STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157581	A. BUILDING B. WING	11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED HOME HEALTHCARE INC	1947 HARDER CT STE B, SCHERERVILLE, IN, 46375

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	This visit was a recertification, re-licensure, and emergency preparedness survey. The survey visit took place from 11/17/2021 to 11/23/2021. Facility ID: 011121 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings.	G0000		2022-03-01
N0000	Initial Comments This visit was a re-licensure survey of a home health agency. The survey visit took place from 11/17/2021 to 11/23/2021. Facility ID: 011121	N0000		2022-03-01
E0000	Initial Comments	E0000		2022-03-01

	This visit was a recertification, re-licensure, and emergency preparedness survey. The survey visit took place from 11/17/2021 to 11/23/2021. Facility ID: 011121 At this Emergency Preparedness survey Assured Home Health Care was found to be in compliance with 42 CFR 484.102 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies.			
G0534	Patient's needs 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Record review on 11/23/2021 evidenced an agency policy titled, "HOME HEALTH PATIENT BILL OF RIGHTS", revised May 2010, which stated, " ... POLICY Each patient will be an active, informed participant in his / her plan of care ... The Patient Bill of Rights statement defines the right of the patient to: ... Be informed in advance about care to be furnished and of any changes in the care to be furnished. E. Be advised in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished...."	G0534	The administrator and the clinical manager have reviewed and are aware of CFR 484.55(c)(4), agency policies titled “HOME HEALTH PATIENT BILL OF RIGHTS” and “CARE PLANNING PROCESS”. Case management conference on 11/23/2021 was discussed with RN H, the needs of patient #1, functional impairment and need of assistance with patient #1’s family involvement, and the need for further education with person A for the availability home health services of patient #1. On RN H’s next visit with patient #1 on 11/29/2021, spouse still refused home health aide services as person	2021-11-29

	Record review evidenced an agency policy titled, "CARE PLANNING PROCESS", revised May 2010, which stated, " ... At the time of the initial assessment, the clinician, along with other involved disciplines, will develop the patient plan of care based upon the patient's identified needs and will review it with the patient and family / caregiver ... All clinicians will consider the conclusions of initial and ongoing assessments in their care planning process, including but not limited to: A. Individualized patient needs and resultant problems related to care, functional status, and family / caregiver support system...." Clinical record review on 11/19/2021, for patient #1, start of care 6/21/2021, certification period 10/19/2021 to 12/17/2021, primary diagnosis of Polyosteoarthritis [a disease where four or more joints in the body become painful and inflamed], evidenced an agency document titled, OASIS D1 [the patient-specific, standardized assessment used in Medicare home health care] Recertification , dated 10/18/2021, and signed by RN [registered nurse] H. This assessment had a subsection titled, Functional Status , which indicated the patient had poor balance, joint stiffness, muscle weakness, unsteady gait, and was a high risk for falls. The functional assessment indicated the patient required the assistance of another person for dressing, bathing, toileting, and transferring. Clinical record review evidenced an		A, family member of patient #1, responded that her daughters come regularly and as needed to take care of the patient's needs. At recertification of home health services on 12/13/2021, person A continued to refuse home health aides services as daughters still continue to help daily care needs of patient #1. And on 12/27/2021 patient's family member, person A, agreed to receive home health services, but wanted to start the next week. A physician's order on 01/03/2022 was made for home health aide services to start. An agency staff meeting was held on 12/03/2021 to discuss the comprehensive assessment and individualized needs of the patient with the availability of home health aide services especially when a patient is observed to have functional impairment and the need of home health aide services would benefit. Who is responsible: The administrator and clinical manager. Implementation Date: 11/29/2021	

	agency document titled, Physical Therapy Assessment / Evaluation , dated 11/12/2021, and signed by PT [physical therapist] E. The assessment had a subsection titled, LIVING SITUATION , which stated, & Patient lives with [family member] who is also having medical issues &. . The assessment had a subsection titled, Functional Assessment Comments , which stated, Comments Patient presents with impaired strength, balance and endurance issues required assistance to maintain safety with transfers, ADLs [activities of daily living] and gait with decreased safety awareness. Clinical record review evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 11/18/2021. The plan of care failed to evidence home health aide services. During an interview on 11/18/2021, at 11:04 a.m., person A, family member of patient #1, stated, They re [the home health agency] supposed to get me someone to help me wash [patent #1] up, but I haven t heard anything . During an interview on 11/23/2021, at 10:06 a.m., the administrator indicated patient #1 required assistance with performing the activities of daily living, but was not receiving home health aide services because person A refused them. When informed of the findings, the administrator indicated the agency would look into providing a home		Monitoring Process: The comprehensive assessment is performed on every patient at the time of admission and is continued to be used to note the patient's functional assessment and for any impairments, and family or caregiver involvement in accomplishing the patient's activities of daily living. Ongoing assessments may be performed at anytime during the patient episode and care needs of the patient and/or family/caregiver involvement. Coordination with field staff is to be ongoing and as needed for any updates especially for patient care needs.	

	health aide for patient #1. 17-14-1(a)(1)(B)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. 1. Record review on 11/23/2021, evidenced an agency policy titled, "CARE PLANNING PROCESS", revised May 2010, which stated, " ...	G0574	The administrator and clinical manager reviewed CFR 484.60(a)(2)(i-xvi) and agency policy titled, “CARE PLANNING PROCESS”, revised May 2010. An office staff meeting was held on 11/23/2021 to discuss this issue on the plan of care and physical therapy plan of care that DME and supplies should be assessed in the home and also on the plan of care. PT G was also discussed with this matter. The plan of care must include the frequency for every medication. An office staff meeting was held on 11/23/2021 to discuss this, and RN for patient #4 that performed the start of care on 10/01/2021 was also discussed about this matter. A full staff meeting on 12/03/2021 was held to further discuss this to meet this regulation and agency policy. Who is responsible: The administrator and clinical	2021-11-23

	initiated within five (5) days of start of care and updated at least every 60 days or as the patient's condition warrants ... All clinicians involved in the patient's care, either directly or indirectly, will contribute to the plan of care ... The clinical plan of care includes: ... I. Safety measures ... K. Medications and treatments ... Specific procedures to be performed by therapies, including amount, frequency, and duration. M. Supplies and equipment required ... P. Frequency and duration of visits...." 2. Clinical record review on 11/19/2021, for patient #3, start of care 11/15/2021, certification period 11/15/2021 to 1/13/2021, primary diagnosis of Type 2 diabetes mellitus [a chronic disease when the body is not able to take sugar into its cells and use it for energy, resulting in a build up of extra sugar in the bloodstream] with foot ulcer [wound], evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". The plan of care had a subsection titled, "DME [durable medical equipment] and Supplies", which stated, "DME: Elevated toilet seat, Grab bars, Tub / Shower Bench...."		manager. Implementation Date: 11/23/2021 Monitoring Process: The office staff has been discussed with office staff to ensure the regulation and agency policy have been met. There shall be a quarterly review of patient charts with physical therapy and to ensure physical therapy plans of care in the DME and supplies are documented properly to the patient’s care needs. There shall also be a medication profile review with patient charts to ensure all patient medications have the route, dose, and frequency.	

Clinical record review evidenced an agency document titled, "Physical Therapy Plan of Care with Full Evaluation", signed by PT [physical therapist] G. The Physical Therapy Plan of Care had a subsection titled, "DME and Supplies", which failed to evidence an elevated toilet seat, grab bars, and a tub / shower bench.

During an interview on 11/23/2021, at 10:22 a.m., the administrator indicated all plans of care should include all equipment in the home, used for or by the patient. The administrator indicated the Physical Therapy Plan of care failed to include all equipment in the home, used for or by the patient.

3. Clinical record review for patient #4, start of care 10/1/2021, certification period 10/1/2021 to 11/29/2021, primary diagnosis of urinary tract infection, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE". The plan of care had a subsection titled, "Medications", which stated, " ... AQUAPHOR TOPICAL OINTMENT [a skin protectant]. Massage coccyx [tailbone] area Topical....". The plan of care failed to evidence the frequency for use of Aquaphor.

During an interview on 11/22/2021, at 10:28 a.m., the clinical supervisor indicated all medication orders should include the name of the medication as well as the route, dose, and frequency of the medication.

During an interview on 11/22/2021, at

	10:29 a.m., the administrator indicated the clinician might have forgotten because it was an over-the-counter medication, but the frequency should have been included. 17-13-1(a)(1)(B)(D)			
G0576	All orders recorded in plan of care 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. 1. Record review on 11/23/2021, evidenced an agency policy titled, CARE PLANNING PROCESS , revised May 2010, which stated, PURPOSE To provide clinical direction to the clinicians providing direct patient care. POLICY A written plan of care will be initiated within five (5) days of start of care and updated at least every 60 days or as the patient s condition warrants & The clinical plan of care includes: & Medications and treatments & Specific procedures to be performed & Changes in the plan of care will be noted with the following documentation: & Verbal orders &. 2. Clinical record review on 11/19/2021, for patient #4, start of care 10/1/2021, certification period 10/1/2021 to 11/29/2021, primary diagnosis of urinary tract infection, evidenced a document titled, Medical Authorization / Verbal Order , from infusion pharmacy C, dated 11/9/2021, and signed by nurse practitioner B. This order stated, & Meropenem [an intravenous antibiotic] 1 gm [gram] / 100 ml [milliliter] NS [normal saline] & IV [intravenous] every 8 hrs & LAB ORDER(S) SN [skilled nurse] TO DRAW CBC W/DIFF [complete blood count with differential] [a measure of the number of red blood cells, white blood cells, and platelets in the blood, including the different types of white blood cells], BUN [blood urea nitrogen] [a blood test that helps measure kidney function], AND SCR [serum creatinine] [a blood test that helps measure kidney function] WEEKLY ON MONDAYS. FAX RESULTS TO [nurse practitioner B] & and [infusion pharmacy C] &. Clinical record review evidenced an agency document titled, Physician Order , dated 11/5/2021, signed by RN [Registered Nurse] C and physician D. The order stated, & New wound order: Sacral area [tailbone area] to be cleansed with saline, pat dry, apply foam dressing. Left scrotum to be cleansed with saline and pat dry, open to air. SN to monitor wound status per visit &. Clinical record review evidenced an agency document	G0576	All patient care orders, including verbal orders, shall be recorded in the plan of care, the administrator and clinical manager have reviewed CFR 484.60(a)(3) and the agency policy. The current process of receiving all physician orders, including verbal orders, have been reviewed in the agency. Once an order is received from the physician, the order is then entered into the patient's electronic clinical record as a new order and a plan of care is then created for that order to document the appropriate discipline's intervention(s) with corresponding goal(s) in the plan of care. The electronic clinical record lists each order in the Plan of Care of Summary that has each order with specific details and is dated as appropriate when it was received by the agency. The agency shall review its current processes, and inform	2021-11-23

	titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 11/2/2021. The plan of care had a subsection titled, MEDICATIONS , which failed to evidence Meropenem. Review of the plan of care failed to evidence any lab draws. Review of the plan of care failed to evidence wound care to sacral area. During an interview on 11/23/2021, at 9:58 a.m., the clinical supervisor indicated the plan of care is always evolving, and should include all current treatment. 3. Clinical record review on 11/19/2021, for patient #5, start of care 2/6/2021, certification period 10/4/2021 to 12/2/2021, primary diagnosis of neuromuscular dysfunction of the bladder [when bladder control is lost due to brain, spinal cord or nerve problems], evidenced a document identified by the clinical supervisor as physician orders. The orders were dated 10/28/2021, and signed by physician E. The orders were stamped RECEIVED , signed & dated by the administrator. The orders stated, & Meropenem 1 gram IV every 8 hrs & Cubicin [an antibiotic] 4 mg / kg [milligrams per kilogram] IV & CBC [with] diff [differential]; CMP [complete metabolic profile] [a group of blood tests that helps monitor the body s metabolism]; weekly &. Clinical record review evidenced an agency policy titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 11/3/2021. The plan of care had a subsection titled, MEDICATIONS , which failed to evidence Meropenem and Cubicin. Review of the plan of care failed to evidence any lab draws. During an interview on 11/23/2021, at 9:58 a.m., the clinical supervisor indicated the plan of care is always evolving, and should include all current treatment.		all agency staff about receiving physician orders and how to record all physician orders in the patient's plan of care. This shall include the use of the patient's electronic clinical record and demonstrate the process from receiving the order to recording the order into the plan of care. Who is responsible: The administrator and clinical manager. Monitoring Process: The clinical manager shall work with all agency staff for the ongoing teaching and review to ensure compliance. All physician orders received have to be reviewed and QA'd with the appropriate staff to ensure compliance of this regulation that all orders are recorded in the patient's plan of care. Date Completed: 11/23/2021	
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. 1. Record review on 11/23/2021, evidenced an agency policy titled, "HOME HEALTH PATIENT BILL OF	G0614	The administrator and clinical manager have reviewed CFR 484.60(e)(1) and agency policy titled, "HOME HEALTH PATIENT BILL OF RIGHTS". A staff meeting on 12/03/2021 discussed this issue with review of agency policy to the staff as	2021-12-03

	RIGHTS", revised May 2010, which stated, " ... POLICY Each patient will be an active, informed participant in his / her plan of care ... The Patient Bill of Rights statement defines the right of the patient to: ... Be informed in advance about care to be furnished and of any changes in the care to be furnished. E. Be advised in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished...." 2. Observation of a home visit for patient #1 on 11/18/2021, at 10:30 a.m., failed to evidence a written schedule of visits from the agency. 3. Observation of a home visit for patient #2 on 11/18/2021, at 12:00 p.m., failed to evidence a written schedule of visits from the agency. 4. Observation of a home visit for patient #3 on 11/19/2021, at 10:00 a.m., failed to evidence a written schedule of physical therapy visits. During observation of the home visit for patient #3, review of the patient folder evidenced a calendar on which skilled nursing visits were indicated each Monday, Wednesday and Friday for 9 weeks. During an interview on 11/19/2021, at 10:26 a.m., patient #3 indicated they were receiving skilled nursing and physical therapy services from Assured Home Healthcare. During an interview on 11/19/2021, at		part of the patient's right to be informed of their visit schedule and that personnel is to use the calendar to write on in the patient's home binder. To ensure that all active patients have visit schedules in their homes, visit schedules and the HHA personnel would be determined for each type of discipline (SN, HHA, PT, OT, ST, and/or MSW) per patient's individualized plan of care, which is then coordinated with each personnel and discipline type according to their frequency schedule. This would then be scheduled out in the electronic clinical record and easily read in a calendar format that can then be printed out to be placed in the patient's home binder for the patient and/or caregiver's further reference. The blank calendar in the patient's binder is to also be utilized for the HHA personnel to fill out their visit schedule until a printed calendar can be made available in the patient's home binder. The agency is also currently reviewing to allow permission for the patient and/or their caregiver electronic access to	

	indicated each discipline should fill out the calendar on their initial visit with their schedule of patient visits. RN D indicated patient #3 was receiving physical therapy and stated about the patient calendar, They [physical therapist] should fill that out . On 11/23/2021, at 10:27 a.m., when informed of the findings, the administrator stated, OK .		the patient's medical record so that the visit schedule of HHA personnel can also be made available. Who is responsible: The administrator and the clinical manager. For current active patients, patient calendars have been printed out and given to the appropriate discipline to place into their patient home binder to ensure immediate compliance. Implementation Date: 12/03/2021	

G0656	Improvements are sustained 484.65(c)(3) The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained. Record review on 11/23/2021, evidenced an agency policy titled, RESPONSIBILITIES IN IMPROVING PERFORMANCE , revised May 2010, which stated, & POLICY & Senior management will have the responsibility: to guide the organization s efforts in improving organizational performance; to define expectations of the performance improvement activities; and to generate the plan and processes the organization will utilize to assess, improve and maintain quality of care and service & Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety, and will be incorporated into program planning and process design and modifications & The Governing Body is responsible for ensuring that the performance improvement program is defined, implemented and maintained, and is evaluated annually & Senior management will: & Identify and set specific outcomes for measurable improvement & Identify and participate in benchmarking activities that utilize: 1. Internal standards: a. Measuring current performance against past performance b. Measuring against internally established goals & Processes and protocols & Practice or service guidelines & Industry research or best practices &. Record review evidenced an agency policy titled, PATIENT FOCUSED PERFORMANCE IMPROVEMENT , revised May 2010, which stated, & POLICY The organization s performance improvement processes will focus on the quality of patient and program outcomes & Program, or process related performance improvement activities will focus on opportunities to improve overall organizational performance & When an opportunity to improve performance is identified, a focused study (indicator) will be developed to measure and improve associated processes & Performance improvement documentation will be maintained by the Performance Improvement Coordinator &. On 11/19/2021 at 11:15 a.m., the clinical supervisor provided what he identified as the agency s QAPI [Quality Assurance and Performance Improvement] binder, in its entirety, to the surveyor. Review of the QAPI binder evidenced a group of documents titled, QUALITY IMPROVEMENT PLAN . Review failed to evidence a quality improvement plan dated after 5/14/2019. Each of the quality improvement plan documents included the following categories: Problem	G0656	The administrator and clinical manager has reviewed CFR 484.65(c)(3) and agency policies titled, “RESPONSIBILITIES IN IMPROVING PERFORMANCE”, and “PATIENT FOCUSED PERFORMANCE IMPROVEMENT”. The clinical manager will review it’s current Quality Assurance and Performance Improvement program and its improvement since the last improvement plan dated 5/14/2019. It will then determine the current needs for the agency moving forward to comply with regulations and policies. Who is responsible: The clinical manager and the administrator. Implementation Date: 11/24/2021 Monitoring Process: The agency’s governing body is composed of the administrator and the clinical manager and the QAPI program has been discussed at the post-survey governing body meeting on 11/24/2021 and its importance to comply and bring to issue at every governing body meeting’s agenda from now on. The next governing body meeting will	2022-03-01

	Outcome, Recommended Actions for Improvement, Persons Responsible for Implementation of Actions, and Results of Implementation. Review of the agency's QAPI binder failed to evidence implementation and tracking of a performance improvement plan. During an interview on 11/18/2021 at 2:50 p.m., the clinical supervisor indicated the Quality Improvement Plan document was initiated and completed on the date documented. When queried how the agency tracked the performance improvement, the clinical supervisor stated, I do have it in my mind, I don t have it documented . 17-12-2(a)		include the current QAPI program and analysis since the last improvement plan to observe its trend and determine the best course moving forward. The governing body shall also determine any other issues for agency improvement.	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Record review on 11/23/2021, evidenced an agency policy titled, STANDARD PRECAUTIONS , revised September 2018, which stated, PURPOSE To follow accepted standards of practice of standard precautions to reduce and prevent the risk of exposure to and transmission of infections and communicable diseases when caring for patients & PROCEDURE & Hand Hygiene & Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient & d. After touching a patient or the patient s immediate environment & f. Immediately after glove removal or other personal protective equipment &. Record review evidenced an agency policy titled, HAND HYGIENE , revised May 2010, which stated, & PROCEDURE & Hand decontamination using an alcohol-based hand rub should be performed: & G. After removing gloves &. Observation of a home health aide visit for patient #2 took place on 11/18/2021, at 12:27 p.m. HHA [home health aide] F was observed assisting patient #2 bathe in the shower. At 12:27 p.m., after washing and rinsing the patient s torso, back, arms, and legs, HHA F was observed removing gloves and applying new gloves.	G0682	The administrator and the clinical manager have reviewed CFR 484.70(a) and the agency policies titled, “STANDARD PRECAUTIONS” and “HAND HYGIENE” and understood its importance for Infection Prevention. Immediately after the agency’s survey the administrator and clinical manager had discussed with HHA F about hand hygiene and it’s procedure when changing gloves with review of agency policies specifically STANDARD PRECAUTIONS and HAND HYGIENE. HHA F has verbalized understanding and also performed a return demonstration satisfactorily using an alcohol-based hand rub in between changing gloves. Staff meeting held on	2021-12-03

	HHA F failed to perform hand hygiene after removing gloves and before applying new gloves. At 12:28 p.m., HHA F assisted the patient to stand and washed the patient s buttocks and genital area. At 12:30 p.m., HHA F was observed assisting the patient to return to sitting on the tub bench, and rinsing the patient with the handheld showerhead. At 12:32 p.m., HHA F was observed turning off the water, then removing gloves and applying new gloves. The HHA failed to perform hand hygiene after removing gloves and before applying new gloves. During an interview on 11/19/2021 at 4:40 p.m., both the administrator and clinical supervisor indicated clinicians should perform hand hygiene after removing gloves, and before applying new gloves. 17-12-1(m)		with all staff about proper hand hygiene and the importance of using an alcohol-based hand rub after removing old gloves and before donning new gloves. Who is responsible: The administrator and clinical manager. Implementation Date: December 3, 2021 Monitoring Process: All staff have been made aware of the agency's policies of STANDARD PRECAUTIONS and HAND HYGIENE in regards to the importance of infection prevention. Staff are made aware of any questions or concerns to ask the administrator and/or clinical manager at any time. Future staff meetings and continuing education will also include the discussion of proper hand hygiene and the importance of infection prevention. Education, training, review, re-education shall ever be ongoing on this issue and subject of infection prevention and will always be discussed when the concern presents itself.	

G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; 1. Record review evidenced an agency policy titled, MONITORING PATIENT S RESPONSE / REPORTING TO PHYSICIAN , revised May 2010, which stated, & POLICY Clinicians will monitor, document, and report the patient s response to care and treatment provided on each home visit. Progress of goals will be measured at regular intervals. Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient & The patient s physician will be contacted on the same day when any of the following occur: & C. Inability to achieve goals within the specified time frame D. Changes in the patient s expected response to treatment or medications & F. When there is any problem implementing the plan of care G. When results are received for relevant laboratory tests ordered & All conferences or attempts to communicate with physician will be documented in the clinical record &. 2. Record review on 11/23/2021, evidenced a document identified by the nursing supervisor as the Registered Nurse job description, revised May 2010. The job description stated, & ESSENTIAL JOB FUNCTIONS / RESPONSIBILITIES & Act as the coordinator of the health care team in order to maintain the proper linkages within a continuum of care & updates the primary physician when necessary & Communicates with the physician regarding the patient s needs and reports any changes in the patient s condition; obtains / receives physician s orders as required & Communicates with community health related persons to coordinate the care plan &. 3. Clinical record review on 11/19/2021, for patient #4, start of care 10/1/2021, certification period 10/1/2021 to 11/29/2021, primary diagnosis of urinary tract infection, evidenced a document titled, Medical Authorization / Verbal Order , from infusion pharmacy C, dated 11/9/2021, and signed by nurse practitioner B. This order stated, & Meropenem [an intravenous antibiotic] 1 gm [gram] / 100 ml [milliliter] NS [normal saline] & IV [intravenous] every 8 hrs & LAB ORDER(S) SN [skilled nurse] TO DRAW CBC W/DIFF [complete blood count with differential] [a measure of the number of red blood cells, white blood cells, and platelets in the blood, including the different types of white blood cells], BUN [blood urea nitrogen] [a blood test that helps measure kidney function], AND SCR [serum creatinine] [a blood test that helps measure kidney function] WEEKLY ON MONDAYS. FAX RESULTS TO [nurse practitioner B] & and [infusion	G0718	The administrator and the clinical manager have reviewed the CFR 484.75(b)(7) and agency policy titled, “MONITORING PATIENT’S RESPONSE / REPORTING TO PHYSICIAN”, and Registered Nurse job description. The agency realizes coordination of care and communication with the physician is very important in patient care. This includes the notification of lab results, and the agency has reviewed their processes and received lab results that are then forwarded to the physician by fax. The agency utilizes the fax cover page as means of communicating with physicians to review lab results as attached, which was unable to be offered to the surveyor during the time of the survey after her exit. In respect, “SN LABS VISIT” dated 11/1/2021 & 11/8/2021, signed by RN C is likely in reference to patient #5, start of care 2/6/2021; and not patient #4, start of care 10/1/2021. Any delay in treatment would also require a communication with the physician, the agency realizes this and it’s importance.	2021-11-23

	pharmacy C] &. Clinical record review evidenced an agency document titled, SN [skilled nurse] LABS VISIT , dated 11/1/2021, signed by RN C. The visit note had a subsection titled, Visit Narrative , which stated, & Weekly labs & done via port-a-catheter &. . Review of the note failed to evidence physician notification of lab results. Review of the communication notes failed to evidence the physician was notified of the lab results. Review of the patient s electronic medical record (Axxess) failed to evidence physician notification of the lab results. Clinical record review evidenced an agency document titled, SN [skilled nurse] LABS VISIT , dated 11/8/2021, signed by RN C. The visit note had a subsection titled, Visit Narrative , which stated, & Weekly lab test done today & Specimen sent to [lab F] &. Review of the note failed to evidence physician notification of lab results. Review of the communication notes failed to evidence the physician was notified of the lab results. Review of the patient s electronic medical record (Axxess) failed to evidence physician notification of the lab results. During an interview on 11/23/2021, at 10:56 a.m., the clinical supervisor indicated the physician should be notified of results of labs drawn. The clinical supervisor indicated this notification should be documented in the nurse s visit note or in a communication note. When informed of the findings, the clinical supervisor and administrator reviewed the patient s record and offered no further documentation. 4. Clinical record review on 11/19/2021, for patient #5, start of care 2/6/2021, certification period 10/4/2021 to 12/2/2021, primary diagnosis of neuromuscular dysfunction of the bladder [when bladder control is lost due to brain, spinal cord or nerve problems], evidenced an agency document titled, PICC / MIDLINE PLACEMENT , identified by the clinical supervisor as the nurse s visit note, dated 10/31/2021, and signed by RN C. The visit note had a subsection titled, Visit Narrative , which stated, Received call (10/28/21) from [physician s nurse, G] regarding new antibiotic orders & Scheduled weekly SN [skilled nurse] visit deferred till arrival of meds from [infusion pharmacy H]. Expected delivery was Friday but did not arrive and was advised by [infusion pharmacy H] it will be Saturday late afternoon. Mother advised. Needed Med / supplies delivered late Saturday and Mother requested to start them Sunday due to lateness in the evening &. . Review of the note failed to evidence physician notification of the delay in treatment.		Despite the agency maintaining and keeping close communication and coordination with the patient's mother and the pharmacy due to the delay of the intravenous antibiotic medication delivery, the physician should have also been notified to comply with the regulation and agency policy. Date Implemented: 11/23/2021 Who is responsible: The administrator and clinical manager. Monitoring Process: When forwarding lab results to physicians there shall have documentation that results were notified to that physician. This was reviewed and discussed during the office staff meeting on 11/23/2021 and in an all-agency staff meeting on 12/03/2021. Processes have been reviewed to utilize fax cover sheets as evidence of communication to physician, further documentation can be also utilized with communication notes and visit notes as necessary for further details of patient care. Any delay in treatment will be	

	Clinical record review evidenced an agency document titled, MISSED VISIT , dated 10/29/2021, signed by RN C, which stated, & Type of Visit: Skilled Nurse Visit & Date of Visit 10/29/2021 & Order Generated: No & Physician Office Notified: No &. Review of the communication notes failed to evidence the physician was notified of the delay in treatment. Review of the patient s electronic medical record (Axxess) failed to evidence physician notification of the delay in treatment. During an interview on 11/23/2021, at 10:54 a.m., the clinical supervisor indicated the physician should be notified if a skilled nurse s visit is missed, and if there is a delay in treatment. During an interview on 11/23/2021, at 10:56 a. m., when informed of the findings, the administrator indicated the patient s family member informed the physician of the delay in treatment. When queried if the patient s clinical record evidenced documentation of anyone notifying the physician of the delay in treatment, the administrator and clinical supervisor offered no further documentation. 17-14-1(a)(1)(G)		documented appropriately in the clinical record. Field and office personnel are to be made aware and to also inform the administrator and / or clinical manager for further guidance and ensure documentation to comply with regulation, agency policy, and job description.	
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. 1. Record review on 11/23/2021, evidenced an agency policy titled, HOME HEALTH AIDE PLAN OF CARE , revised May 2010, which stated, & POLICY Each patient receiving home health aide services will have an individualized plan developed by an appropriate professional and utilized to direct the care performed by the assigned aide &. 2. Record review evidenced an agency policy titled,	G0800	The administrator and the clinical manager have reviewed CFR 484.80(g)(2) and agency policy titled, “HOME HEALTH AIDE PLAN OF CARE” and “HOME HEALTH AIDE TRAINING”.	2021-12-17

	which stated, & POLICY Assured Home Healthcare Inc. will only hire individuals as home health aides & who have completed a training program or a competency evaluation program that meets the organization s criteria described below & The home health aide training program must include each of the following subject areas: & B. Overall responsibilities and limitations & E. Observation, reporting, and documentation of patient status and care or service furnished &. 3. Clinical record review on 11/19/2021, for patient #2, start of care 10/26/2021, certification period 10/26/2021 to 12/24/2021, primary diagnosis of Chronic obstructive pulmonary disease [a chronic inflammatory lung disease that causes obstructed airflow from the lungs], evidenced an agency document titled, HHA [home health aide] Care Plan , dated 10/26/2021, and signed by RN [registered nurse] H. The care plan had a subsection titled, Safety Precautions , which indicated the following precautions: Anticoagulant [blood thinner medication] Precautions, Keep Pathway Clear, Standard Precautions / Infection Control, Emergency Plan Developed, Sharps Safety, Support During Transfer / Ambulation, Fall Precautions, Safety in ADLs [activities of daily living], Use of Assistive Devices, Proper Handling of Biohazard Waste, and Bleeding Precautions. The Care Plan had a subsection titled, Plan Details , which indicated the task, Range of Motion was to be completed at each HHA visit. Clinical record review evidenced a group of agency documents titled, HHA Visit , each signed by HHA F. Review of all HHA notes from 10/26/2021 to 11/18/2021, failed to evidence any safety precautions. Clinical record review of an HHA visit note dated 11/18/2021, indicated the HHA task, Range of Motion [movement of a joint to its fullest extent] was completed. Observation of a home visit by HHA F on 11/18/2021, at 12:00 p.m. failed to evidence range of motion exercises. The surveyor and administrator were present throughout the entire visit. During an interview on 11/23/2021, at 10:16 a.m., the administrator indicated the HHA should document all tasks completed on the HHA Visit form. The administrator indicated the task, Range of Motion indicated the HHA assisted the patient to move their joints for exercise. When informed this was not evidenced during the home visit, the administrator stated, OK . When queried, the administrator indicated she did not see the HHA perform range of motion exercises at the home visit.		The administrator discussed with HHA F about proper range of motion exercises and review with return demonstration. HHA F has verbalized understanding and has performed adequate return demonstration. The next HHA continuing education inservice will include normal range of motion scheduled for 12/17/2021. The administrator discussed with HHA I about the documentation that patient #7 refused range of motion exercises, and informed HHA I that if the patient may refuse to perform a task on the care plan to inform supervising staff for further assessment of the patient and possible updates to the care plan can be made as appropriate. The next HHA continuing education inservice with also include observing, reporting, and documenting patient status and the care or service furnished scheduled for 12/17/2021. Date of Implementation: 12/03/2021	

	start of care 5/18/2021, certification period 7/17/2021 to 9/14/2021, primary diagnosis of Myotonic muscular dystrophy [a disease characterized by progressive muscle wasting and weakness], evidenced an agency document titled, HHA [home health aide] Care Plan , dated 7/16/2021, and signed by PT [physical therapist] G. The care plan had a subsection titled, Safety Precautions , which indicated the following precautions: Keep Pathway Clear, Standard Precautions / Infection Control, Emergency Plan Developed, Sharps Safety, Support During Transfer / Ambulation, Fall Precautions, Slow Position Change, Use of Assistive Devices, 24 Hour Supervision, Presence of Animals (cat), Prone to Skin Breakdown Precaution. The Care Plan had a subsection titled, Plan Details , which indicated the task, Range of Motion was to be completed at each HHA visit. Clinical record review evidenced a group of agency documents titled, HHA Visit , each signed by HHA I. Review of all HHA notes from 7/17/2021 to 9/14/2021, failed to evidence any safety precautions. Review of the HHA notes evidenced the patient refused Range of Motion on 7/16/2021, 7/19/2021, 7/23/2021, 7/26/2021, 8/6/2021, 8/23/2021, and 9/3/2021. Review of the HHA notes and all communication notes from 7/17/2021 to 9/14/2021, failed to evidence the HHA notified supervising staff of the patient s refusal of daily assigned care. During an interview on 11/23/2021, at 10:16 a.m., the administrator indicated the HHA should document all tasks completed on the HHA Visit form. During an interview on 11/23/2021, at 11:21 a.m., the administrator indicated if assigned tasks are not completed, the HHA should document the refusal, notify the supervising staff member, and document that communication in the patient s clinical record. When informed of the findings, the administrator stated, Oh, OK , and offered no further documentation.		Who is Responsible: The administrator and clinical manager. Monitoring Process: All home health aides will have the patient's care plan be made available and tasks performed and documented as appropriate. Frequent reporting about their patient care will be reported to supervising staff every two weeks to ensure the care plan is being followed. Appropriate nursing staff have been inserviced to ensure accuracy of the tasks to be performed by the home health aide on the care plan, and nursing staff can further assess with the patient.	
G1014	Interventions and patient response 484.110(a)(2) All interventions, including medication administration, treatments, and services, and responses to those interventions; 1. Record review evidenced an agency policy titled, MONITORING PATIENT S RESPONSE / REPORTING TO PHYSICIAN , revised May 2010, which stated, & POLICY Clinicians will monitor, document, and report the patient s response to care	G1014	The administrator and the clinical manager reviewed CFR 484.110(a)(2), agency policy titled, "MONITORING PATIENT'S RESPONSE REPORTING TO PHYSICIAN", and the Physical Therapy Job Description.	2021-12-03

	and treatment provided on each home visit &. 2. Record review on 11/23/2021, evidenced an agency document, identified by the clinical supervisor as the Physical Therapist job description, revised May 2010. This document stated, & ESSENTIAL JOB FUNCTIONS / RESPONSIBILITIES 1. Provides physical therapy services to patients according to a written physician s plan of care. This may include, but will not be limited to: A. Assessing and evaluating therapeutic / rehabilitative / functional status, and participation in the development of the total plan of care Evaluates home environment. B. Assesses for muscle strength, mobility, gait, ROM [range of motion] potential for rehab & F. Reporting to physician patient s reaction to treatment or changes in condition &. 3. Clinical record review on 11/19/2021, for patient #1, start of care 6/21/2021, certification period 10/19/2021, to 12/17/2021, primary diagnosis of Polyosteoarthritis [a disease where four or more joints in the body become painful and inflamed], evidenced a group of agency documents titled, PT [physical therapy] VISIT . Review of visit notes dated 11/16/2021 and 11/18/2021, signed by PT [physical therapist] E, failed to evidence how the patient tolerated physical therapy. 4. Clinical record review on 11/22/2021, for patient #7, start of care 5/18/2021, certification period 7/17/2021 to 9/14/2021, primary diagnosis of Myotonic muscular dystrophy [a disease characterized by progressive muscle wasting and weakness], evidenced a group of agency documents titled, OT [occupational therapy] VISIT . Review of visit notes dated 7/27/2021, 7/29/2021, 8/2/2021, 8/3/2021, and 8/10/2021, signed by former employee B, OT [occupational therapist], failed to evidence how the patient tolerated occupational therapy. During an interview on 11/23/2021, at 10:11 a.m., the clinical supervisor indicated the therapists should observe the patient, use the pain scale, and ask the patient how they are feeling to determine how the patient is tolerating therapy. When informed of the findings, the administrator and clinical supervisor were silent.		This was discussed during the office staff meeting on 11/23/2021 to make awareness, and bring attention when reviewing clinical records. PT E was immediately conferenced by the administrator and the clinical manager about documentation of physical therapy visit notes and especially the patient responses to the interventions provided during home visits, and the importance of documenting the patient's response to the intervention(s) provided. The clinical record was further reviewed with PT E and some examples documenting patient responses were discussed. PT E has verbalized understanding. During an all-agency staff meeting this was further discussed with all field staff and the importance of documenting patient responses when an intervention is performed on home visits. Implementation Date: 11/23/2021 Who is responsible: The administrator and clinical	

			manager. Monitoring Process: All agency staff have been made aware of the importance of documenting patient responses to all interventions, which include medication administration, treatments, and services. As field personnel visit notes get submitted, office staff review those visit notes to ensure compliance of the documentation of patient responses when an intervention is performed during the home visit. Field personnel may be queried about any patient responses in the medical record the patient may have had or even lack of thereof. The administrator and clinical manager shall review clinical charts, especially those charts with a therapy service or services, quarterly for at least up to one year to ensure this regulation is in compliance.	
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. 1. Record review on 11/23/2021, evidenced an agency document identified by the clinical supervisor as the	G1024	The administrator and the clinical manager have reviewed CFR 484.110(b) and the clinical records of patient #1 and #5. The administrator and the clinical manager have discussed with RN H about the importance of having complete	2021-12-03

	2020. This document stated, & The registered nurse plans, organizes and directs home care services & Initiates the plan of care and makes necessary revisions as patient status and needs change & maintain a clinical record for each patient receiving care & Prepares clinical notes &. 2. Clinical record review on 11/19/2021, for patient #1, start of care 6/21/2021, certification period 10/19/2021 to 12/17/2021, primary diagnosis of Polyosteoarthritis [a disease where four or more joints in the body become painful and inflamed], evidenced an agency document titled, OASIS D1 [the patient-specific, standardized assessment used in Medicare home health care] Recertification , dated 10/18/2021, and signed by RN [registered nurse] H. The assessment had a subsection titled, Genitourinary [related to the genital and urinary systems] Assessment , which indicated the patient had a suprapubic catheter [a tube inserted through the abdomen into the bladder to drain urine]. Clinical record review evidenced an agency document titled, SKILLED NURSE VISIT , dated 10/26/2021, and signed by RN H. The assessment had a subsection titled, Genitourinary , which indicated the patient was receiving intermittent catheterization, and had an indwelling Foley catheter [a catheter inserted through the urethra into the bladder to drain urine]. The assessment failed to indicate the patient had a suprapubic catheter. Clinical record review evidenced an agency document titled, OASIS-D1 Resumption of Care , dated 11/10/2021, and signed by employee H. The assessment had a subsection titled, Genitourinary Assessment , which indicated the patient had a suprapubic catheter. During an interview on 11/23/2021, at 10:08 a.m., the administrator indicated the nurse documented incorrectly on the skilled nurse visit from 10/26/2021. During an interview on 11/23/2021, at 10:08 a.m., the clinical supervisor indicated the nurse failed to document the correct type of catheter in the patient s assessment. 3. Clinical record review on 11/19/2021, for patient #5, start of care 2/6/2021, certification period 10/4/2021 to 12/2/2021, primary diagnosis of neuromuscular dysfunction of the bladder [when bladder control is lost due to brain, spinal cord or nerve problems], evidenced a group of agency documents titled, SKILLED NURSE VISIT . The notes dated 10/9/2021,		and accurate documentation. RN H has verbalized understanding, admitted the mistake, and the medical record has been corrected to the SKILLED VISIT NOTE dated 10/26/2021 appropriately to reflect the proper type of catheter (suprapubic catheter) as attached. The administrator and the clinical manager have discussed with RN C about the redundant documentation of sending urine specimen to the lab on 10/9/2021, 10/15/2021, and 10/22/2021, but in actuality did not happen as previous notes can be copied and pasted onto the next note without being edited and updated to the day of that visit. RN C realized and verbalized understanding of the mistake, and the note was then corrected accordingly. Office staff meeting on 11/23/2021 was held to review the regulation and processes to ensure compliance. Agency staff meeting was held on 12/03/2021 to further discuss the importance of accurately and properly documenting patient assessments for authentication. Who is Responsible: The	

10/15/2021, and 10/22/2021, signed by RN C, evidenced a subsection titled, Interventions , which stated, & Urine specimen sent to lab &. .

Clinical record review of all physician orders for the certification period 10/4/2021 to 12/2/2021 failed to evidence an order for a urine specimen to be sent to the lab. Review of the patient s electronic record (Axxess) for the certification period of 10/4/2021 to 12/2/2021 failed to evidence any physician orders or results for urine lab tests.

During an interview on 11/23/2021 at 10:50 a.m., the clinical supervisor indicated he would assume the nurse did not send a urine specimen to the lab on 10/9/2021, 10/15/2021, and 10/22/2021, and that the documentation was carried over from one visit to the next . The clinical supervisor indicated the nurse s notes on 10/9/2021, 10/15/2021, and 10/22/2021 were not accurate and stated, This is the problem with electronic documentation .

17-15-1(a)(7)

administrator and clinical manager.

Date of Implementation: 11/23/2021

Monitoring Process: In coordination with the office staff, the administrator and the clinical manager will monitor this process to ensure compliance with the regulation and the agency's RN job description as follows.

The field personnel have been made aware of the importance of accurate documentation when authenticating their notes. Office staff will verify notes as they are submitted to ensure documentation is accurate. Any questions and concerns are to be made to the personnel as necessary and coordination with the administrator and clinical manager can be made as necessary for further guidance.

The field personnel have been made aware of the issue of copying and pasting previous notes onto the next note without updating and editing the note to current. Once documentation has been authenticated, signed and dated, office staff will

			confirm accuracy. If any documentation is questioned the appropriate personnel will be asked to confirm and any correction may be performed as appropriate.	

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

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