STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157570	A. BUILDING B. WING	12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTAL HOME HEALTH SERVICES INC	620 RIDGE RD, MUNSTER, IN, 46321

(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 12/7/2021 to 12/17/2021. Facility ID: 004658 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings. quality reviewed completed 01/24/22	G0000		2022-02-24
N0000	Initial Comments This visit was a re-licensure survey of a home health agency. The survey visit took place from 12/7/2021 to 12/17/2021. Facility ID: 004658	N0000		2022-02-24

E0000	Initial Comments This visit was a recertification, re-licensure, and emergency preparedness survey. The survey visit took place from 12/7/2021 to 12/17/2021. Facility ID: 004658 At this Emergency Preparedness survey, Total 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.	E0000		2022-02-24
G0374	Accuracy of encoded OASIS data 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on record review and interview the agency failed to ensure OASIS data accurately reflected the patient s status in 1 of 1 discharged patients receiving therapy services only (#12). The findings include: Record review on 12/17/2021, evidenced an undated agency policy titled, REPORTING OASIS DATA , which stated, & During the comprehensive assessment, clinicians will record OASIS data & Data must accurately reflect the patient s status at the time of the assessment &. Record review evidenced an agency policy	G0374	G-0374 1. How the deficiency will be or has beenimmediately corrected. Physicaltherapist W and clinical supervisor have reviewed together Policy 5-T “PatientTransfer or Discharge from Agency”, specifically subsection 4 which states:“Prior to discharge, the home care team will conference on the progress togoals, pending discharge date, and follow-up needed.” to address thisdiscrepancy. Since it hasbeen determined that	2022-02-24

	titled, COMPREHENSIVE ASSESSMENT , revised 1/8/2019, which stated, & POLICY All patient [sic] shall receive a patient specific comprehensive assessment that accurately reflects their current health status & The comprehensive assessment includes, but is not limited to: a. The patient s medical, nursing, rehabilitative, social and discharge planning needs. b. An assessment of the patient s current health status & a head to toe assessment, vital signs, allergies, a review of all systems, skin integrity, and nutritional status &. Clinical record review for patient #12 on 12/14/2021, start of care 6/19/2021, primary diagnosis of Rotator cuff tear / rupture of right shoulder, evidenced an agency document titled, PT [physical therapy] VISIT , dated 7/7/2021, and signed by PT [physical therapist] W, which stated, & Functional Limitations & Pain & patient ambulates & with 4 wheeled walker &. Clinical record review evidenced an agency document titled, OASIS [the patient-specific, standardized assessment used in Medicare home health care to plan care, determine reimbursement, and measure quality]-D1 Discharge , dated 7/7/2021, and signed by the clinical supervisor. The assessment had a subsection titled, FUNCTIONAL STATUS , which indicated the patient was able to independently transfer, walk on uneven surfaces and negotiate stairs without human assistance or assistive device. The assessment had a subsection titled, FUNCTIONAL ABILITIES & GOALS , which indicated the patient was independent at time of discharge in the following tasks: standing from sitting position, transferring to and from a bed to a chair, getting on and off a toilet, transfer in and out of a car, walk 10 feet, walk 50 feet, walk 150 feet, go up and down four steps, and go up and down 12 steps without a rail. Review of the OASIS discharge assessment failed to evidence the patient s functional limitations and need to use a walker. During an interview on 12/17/2021, at 11:03 a.m., the clinical supervisor indicated the OASIS discharge assessment should reflect the patient s condition at discharge. When informed of the findings, the clinical supervisor stated, There is a discrepancy and there shouldn t be.		disciplines was noted, allagency clinicians have been re-educated on Policy 5-T and the requirement forclinical coordination at time of discharge and/or transfer to ensure accurate,comprehensive documentation of the client's current condition is obtained. Additionally,all agency clinicians have been re-educated on policy 5-J "Coordination ofPatient Services" so that all clinicians understand the requirement ofcontributing to the ongoing interdisciplinary assessment. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to insure thedeficiency will not recur. Policies 5-T"Patient Transfer or Discharge from Agency" and 5-J "Coordination of PatientServices" will be reviewed at our February 2022 inservice as well as duringonboarding and ongoing educational activities. The clinicalrecord review team will audit 100% of patients' medical records to identify anynoted discrepancies among disciplines and seek clarification by returningdocuments to clinician as needed for additional documentation. Allclinicians will be scheduled a	

			their patientsweekly in which the clinician will be expected to document a report of theirpatient's current condition using the SBAR format. The clinical manager willschedule and monitor the case communications for accuracy and comprehensiveness.Clinicians will be expected to review the other disciplines' casecommunications for care coordination purposes. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Clinicalmanager or designee 4. By what date are you going to have thedeficiency corrected? 2/24/2022	
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2.	N0458	**N-0458** 1. How the deficiency will be or has beenimmediately corrected. Agencyobtained job descriptions; national background checks; and annual performanceevaluations for 7 personnel records identified. 2. How the deficiency will be prevented fromrecurring i.e.	2022-02-24

	(4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the home health agency failed to ensure personnel records included documentation of receipt of job description, completion of annual evaluations, and criminal background checks in 7 of 9 personnel records reviewed. (A, B, D, E, H, I, V) 1. Record review on 12/14/2021 evidenced an agency document revised 1/8/2019, titled, "Personnel Files," which stated, "... Personnel records for all employees shall contain the following information: ... d. Criminal record check, ... n. Signed job description...." 2. Record review on 12/14/2021 evidenced an undated agency document titled, "Performance Evaluations, " which stated, "... A performance evaluation will be conducted annually on all employees...." 3. Record review on 12/14/2021 evidenced an undated agency document titled, "Employment Practices," which stated, " ... 13. Applicants providing patient care or with access to patient records shall have a criminal record background check...." 4. Record review on 12/14/2021 evidenced an undated agency document titled, "Contracted Services," which stated, "... Provider Responsibilities: ... 9. Submit to the agency a copy of the professional license of all individuals providing patient care to Agency' [sic] patients. Upon agency request, Provider must also submit to the agency within one business day a copy of other personnel file documents within one business day [sic] including: Criminal record check, ... Signed job description ...." 5. Personnel record review on 12/9/2021 for administrator A, start date of 8/1/2005, failed to evidence documentation of a national criminal background check. 6. Personnel record review on 12/9/2021 for		systematic changes made to insure thedeficiency will not recur. Agencyconducted an audit in order to identify any other like circumstances. The agency has confirmed the presence ofrequired national criminal back ground checks job descriptions, signed jobdescriptions and performance evaluation for all identified staff. Agency willaudit 100% of HR files quarterly on order to monitor for compliance. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Administratoror designee 4. By what date are you going to have thedeficiency corrected? February 24,2022 _____ _____ _____ Report ID. 1283890 Order Date 08/21/2020 Completion Date 09/01/2020 Ordered by MichelleYablonowski Report Provided bySafe Hiring Solutions***P.O. Box	

director of nursing B, start date of 5/14/19, failed to evidence documentation of an annual performance evaluation.

7. Personnel record review on 12/9/2021 for office director D, unknown start date, failed to evidence documentation of a national criminal background check.

8. Personnel record review on 12/9/2021 for alternate administrator E, start date of 12/1/2005, failed to evidence documentation of a national criminal background check or signed job description for alternate administrator.

9. Personnel record review on 12/9/2021 for RN [registered nurse] H, start date of 9/17/15, failed to evidence documentation of a national criminal background check or an annual performance evaluation.

10. Personnel record review on 12/9/2021 for PT [physical therapist] I, start date of 1/6/2015, failed to evidence documentation of a national criminal background check.

11. Personnel record review on 12/9/2021 for LPN [licensed practical nurse] V, start date of 4/13/2012, failed to evidence documentation of a national criminal background check or an annual evaluation.

12. During an interview on 12/9/2021 at 4:57 p.m., office director D indicated the agency failed to evidence annual performance evaluations for its employees, failed to evidence a signed job description, and failed to obtain national criminal background checks.

186***Crawfordsville, IN 47933

Report Ordered byTOTAL HOME HEALTH SERVICES, INC620 RIDGE ROADMUNSTER, IN 46321

Applicant ScreenedSTANISLAW SROKAAliases: STAN SROKA

Date of Birth: XX/XX/1970

SSN: XXX-XX-0998

Address: 1924 Briarwood Circle Munster, IN 46321

Exp Crim HistoryNational Lifetime Search (IN) CP

5624287 County Criminal Search - LAKE, IN ALERT5624284

SSN Trace COMPLETE

5638715 County Criminal Search - BERRIEN, MI NO RECORD

5624290 Federal Criminal Search - Western District Court, MI NO RECORD

5624289 Federal Criminal Search - Northern District Court, IN NO RECORD

5624285 Indiana Participating Courts NO RECORD

5624286 National Criminal Search & Sex Offender NO RECORD

DisclaimerThis report is furnished to you pursuant to the

			Service Agreement between the parties and in compliance with theFair Credit Reporting Act. This report is furnished based on your certification that you have a permissible purpose toobtain the report. The information contained herein was obtained in good faith from sources deemed reliable, butcompleteness or accuracy is not guaranteed	
N0466	Home health agency administration/management 410 IAC 17-12-1(j) Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on record review and interview, the home health agency failed to ensure the health information for personnel was maintained in separate medical files for 3 of 3 contracted personnel records reviewed. (E, I, J) 1. Record review on 12/14/2021 evidenced an agency document titled, "Personnel Files," revised 1/8/2019, which stated, "... Personnel files will be initiated at the time of hire and maintained for all employees. ... Personnel files for employees providing patient services shall also include: ... Medical files maintained separately from personnel files containing a pre-employment history and physical examination, tuberculosis screening, Mantoux administration, hepatitis consent form, and any other medical-related information...." 2. Personnel record review on 12/9/2021 for PT	N0466	**N-0466** 1. How the deficiency will be or has beenimmediately corrected. Agencyimmediately ensured that not only were the 3 identified personnel records but allpersonnel records are maintained pursuant to agency policy - 4-D Personnel File.Specifically, that any medically related personnel documents are maintained in aseparate file and are treated as confidential medical records. 2. How thedeficiency will be prevented from recurring i.e. measure put into place orsystematic changes made to insure the deficiency will not recur. The agencyhas educated all contracted services HR Staff on agency policy - 4-D	2022-02-24

	E, failed to evidence the patient's tuberculosis (potentially serious infectious bacterial disease that mainly affects the lungs) test and physical examination were maintained in a separate medical file. 3. Personnel record review on 12/9/2021 for PT I, failed to evidence the patient's tuberculosis test and physical examination were maintained in a separate medical file. 4. Personnel record review on 12/9/2021 for PT J, failed to evidence the patient's tuberculosis test and physical examination were maintained in a separate medical file. 5. During an interview on 12/9/2021 at 4:40 p.m., office director D indicated the contracted personnel files and medical files are stored together.		PersonnelFile and the importance of maintaining separate medical personal files formedically related documents. The agencywill monitor for compliance with agency Policy - 4-D Personnel File on aquarterly basis. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Administratoror Designee 4. By what date are you going to have thedeficiency corrected? February 24th,2022	
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment was complete in 1 of 3 active patient records reviewed with surgical wounds (#3). Record review on 12/17/2021, evidenced an agency policy titled, COMPREHENSIVE ASSESSMENT , revised 1/8/2019, which stated, & POLICY All patient [sic] shall receive a patient specific comprehensive assessment that accurately reflects their current health status & The comprehensive assessment includes, but is not limited to: a. The patient s medical, nursing, rehabilitative, social and discharge planning needs. b. An assessment of the patient s current health status & a head to toe assessment, vital signs, allergies, a review of all systems, skin integrity, and nutritional status &. During observation of a home visit for patient #3 on 12/10/2021, at 9:20 a.m., RN [registered	G0528	G-0528 1. How the deficiency will be or has beenimmediately corrected. Patient #3’sOASIS Start of Care on 12/10/2021 was not yet reviewed by the clinical recordreview team. This document was returned to the clinician requestingclarification of the documentation of the patient’s wounds. The clinician addedthe second wound to the wound care worksheet, documented notification of the MDof the second wound and addressed wound care orders for all identified woundsin the OASIS Start of Care document.	2022-02-01

	nurse] R was observed assessing the patient s right hip. Two separate dressings were observed on the patient s right hip. A large, non-removable surgical dressing was observed on the lower hip. A smaller dry dressing was observed on the upper hip. At 10:02 a.m., RN R was observed removing the upper hip dressing. A surgical incision was observed on the upper hip. RN R placed a new dry dressing on the upper hip surgical incision. Clinical record review for patient #3 on 12/17/2021, start of care 12/10/2021, certification period 12/10/2021 to 2/7/2022, with primary diagnosis of Aftercare following joint replacement surgery (right hip), evidenced an agency document titled, OASIS [the patient-specific, standardized assessment used in Medicare home health care to plan care, determine reimbursement, and measure quality]-D1 Start of Care , dated 12/10/2021, and signed by RN R. This assessment failed to evidence the patient had 2 wounds to the right hip. During an interview on 12/17/2021, at 10:31 a.m., the clinical supervisor indicated the comprehensive assessment should include all wounds. 17-14-1(a)(1)(A)		The clinicalmanager also reviewed policy 5-K with the assessing clinician (RN R) andprovided re-education related to accurate, comprehensive documentation. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to insure thedeficiency will not recur. The Agencywill provide training and education to ensure all admitting clinicians aretrained and competent to perform the comprehensive head-to-toe assessment oftheir patients at SOC and all subsequent certification time-points to ensureaccurate and comprehensive documentation is obtained. 100% of allOASIS Comprehensive Assessment will be reviewed by the clinical record reviewteam before exporting for accuracy. Inthe event an inaccuracy is identified, the OASIS Comprehensive Assessment willbe returned to the assessing clinician for correction. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. ClinicalManager or designee	

			4. By what date are you going to have thedeficiency corrected? 2/1/2022	
G0534	Patient's needs 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on clinical record review and interview, the home health agency failed to assess and meet the patient's needs in 1 of 2 discharged patient records reviewed receiving wound care (#11). The findings include: Record review on 12/17/2021, evidenced an agency policy titled, PLAN OF CARE , revised 1/8/2019, which stated, & 1. The plan of care will be established, periodically reviewed, and signed by a doctor or (sic) medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. 2. Physician orders are obtained prior to the initiation of care and with any changes in the plan of care & 3. The plan of care is individualized to each patient and developed through consultation with the patient / legal representative, the physician and all clinicians involved in the patient s care. 4. The individualized plan of care will specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment &. . Clinical record review on 12/16/2021, for patient #11, start of care 9/5/2020, certification period 9/5/2020 to 11/3/2020, primary diagnosis of Encounter for change or removal of non-surgical wound dressing, evidenced an agency document titled, OASIS [the patient-specific, standardized assessment used in Medicare home health care to plan care, determine reimbursement, and measure quality]-D1 Start of Care , dated 9/5/2021, and signed by RN [registered nurse] F. This assessment had a	G0534	G-0534 1. How the deficiency will be or has beenimmediately corrected. Patient#11’s chart has been reviewed for accuracy and the proper identification ofpatient’s needs and safety within their environment. The clinician (RN F) hasbeen re-educated on policy 2-S “Home Health Aide Services” and policy 7-D“Patient Safety” to ensure the clinician understands the appropriate use ofhome health aide services. The clinician was also re-educated on documentationof refusal of services if the patient/family refuses ordered/discussed servicessuch as a home health aide. Patient #11was referred to physical therapy, occupational therapy and medical socialworker services and assessments occurred within 5 days of the OASIS Start ofCare visit. A medical social worker evaluation was performed where it wasdetermined the patient/family required additional	2022-02-10

	subsection titled, FUNCTIONAL STATUS , which indicated the patient depended entirely on another person for grooming, dressing, bathing, toileting, and transferring. The assessment had a subsection titled, Visit Interventions , which stated, & Multiple family in home with pt [patient] that live there and it does not appear pt has much support & Family unable to manage any care in home as they all state they have scoliosis and are unable to move pt in bed &. Clinical record review failed to evidence home health aide was offered to the patient to assist with grooming, dressing, bathing, toileting, and transferring needs. During an interview on 12/17/2021, at 10:41 a.m., the clinical supervisor indicated the plan of care is created and individualized based on the patient s needs. On 12/17/2021, at 11:11 a.m., when queried, the clinical supervisor indicated she did not know why the patient did not receive HHA services, and stated, I don t have an answer. At minimum it should have been addressed. 17-14-1(a)(1)(B)		assistance with ADLs andIADLs. The medical social worker offered long-range planning to preventinstitutionalization, but the patient and family refused. The medical socialworker offered assistance with applying for additional assistance in the homeand the patient/family refused. During the skilled nurse visit that occurred 6days after the OASIS Start of Care visit, the nurse noted hematuria and thepatient was then admitted to the hospital for evaluation and treatment. Thepatient was then transferred to long term care and was discharged from the homehealth agency. All agencyclinicians have been re-educated on policy 2-S and 7-D to ensure that patientsreceive required services and are safe within their home environment. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to insure thedeficiency will not recur. Agency staffwill be educated on policies 5-K, 2-S and 7-D no less than annually. Thesepolicies will be incorporated consistently into monthly inservices andonboarding and ongoing education. The clinicalrecord review team will audit 100% of submitted	

			documentation in accordancewith policy 5-K "Documentation of Patient Services" and policy 7-D "PatientSafety" to ensure any identified needs are addressed. If a discrepancy isnoted, the document will be returned to the clinician for correction. If apatient need is unmet, the clinical manager will coordinate with the patient,family/caregivers and physician to determine services required to meet thepatient's needs in the home environment. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Clinicalmanager or designee 4. By what date are you going to have thedeficiency corrected? 2/10/2022	
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the home	G0572	G-0572 1. How the deficiency will be or has beenimmediately corrected. Each patient will receive all services and treatments asordered by the physician. This deficient practice will be immediately corrected as theagency will ensure all agency clinicians provide care in	2022-02-24

	health agency failed to ensure the plan of care was followed and individualized in 3 of 5 active patient records reviewed receiving wound care (#2, #7, #8). The findings include: 1. Record review on 12/17/2021, evidenced an agency policy titled, PLAN OF CARE , revised 1/8/2019, which stated, & 1. The plan of care will be established, periodically reviewed, and signed by a doctor or (sic) medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. 2. Physician orders are obtained prior to the initiation of care and with any changes in the plan of care & 3. The plan of care is individualized to each patient and developed through consultation with the patient / legal representative, the physician and all clinicians involved in the patient s care. 4. The individualized plan of care will specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment &. . 2. Record review on 12/17/2021, evidenced an undated agency policy titled, SKILLED NURSING SERVICES , which stated, & The Registered Nurse will: & Provide appropriate and rehabilitative nursing procedures according to the Plan of Care &. 3. Clinical record review for patient #2 on 12/9/2021, start of care 12/3/2021, certification period 12/3/2021 to 1/31/2022, primary diagnosis of Aftercare following joint replacement surgery, evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 12/8/2021. The plan of care had a subsection titled, Orders for Discipline and Treatment , which stated, & SN [skilled nurse] to assess for surgical wound signs and symptoms of infections &. Clinical record review evidenced an agency document titled, SKILLED NURSE VISIT , dated 12/9/2021, and signed by RN [registered nurse] R. The visit note had a subsection titled, Integumentary [skin] , which stated, & Incision & dressing to be removed 12/9/21 . The visit note had a subsection titled, Visit Narrative , which stated, Received patient sitting in recliner. 7 day surgical dressing changed using aseptic technique. Patient states that pain is better		accordance with the planof care. Review of the medical plan of carefor patient #2 evidenced the clinician failed to document their interventionsbased on the patient's specific individualized needs. The clinical managerreviewed policy 2-N entitled "Skilled Nursing Services" with RN R. The clinical manager has also reviewed policy 2-N with RN Fregarding the noted deficiency of this clinician in regards to documentingcomprehensive education provided to patient #8. All case managers and the clinical record review team havebeen instructed to review the medical plans of care for their current patientcase load to ensure that all orders on the individualized POC are being carriedout accordingly for all active patients. This will include such orders asobtaining weekly weights as ordered in the medical plan of care. In the eventthat a clinician does not document an ordered intervention, such as a weeklyweight, the document will be returned to the clinician for documentation of theweight or a reason why the weight was not obtained with care coordination asindicated. Additionally, all agency registered nurses have beenre-educated on policy 2-N	

	today &. Review of the visit note failed to evidence a wound assessment. During an interview on 12/17/2021, at 9:57 a.m., the clinical supervisor indicated a wound assessment should be documented on each nurse visit when a dressing change is done. When informed of the findings, the clinical supervisor indicated the nurse failed to include a wound care worksheet in the visit note. 4. Clinical record review for patient #7 on 12/15/2021, start of care 10/11/2021, certification period 10/11/2021 to 12/9/2021, primary diagnosis of Erysipelas [a bacterial skin infection], evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 10/28/2021. The plan of care had a subsection titled, Orders For Discipline and Treatment , which stated, SN [skilled nurse] TO TEACH PATIENT / PCG [patient caregiver] & VALIDATION / RESPONSE TO TEACHINGS: 1. On signs and symptoms of potential complications / further alterations on general health status related to Erysipelas. 2. Demonstrate and validate primary caregiver s ability for proper wound dressings care / management on Venous Stasis Ulcer [a wound on the leg or ankle caused by abnormal or damaged veins] of Right Lower Leg as prescribed observing infection control measures and safe disposal of contaminated supplies. 3. On signs and symptoms of vascular disease [an abnormal condition of the blood vessels] & 4. Critical signs and symptoms of Hypertension [a condition in which the force of the blood against the artery walls is too high] exacerbation such as chest pain, palpitations, severe headache, dizziness, vertigo, nausea & vomiting, visual disturbances. Assist the patient / primary caregiver to identify risk factors that can be modified & 5. On signs and symptoms of nephrologic [related to the kidneys] / general complications related to Stage 3a Chronic kidney disease. 6. Pain relief measures & 7. On Signs and symptoms of COVID-19 infection & 8. SN to instruct infection control precautions & 9. SN instruct patient and caregiver: Close contacts should monitor their health & 10. Pt / PCG will demonstrate general and COVID 19 infection control precautions & 11. Energy conservation techniques, activities as tolerated with planned rest periods & 12. Safety measures & 13. Multiple medications regimen; actions / adverse effects, prescribed dietary regimen and importance of good compliance &. Clinical record review evidenced a group of		entitled, “Skilled Nursing Services” regarding therequirement to provide appropriate and rehabilitative services according to theplan of care. The agency has already implemented improved practicesregarding missed visits. Agency staff have already received an electronicmessage within the agency EMR detailing the procedures regarding missed visitsand the need to make all attempts to reschedule the visit prior to documentinga missed visit. Agency staff are required to document the attempts made atrescheduling the visit as well as notification of the patient’s physicianregarding the missed visit. Furthermore, all agency clinicians have been re-educated onpolicies 2-N “Skilled Nursing Services”, 2-O “Physical Therapy Services”, 2-P“Occupational Services” as applicable to the clinician’s discipline. Theclinical record review team has also reviewed these policies during a clinicalmanagement meeting to ensure compliance with following the plan of care. 2. How thedeficiency will be prevented from recurring i.e. measure put into place orsystematic changes made to	

	documents titled, SKILLED NURSE VISIT . Nurse s visit notes, signed by RN F, with the following dates failed to evidence patient / caregiver teaching about Erysipelas, wound care, vascular disease, hypertension, chronic kidney disease, and energy conservation: 10/13/2021, 10/18/2021, 10/20/2021, 10/22/2021, 10/25/2021, 10/27/2021, 10/29/2021, 11/1/2021, 11/3/2021, 11/5/2021, 11/8/2021, 11/10/2021, 11/12/2021, 11/15/2021, 11/17/2021, 11/19/2021, 11/22/2021, 11/24/2021, 11/26/2021, 11/29/2021, 12/1/2021, and 12/3/2021. During an interview on 12/17/2021, at 10:09 a.m., the clinical supervisor indicated the nurse should document all teaching completed in the visit notes. When informed of the findings, the clinical supervisor indicated the nurse was focusing on the primary diagnosis of the wound. 5. Clinical record review for patient #8 on 12/15/2021, start of care 8/18/2021, certification period 10/17/2021 to 12/15/2021, primary diagnosis of Type 2 diabetes mellitus with foot ulcer [a chronic disease where the body doesn t produce enough or resists insulin], evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , dated 10/29/2021, and signed by the physician. The plan of care had a subsection titled, Orders for Discipline and Treatment , which stated, " ... CHHA [certified home health aide] Frequency: 1w9 [once a week, for 9 weeks]...." Clinical record review failed to evidence home health aide visits for the weeks of 10/24/2021 to 10/30/2021, 11/7/2021 to 11/13/2021, and 11/14/2021 to 11/20/2021. Clinical record review evidenced a group of agency documents titled, "MISSED VISIT NOTE", dated 10/26/2021, 11/9/2021, and 11/16/2021, each signed by HHA [home health aide] G. Clinical record review failed to evidence re-scheduling of the missed HHA visits. Clinical record review failed to evidence the agency provided HHA visits as ordered. During a interview on 12/17/2021, at		recur. All agency staffwill be educated at regular intervals (no less than onboarding and quarterly)regarding the requirement to adhere to the patient’s medical plan of care. The clinicalrecord review team will refer to the patient’s medical plan of care during thereview process. If a discrepancy is noted, the document will be returned to theclinician for clarification. Physicianorders will be obtained when patient condition requires a change to the medicalplan of care. All changes to the medical plan of care will be clearlydocumented and communicated to the patient, patient representative(s), otherdisciplines on the case and the patient’s physician. Policy 2-Nand the importance of adhering to the medical plan of care will be discussedduring our February 2022 in-service with ongoing education provided no less thanquarterly. All missedvisits are now being reviewed by the clinical management team during our weeklyClinical Management Meetings (held every Monday at 11:00am via Skype). Eachmissed visit is reviewed for comprehensiveness and appropriateness. If themissed	

	10:52 a.m., the clinical supervisor indicated if a visit is missed, the clinician is expected to reschedule the visit for that same week. Clinical record review evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , dated 10/29/2021, and signed by the physician, which stated, & SN [skilled nurse] TO PERFORM: & 5. Weigh patient weekly &. Clinical record review evidenced a group of documents titled, SKILLED NURSE VISIT . Review of all visit notes for the certification period 10/17/2021 to 12/15/2021 failed to evidence a patient weight. Review of the patient s electronic medical record (Axxess) failed to evidence any patient weight since start of care on 8/18/2021. During an interview on 12/17/2021, at 10:37 a.m., the clinical supervisor indicated if a physician orders for a patient to be weighed weekly, it should be documented in the skilled nurse visit notes and visible in the patient s record in Axxess. The clinical supervisor indicated if the nurse was unable to weigh the patient, they should communicate that to the physician and get an order to discontinue the weekly weight. When informed of the findings, the clinical supervisor reviewed the patient s record and indicated it failed to evidence weekly patient weight. Clinical record review for patient #8 on 12/15/2021, start of care 8/18/2021, certification period 10/17/2021 to 12/15/2021, evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , dated 10/29/2021 and signed by the physician. The plan of care had a subsection titled, Orders for Discipline and Treatment , which stated, & SN [skilled nurse] TO TEACH PATIENT / PCG [patient caregiver] & VALIDATION / RESPONSE TO TEACHINGS: 1. On the signs and symptoms of hypo / hyperglycemia [low or high blood sugar] & 2. On importance of inspecting skin and feet daily & 3. Demonstrate and validate primary caregiver s ability for proper wound dressings care / management on Diabetic ulcer & 4. On signs and symptoms of Hypertensive heart disease with heart failure & 5. On checking pulse rate every day for 1 month, then every week, and to notify physician		visit form does not detail the clinician’s attempt at rescheduling thevisit, the missed visit form is returned to the clinician for clarification.The clinical management team also reviews the patient’s chart during this timeto ensure proper care coordination has been performed if warranted. 100% ofcharts will be audited for adhesion to the established medical plan of care. Ifat any time a discrepancy is noted, the documentation will be returned to theclinician and care coordination will be implemented as applicable. In addition toconsistent auditing of 100% of submitted documentation, quarterly qualityassurance/performance improvement efforts will continue. Each quarter, 10% ofpatient charts from each branch will be reviewed in their entirety foraccuracy, comprehensiveness, adherence to the plan of care and agency policyand procedure protocols. This review will include monitoring of educationprovided to patients as indicated on the plan of care and theirrepresentative(s) as well as their response, implementation of orders such asweekly weights and full review regarding any missed visits and the carecoordination that was implemented. All findings will be	

	Recognize the signs and symptoms of respiratory infection and hypoxia [low oxygen levels] & 7. Teach disease process of diabetic polyneuropathy [a complication of diabetes mellitus characterized by progressive death of nerve fibers, which leads to loss of nerves, increased sensitivity, and the development of foot ulcers] & 8. Signs and symptoms of gastrointestinal compromise / complications [problems with stomach and intestines] & 9. On signs and symptoms of bleeding & 10. Pain relief measures & 11. Energy conservation techniques & 12. Safety measures & 13. Multiple medications regimen; actions / adverse effects, prescribed dietary regimen and importance of good compliance &. Clinical record review evidenced a group of documents titled, SKILLED NURSE VISIT . Nurse s visit notes, signed by RN F, with the following dates failed to evidence patient / caregiver teaching about wound dressing care, inspecting feet daily, hypertensive heart failure, checking pulse rate, signs and symptoms of respiratory infection and hypoxia, diabetic polyneuropathy, gastrointestinal compromise / complications, energy conservation techniques, and safety measures: 10/18/2021, 10/20/2021, 10/22/2021, 10/25/2021, 10/27/2021, 10/29/2021, 11/1/2021, 11/3/2021, 11/5/2021, 11/8/2021, 11/10/2021, 11/12/2021, 11/15/2021, 11/17/2021, 11/19/2021, 11/22/2021, 11/24/2021, 11/26/2021, 11/29/2021, 12/1/2021, 12/3/2021, 12/6/2021, 12/8/2021, 12/10/2021, and 12/13/2021. During an interview on 12/17/2021, at 10:09 a.m., the clinical supervisor indicated the nurse should document all teaching completed in the visit notes. When informed of the findings, the clinical supervisor offered no further information. 17-13-1(a)		reviewed and discussedduring agency quarterly QAPI meetings. Performance improvement projects,in-services and educational efforts will be tailored to quarterly QAPI findings. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. ClinicalManager or designee 4. By what date are you going to have thedeficiency corrected? 2/24/2022	
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	G0574	G-0574 1. How the deficiency will be or has beenimmediately corrected. The noteddeficiency regarding	2022-02-24

	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. Based on observation, record review and interview, the agency failed to ensure the individualized plan of care included all services, safety measures, medications and treatments in 6 of 12 records reviewed receiving skilled nursing services (#1, #4, #7, #8, #9, #13). The findings include: 1. Record review on 12/17/2021, evidenced an agency policy titled, PLAN OF CARE , revised 1/8/2019, which stated, & 1. The plan of care will be established, periodically reviewed, and signed by a doctor or (sic) medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. 2. Physician orders are obtained prior to the initiation of care and with any changes in the plan of care & 3. The plan of care is individualized to each patient and developed through consultation with the patient / legal representative, the physician and all clinicians involved in the patient s care. 4. The individualized plan of care will specify the care		patient #1’s medication profile was immediately corrected.The medication Biofreeze was updated by the registered nurse to reflect itsadministration as topical instead of by mouth. The updated medication profilewas sent via fax to the patient’s physician for signature. Regardingpatient #7’s medication profile in which there was no indication for the asneeded use of meclizine, the assessing clinician updated the patient’smedication profile to reflect the as needed use for nausea after confirmingthis medication with the patient’s physician. The patient was contacted toensure the patient understood the use of this medication and its schedule. The updatedmedication profile was sent via fax to the patient’s physician for signature. Regardingpatient #8’s medical record which includes reference to podiatry visits for thepatient without a reference to podiatry in the plan of care, RN F has beeneducated regarding inclusion of all services that the patient is receiving inthe medical plan of care. Patient #4’smedication profile has been reviewed and reconciled with the patient, patientrepresentative(s), care team and physician. An updated medication profile hasbeen sent	

	patient-specific needs as identified in the comprehensive assessment & 5. The plan of care will include the following: & d. The frequency and duration of visits to be made & All medications and treatments; k. Safety measures to protect against injury & n. The care and services necessary to meet the patient-specific needs identified in the comprehensive assessment; o. Measurable outcomes and goals based on the patient s diagnosis, physician s orders, comprehensive assessment, and patient input &. 2. Record review on 12/17/2021, evidenced an agency policy revised on 1/8/2019, titled "Coordination of Patient Services." This policy stated, " & Clear written communication will be provided to the patient and caregiver/representative (if any) regarding visit schedules and frequencies consistent with the current plan of care; patient medication schedule/instructions including medication name, dosage and frequency, and medications that will be administered by agency personnel &. 3. Clinical record review for patient #1 on 12/9/2021, start of care 12/1/2021, certification period 12/1/2021 to 1/29/2022, primary diagnosis of Infection following a procedure, surgical site, evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 12/14/2021. The plan of care had a subsection titled, Medications , which stated, & BIOFREEZE [a topical pain reliever] &apply to left knee twice a day for pain By mouth &. During an interview on 12/16/2021, at 2:31 p.m., the clinical supervisor indicated all medication orders should contain the name of the medication, dosage, frequency, route, and reason for taking if the medication is ordered PRN [as needed]. When informed of the findings, the clinical supervisor indicated Biofreeze was used topically, not by mouth, and stated, It s a common problem [wrong route] & I can fix it & 4. Clinical record review for patient #7 on 12/15/2021, start of care 10/11/2021, certification period 10/11/2021 to 12/9/2021, primary diagnosis of Erysipelas [a bacterial skin infection], evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 10/28/2021. The plan of care had a subsection titled, Medications , which stated, & MECLIZINE [a medication used to treat vertigo]		to the physician for signature. This updated medication profile hasalso been left in the patient's home. In regardsto all medication issues identified during survey, including previouslydischarged patients #13 and #9, all agency clinicians have been re-educatedregarding policy 5-E entitled "Plan of Care" which requires that care isspecified to meet the patient specific needs as identified and ordered. Additionally,all agency clinicians have been re-educated on medication reconciliation anddocumentation of medications in the patient's medication profile. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to insure thedeficiency will not recur. Agencyclinicians will be consistently educated on agency policy regarding reviewingand reconciling patient medications at each encounter. If a medication issue isidentified, the physician will be immediately notified. Physician orders willbe obtained as appropriate. The clinicalrecord review team will closely monitor patient's medication profiles duringthe	

	25 MG [milligram] ORAL TABLET 1 tab TID [three times a day] PRN [as needed] By mouth &. The plan of care failed to evidence the indication for use of the Meclizine. During an interview on 12/16/2021, at 2:31 p.m., the clinical supervisor indicated all medication orders should contain the name of the medication, dosage, frequency, route, and reason for taking if the medication is ordered PRN [as needed]. 5. Clinical record review for patient #8 on 12/15/2021, start of care 8/18/2021, certification period 10/17/2021 to 12/15/2021, primary diagnosis of Type 2 diabetes mellitus with foot ulcer [a chronic disease where the body doesn t produce enough or resists insulin], evidenced a group of agency documents titled, SKILLED NURSE VISIT . Nurse s visit notes dated 10/18/2021, 10/20/2021, and 10/22/2021, signed by RN [registered nurse] F, stated, & Visiting home physicians seeing pt [patient] as needed as well as Podiatrist [foot doctor] as needed &. A nurse s visit note dated 10/25/2021, signed by RN F, stated, & Podiatry to be scheduled to follow pt in home for wound eval. [evaluation] &. . A nurse s note dated 11/3/2021, signed by RN F, stated, & Podiatry is due to see pt later this week for wound assessment and callous removal in home &. . A nurse s note dated 11/5/2021, signed by RN F, stated, & Podiatry is due to see pt later today &. . A nurse s note dated 11/8/2021, signed by RN F, stated, & Podiatry saw pt late last week and removed callouses surrounding wound &. . A nurse s note dated 11/19/2021, signed by RN F, stated, & Surrounding skin remains calloused. Podiatry will have to return to remove again &. . A nurse s note dated 11/24/2021, signed by RN F, stated, & Message left for Podiatry &. . A nurse s note dated 11/29/2021, signed by RN F, stated, & Care Coordinated with: Physician, other Name / Title Podiatry &. . A nurse s note dated 12/6/2021, signed by RN F, stated, & Podiatry to see pt for callous removal this week on Wed &. . Clinical record review evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 10/29/2021. Review of the plan of care failed to evidence Podiatry. During an interview on 12/17/2021, at 10:41 a.m., the clinical supervisor indicated all therapies and services a patient is receiving should be in the plan of care. When informed of		an error or medication issue isidentified, care coordination will occur as needed to rectify the error oraddress the issue, including but not limited to revision of the medicationprofile and notification of the patient, patient representative(s), care teamand physician. Review andreconciliation of medications will be addressed no less than quarterly duringagency in-services provided to clinicians. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. Clinicalmanager or designee 4. By what date are you going to have thedeficiency corrected? 2/24/2022	

plan of care failed to evidence all treatments the patient was receiving.

6. Clinical record review for patient #13 on 12/15/2021, start of care 6/1/2021, certification period 7/31/2021 to 9/28/2021, primary diagnosis of Venous insufficiency [a condition caused by impaired leg circulation which causes swelling and skin changes], evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 9/15/2021. The plan of care had a subsection titled, Medications , which stated, & ATROPINE DIPHENOXYLATE [an anti-diarrheal medication] 0.025 MG [milligram] 2.5 MG ORAL TABLET 1 tablet 2 times daily as needed By mouth &. . The plan of care failed to evidence an indication for usage of the as-needed medication.

During an interview on 12/16/2021, at 2:31 p.m., the clinical supervisor indicated all medication orders should contain the name of the medication, dosage, frequency, route, and reason for taking if the medication is ordered PRN [as needed]. When informed of the findings, the clinical supervisor offered no further information.

7. Clinical record review for patient #9 on 12/14/2021, start of care 10/27/2021, certification period 10/27/2021 to 12/25/2021, evidenced an agency document titled Home Health Certification and Plan of Care. The plan of care had a subsection titled, Medications, which stated, Epi EZ Pen [used to treat emergent allergic reactions] 0.3 mg Injectable Kit As directed As directed [sic] Intramuscular (IM) ... Ester-C Plus [a vitamin/dietary supplement] As directed as directed [sic] By mouth (PO) ... Meclizine 25 mg Oral Tablet 1 tab three times daily as needed By mouth (PO) ... Alprazolam [a medication used to treat anxiety and panic disorder] 0.25 mg Oral Tablet 1 tab daily as needed By mouth (PO) ... Calcium [mineral/supplement needed for many functions of the body] 2 tabs daily By mouth (PO) ...." The plan of care failed to evidence an indication for using the medication Epi EZ Pen, the dose or time for Ester-C Plus, an indication for using the medication Meclizine, an indication for using the medication Alprazolam, and a dose amount for the

	medication Calcium. 8. During a home visit observation for patient #4 on 12/8/2021 at 1:00 p.m., RN H asked patient #4 about his medications. Patient #4's wife indicated the medication records were old because he does not take Glipizide [an oral medication used to control high blood sugar levels] anymore and his Lupron injection [a hormone used to treat symptoms of prostate cancer] was not listed. Clinical record review for patient #4 on 12/14/2021, start of care 7/7/2021, certification period 11/4/2021 to 1/2/2022 evidenced an agency document titled Home Health Certification and Plan of Care. The plan of care had a subsection titled, Medications, which included the following medications: Glipizide, Amlodipine Besylate [used to treat high blood pressure], Flomax [used to treat enlarged prostate], Fenofibrate [used to lower high cholesterol and high triglyceride levels], Niacin [used to treat high cholesterol and high triglyceride levels], Plavix [blood thinner], Bisoprolol Fumarate [used to treat high blood pressure], Atorvastatin [used to treat high cholesterol and triglyceride levels], Docusate Sodium [used to treat constipation], and Tylenol [a pain reliever/fever reducer]. The plan of care failed to evidence Lupron as indicated by the patient's wife as a current medication for the patient. 17-13-1(a)(1)(D)(ii, x, ix)			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on observation, record review, and interview, the agency failed to ensure all medications, services and treatments were administered only as ordered by the physician in 2 of 5 active patient records reviewed receiving wound care (#2, #7). The findings include: 1. Record review on 12/17/2021, evidenced an undated agency policy titled, PHYSICAL	G0580	**G-0580** 1. How the deficiency will be or has beenimmediately corrected.	2022-02-24

	Registered Physical Therapist (RPT) will: & 4. Plan and prepare a written treatment program based on the evaluation of patient data and assessment and notify the patient s physician to obtain orders for further treatment & 6. Plan and administer prescribed physical therapy & 10. Contact the physician for approval of services prior to administering the plan of care and document the approval in the assessment &. 2. Record review evidenced an agency titled, PLAN OF CARE , revised 1/8/2019, which stated, POLICY Home care services are furnished under the supervision and direction of the patient s physician in accordance with a plan of care & Physician orders are obtained prior to the initiation of care and with any changes in the plan of care &. 3. Record review evidenced an agency titled, PHYSICIAN ORDERS , revised 1/8/2019, which stated, POLICY All drugs, treatments, procedures, and care provided to patients must be ordered by a physician & 5. All additions, changes, or deletion of medications obtained by a clinician & require a verbal order &. 4. Observation of a home visit on 12/8/2021, at 1:29 p.m., patient #2, primary diagnosis of aftercare following joint replacement surgery (right knee), was observed wearing a brace on the right knee. At 1:36 p.m., PT [physical therapist] J was observed removing the knee brace and assisting the patient to exercise the knee. At 1:59 p.m., PT J reapplied the brace to the patient s right knee. Clinical record review for patient #2, start of care 12/3/2021, certification period 12/3/2021 to 1/31/2022, evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 12/8/2021. Review of the plan of care failed to evidence an order or instruction for the patient to use a knee brace. Clinical record review of all physician orders for patient #2 failed to evidence an order for use of a knee brace. Clinical record review of all communication notes for patient #2 failed to evidence communication with physician about use of a knee brace. Clinical record review of the patient s electronic medical record (Axxess) failed to evidence a physician order for the patient to use a knee brace.		The agencyobtained a physician order for intended use of the right knee brace for patient#2. The clinical manager immediately reviewed policy 2-O “Physical TherapyServices” with PT J regarding obtaining orders for all treatment rendered. The agency obtained a physician order for the changed doseof penicillin for patient #7. Additionally, the clinical manager reviewed policy2-N “Skilled Nursing Services” with RN F regarding obtaining orders for alltreatment rendered, including changes to current treatments. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to insure thedeficiency will not recur. The clinicalmanager will educate all clinicians, no less than quarterly and as part ofonboarding and ongoing educational efforts, on the following: Each staff memberis to review the EMR clinical record prior to each skilled visit. The clinician is to review the plan of careto ensure there are physician orders for all services, treatments, andmedications. Physician orders are to beobtained if the clinician identifies the need for a medication, service, and/ortreatment that is not	

	During an interview on 12/8/2021, at 2:00 p.m., PT J indicated most patients do not use a knee brace after knee replacement surgery, and stated, I spoke to the doctor, so I know he wants it. During an interview on 12/17/2021, at 9:50 a.m., the clinical supervisor indicated all therapies and treatments should be completed as ordered. The clinical supervisor indicated the clinical record failed to evidence an order for use of a knee brace. 5. Clinical record review for patient #7 on 12/15/2021, start of care 10/11/2021, certification period 10/11/2021 to 12/9/2021, primary diagnosis of Erysipelas [a bacterial skin infection], evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 10/28/2021. The plan of care had a subsection titled Medications , which stated, PENICILLIN 250 MG [milligram] TAB 1 TAB 2xday [two times a day] x 30 days [for 30 days] By mouth &. Clinical record review evidenced an agency document titled, SKILLED NURSE VISIT , dated 11/17/2021, and signed by RN [registered nurse] F, which stated, &. Increased PCN [penicillin] to 500 mg BID [twice a day] with no end date noted at this time &. . Clinical record review of all physician orders from certification period 10/11/2021 to 12/9/2021, failed to evidence a physician s order for the changed dose of penicillin. Clinical record review of the patient s electronic medical record (Axxess) failed to evidence a physician order for the changed dose of penicillin. During an interview on 12/7/2021, at 10:06 a.m., the clinical supervisor indicated the nurse should do a full medication reconciliation at every visit, and if any changes are noted, the nurse should call the physician and get an order for the new or changed medication. When informed of the findings, the clinical supervisor indicated the clinical record failed to evidence an order for the changed dose of penicillin. 17-13-1(a)		currently ordered. The order is to be obtained prior to performing the task or service. Ongoing compliance will be addressed through 100% auditingof clinical documentation. In addition toconsistent auditing of 100% of submitted documentation, quarterly qualityassurance/performance improvement efforts will continue. Each quarter, 10% ofpatient charts from each branch will be reviewed in their entirety foraccuracy, comprehensiveness, adherence to the plan of care and agency policyand procedure protocols. All findings will be reviewed and discussed duringagency quarterly QAPI meetings. Performance improvement projects, in-servicesand educational efforts will be tailored to quarterly QAPI findings. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. ClinicalManager or designee 4. By what date are you going to have thedeficiency corrected? 2/24/2022	

G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to promptly alert the physician to change in a patient's condition in 2 of 4 records reviewed receiving occupational therapy (#9, #11). The findings include: 1. Record review on 12/17/2021, evidenced an undated agency policy titled, SKILLED NURSING SERVICES , which stated, & The Registered Nurse will: & 10. Inform the physician and other appropriate medical personnel of changes in the patient s condition and needs &. 2. Record review evidenced an undated agency policy titled, PHYSICAL THERAPY SERVICES , which stated, & The Registered Physical Therapist (RPT) will: & 12. Observe and record the patient s treatment, education, response, and progress, and notify the physician of any significant changes in condition &. 3. Clinical record review on 12/16/2021, for patient #11, start of care 9/5/2020, certification period 9/5/2020 to 11/3/2020, primary diagnosis of Encounter for change or removal of non-surgical wound dressing, evidenced a group of agency documents titled, PT [physical therapy] VISIT , signed by PT [physical therapist] J. Review of a note dated 9/7/2021, indicated the patient s oxygen saturation was 80%. Review of the visit note failed to evidence physician notification of the patient s low oxygen saturation. Review of all communication notes for certification period 9/5/2020 to 11/3/2020, failed to evidence physician notification of the patient s low oxygen saturation. Review of a note dated 9/10/2021, indicated the patient s oxygen saturation was 87%. Review of the visit note failed to evidence physician notification of the patient s low oxygen saturation. Review of all communication notes for certification period 9/5/2020 to 11/3/2020 failed to evidence physician notification of the patient s low oxygen saturation.	G0590	**G-0590** 1. How the deficiency will be or has beenimmediately corrected. Allclinicians are required to notify the patient’s physician of all changes inpatient needs or significant assessment findings. These deficiencies have been immediatelycorrected with the following actions: · Physicians have been notified of the identifiedchanges in the patients’ conditions as noted, with no new orders received dueto the length of time that has transpired. · Physical therapist J and RN X have beenre-educated on policies 2-N, “Skilled Nursing Services”, 2-O, “Physical TherapyServices” and 5-J “Coordination of Patient Services.” · All agency staff has received updated trainingon these named policies with reinforcement regarding notification of physicianof all changes in the patient’s condition. · The clinical record review team has been re-educatedon identifying changes in the patient’s condition during the review process.	2022-02-24

	4. During an interview on 12/17/2021, at 11:20 a.m., the clinical supervisor indicated if a clinician measured a patient s oxygen saturation to be 80% or 87%, they should do a follow up re-assessment and call the physician. When informed of the findings, the clinical supervisor stated, I would hope a clinician wouldn t leave something like that. 5. Clinical record review for patient #9 on 12/14/2021, certification period 10/27/2021 to 12/25/2021, evidenced an agency document titled Home Health Certification and Plan of Care. The plan of care had a subsection titled, Reporting Parameters, which stated, & 5. Any significant changes in clinical status...." Clinical record review for patient #9 on 12/14/2021, evidenced an agency document titled, "Skilled Nurse Visit" electronically signed by Registered Nurse X. This document had a subsection titled, "Pain Profile," which stated, "... Potential Aberrant Behavior Noted: Appears intoxicated...." This document had another subsection titled, "Visit Narrative," which stated, "... Pt has has [sic] some dizziness today. 'Feels like I'm on a boat'...." The registered nurse failed to notify the physician of a change in the patient's clinical status. 6. During an interview on 12/16/2021 at 3:35 p.m., the clinical supervisor indicated the registered nurse should have further assessed the patient and notified the physician. 17-13-1(a)(2)		2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to insure thedeficiency will not recur. The Agency Clinical Manager/designee will educate all field staff of thefollowing case management and coordination of care responsibilities: · Responsibility to report all changes in patientcondition to the physician immediately; · Responsibility to document this physiciancommunication and the physician response; · Responsibility to communicate changes in patientcondition to all team members and document this communication in the EMR; · Responsibility to case conference patientsexperiencing changes in condition, falls, skin tears, elevated pain levels,etc. The goal of the case conference iscollaboration and problem solving to implement measures that will facilitatebetter pain control, the prevention of falls, etc. All above measures are to be documented in the EMR Additionally, the clinical record	

			review team will monitorfor any documented changes in the patient's condition. If a change is noted,the clinical record review team will then audit the patient's chart for carecoordination. If care coordination is not present, the assessing clinician willbe contacted and/or the clinical document will be returned to the clinician fordocumentation of care coordination. If needed, the clinical manager willcoordinate with the patient, patient representative(s), care team and physicianto aide in the notification of patient status changes. In addition toconsistent auditing of 100% of submitted documentation, quarterly qualityassurance/performance improvement efforts will continue. Each quarter, 10% ofpatient charts from each branch will be reviewed in their entirety foraccuracy, comprehensiveness, adherence to the plan of care and agency policyand procedure protocols. All findings will be reviewed and discussed duringagency quarterly QAPI meetings. Performance improvement projects, in-servicesand educational efforts will be tailored to quarterly QAPI findings.	

			3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. ClinicalManager or designee 4. By what date are you going to have thedeficiency corrected? 2/24/2022	
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review and interview, the agency failed to provide the patient with an updated medication schedule in 2 of 9 active patients. (#4, #9) 1. Record review on 12/14/2021 evidenced an undated agency document titled "Skilled Nursing Services," which stated, "...The Registered Nurse will: ... 4. Write the medication profile at the Start of Care and update every 60 days and with any changes throughout the time of service...." 2. Clinical record review for patient #9 on 12/14/2021, start of care 10/27/2021, certification period 10/27/2021 to 12/25/2021, evidenced an agency document titled Home Health Certification and Plan of Care. The plan of care had a subsection titled, Medications, which stated, Epi EZ Pen [used to treat emergent allergic reactions] 0.3 mg Injectable Kit As directed As directed [sic] Intramuscular (IM) ... Ester-C Plus [a vitamin/dietary supplement] As directed as directed [sic] By mouth (PO) ... Meclizine 25 mg Oral Tablet 1 tab three times daily as needed By mouth (PO) ... Alprazolam [a medication used to treat anxiety	G0616	**G-0616** 1. How the deficiency will be or has beenimmediately corrected. Themedication profile for patient #4 has been updated to accurately reflectindications, dosages and frequencies for all prescribed medications withcoordination with the patient's physician and the patient and patientrepresentative(s) to ensure accurate and safe medication administration. Theupdated medication profile has been sent to physician for signature and anupdated medication profile has been left in the patient's home and reviewedwith patient and representative(s). In regard to themedication profile issues identified for both patient #4 and patient #9, allagency	2022-02-24

	and panic disorder] 0.25 mg Oral Tablet 1 tab daily as needed By mouth (PO) ... Calcium [mineral/supplement needed for many functions of the body] 2 tabs daily By mouth (PO) ...." The plan of care failed to evidence an indication for using the medication Epi EZ Pen, the dose or time for Ester-C Plus, an indication for using the medication Meclizine, an indication for using the medication Alprazolam, and a dose amount for the medication Calcium. 3. During a home visit observation for patient #4 on 12/8/2021 at 1:00 p.m., RN H asked patient #4 about his medications. Patient #4's wife indicated the medication records were old because he does not take Glipizide [an oral medication used to control high blood sugar levels] anymore and his Lupron injection [a hormone used to treat symptoms of prostate cancer] was not listed. Clinical record review for patient #4 on 12/14/2021, start of care 7/7/2021, certification period 11/4/2021 to 1/2/2022 evidenced an agency document titled Home Health Certification and Plan of Care. The plan of care had a subsection titled, Medications, which included the following medications: Glipizide, Amlodipine Besylate [used to treat high blood pressure], Flomax [used to treat enlarged prostate], Fenofibrate [used to lower high cholesterol and high triglyceride levels], Niacin used to treat high cholesterol and high triglyceride levels], Plavix [blood thinner], Bisoprolol Fumarate [used to treat high blood pressure], Atorvastatin [used to treat high cholesterol and triglyceride levels], Docusate Sodium [used to treat constipation], and Tylenol [a pain reliever/fever reducer]. During an interview on 12/16/2021 at 3:08 p.m., the alternate clinical supervisor indicated the patient's case manager or registered nurse should reconcile the medication list at every visit.		clinicians have been re-educated on medication reconciliation anddocumentation of medications in the patient's medication profile. RN H hasreceived one on one training regarding policy 2-N "Skilled Nurse Services" witha focus on the requirement to write the medication profile comprehensively andaccurately. The clinicalrecord review team has been re-educated about reviewing the medication profileduring the clinical record review process. If a discrepancy is noted orclarification is needed, the document will be returned to the assessingclinician for revision. All changes to a patient's medication profile will beconfirmed with the patient's physician and the updated medication profile willbe sent for physician signature. 2. How thedeficiency will be prevented from recurring i.e. measure put into place orsystematic changes made to insure the deficiency will not recur. Agencyclinicians will be consistently educated on agency policy regarding reviewingand reconciling patient medications at each encounter. If a medication issue isidentified, the physician will be immediately notified. Physician orders willbe obtained as appropriate.	

			The clinicalrecord review team will closely monitor patient's medication profiles duringthe documentation review process. If an error or medication issue isidentified, care coordination will occur as needed to rectify the error oraddress the issue, including but not limited to revision of the medicationprofile and notification of the patient, patient representative(s), care teamand physician. Review andreconciliation of medications be addressed no less than quarterly during agencyin-services provided to clinicians. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. ClinicalManager or designee 4. By what date are you going to have thedeficiency corrected? 2/24/2022	
G0704	Responsibilities of skilled professionals 484.75(b) Standard: Responsibilities of skilled professionals. Skilled professionals must assume responsibility for, but not be restricted to, the following: Based on record review and interview, the agency failed to ensure the clinician performed full documented assessments during visits in 6 of 9 patient records reviewed receiving physical therapy (#2, #4, #5, #6, #7, #11).	G0704	**G-0704** 1. How the deficiency will be or has beenimmediately corrected. Regardingpatients #2, 4, 5, 6, 7, and 11, therapists have been educated about policy 2-O"Physical Therapy Services"	2022-02-24

	The findings include: 7. Clinical record review for patient #2 on 12/9/2021, start of care 12/3/2021, certification period 12/3/2021 to 1/31/2022, primary diagnosis of Aftercare following joint replacement surgery, evidenced a group of agency documents titled, PT [physical therapy] Visit," dated 12/4/2021, 12/6/2021, and 12/9/2021, and signed by PT [physical therapist] J. Each of the PT visit notes failed to evidence a patient respiratory rate. 8. Clinical record review for patient #7 on 12/15/2021, start of care 10/11/2021, certification period 10/11/2021 to 12/9/2021, primary diagnosis of Erysipelas [a bacterial skin infection], evidenced a group of agency documents titled, PT [physical therapy] Visit," dated 10/15/2021, 10/19/2021, 10/22/2021, 10/26/2021, 10/28/2021, 11/2/2021, 11/6/2021, and 11/22/2021 and signed by PT [physical therapist] S. Each of the PT visit notes failed to evidence a patient respiratory rate. Clinical record review evidenced an agency document titled, Physical Therapy Reassessment / Re-Evaluation , dated 11/9/2021, and signed by PT S, which failed to evidence a patient respiratory rate. 9. Clinical record review for patient #11 on 12/16/202, start of care 9/5/2020, certification period 9/5/2020 to 11/3/2020, primary diagnosis of Encounter for change or removal of non-surgical wound dressing, evidenced an agency document titled, Physical Therapy Assessment / Evaluation , dated 9/5/2020, signed by PT J, which failed to evidence a patient respiratory rate. Clinical record review evidenced a group of agency documents titled PT [physical therapy] Visit," dated 9/7/2020 and 9/10/2020, signed by PT J, which failed to evidence a patient respiratory rate. Clinical record review evidenced an agency document titled, Occupational Therapy Assessment / Evaluation , dated 9/9/2020, signed by OT [occupational therapist] M, which failed to evidence a patient respiratory rate.		Therapy Services" witha focus on vital sign assessment. Therapists have been educated by the clinicalmanager and the therapy coordinator regarding assessment of a patient's bloodpressure, heart rate, respirations, temperature at every visit. Specifically,the clinical manager has met with OTA P, OT M, PTA L, PT J and PT S to discussthese policies and the assessment and documentation of vital signs at everyvisit. The clinicalrecord review team responsible for therapy documentation review has beenre-educated on these same policies. If clinical documentation of a therapyvisit is submitted without these vital signs, the document will be returned tothe assessing clinician for addition of the vitals and/or reasonablejustification as to why the vital sign was not assessed with appropriate carecoordination with the physician. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to insure thedeficiency will not recur. TheAgency Clinical Manager/designee will educate all field staff of the followingcase management and coordination of care responsibilities:	

	During an interview on 12/17/2021, at 9:57 a.m., the clinical supervisor indicated therapists typically document vital signs at least once each visit. 1. Record review on 12/14/2021 evidenced an undated agency document titled, "Physical Therapy Services," which stated, "... Physical therapy services shall be provided by a Registered Physical Therapist or a Physical Therapy Assistant ... The Registered Physical Therapist (RPT) will: ... 2. Complete a patient assessment appropriate to the patient's diagnosis and age and based on patient need, and record and evaluate findings to aid in establishing or revising the treatment programs. The evaluation assessment will address: ... c. Physical assessment which may include diagnoses, vital signs, pulse oximetry readings, ..." 2. Record review on 12/14/2021 evidenced an undated agency document titled, "Occupational Therapy Services," which stated, "Occupational therapy services shall be provided by a Registered Occupational Therapist (OT) or a Certified Occupational Therapy Assistant (COTA) ... The Registered Occupational Therapist (OT) will: ... 2. Complete a patient assessment appropriate to the patient's diagnosis and age and based on patient need, and record and evaluate findings to aid in establishing or revising the treatment programs. The evaluation assessment will address: ... c. Physical assessment which may include diagnoses, vital signs, pulse oximetry readings, ..." 3. Clinical record review on 12/15/2021 for patient #4, start of care 7/7/2021, for certification period 11/4/2021 to 1/2/2022, evidenced agency documents titled COTA [certified occupational therapist assistant] Visit," dated 11/2/2021, 11/8/2021, 11/10/2021, 11/17/2021, 11/19/2021, and 11/23/2021, all electronically signed by OTA P. Review indicated the OTA failed to assess the patient's respirations during the therapy session. 4. Clinical record review on 12/15/2021 for patient #5, start of care 9/7/2021, for certification period 9/7/2021 to 11/5/2021, evidenced agency documents titled OT [occupational therapist] Visit," dated 9/13/2021, 9/15/20221, 9/20/2021,		· Responsibility to assess vital signs during allskilled visits. · Responsibility to report vital signs that areoutside ordered vital sign parameters. · Responsibility to coordinate with the patient,patient representative(s), care team and physician as needed in regards toassessment of vital signs. All above measures are to be documented in the EMR. Theclinical record review team will audit 100% of submitted documentation foradherence to these expectations. In the event the expectations are unmet, thedocument will be returned to the clinician for correction. The attainment of vital signs at every skilled visit will bereviewed during our February 2022 in-service with ongoing education provided noless than quarterly each year. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. ClinicalManager or designee 4. By what date are you going to have thedeficiency corrected? 2/24/2022	

	9/22/2021, 9/27/2021, 9/29/2021, 10/4/2021, 10/11/2021, 10/13/2021, 10/18/2021, 10/20/2021, 10/25/2021, 10/30/2021, 11/1/2021, and 11/5/2021, all digitally signed by OT M. Review indicated the OT failed to assess the patient's respirations during the therapy session. 5. Clinical record review on 12/15/2021 for patient #6, start of care 9/16/2021, for certification period 9/16/2021 to 11/14/2021, evidenced an agency document titled PTA [physical therapy assistant] Visit," dated 9/23/2021, 9/28/2021, 9/30/2021, 10/5/2021,10/7/2021, 10/12/2021, 10/14/2021, 10/26/2021, and 11/2/2021, all digitally signed by PTA L. Review indicated the PTA failed to assess the patient's respirations during the therapy session. 6. During an interview on 12/16/2021 at 2:12 p.m., the clinical supervisor indicated therapy was able to document respirations.			
G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on record review and interview, the agency failed to ensure coordination of care between disciplines in 2 of 9 active patients. (#4, #6) 1. Record review on 12/17/2021 evidenced an agency policy revised on 1/8/2019 titled "Coordination of Patient Services." This policy stated, "...All members of the home care team will coordinate services to maintain continuity of care, facilitate patient/caregiver involvement, and maximize patient outcomes. ... All clinicians involved in the patient's plan of care will contribute to an ongoing interdisciplinary assessment to discuss the patient's health status, patient needs, factors that could affect patient safety and treatment effectiveness...." 2. Clinical record review on 12/15/2021 for patient #4, start of care 7/7/2021, certification period 11/4/2021 to 1/2/2022, evidenced an agency document titled Physical Therapy Reassessment/Re-Evaluation, dated	G0706	G-0706 1. How the deficiency will be or has beenimmediately corrected. The Agency will ensure clinicians perform and document completeinterdisciplinary assessments at every home visit. The nature and scope of the assessment isbased on the medical POC and physician verbal orders. Clinicians have beenre-educated on policy 5-J “Coordination of Patient Services” to ensureunderstanding of the requirement to coordinate services and any changes to thepatient’s plan of care,	2022-02-24

	[physical therapist] N, which had a subsection titled "Functional Assessment Comments: Comments" which stated, "...patient/wife reported an unwitnessed fall yesterday. Patient were walking [sic]with walker ... Patient fell. Wife saw patient on the floor laying on his side...." Further record review evidenced an agency document titled Skilled Nurse Visit, dated 12/2/2021 and electronically signed by RN [registered nurse] O, which had a subsection titled "Visit Narrative" which stated, "...No falls...." The physical therapist failed to report the change in patient condition to the registered nurse. 3. Clinical record review on 12/15/2021 for patient #6, start of care 9/16/2021, certification period 9/16/2021 to 11/14/2021, evidenced an agency document titled Skilled Nurse Visit, dated 10/11/2021, which had a subsection titled "Visit Narrative" which stated, "...New wound to right lower leg...." The registered nurse failed to report the change in patient condition to physical therapy. Clinical record review evidenced an agency document titled "PTA Visit," dated 10/12/2021, which had a subsection titled "Subjective" which stated, "...Pt [patient] reports he has a new wound on R [right] leg. Spoke with nurse ... and she confirmed...." The registered nurse failed to report the change in patient condition to the physical therapist. Clinical record review evidenced an agency document titled "Missed Visit" dated 10/19/2021, which under the "Reason" subsection stated, "No Answer to Locked Door," and under the "Comments" subsection stated, "Called client, looked all over facility, asked receptionist, knocked on door twice. No answer, unable to find client." The home health agency failed to coordinate care with the assisted living facility. Clinical record review evidenced an agency document titled "Missed Visit" dated 10/20/2021, which under the "Reason" subsection stated, "No Answer to Locked Door," and under the "Comments" subsection stated, "Client not in facility at time of SN [skilled nurse] arrival." The home health agency failed to coordinate care with the assisted living facility. Clinical record review evidenced an agency		progress towards goals or changes in condition. The fall reported by PT N for patient #4 has been reportedto the care team and physician as assessed. The wound reported by the RN for patient #6 has been reportedto the care team and physician as assessed. PT N has received one on one education regarding policy 5-J“Coordination of Patient Services” and the requirement to coordinate servicesto maintain continuity of care, facilitate patient/caregiver involvement, andmaximize patient outcomes. All clinicians have been educated on the need to coordinateservices for agency patients that reside in assisted living facilities and/orreceive treatment at medical clinics such as wound clinics or dialysis centersin order to adhere to the plan of care.	

	document titled "Missed Visit" dated 10/27/2021, which under the "Reason" subsection stated, "No Answer to Locked Door," and under the "Comments" subsection stated, "Receptionist states client has dialysis, leaves around noon. ... RN [registered nurse] notified." The home health agency failed to coordinate care with the assisted living facility and the dialysis center. Clinical record review evidenced an agency document titled "Missed Visit" dated 10/29/2021, which under the "Reason" subsection stated, "No Answer to Locked Door," and under the "Comments" subsection stated, "Client not at facility. ... RN notified." The home health agency failed to coordinate care with the assisted living facility. During an interview on 12/17/2021 at 9:38 a.m., the clinical supervisor indicated an in-service needs to be done on care coordination. 17-12-2(g)		Missed visits are currently being reviewed weekly duringclinical management meetings. If a missed visit is documented withoutappropriate care coordination with physician, assisted living staff, patient representative(s),etc., the missed visit form is returned for clarification for care coordinationto be appropriately documented. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to insure thedeficiency will not recur. All agency clinicians will beeducated during onboarding and no less than quarterly on policy 5-J“Coordination of Patient Services”. This policy will be reviewed during ourFebruary 2022 inservice to ensure compliance. Individualized training will beprovided when failure to coordinate care is identified during clinical recordreview. Patients who often require carecoordination such as those residing in assisted living facilities, receivingdialysis treatment, attending wound clinics, etc., are now identifiable in the agencyEMR due to a new feature provided by the current EHR service. These	

			closely monitored for care coordination utilizing thisnew feature; if the clinical record review team identifies any lack of care coordination,the document will be returned to the clinical for correction. The clinicalmanager will assist with care coordination efforts as needed to ensure allmembers of the care team are coordinating services as required. The clinical record review teamwill audit 100% of submitted documentation to ensure care coordination is welldocumented. If a document is reviewed that requires care coordination and nocare coordination has been identified in the medical record, the document willbe returned to the assessing clinician for clarification/documentation. Ifnecessary, the clinical manager will assist the assessing clinician with carecoordination activities. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. ClinicalManager or designee 4. By what date are you going to have thedeficiency corrected? 2/24/2022	
G0800	Services provided by HH aide 484.80(g)(2)	G0800	**G-0800**	2022-02-24

	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. Based on record review and interview, the home health aide failed to provide services as indicated in the aide care plan in 2 of 4 records reviewed receiving home health aide services (#1, #8). The findings include: 1. Record review on 12/17/2021, evidenced an agency policy titled, HOME HEALTH AIDE SERVICES , revised 1/8/2019, which stated, & Home health aids (sic) will provide services that are & Ordered by the physician & Included in the plan of care & The HHA [home health aide] shall provide patient services and direct care by following the care plan exactly as written by the registered nurse &. 2. Clinical record review for patient #1 on 12/9/2021, start of care 12/1/2021, certification period 12/1/2021 to 1/29/2022, primary diagnosis of Infection following a procedure, surgical site, evidenced an agency document titled, HHA Care Plan , dated 12/1/2021, and signed by the clinical supervisor. The HHA Care Plan had a subsection titled, Safety Precautions , which evidenced the following safety precautions: Anticoagulant [blood thinner] Precautions, Keep Pathway Clear, Standard Precautions / Infection Control, Emergency Plan Developed, Proper Position During Meals, Sharps Safety, Support During Transfer / Ambulation, Fall Precautions, Safety in ADL s [activities of daily living], Slow Position Change, and Use of Assistive Devices.		1. How the deficiency will be or has beenimmediately corrected. Patient #1 and patient #8’sHHA visit documentation has been updated to reflect the safety precautionsestablished in the HHA care plan. HHA G has been individually re-educated onpolicy 2-S “Home Health Aide services” which includes adherence to theestablished HHA care plan. Additionally, our home health aide hasbeen provided reinforcement on the importance of following the plan ofcare. The home health aide plan of carewill be reviewed by the home health aide at each visit to ensure thatservices are being carried out according to plan of care. Any issuesidentified that need clarification or change will be communicated tothe registered nurse or qualified therapist overseeing the HHA care plan. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to insure thedeficiency will not recur. 100% of patient records will be audited forevidence that the home health aide provides services that are ordered by thephysician and included in the plan of care. Audit results willbe reviewed by the QA committee quarterly. Any non-compliance willresult in re-education with any staff involved with documentation retainedin personnel records. All newly hired employees willbe in-serviced on the agency policy titled "Home Health Aide ServicesPolicy", and the agency job description titled "Home HealthAide" focusing on responsibilities of the home health aide. Educationwill focus on the need to provide services as ordered on the plan ofcare, coordination of care, the requirement to notify	

	Clinical record review evidenced an agency document titled, HHA Visit , dated 12/8/2021, signed by HHA G. Review of the HHA visit note failed to evidence the HHA followed Anticoagulant [blood thinner] Precautions, Keep Pathway Clear, Standard Precautions / Infection Control, Emergency Plan Developed, Fall Precautions, Safety in ADL s [activities of daily living], Slow Position Change, and Use of Assistive Devices. During an interview on 12/16/2021, at 2:49 p.m., the clinical supervisor indicated the HHA should perform tasks as written in the HHA Care Plan and document all tasks completed on the HHA visit notes. 3. Clinical record review for patient #8 on 12/15/2021, start of care 8/18/2021, certification period 10/17/2021 to 12/15/202, primary diagnosis of Type 2 diabetes mellitus with foot ulcer [a chronic disease where the body doesn t produce enough or resists insulin], evidenced an agency document titled, HHA Care Plan , dated 10/17/2021 and signed by RN [registered nurse] F. The HHA Care Plan had a subsection titled, Safety Precautions , which evidenced the following safety precautions: Anticoagulant [blood thinner] Precautions, Keep Pathway Clear, Standard Precautions / Infection Control, Emergency Plan Developed, Sharps Safety, Fall Precautions, Safety in ADL s [activities of daily living], and Use of Assistive Devices. Clinical record review evidenced a group of agency documents titled, HHA Visit , signed by HHA G. Review of HHA visit notes dated 10/19/2021, 11/2/2021, 11/23/2021, and 11/30/2021 failed to evidence the HHA followed Anticoagulant [blood thinner] Precautions, Keep Pathway Clear, Standard Precautions / Infection Control, Emergency Plan Developed, Sharps Safety, Fall Precautions, Safety in ADL s [activities of daily living], and Use of Assistive Devices. During an interview on 12/16/2021, at 2:49 p.m., the clinical supervisor indicated the HHA should perform tasks as written in the HHA Care Plan and document all tasks completed on the HHA visit notes.		the registered nurseor qualified therapist of changes in the patient's condition, and properdocumentation of patient visit notes. In addition to consistent auditing of 100% of submitteddocumentation, quarterly quality assurance/performance improvement efforts willcontinue. Each quarter, 10% of patient charts from each branch will be reviewedin their entirety for accuracy, comprehensiveness, adherence to the plan ofcare and agency policy and procedure protocols. All findings will be reviewedand discussed during agency quarterly QAPI meetings. Performance improvementprojects, in-services and educational efforts will be tailored to quarterly QAPIfindings. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%. ClinicalManager or designee 4. By what date are you going to have thedeficiency corrected? 2/24/2022	
G1014	Interventions and patient response	G1014	**G-1014**	2022-02-24

	484.110(a)(2) All interventions, including medication administration, treatments, and services, and responses to those interventions; Based on record review and interview, the agency failed to ensure the patient's clinical record evidenced all interventions and responses to those interventions in 4 of 9 patient records reviewed receiving physical therapy (#2, #7, #11, #12). The findings include: 1. Record review on 12/17/2021, evidenced an undated agency policy titled, PHYSICAL THERAPY SERVICES , which stated, & The Registered Physical Therapist (RPT) will: & 12. Observe and record the patient s treatment, education, response, and progress &. 2. Record review evidenced an undated agency policy titled, OCCUPATIONAL THERAPY SERVICES , which stated, & The Registered Occupational Therapist (OT) will: & 9. Observe and record the patient s treatment, education, response, and progress &. 3. Record review evidenced an agency policy titled, DOCUMENTATION OF PATIENT SERVICES , revised 9/12/2018, which stated, POLICY Clinical documentation of patient care shall be according to accepted standards of practice to ensure authenticity, adequacy, and accuracy & 6. Documentation should include all services provided. For nursing, therapy and social worker services, documentation should include assessment findings, treatments, education, patient / caregiver response, and progress toward meeting goals &. 4. Clinical record review on 12/9/2021, for patient #2, start of care 12/3/2021, certification period 12/3/2021 to 1/31/2022, primary diagnosis of Aftercare following joint replacement surgery, evidenced a group of agency documents titled, PT [physical therapy] Visit," dated 12/4/2021, 12/6/2021, and 12/9/2021 and signed by PT [physical therapist] J. Each of the PT visit notes failed to evidence how the patient tolerated therapy. 5. Clinical record review on 12/15/2021, for patient #7 start of care 10/11/2021, certification period 10/11/2021 to 12/9/2021, primary		1. How the deficiency will be or has beenimmediately corrected. Employees J,S and T have been educated about the requirement to document how a patient iscurrently tolerating the therapy services provided. All agencystaff have been provided reinforcement of education related to documentation ofa patient’s response to treatment including how the patient toleratesinterventions. The clinicalrecord review team has been educated on ensuring all clinical documentationaccurately reflects how a patient tolerated the services provided (i.e., woundcare, therapy, education, etc.) in order to accurately reflect the patient’sresponse to treatment and progress towards goals. 2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur. Agency hasre-educated field staff on agency policy 5-K “Documentation of PatientServices”. Clinical documentation ofpatient care shall be according to accepted	

	infection], evidenced a group of agency documents titled, PT [physical therapy] Visit," dated 10/15/2021, 10/19/2021, 10/22/2021, 10/26/2021, 10/28/2021, 11/2/2021, 11/6/2021, and 11/22/2021 and signed by PT [physical therapist] S. Each of the PT visit notes failed to evidence how the patient tolerated therapy. 6. Clinical record review on 12/16/2021, for patient #11, start of care 9/5/2020, certification period 9/5/2020 to 11/3/2020, primary diagnosis of Encounter for change or removal of non-surgical wound dressing, evidenced an agency document titled, Physical Therapy Assessment / Evaluation , dated 9/5/2020, signed by PT J, which failed to evidence how the patient tolerated therapy. Clinical record review evidenced a group of agency documents titled PT [physical therapy] Visit," dated 9/7/2020, and 9/10/2020, signed by PT J. Each of the visit notes failed to evidence how the patient tolerated therapy. 7. Clinical record review on 12/14/2021, for patient #12, start of care 6/19/2021, certification period 6/19/2021 to 8/17/2021, primary diagnosis of Rotator cuff tear / rupture of right shoulder, evidenced a group of agency documents titled, "PTA [physical therapy assistant] VISIT", dated 6/23/2021, 6/25/2021, and 6/28/2021, and signed by PTA T. Each of the visit notes failed to evidence how the patient tolerated therapy. 8. During an interview on 12/16/2021, at 2:20 p.m., the clinical supervisor indicated tasks completed during a visit should be documented in each clinician s visit notes. When informed of the findings, the clinical supervisor offered no further documentation.		standards of practice to ensureauthenticity, adequacy, and accuracy. 100% of allfield staff visit notes will be reviewed upon being submitted to QA center in agenciesEMR for accuracy. The specificdocumentation of a patient's response to treatment (I.e., how a patienttolerates therapy, wound care, etc.) will be included in our February 2022in-service as well as onboarding and ongoing educational efforts. In addition toconsistent auditing of 100% of submitted documentation, quarterly qualityassurance/performance improvement efforts will continue. Each quarter, 10% ofpatient charts from each branch will be reviewed in their entirety foraccuracy, comprehensiveness, adherence to the plan of care and agency policyand procedure protocols. All findings will be reviewed and discussed duringagency quarterly QAPI meetings. Performance improvement projects, in-servicesand educational efforts will be tailored to quarterly QAPI findings. 3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%.	

			ClinicalManager or designee 4. By what date are you going to have thedeficiency corrected? 2/24/2022	
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. Based on record review and interview, the home health agency failed to ensure all entries in the clinical record were complete and appropriately authenticated in 4 of 13 patient records reviewed (#2, #3, #12, #13). The findings include: 1. Record review on 12/17/2021, evidenced an agency policy titled, DOCUMENTATION OF PATIENT SERVICES , revised 9/12/2018, which stated, POLICY Clinical documentation of patient care shall be according to accepted standards of practice to ensure authenticity, adequacy, and accuracy & 6. Documentation should include all services provided. For nursing, therapy and social worker services, documentation should include assessment findings, treatments, education, patient / caregiver response, and progress toward meeting goals &. 2. Record review evidenced an agency policy titled, CLINICAL RECORDS , revised 1/10/2018, which stated, & Contents of the Clinical Record: & A medication profile including dates, revisions, and drug regimen review according [sic] the medication policy &.	G1024	**G-1024** 1. How the deficiency will be or has beenimmediately corrected. Noteddiscrepancies during the survey process have been addressed with specificclinicians as an educational discussion regarding policy 5-K “Documentation ofPatient Services”. Agencyre-educated all field staff, including contracted therapy, on policy 5-K“Documentation of Patient Services” including “clinical documentation ofpatient care shall be according to accepted standards of practice to ensureauthenticity, adequacy, and accuracy including the necessity that of alldocumentation including the correct date, time, credentials and clinician namethat authored the clinical note. All medical record entries should bemade as soon as possible after the care is provided or an event or observationis made. An entry should never be created in advance of the event	2022-02-24

12/9/2021, start of care 12/3/2021, certification period 12/3/2021 to 1/31/2022, primary diagnosis of Aftercare following joint replacement surgery, evidenced an agency document titled, PT [physical therapy] Visit," dated 12/9/2021, signed by PT [physical therapist] J. The visit note had a section titled, Assessment , which stated, & Patient has to walk with brace over R [right] knee while standing and walking and is on NWBAT status.

During an interview on 12/17/2021, at 9:50 a.m., the clinical supervisor indicated NWBAT was an error in documentation by PT J. The clinical supervisor stated, it should be WBAT [weight bearing as tolerated] .

4. Clinical record review for patient #3 on 12/17/2021, start of care 12/10/2021, certification period 12/10/2021 to 2/7/2022, with primary diagnosis of Aftercare following joint replacement surgery (right hip), evidenced an agency document titled, OASIS [the patient-specific, standardized assessment used in Medicare home health care to plan care, determine reimbursement, and measure quality]-D1 Start of Care , dated 12/10/2021, and signed by RN [registered nurse] R. The assessment had a subsection titled, Wound Care Flowsheet , which stated, & Drainage: Serous [a thin, clear to yellow, watery fluid] & Treatment Performed: Patient has on a 7 day surgical dressing blood noted to pad of dressing.

During an interview on 12/17/2021, at 10:31 a.m., the clinical supervisor indicated the assessment of wound drainage was unclear and stated, I would return this [documentation]. I need clarification.

5. Clinical record review for patient #12 on 12/14/2021, start of care 6/19/2021, primary diagnosis of Rotator cuff tear / rupture of right shoulder, evidenced an agency document titled, OASIS [the patient-specific, standardized assessment used in Medicare home health care to plan care, determine reimbursement, and measure quality]-D1 Start of Care (PT) [physical therapy] , dated 6/19/2021, and signed by RN [registered nurse] U. This assessment had a subsection titled, RESPIRATORY STATUS , which stated, & uses albuterol inhaler as needed &. Clinical record review evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , for certification period 6/19/2021 to 8/17/2021, signed by the physician. The plan of care had a subsection titled, Medications , which stated, &

orobservation. Clinical documentationshall be incorporated into the medical record within 14 days".

Allclinicians involved in the review of clinical documentation have beenre-educated on Policy 5-I, "Clinical Records" to include and highlight therequirement of ensuring submitted documentation is accurate, comprehensive andadheres to the plan of care.

2. How the deficiency will be prevented fromrecurring i.e. measure put into place or systematic changes made to ensure thedeficiency will not recur.

Agency willaudit 100% of all submitted documentation to ensure authenticity, adequacy, andaccuracy in adherence to policies 5-K and 5-I. Any identified errors or lack ofcompliance with agency policy 5-K "Documentation of Patient Services" will bereturned to the clinician for correction. Clinicians will be educated regardingclinical documentation expectations at every in-service. Specifically, policy5-K will be the focus of our scheduled February 2022 in-service.

In addition toconsistent auditing of 100% of submitted documentation, quarterly

albuteral [sic] sulfate [used to prevent and treat wheezing and shortness of breath] 90 mg [milligram] 2 puffs twice daily &. Review of the plan of care failed to evidence the albuterol was used as needed.

During an interview on 12/17/2021, at 10:53 a.m., the clinical supervisor indicated she did not think the albuterol was as needed, but the patient s clinical record was unclear.

Clinical record review evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , for certification period 6/19/2021 to 8/17/2021, signed by the physician. The plan of care had a subsection titled, Medical Necessity , which stated, & Patient needs skilled nursing for continuous monitoring of current status &. Review of the patient s clinical record and electronic medical record (Axxess) failed to evidence the patient was receiving skilled nursing.

During an interview on 12/17/2021, at 10:56 a.m., the clinical supervisor indicated patient #12 was not receiving skilled nursing. When informed of the findings, the clinical supervisor indicated the patient did not need skilled nursing, and stated, that should not be on there .

6. Clinical record review for patient #13 on 12/15/2021, start of care 6/1/2021, certification period 7/31/2021 to 9/28/2021, primary diagnosis of Venous insufficiency [a condition caused by impaired leg circulation which causes swelling and skin changes], evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 9/15/2021. The plan of care had a subsection titled, Medical Necessity , which stated, Patient requires skilled intervention of occupational therapy & Patient requires skilled intervention of physical therapy &. Review of the patient s clinical record and electronic medical record (Axxess) failed to evidence the patient was receiving physical therapy or occupational therapy.

During an interview on 9/17/2021, at 9:20 a.m., the clinical manager indicated the patient no longer receiving physical therapy and that the documentation was carried over from a previous plan of care.

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qualityassurance/performance improvement efforts will continue. Each quarter, 10% ofpatient charts from each branch will be reviewed in their entirety foraccuracy, comprehensiveness, adherence to the plan of care and agency policyand procedure protocols. All findings will be reviewed and discussed duringagency quarterly QAPI meetings. Performance improvement projects, in-servicesand educational efforts will be tailored to quarterly QAPI findings.

3. Who is responsible to ensure the deficiencywill be/has been corrected and compliance maintained at 100%.

ClinicalManager or designee

4. By what date are you going to have thedeficiency corrected?

2/24/2022

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