29/18 was completed by administrator/ director of nursing on 7/31/18. This plan of care was not complete and failed to include the DME/ supplies, safety measures, and goals. The orders evidenced a SN frequency and duration 2 hours a day 3 days a week for 26 weeks and HHA orders for 5 hours a day, 7 days a week for 26 weeks. A review of skilled nurse visit noted dated 8/1, 8/4, 8/6, and 8/9/18, indicated nursing assessments, vital signs, dressing change for wounds on sacral, coccyx area and right elbow	G 968		

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area, wound measurements, suprapubic catheter assessments, and catheter was irrigated with 60 cc of normal saline.

11. A review of clinical record #3 with a start of care 12/13/17 and principal diagnosis of essential hypertension, the plan of care for the certification period of 6/11/18 - 8/9/18 failed to evidence the skilled nurse was to set up the patient's medications. This was evidenced by the following:

Review of A skilled nursing visit notes, completed by Employee B dated 6/16, 6/23, and 6/3018, evidenced the nurse set up the patient's medications for the following week. A note on 6/16/18 stated, "Medications dispensed as ordered."

During an interview on 8/16/18 at 12 noon, the administrator / director of nursing indicated the medication set up was not on the plan of care.

12. A review of clinical record #4 with a start of care 11/16/17 and principal diagnosis of Quadriplegia, the plan of care for the certification period of 7/14/18 - 911/18 failed to evidence the tasks to be completed by the skilled nurse. This was evidenced by the following:

A review of the Home Health Certification and Plan of Care for the certification period of 7/14/18 - 9/11/18 evidenced the skilled nurse was to visit 5 hours day/ 7 days a week. There were no additional tasks written on this document except under Medications: Renadicin 30 cc ml daily irrigation.

A review of an Adult Extended Hour Nursing Flow

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Sheet dated 7/14, 7/15, 7/16, 7/17, 7/18, 7/19, 7/20, 7/21 (x2 visits), 7/22 (x2 visits), 7/23, 7/27, and 7/28/18, indicated physical assessment including vital signs, nutritional assessment, neurological assessment, cardiovascular assessment, respiratory assessment, gastrointestinal assessment, genitourinary assessment including suprapubic catheter assessment and irrigation, repositioning every 2 hours, pain assessment, skin assessment, trach care, and trach change with fenestrated size 4 uncuffed trach, wound care on right buttock was measured and cleansed with soap and water, patted dry, with dressing applied, patient education with discussion, medications were administered, bladder irrigated, shower given, suprapubic and trach care, trach collar changed and new dressings placed, bowel program was being completed and suprapubic catheter change with a 26 French 10 cc catheter was completed.

During an interview on 8/16/18 at 12:05 PM, the administrator / director of nursing indicated the record lacked a complete plan of care. The record was lacking orders for the care received.

13. During an observation of the home visit on 8/13/18 at 9:10 AM, patient #9 was observed to be in a hospital bed with an air mattress. The administrator / director of nursing was observed to assess the patient by taking vital signs and then give the patient a nebulizer treatment with albuterol. The CPT vest treatment was started at approximately 9:25 AM. The CPT treatment was completed at approximately 9:50 AM. Also completed was a nebulizer treatment with the medication albuterol. Suctioning of the tracheostomy with a 14 French suction tube and cough assist.

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G 968	Continued From page 183 A review of clinical record #9 with a start of care 6/27/18 and principal diagnosis of Quadriplegia, evidenced the Comprehensive Adult Assessment dated 6/27/18. The document indicated the administrator / director of nursing conducted the admission and indicated a physical assessment was completed, the patient had colostomy, suprapubic catheter, and a feeding tube. The document indicated orders for the enteral feedings was a bolus 240 CC every 4 hours to be performed by family. The document indicated the site was washed with soap and water and patted dry and the suprapubic catheter was washed with soap and water, rinsed well, patted dry. Review of the plan of care for the certification period of 6/27/18 - 8/25/18, evidenced the skilled nurse was to visit 60 hours a month. The plan of care failed to contain all the required elements such a as safety measures, DME and supplies, nutritional requirements, and goals/ rehabilitation potential / discharge plans box were blank, failed to include size of suprapubic catheter, colostomy care, gastric tube care and failed to evidence the tasks to be provided by skilled nursing. This was evidenced by the following: A review of an Adult Extended Hour Nursing Flow Sheet dated 7/2,7/9, 7/30, and 8/6/18, evidenced the administrator/ director of nursing conducted a physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with a note: humidification, CPT vest treatment completed, gastrointestinal assessment (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm	G 968		

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G 968	Continued From page 184 soapy H20; reposition every 2 hours; pain assessment; skin assessment; trach ties changed and inner cannula changed; oral and tracheal suctioning completed; intake recorded; leg bag applied to suprapubic catheter draining urine; full and passive range of motion completed on upper and lower extremities; bed bath given; A review of an Adult Extended Hour Nursing Flow Sheet dated 7/16/18 and completed by the administrator / director of nursing, indicated a physical assessment, nutritional assessment (the patient receives nothing by mouth); neurological assessment, cardiovascular assessment, respiratory assessment with note concerning humidification, CPT vest X 1/2 hour; Gastrointestinal assessment (patient has a colostomy); genito - urinary assessment with suprapubic catheter site cleansed with warm soapy H20; reposition every 2 hours; pain assessment; skin assessment; Trach ties changed and inner cannula changed; Humidification removed from tracheotomy #6 Shiley, uncuffed trach, midline secured with Dale straps; Pacimuir valve in place to aid with speaking; CPT vest placed on for 15 minute intervals at 14 pressure. Range of motion on upper and lower extremities; Feeding of Isosource 240 cc followed by 200 cc of water for flush. During an interview on 8/13/18 at 10 AM, the administrator / director of nursing indicated the plan of care was not complete.	G 968		
G1008	Clinical records CFR(s): 484.110 Condition of participation: Clinical records.	G1008		

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G1008	Continued From page 185 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) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically. This CONDITION is not met as evidenced by: Based on record review, the home health agency failed to ensure the goals were patient specific and based on the comprehensive assessment findings (see G1016; failed to ensure the Registered Nurse completed a discharge assessment and discharge summary with the patient's progress in meeting the care plan goals (see G 1022); and failed to ensure clinical records were completed and signed the date services were rendered (see G 1024). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation: 484: 110 Condition: Clinical Records.	G1008		
G1016	Goals in the patient's plans of care CFR(s): 484.110(a)(3) Goals in the patient's plans of care and the patient's progress toward achieving them; This ELEMENT is not met as evidenced by: Based on record review, the home health agency failed to ensure the goals were patient specific	G1016		

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G1016	Continued From page 186	G1016		

and based on the comprehensive assessment findings in 2 of 6 active clinical records reviewed (#2 and #9).

The findings include:

1. The agency policy titled "Comprehensive Assessment" dated 7/11/18 stated, "Plan of care will be developed from the comprehensive assessment plan with information from client, family, and physician."

2. The agency policy titled "2.8 Care Plan" dated 2015 stated, "4. Determine of the nature of the home care services needed. To determine this ... Based upon the goals to be achieved, what actions must be taken to achieve them?"

3. Clinical record review on 8/13/18 and 8/16/18 for patient #2, start of care 12/4/17, evidenced a document titled "Home Health Certification and Plan of Care" with a primary diagnosis of pressure ulcer of sacral region stage 2, for the certification period of 6/2/18 - 7/31/18, and signed by administrator / director of nursing on 5/31/18. The physician signed this document on 6/7/18. This document had an area subtitled "Goals / Rehabilitation potential / discharge plans that was blank. The assessment below evidenced comprehensive assessment findings that did not lead to the addition of goals on the plan of care.

A review of the "Recertification Follow up Assessment including OASIS elements with plan of care / 485 information evidenced the following: Integumentary Status evidenced the patient had a Stage II sacrum / coccyx pressure ulcer, skin turgor poor. Measurements of the pressure ulcer were length 7 centimeters, width 5 centimeters,

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G1016	Continued From page 187 and depth 4.5 centimeters. This assessment evidenced the patient had chronic pain issues with above knee amputation sites that were presently at a "3" level (0 -10), with aching, throbbing and with the back with present level "2" and worst pain gets at a "9". This pain was shooting, aching. The patient had a chronic productive cough described as a smoker's cough and COPD (chronic obstructive pulmonary disease) due to smoking. Patient last smoked 5/31/18. Elimination status evidenced the patient had a urinary catheter due to neurogenic bladder due to paralysis below the waist level. The catheter was described as a Suprapubic catheter 26 French 10 cc ml (cubic centimeter milliliter) with amber colored urine with sediment. The elimination status was one to three times weekly with bowel incontinence and removal of feces with digital stimulation and digital removal of feces. This document stated, "Laxative ... reglan, docusate sodium ... Incontinence products ... chux, adult diapers ... Mental status ... awake and alert. Oriented X 3. Needs prompting when stressed or unfamiliar in the situation. Paranoid behaviors noted - states trusts no one to set up medications but [him / her] self ... impaired decision making as evidenced by trying to do self disimpaction of stool without assistance ... Neuro ... Spasms: abdomen, back, bladder ... Paraplegia Needs assist with transfers, ADLs [activities of daily living], IADLs [instrumental activities of daily living]; needs assistance with leaving the home, specialized transportation. Musculoskeletal status: bilateral amputations above the knees ... Patient is wheel chair bound, needs assistance for transfers from bed to chair, uses regular w / c [wheelchair] in apartment and electric w / c when out in the community with assistance and for safety ... Fall Risk assessment	G1016		

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G1016	Continued From page 188	G1016		

tool ... patient is at risk for falls ... Psychosocial Is the patient able to communicate their needs?" Yes was checked. The sections were blank about the patient's report about their progress towards their personal goals and the HHA measurable goals. Potential goals were listed as SN (skilled nurse) gastrointestinal goals, SN genitourinary goals: will be free of S / S (signs / symptoms) of UTI (urinary tract infection) SN Integumentary Goals including healing of wounds and safe effective wound care teaching / education / understanding of patient.

3. Clinical record review on 8/16/18 for patient #9, start of care 6/27/18, evidenced a document titled "Home Health Certification and Plan of Care" with a primary diagnosis of quadriplegia C - 5 - C-7, for the certification period of 6/2718 - 8/25/18, and signed by administrator / director of nursing on 6/28/18. The physician signed this document on 7/11/18. This document had an area subtitled "Goals / Rehabilitation potential / discharge plans that was blank. The assessment below evidenced comprehensive assessment findings that did not lead to the addition of goals on the plan of care:

A review of the "Comprehensive Adult Assessment including SOC / ROC OASIS elements with plan of care / 485 information dated 6/27/18 and signed by administrator / director of nursing and patient caregiver on this date evidenced the following: Cardiopulmonary: Cardiac pacemaker in left chest. Tracheostomy with history of adult respiratory distress syndrome. Intermittent treatments: albuterol updrafts; Enteral feedings - access device. Gastrostomy, bolus, 240 cc every 4 hours and 200 cc every 4 hours water, Dressing site wash

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G1016	Continued From page 189 with soap and water, pat dry; Elimination status, incontinence: suprapubic catheter placement due to urinary incontinence and past skin issues ... Type 26 French / 10 CC balloon date last changed 6/7/18, disease management problems: colostomy and suprapubic catheter - wash with soap and water, rinse well, pat dry; neuro/ emotional / behavioral status, quadriplegia with spasticity, history of a traumatic brain injury date 12/6/16 - needs full assistance with all activities of daily living, all IADLs; Musculoskeletal: Quadriplegia , fracture C 5 neck fracture, hand grips weak; How does the patient's condition affect their functional activity and safety? Needs assistance with all activities. Full assistance with ADLs and IADLs? Transfers, toileting, gastrostomy feedings. The document stated, "Potential Goals: SN Patient Centered Goal: Maintain current health status start effective date: 6/27/18; SN Respiratory Goals: Pt / Pcg [patient caregiver] will demonstrate proper suction technique ... proper use of respiratory treatments ... demonstrate trach care start effective date 6/27/18, SN Cardiovascular goals: Pt / PCG will state understanding of measures to manage to manage disease and identify S / S to report; SN Gastrointestinal goals: Enteral feeding tube site will remain intact without S / S infection. Start effective: 6/27/18, pt. will be able to tolerate feedings without complications. Start effective date 6/27/18."	G1016		
G1022	Discharge and transfer summaries CFR(s): 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge	G1022		

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G1022	Continued From page 190	G1022		

from the HHA (if any) within 5 business days of the patient's discharge; or
(ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or
(iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.
This ELEMENT is not met as evidenced by:
Based on record review and interview, the agency failed to ensure the Registered Nurse completed a discharge assessment and discharge summary with the patient's progress in meeting the care plan goals for 1 of 3 closed records reviewed (#8).

The findings include:

The policy titled "2.17 Discharge / Transfer Policy" dated 2015 stated, "The agency will maintain a process for the ongoing assessment of each patient's continuing care and discharge planning needs ... at the visit before this discharge, the patient and the physician will be notified of the discharge ... all patients will receive discharge instructions regarding his / her ongoing care ... prior to discharge the patient, the attending physician shall be notified. A written discharge summary which shall be prepared within 30 days of discharge will be made available to the physician with a copy maintained in the record. The discharge summary will include: A. The reason for discharge B. The patient's physical and psychosocial status at the time of discharge. C. A summary of the care and services provided. D. Patient's progress toward desired goals. E.

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G1022	Continued From page 191 Instructions and referrals provided to the patient." A review of clinical record #8, start of care 4/25/16, for the certification period of 8/18/17 - 10/16/17, diagnosis of physical abuse complicating pregnancy, failed to evidence that a discharge assessment and discharge summary had been completed after a discharge was requested by the agency due to the caregiver's refusal to sign staff visit notes. The discharge plans on the plan of care did not evidence goals the patient was to progress to. This was further evidenced by the following: A review of the record evidenced a Comprehensive Adult Assessment dated 8/14/17. This note evidenced a visit was completed by Employee H, RN, and signed on this date. Under discharge plans, Employee H checked box "other" and stated, "When services are no longer needed or can be provided by another source." Review of the home health certification and plan of care for the certification period of 8/18/17 - 10/16/17, included under the goals / rehabilitation potential / discharge plans this statement, "When services are no longer needed or can be provided by another source." There were no other goals on this plan of care. A review of the record evidenced home health visits completed on 8/18/17, 8/19/17, 8/21/17, 8/22/17, 8/23/18, 8/24/17, 8/25/17, 8/26/17, 8/28/17, 8/29/17, 8/30/17, 8/31/17, 9/1/17, 9/2/17, 9/5/17, 9/6/17, 9/7/17, 9/8/17, 9/9/17, 9/11/17, 9/12/17, 9/13/17, 9/14/17, 9/15/17, 9/18/17, 9/19/17, 9/20/17, 9/21/17, 9/22/17. A supervisory nurse visit was completed on 8/18/17.	G1022		

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G1022	Continued From page 192	G1022		

A review of the record evidenced a home health visit with no tasks completed on 10/2/17. The note was signed by Employee K, Home Health Aide. A note on this note under patient's signature stated, "Power of attorney verbalized [illegible words after this.]" This was electronically signed by Employee K on 10/19/17.

During record review, the only communication about the discharge in the notes was dated 9/28/17 from Employee L, RN, which stated, "Please complete note on 8/14/17. Need to use that note to discharge patient as of 9/23/17." This review occurred 8/14/18 - 8/16/18.

During an interview on 8/14/18 at 3:20 PM, the owner of the agency indicated the patient representative for patient #8 refused to sign the visit notes. The patient representative wanted all of the records that he/ she signed and would not sign without receiving copies. The patient was grabbing aides inappropriately. The owner stated, "[Patient #8] was abusive and would grab ... aides." The owner indicated talking to the past administrator and told the past administrator that the patient representative needed to sign the visit notes. She stated, "I told [the patient representative] we would not service [him / her] if she would not sign the visit notes."

During an interview on 8/15/18 at 9:40 AM, the patient representative of patient #8 indicated refusing to sign the agency visit notes because the agency refused to give him/ her copies and complaining to the agency and case manager and the agency discharging the patient because of her/ his refusal to sign the visit notes. The patient representative also indicated complaining to the agency when the aide did not show up or

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G1022	Continued From page 193 called in sick. A new aide, Employee K, HHA, was assigned after the complaint. The patient representative recalled complaining to the owner and administrator due to Employee K's smoking and the smell of the smoke in the home. During an interview on 8/15/18 at 10:18 AM, Person C, the case manager for patient #8, indicated billing concerns with the agency. She indicated there was a complaint filed and the administrator and owner of the agency were aware of the complaint. This pertained to the patient's discharge from the agency. A letter dated September 26, 2017 stated, "[Patient #8] ... Date of Service: 5/26/17 - 11/24/17, To Whom It May Concern: This letter is to confirm that [Patient #8] has been discharged from our agency as of September 23, 2017 due to noncompliance of caregiver to inform [agency] of changes of [patient #8] physician; also caregiver's refusal to sign in order to be compliant with home health aide services. If you have any further questions or concerns regarding this matter please contact our office. Thank you. [past administrator, director of nursing] RN BSN, administrator During an interview on 8/14/18 at 3:45 PM, the administrator / director of nursing indicated the patient went to a group home. The administrator/ director of nursing indicated the discharge oasis and summary were not found in the record.	G1022		
G1024	Authentication CFR(s): 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and	G1024		

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G1024	Continued From page 194	G1024		

appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.
This STANDARD is not met as evidenced by:
Based on record review and interview, the agency failed to ensure clinical records were completed and signed the date services were rendered for 7 of 9 records reviewed (#1 - #7) in a timely manner.

The findings include:

1. A review of a policy dated 8/16/18 and titled "Policy for Charting Corrections" for Nursing, HHA, ATTC" stated, "Daily observations of charting by nursing personnel and home health aides. Charting must be completed on the computer and turned in. When submitted it will be checked by billing and skilled nurse for accuracy, misspellings, accurate wording and appropriate actions will be monitored and sent back to the staff members for corrections if appropriate. This was signed by the administrator / director of nursing on 8/16/18.

2. A review of a policy dated 7/12/18 and titled "Entering Late Charting" revised 7/12/18 stated, "Entering late charting must be completed promptly when indicated. Purpose: entering late charting is to provide accurate and up to date information on clients. 2. Entering late charting to provide documentation of services / care provider. Special instruction: On a clinical note document current date, time, and enter in narrative area - [late entry for fill in date]."

3. A review of a policy dated 7/6/18 titled "Home

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Health Aide Documentation" stated, "Home Health Aides are to document care / services provided on the visit record and be in concurrence with care plan. Purpose 1. Provides documentation of care / services provided during the home health aide visit. 2. Provides documentation of the home health aide's observations during the visits and evidence of client's progress or demise. Special instruction: 1. The home health aide is responsible for reporting any changes in the client's condition to the supervising nurse, such as the following but not limited to a). increased pain, reddened area to skin, foul smelling urine, falls, fatigue, edema. 2. The original documentation is to be completed and filed in the chart within 14 days of the visit."

4. A review of a policy titled "2.10 Submission of Clinical Record Visits" dated 2015 stated, "All initial assessments must be submitted within 48 hours. All nursing visits must be submitted within 7 days of services and must be filed in the patient's chart within 14 days of the visit. Home health aide notes must be submitted once weekly with their time sheets ... all discharges must be completed and filed within 30 days of discharge."

5. A review of clinical record #1 evidenced an aide supervision note not completed in a timely manner. This was further evidenced by the following:

A review of skilled nurse supervisory visit note with a date of 7/13/18 and completed by the administrator / director of nursing evidenced a completion date of 8/7/18 at 12:31 PM.

During an interview on 8/16/18 at 10:05 AM, the administrator / director of nursing indicated this

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G1024	Continued From page 196 had been done on paper but not in the electronic record. She also indicated that her tablet went down that day. 6. A review of clinical record #2 evidenced visit notes not completed in a timely manner. This was further evidenced by the following: A review of a Comprehensive Adult Nursing Assessment including SOC (start of care)/ ROC (resumption of care) OASIS elements with CMS 485 Information evidenced a start of care date of 12/4/17 and a visit date on this document of 12/26/17. The administrator / director of nursing electronically signed this document on 12/28/17 and 12/29/17. Also signing this document was Employee F, billing employee on 1/10/18. A review of AM HHA (home health aide) visit note with a date of 6/6/2007, was signed by patient #2 and Employee E, HHA on 8/13/18. A review of HHA visit note with a date of 6/2/18, was signed by patient #2 and Employee E on 6/18/18. A review of the AM HHA visit note with a date of 6/2/18, was signed by patient #2 and Employee E on 8/13/18. A review of HHA visit note with a date of 6/5/18, and signed by patient #2 and Employee E on 6/18/18. A review of AM HHA visit note with a date of 6/7/18, was signed by patient #2 and Employee E on 8/13/18. A review of AM HHA visit note with a date of	G1024		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G1024	Continued From page 197 6/22/18, was signed by patient #2 and Employee E on 8/13/18. A review of a skilled nursing visit note with a date of 6/29/18, and completed by Employee B, Licensed Practical Nurse (LPN), evidenced the note was not completed until 7/10/18 by this employee. A review of a skilled nurse supervisory visit dated 7/13/18, evidenced this supervisory visit was not completed until 8/7/18. This form was completed by the administrator / director of nursing. A review of a skilled nursing visit note with a date of 7/18/18, and completed by Employee B, evidenced the note was not completed until 8/2/18 by this employee. 7. A review of clinical record #3 failed to evidence timely documentation. This was evidenced by the following: A review of PM HHA visit note with a date of 4/27/18, was signed by patient #3 and Employee D on 7/17/18. A review of skilled nurse supervisory visit note for the supervision, with a date of 7/12/18, was completed by the administrator / director of nursing, evidenced a completion date of 8/8/18 at 10:05 AM. A review of AM HHA visit note with a date of 6/10/18, was signed by patient #3 and Employee D on 7/17/18. 8. A review of clinical record #4 failed to evidence timely documentation. This was evidenced by the	G1024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K070	A. BUILDING ______ B. WING ______	C 08/16/2018

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G1024	Continued From page 198	G1024		

following:

A review of a document titled "Comprehensive Adult Assessment" which included SOC / ROC OASIS elements with CMS 485 Information, date of visit of 11/16/17 and start date of 11/16/17, evidenced this document was signed by the administrator / director of nursing on 11/28/17.

A review of an adult extended hour nursing flow sheet dated 7/21/18, and completed by Employee B, was signed on 8/7/18.

A review of an adult extended hour nursing flow sheet dated 7/22/18, and completed by Employee B, was signed this document on 8/8/18 and the patient signed on 8/9/18.

9. A review of clinical record #5 failed to evidence timely documentation. This was evidenced by the following:

A review of a skilled nurse supervisory visit dated 7/31/18, evidenced this supervisory visit was not completed until 8/7/18. This form was completed by the administrator / director of nursing.

During an interview on 8/16/18 at 12:30 PM, the administrator / director of nursing stated, "I was in the neighborhood."

10. A review of clinical record #6, start of care 1/18/18, failed to evidence timely documentation. This was evidenced by the following:

A review of a Comprehensive Adult assessment with a visit date of 1/18/18, was signed by the administrator / director of nursing on 1/25/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K070	A. BUILDING ______ B. WING ______	C 08/16/2018

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G1024	Continued From page 199 11. A review of clinical record #7, start of care 2/23/18, failed to evidence timely documentation. This was evidenced by the following: A review of a Comprehensive Adult assessment with a visit date of 2/23/18, was signed by the administrator / director of nursing on 3/1/18. 12. During an interview on 8/16/18 at 11:50 AM, the administrator / director of nursing indicated home health aides and other staff were not turning in documentation in a timely manner.	G1024		