STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157550	A. BUILDING B. WING	01/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE AT HOME INC	8929 BROADWAY, MERRILLVILLE, IN, 46410

(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 1/13/2022 to 1/25/2022. Facility ID: 003435 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings. Providence At Home Inc., is precluded from providing its own home health aide training and competency evaluation for a period of two years from 1/25/2022 - 1/24/2024, due to being found out of compliance with Conditions of Participation 42 CFR 484.60 Care Planning, Coordination of Care and Quality of Care. Quality Review Completed 02/09/2022	G0000	CREDIBLE ALLEGATION OF CORRECTION AND COMPLIANCE For purposes of any allegation that Providence at Home INC is not in compliance with regulations as set forth in this statement of deficiencies, this Plan of Correction constitutes credible allegation of correction and compliance. The preparation and execution of this response and Plan of Correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.	2022-02-25
N0000	Initial Comments This visit was a re-licensure survey of a home health agency.	N0000	CREDIBLE ALLEGATION OF CORRECTION AND COMPLIANCE For purposes of any allegations that Providence at Home INC is not in compliance with regulations as set forth in this statement of	2022-02-25

	The survey visit took place from 1/13/2022 to 1/25/2022. Facility ID: 003435		credible allegation of correction and compliance. The preparation and execution of this Response and Plan of Correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.	
E0000	Initial Comments This visit was a recertification, re-licensure, and emergency preparedness survey. The survey visit took place from 1/13/2022 to 1/25/2022. Facility ID: 003435 At this Emergency Preparedness survey, Providence at Home Inc. 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		2022-02-25
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 home health agency failed to ensure OASIS data accurately reflected the patient's status at the time of assessment in 1 of 7 patient records reviewed with a home visit. (#7) The findings include: Review of an agency policy, with an agency revised date of January 2015, and received 1/25/2022, titled, "OASIS Data Transmission," stated, "Purpose: To outline the OASIS data transmission requirements. Procedure: ... The encoded OASIS data must accurately reflect the patient's status at the time of assessment...."	G0374	What action will we take to correct the deficiency cited? All actively employed field staff, with the exception of the home health aide, were and will continue to be educated individually and collaboratively regarding the completion of accurate oasis documentation. Clinical Documentation Review Coordinator will review oasis documentation utilizing an oasis documentation audit tool 100% of the time to ensure accurate oasis submission. Oasis Data Transmission Policy 5-020.1 was reviewed and will be provided to all actively employed staff members. Who is responsible to implement the corrective action? Nurse Case Managers, Registered Therapists, Nursing Supervisor and Clinical Documentation Review Coordinator. Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur.	2022-02-25

	Clinical record review on 1/18/2022 for patient #7, start of care 1/6/2022, for certification period 1/6/2022 to 3/6/2022, evidenced an agency document titled "SOC [Start of Care] OASIS [Outcomes and Assessment Information Set] D-1 (ver 21.2) (SOC)" dated 1/6/2022 and electronically signed by RN [registered nurse] R. This document had a subsection titled "Management of Injectable Medications, " which stated, "...NA - No injectable medications prescribed...." This document failed to have the patient's correct medication listed. Clinical record review evidenced an agency document titled "Home Health Certification and Plan of Care," electronically signed by RN M on 1/12/2022. This document had a subsection titled "Medication," which included but was not limited to, "...cyanocobalamin [used to treat vitamin B12 deficiency] 1000 mcg/mL [micrograms/milliliter] injectable solution; Inject 1000 microgram(s) intramuscularly [into the muscle] once a month; Vitamin Start Date: 01/06/2022...." During an interview on 1/24/2022 at 11:18 a.m., employee B (Quality Director) indicated the error was a mistake and mistakes are hard to catch.		What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Clinical Documentation Review Coordinator will audit 100% of all Oasis documents to ensure accuracy of oasis data prior to submission utilizing oasis documentation audit tool. Further deficiencies will be addressed with individual staff members as warranted.	
G0442	Written notice for non-covered care 484.50(c)(8) Receive proper written notice, in advance of a specific service being furnished, if the HHA believes that the service may be non-covered care; or in advance of the HHA reducing or terminating on-going care. The HHA must also comply with the requirements of 42 CFR 405.1200 through 405.1204. Based on record review and interview, the home health agency failed to provide the patient with a written notice of termination of service in 1 of 5 discharged patient records reviewed. (#13) The findings include: Review of an agency policy, with an agency reviewed date of 4/2020, and obtained 1/25/2022, titled, "Patient Notification of Changes in Care," stated, "Purpose: To define organization requirements for patient notification	G0442	What action will we take to correct the deficiency cited? Patient Notification of Changes in Care Policy No. 2-030.1, Discharge Planning Policy No. 2-024.2 and Discharge Criteria and Process Policy No. 2-042.1 were reviewed and revised. All actively employed field staff, with the exception of the home health aide, will be re-educated, individually and collaboratively, regarding the need for written notification prior to termination of services or the requirement to provide patient and caregiver with community resources to assist the patient follow discharge, as we provide already in our patient handbook. If reason for discharge doesn't require a 15 day notice including: health, safety and welfare of home health agency employees, refusal of services, services are no longer reimbursable based on applicable reimbursement requirements, and patient no longer meets applicable regulatory criteria, patients will be reminded of community resources listed in patient handbook and physician will be notified of discharge. Clinical Supervisor will monitor to ensure 100% of patients discharged received a	2022-02-25

	notified within 24 hours of any significant changes in the agreed-upon schedule or plan of care...." Review of an agency policy, with an agency reviewed date of 4/2020, and obtained 1/25/2022, titled, "Discharge Planning," stated, "... Patients will not be discharged without appropriate preparation. The patient's continuing care needs will be assessed on an ongoing basis, as well as at discharge. Information will be provided to assist the patient in planning his/her discharge, including referral and transfer. ... Clinicians will assist patients regarding their discharge by: A. Consulting with the patient and family/caregiver regarding plans for discharge from the organization, B. Serving as a referral source for the patient/caregiver in obtaining follow-up support services ... All communication and information regarding discharge planning will be documented in the clinical record...." Clinical record review on 1/21/2022 for patient #13, start of care 11/23/2021, certification period 11/23/2021 to 1/21/2022, failed to evidence documentation the agency provided written notice prior to termination of services. Clinical record review evidenced an agency document titled, "Administrative Communication" with two entries dated 12/29/2021 and created by RN [registered nurse] M. The first entry, timed at 2:05:27 p.m., stated, "Spoke with NP [nurse practitioner] ... office to notify that insurance has suspended authorization and will not give further auth. There is an issue with the SOC date for their auth and when services were actually started and the insurance has not corrected the date. This writer stated we have discharged as of 12/16/21." The second entry, timed at 2:27:59 p.m., stated, "Contacted daughter of patient ... to notify her of the insurance auth issues. Patient is discharged from agency services as of 12/16/21." Clinical record review evidenced an agency document titled, "Speech Therapy Visit Note," dated 12/16/2021, which stated, "...No Visit Made, Reason Visit Not Made: Other: Insurance denied visits Actions Taken by Clinician No further actions needed, Narrative Notes: ST [Speech Therapy] DC [Discharge]: Insurance denied coverage. Goals met/partially met...."		15 day discharge notice or are reminded of/provided community resources as provided in patient handbook. Who is responsible to implement the corrective action? Nurse Case Managers, Registered Therapists, and Clinical Supervisor will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Clinical Supervisor will monitor to ensure 100% of patients discharged receive a 15 day discharge notice or are reminded/provided community resources as provided in patient handbook.	

	Clinical record review evidenced an agency document titled, "Skilled Nursing Visit Note," dated 12/16/2021, which stated, "...Visit Plan - No Visit Made ... Narrative Notes: 12/16/21 No insurance authorization to make SN visit today...." Clinical record review evidenced an agency document titled, "Discharge OASIS-D1 (ver21.2) (Discharge)," dated 12/16/2021 and completed by physical therapist O. This document indicated the patient was discharged from physical therapy services on 12/16/2021. During an interview on 1/25/2022 at 9:42 a.m., when queried as to how many days between denial of insurance and discharge of services, the clinical supervisor indicated the agency asked the insurance company for more visits on 12/16/2021 but was denied, so the agency kept the patient without services until 12/29/2021 for billing purposes only.			
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. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the home	N0458	What Action will we take to correct the deficiency cited? Employee C will be sent for a limited criminal background check. All potential employees will have a limited criminal background check completed prior to job offer and/or hire date. Who is responsible to implement the corrective action? Human Resource department and Clinical Supervisor will be active participants in implementing the corrective action. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Human Resources department will utilize a new hire checklist. Clinical Supervisor will also ensure a limited criminal background check was completed prior to job offer and/or hire date.	2022-02-25

	health agency failed to ensure personnel records included documentation of receipt of a national criminal background check in 1 of 1 home health aide personnel records reviewed. (employee C) The findings include: Personnel record review on 1/19/2022 for home health aide C, start date of 11/22/2011, first patient contact date of 11/22/2011, failed to evidence documentation of a national criminal background check. During an interview on 1/19/2022 at 1:15 p.m., clinical supervisor A indicated the agency did not have a national criminal background check for home health aide C.			
N0462	Home health agency administration/management 410 IAC 17-12-1(h) Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on record review and interview, the home health agency failed to ensure physical examinations indicated employees were free of communicable disease in 7 of 10 personnel records reviewed. (employees A, E, F, G, H, I, J) The findings include: 1. Personnel record review on 1/19/2022 for clinical supervisor A, start date of 7/23/2019, first patient contact of 7/23/2019, failed to evidence a physical examination form declaring them free from communicable disease prior to patient contact. 2. Personnel record review on 1/19/2022 for	N0462	What action will we take to correct the deficiency cited? All employee files were reviewed for indication of declaring them free from communicable disease prior to patient contact. All employees who initial pre-employment physical exam didn't indicate freedom of infectious and communicable disease will be sent for updated physicals to ensure they are free from infection and communicable disease. Moving forward, Human Resource department will request this be completed on all initial pre-employment physical exams to providers that complete the exams. Who is responsible to implement the corrective action? Human Resource department and Clinical Supervisor will be active participants in implementing the corrective plan. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Human Resource department will ensure potential employees are free of communicable and infectious disease by reviewing completed physical forms prior to acceptance from provider that completed physical exam.	2022-02-25

licensed practical nurse E, start date of 11/14/2017, first patient contact of 11/14/2017, failed to evidence a physical examination form declaring them free from communicable disease prior to patient contact.

3. Personnel record review on 1/19/2022 for occupational therapist F, start date of 9/14/2016, first patient contact of 9/15/2016, first patient contact of 9/15/2016, failed to evidence a physical examination form declaring them free from communicable disease prior to patient contact.

4. Personnel record review on 1/19/2022 for physical therapist G, start date of 1/14/2016, first patient contact of 1/15/2016, failed to evidence a physical examination form declaring them free from communicable disease prior to patient contact.

5. Personnel record review on 1/19/2022 for RN [registered nurse] H, start date of 1/19/2021, first patient contact of 1/20/2021, failed to evidence a physical examination form declaring them free from communicable disease prior to patient contact.

6. Personnel record review on 1/19/2022 for RN I, start date of 3/9/2020, first patient contact of 3/10/2020, failed to evidence a physical examination form declaring them free from communicable disease prior to patient contact.

7. Personnel record review on 1/19/2022 for speech therapist J, start date of 3/28/2017, first patient contact of 4/4/2017, failed to evidence a physical examination form declaring them free from communicable disease prior to patient contact.

8. During an interview on 1/19/2022 at 2:35 p.m., clinical supervisor A indicated there were no other physical examination documents available for the employees.

G0468	Provide contact info other services 484.50(d)(5)(iii) (iii) Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and Based on record review and interview, the home health agency failed to provide the patient and caregivers with information for other agencies or resources who may be able to provide care in 1 of 5 discharged patient records reviewed. (#13) The findings include: Review of an agency policy, with an agency reviewed date of 4/2020, and obtained 1/25/2022, titled, "Discharge Planning," stated, "... Patients will not be discharged without appropriate preparation. The patient's continuing care needs will be assessed on an ongoing basis, as well as at discharge. Information will be provided to assist the patient in planning his/her discharge, including referral and transfer. ... Clinicians will assist patients regarding their discharge by: A. Consulting with the patient and family/caregiver regarding plans for discharge from the organization, B. Serving as a referral source for the patient/caregiver in obtaining follow-up support services ... All communication and information regarding discharge planning will be documented in the clinical record...." Clinical record review on 1/21/2022 for patient #13, start of care 11/23/2021, certification period 11/23/2021 to 1/21/2022, failed to evidence documentation the agency gave the patient/caregiver information for other agencies/providers or community resources that may have been able to provide services to the patient upon discharge. During an interview on 1/25/2022 at 9:42 a.m., when queried if the agency provided assistance to the patient or caregiver in finding another agency, the clinical supervisor indicated that the agency does not provide that assistance.	G0468	What action will we take to correct the deficiency cited? Patient Notification of Changes in Care Policy No. 2-030.1, Discharge Planning Policy No. 2-024.2 and Discharge Criteria and Process Policy No. 2-042.1 were reviewed and revised. All actively employed field staff, with the exception of the home health aide, will be re-educated, individually and collaboratively, regarding the need for written notification prior to termination of services or the requirement to provide patient and caregiver with community resources to assist the patient follow discharge, as we provide already in our patient handbook. If reason for discharge doesn't require a 15 day notice including: health, safety and welfare of home health agency employees, refusal of services, services are no longer reimbursable based on applicable reimbursement requirements, and patient no longer meets applicable regulatory criteria, patient's will be reminded of community resources listed in patient handbook and physician will be notified of discharge. Clinical Supervisor will monitor to ensure 100% of patients discharged received a 15 day discharge notice or are reminded/provided community resources as provided in patient handbook. Who is responsible to implement the corrective action? Nurse Case Managers, Registered Therapists, and Clinical Supervisor will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Clinical Supervisor will monitor to ensure 100% of patients discharged receive a 15 day discharge notice or are reminded/provided community resources as provided in patient handbook.	2022-02-25
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must	N0488	What action will we take to correct the deficiency cited? Patient Notification of Changes in Care Policy	2022-02-25

	develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review and interview, the home health agency failed to provide the patient with a 15 day discharge notice in 1 of 5 discharged patient records reviewed. (#13)		2-024.2 and Discharge Criteria and Process Policy No. 2-042.1 were reviewed and revised. All actively employed field staff, with the exception of the home health aide, will be re-educated, individually and collaboratively, regarding the need for written notification prior to termination of services or the requirement to provide patient and caregiver with community resources to assist the patient follow discharge, as we provide already in our patient handbook. If reason for discharge doesn't require a 15 day notice including: health, safety and welfare of home health agency employees, refusal of services, services are no longer reimbursable based on applicable reimbursement requirements, and patient no longer meets applicable regulatory criteria, patient's will be reminded of community resources listed in patient handbook and physician will be notified of discharge. Clinical Supervisor will monitor to ensure 100% of patients discharged received a 15 day discharge notice or are reminded/provided community resources as provided in patient handbook. Who is responsible to implement the corrective action? Nurse Case Managers, Registered Therapists, and Clinical Supervisor will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Clinical Supervisor will monitor to ensure 100% of patients discharged receive a 15 day discharge notice or are reminded/provided community resources as provided in patient handbook.	

	The findings include: Review of an agency policy, with an agency reviewed date of 4/2020, and obtained 1/25/2022, titled, "Discharge Planning," stated, "... Patients will not be discharged without appropriate preparation...." Clinical record review on 1/21/2022 for patient #13, start of care 11/23/2021, certification period 11/23/2021 to 1/21/2022, evidenced an agency document titled, "Administrative Communication" with two entries dated 12/29/2021 and created by RN [registered nurse] M. The first entry, timed at 2:05:27 p.m., stated, "Spoke with NP [nurse practitioner] ... office to notify that insurance has suspended authorization and will not give further auth. There is an issue with the SOC date for their auth and when services were actually started and the insurance has not corrected the date. This writer stated we have discharged as of 12/16/21." The second entry, timed at 2:27:59 p.m., stated, "Contacted daughter of patient ... to notify her of the insurance auth issues. Patient is discharged from agency services as of 12/16/21." Clinical record review failed to evidence the agency gave the patient a 15 day discharge notice. During an interview on 1/25/2022 at 9:45 a.m., the clinical supervisor indicated the agency received denial from the patient's insurance on 12/16/2021, then kept the patient on without services through 12/29/2021 for billing purposes only.			
N0490	Q A and performance improvement 410 IAC 17-12-2(k) Rule 12 Sec. 2(k) A home health agency must continue, in good faith, to attempt to provide services during the fifteen (15) day period described in subsection (i) of this rule. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented.	N0490	What action will we take to correct the deficiency cited? Patient Notification of Changes in Care Policy No. 2-030.1, Discharge Planning Policy No. 2-024.2 and Discharge Criteria and Process Policy No. 2-042.1 were reviewed and revised. All actively employed field staff, with the exception of the home health aide, will be re-educated, individually and collaboratively, regarding the need for written notification prior to termination of services or the requirement to provide patient and caregiver with community resources to assist the patient follow discharge, as we provide already in our patient handbook. If reason for discharge doesn't require a 15 day	2022-02-25

	Based on record review and interview, the agency failed to continue to provide services during the fifteen days following notice of discharge in 1 of 5 discharged patient records. (#13) The findings include: Review of an agency policy, with an agency reviewed date of 4/2020, and obtained 1/25/2022, titled, "Discharge Planning," stated, "... Patients will not be discharged without appropriate preparation. ... Clinicians will assist patients regarding their discharge by: A. Consulting with the patient and family/caregiver regarding plans for discharge from the organization B. Serving as a referral source for the patient and family/caregiver in obtaining follow-up support services...." Clinical record review on 1/21/2022 for patient #13, start of care 11/23/2021, certification period 11/23/2021 to 1/21/2022, failed to evidence documentation the agency provided services during the 15 days following notice of discharge. Clinical record review evidenced an agency document titled, "Administrative Communication" with two entries dated 12/29/2021 and created by RN [registered nurse] M. The first entry, timed at 2:05:27 p.m., stated, "Spoke with NP [nurse practitioner] ... office to notify that insurance has suspended authorization and will not give further auth. There is an issue with the SOC date for their auth and when services were actually started and the insurance has not corrected the date. This writer stated we have discharged as of 12/16/21." The second entry, timed at 2:27:59 p.m., stated, "Contacted daughter of patient ... to notify her of the insurance auth issues. Patient is discharged from agency services as of 12/16/21." Clinical record review evidenced an agency document titled, "Speech Therapy Visit Note," dated 12/16/2021, which stated, "...No Visit Made, Reason Visit Not Made: Other: Insurance denied visits Actions Taken by Clinician No further actions needed, Narrative Notes: ST		notice including: health, safety and welfare of home health agency employees, refusal of services, services are no longer reimbursable based on applicable reimbursement requirements, and patient no longer meets applicable regulatory criteria, patient's will be reminded of community resources listed in patient handbook and physician will be notified of discharge. Clinical Supervisor will monitor to ensure 100% of patients discharged received a 15 day discharge notice or are reminded/provided community resources as provided in patient handbook. Who is responsible to implement the corrective action? Nurse Case Managers, Registered Therapists, and Clinical Supervisor will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Clinical Supervisor will monitor to ensure 100% of patients discharged receive a 15 day discharge notice or are reminded/provided community resources as provided in patient handbook.	

	[Speech Therapy] DC [Discharge]: Insurance denied coverage. Goals met/partially met...." Clinical record review evidenced an agency document titled, "Skilled Nursing Visit Note," dated 12/16/2021, which stated, "...Visit Plan - No Visit Made ... Narrative Notes: 12/16/21 No insurance authorization to make SN visit today...." Clinical record review evidenced an agency document titled, "Discharge OASIS-D1 (ver21.2) (Discharge)," dated 12/16/2021 and completed by physical therapist O. This document indicated the patient was discharged from physical therapy services on 12/16/2021. During an interview on 1/25/2022 at 9:42 a.m., the clinical supervisor indicated the agency failed to continue to provide services to the patient after 12/16/2021.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the home health agency failed to review all medications the patient was currently taking in 1 of 7 patient records reviewed with a home visit. (#6) The findings include: Review of an agency policy, with an agency revised date of 6/2021, and obtained 1/25/2022, titled "Medication Profile," stated, "... Patients receiving medications will have a current, accurate medication profile in the clinical record. Medication profiles will be updated for each change to reflect current medications and new and/or discontinued medications...." Clinical record review on 1/13/2022 for patient	G0536	What action will we take to correct the deficiency cited? All actively employed field staff, with the exception of home health aides, were re-educated individually and collaboratively, regarding the need to consistently perform medication review, reconciliation and documentation in collaboration with the physician; including identification of ineffective drug therapy, potential adverse effects, side effects on 1/25/22 and with intermittent, individual counsel as warranted. Members of the Quality team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Who is responsible to implement the corrective action? Nurse Care Managers. Licensed Practical Nurses, Registered Therapists, Clinical Supervisor and Clinical Documentation Review Coordinator will be active participants in implementing the corrective plan. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur.	2022-01-25

	12/21/2021 to 2/18/2022, evidenced an agency document titled, "Medication Profile," dated 1/18/2022. This document stated, "...10/28/2021 - 11/3/2021 [start date - end date] Tramadol Hydrochloride (a narcotic medication used to treat moderate to severe pain) 50 mg oral tablet; Take 1 tab(s) oral every 6 hours for 7 day(s) as needed for pain, narcotic analgesics [classification of drug], Active [status]...." During an interview on 1/24/2022 at 11:04 a.m., clinical supervisor A indicated medications should not be shown as active in the medication profile once they are completed. 17-14-1(a)(1)(B)		What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective plan? Members of the Quality team will audit 10% of all active clinical records each quarter to assure that medication reconciliation is completed and documented adequately at each comprehensive assessment and when made aware of medication changes or concerns. Results of chart audits will be discussed at the QAPI meeting to assess if processes have improved to the required level, and what deficiencies remain. Further deficiencies will be addressed individually with staff on a ongoing basis to monitor and ensure compliance.	
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview, the home health agency failed to ensure: the plan of care was individualized to meet the patient needs (see tag G0570), the plan of care was followed (see tag G0572), the individualized plan of care included all services, safety measures, medications and treatments (see tag G0574), services and treatments only as ordered by a physician were provided (see tag G0580), the physician was promptly alerted to changes in the patient's condition (see tag G0590), and care was coordinated with other entities providing care for the patient (see tag G0608). The cumulative effect of these systemic	G0570	What is the action we will take to correct the deficiency cited? All actively employed field staff with the exception of the home health aide were re-educated individually and collaboratively on need to ensure the plan of care is individualized to meet the patient needs, the plan of care was followed, the individualized plan of care includes all services, safety measures, medications and treatments only as ordered by a physician were provided, the physician was promptly notified of changes to the patient's condition, care was coordinated with other entities providing care to the patient, and also the requirement to ensure comprehensive assessments include complete wound assessments and physician notification of patient needs. All field staff were re-educated on the requirement that missed visits will be rescheduled with physician notification, extended length of time period of known missed visits will be communicated to the physician. ordered frequency will be completed unless new physician order is received. Who is responsible to implement the corrective action? Field Case Managers, Registered Therapists, Clinical Supervisor, and Clinical Documentation Review Coordinator will be active participants in implementing the corrective plan. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur.	2022-02-25

	problems has resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination, Quality of Care. A deficient practice citation was also evidenced at this standard as follows: Based on record review and interview, the agency failed to provide services to meet the patient's medical, nursing, and rehabilitative needs in 8 of 17 clinical records reviewed (#2, #6, #9, #11, #12, #13, #15, #17). The findings include: 11. Clinical record review on 1/18/2022, for patient #2, start of care 6/6/2020, certification period 11/28/2021 to 1/26/2022, primary diagnosis of venous insufficiency (improper functioning of the vein valves in the leg, causing swelling and skin changes), evidenced an agency document titled, Home Health Care Certification and Plan of Care , signed by the physician on 1/10/2022. The plan of care had a subsection titled, Orders / Treatments , which stated, & Skilled Nursing; 3 wk 8 wk [three times a week for eight weeks]; 2 wk 1 wk [two times a week for 8 weeks]; Beginning during week of 11/29/2021 Ending on 1/26/2022 &. Clinical record review evidenced a group of agency documents titled, Skilled Nursing Visit Note . A visit note dated 12/15/2021, signed by LPN [licensed practical nurse] E stated, & No Visit Made & Reason Visit Not Made: Patient Unavailable / Unable to Contact Patient & . Clinical record review failed to evidence the visit was rescheduled. A visit note dated 12/24/2021, signed by RN [registered nurse] I, stated, & No Visit Made & Reason Visit Not Made: Schedule conflicts between Clinician and Patient &. . Clinical record review failed to evidence the visit was rescheduled. A visit note dated 1/4/2022, signed by RN I stated, & No Visit Made & Reason Visit Not Made: Other: Seen by SN [skilled nurse] yesterday &. . Clinical record review failed to evidence the visit was rescheduled. Clinical record review evidenced the agency failed to provide 3 skilled nursing visits per week for 8 weeks. During an interview on 1/24/2022, at 10:36 a.m.,		What is the monitoring process we put into place to ensure implementation and effectiveness of this corrective action plan? The Clinical Review Documentation Coordinator will review 100% of all admissions, recertification, and resumption of care documents to ensure all standards are included on the plan or care. Missed visits will be monitored 100% by the Clinical Supervisor to ensure requirements are met regarding rescheduling and physician notification. Further deficiencies will be addressed with individual staff members as warranted.	

the clinical supervisor indicated the frequency of patient visits was based on what the patient needs. The clinical supervisor indicated clinicians should attempt to reschedule visits that are missed.

12. Clinical record review on 1/20/2022, for patient #9, start of care 12/9/2021, certification period 12/9/2021 to 2/6/2022, primary diagnosis of Osteomyelitis (infection in a bone) of the ankle and foot, evidenced an agency document titled, Home Health Care Certification and Plan of Care , signed by the physician on 12/28/2021. The plan of care had a subsection titled, Orders / Treatments , which stated, & Skilled Nursing; 2 wk 8 wk [two times a week for 8 weeks]; Beginning during week of 12/13/2021 Ending on 2/5/2022.

Clinical record review evidenced an agency document titled, Skilled Nursing Visit Note , dated 12/30/2021, signed by RN [registered nurse] H stated, & No Visit Made & Reason Visit Not Made: Other Schedule Conflicts &. . Clinical record review failed to evidence the visit was rescheduled.

During an interview on 1/24/2022, at 10:36 a.m., the clinical supervisor indicated the frequency of patient visits was based on what the patient needs. The clinical supervisor indicated clinicians should attempt to reschedule visits that are missed.

13. Clinical record review on 1/21/2022, for patient #15, start of care 2/12/2021, certification period 2/12/2021 to 4/12/2021, primary diagnosis of Primary generalized osteoarthritis (the breakdown of cartilage in the joint causing pain and limited movement), evidenced an agency document titled, SOC [start of care] OASIS [Outcome and Assessment Information Set] [the patient-specific, standardized assessment used in Medicare home health care]-D1 , dated 2/12/2021, and signed by RN N. The assessment had a subsection titled, REVIEW OF SYSTEMS INTEGUMENTARY [related to the skin] STATUS , which stated, &. CLINICAL FINDINGS INTEGUMENTARY Skin tear Location(s) Rt [right] upper arm &.

Clinical record review evidenced an agency document titled, Home Health Care Certification and Plan of Care , signed by the physician on

2/28/2021. Review of the plan of care failed to evidence skilled nursing care. Review of the plan of care failed to evidence wound care instructions.

Review of all visit notes, orders, and communication notes failed to evidence assessment or treatment of the patient s wound. The home health agency failed to ensure the skilled nurse completed a comprehensive assessment to include a complete wound assessment and failed to notify the primary physician of the patient s medical needs.

During an interview on 1/25/2022, at 10:12 a.m., the clinical supervisor indicated if a wound was found at start of care, skilled nursing care should be ordered for the patient. The clinical supervisor indicated the nurse should measure the wound and call the physician for wound care orders. When queried, the clinical supervisor indicated the agency failed to document a full wound assessment, inform the physician of the wound, obtain wound care orders, and re-assess the wound at subsequent visits.

17-13-1(a)

1. Review of an agency policy, with an agency reviewed date of 06/2014, and received 1/25/2022, titled, "Rights/Responsibilities," stated, "Purpose: To encourage awareness of patient rights and responsibilities, to provide guidelines to assist patients making decisions regarding care, and to support active participation in care planning. ... The patient will be informed upon admission and, as needed, of: A. The organization's mission and care/services provided directly or through contractual arrangements ... D. The right to be informed of his/her condition, participate in all aspects of care, and the right to refuse all or part of his/her care to the extent permitted by law...."

2. Review of an agency policy, with an agency reviewed date of 04/2020, and received 1/25/2022, titled, Care Decisions, stated, Purpose: To ensure that the integrity of clinical decision-making is not compromised. Policy: Clinical decisions are based on identified patient health care needs. Decisions are not based solely on compensation or financial risk & Procedure: & Initial and ongoing patient

assessment data will identify patient health care needs & all home health services will be delivered under a physician s (or other authorized licensed independent practitioner's) orders &.

3. Review of an agency policy, with an agency reviewed date of 4/2020, and received 1/25/2022, titled, "Uniform Quality of Care," stated, Purpose: To ensure uniform quality of patient care and service throughout the organization and to ensure that patients have access to the home health resources they need to meet their health care needs & Procedure: & The care and resources each patient receive [sic] & will be based on the standards of care and practices & as well as on the patient s health care needs &.

4. Review of an agency policy, with an agency reviewed date of 12/2015, and received 1/25/2022, titled, "Care Planning Process," stated, "...The plan of care will be based upon the physician's (or other authorized licensed independent practitioner's) orders and will encompass the equipment, supplies, and services required to meet the patient's needs...."

5. Review of an agency policy, with an agency reviewed date of 4/2020, and received 1/25/2022, titled, "Missed Visits Policy," stated, "...A missed visit modifies the frequency of visits ordered by the physician. If the visits cannot be rescheduled within the week it was missed, it is considered a missed visit. If the agency can reschedule the visit during the same week in which it was missed, the physician-ordered frequency of visits is maintained, and there is no missed visit. ... Visit schedules are created based on patient clinical need. ... All reasonable attempts will be made to re-schedule and make up missed visits within 24 hours...."

6. Clinical record review on 1/13/2022 for patient #6, start of care 10/22/2021, for certification period 12/21/2021 to 2/18/2022, evidenced an agency document titled "Home Health Care Certification and Plan of Care" electronically signed by RN [registered nurse] M. This document had an area subtitled "Orders/Treatments," which stated, "...Skilled Nursing; 2 wk 1 wk [twice a week for one week];

Start Date: 12/21/2021 - End Date: 2/18/2022...."

Clinical record review evidenced two agency documents titled, "Skilled Nursing Visit Note." The document dated 12/24/2021, stated, "...Visit Plan - No Visit Made: ... Reason Visit Not Made: Patient Unavailable / Unable to Contact Patient ... Narrative Notes: Patient refusing visit due to holiday weekend...." The document dated 12/31/2021 stated, "...Visit Plan - No Visit Made: ... Reason Visit Not Made: Schedule conflicts between Clinician and Patient ... Narrative Notes: Scheduling conflict...." There failed to be evidence in the patient's record these visits were rescheduled. The home health agency failed to meet the patient s skilled nursing needs as ordered by the primary physician.

7. Clinical record review on 1/20/2022 for patient #11, start of care 12/10/2021, for certification period 12/10/2021 to 2/7/2022, evidenced an agency document titled "Home Health Care Certification and Plan of Care" electronically signed by RN M. This document had an area subtitled "Orders/Treatments," which stated, "...Physical Therapy to Assess and Evaluate 12/10/2021 through 12/17/2021, Physical Therapy; 2 wk 5 wk [twice a week for five weeks]; Beginning during week of 12/13/2021 - Ending on 1/15/2022...."

Clinical record review evidenced an agency document titled, "Verbal Order," signed 12/22/2021 by nurse practitioner D. This document stated, "1: Aide; 1 wk 2 wk [once a week for two weeks]; 2 wk 1 wk [twice a week for one week]; 1 wk 1 wk [once a week for one week]; For assistance with bathing and personal care. ; Start Date: 12/21/2021 -- End Date: 1/15/2022; Total number of visits: 5...."

Clinical record review evidenced an agency document titled, "Aide Visit Note," dated 12/24/2021, which stated, "...Visit Plan - No Visit Made ... Narrative Notes: Pt [patient] already bathe [sic] ...." There failed to be evidence in the patient's record this visit was rescheduled. The home health agency failed to meet the patient s home health aide needs as ordered by the primary physician.

Clinical record review evidenced an agency

dated 12/25/2021, which stated, "...Visit Plan - No Visit Made ... Narrative Notes: 12/25/21 patient called and cancelled today due to holiday...." There failed to be evidence in the patient's record this visit was rescheduled. The home health agency failed to meet the patient s physical therapy needs as ordered by the primary physician.

8. Clinical record review on 1/20/2022 for patient #12, start of care 8/27/2021, for certification period 12/25/2021 to 2/22/2022, evidenced an agency document titled "Home Health Care Certification and Plan of Care" electronically signed by RN M. This document had an area subtitled "Orders/Treatments," which stated, "...Skilled Nursing; 2 wk 8 wk [twice a week for eight weeks]; Beginning during week of 12/27/2021 - Ending on 2/19/2022...."

Clinical record review evidenced four agency documents titled, "Skilled Nursing Visit Note." The document dated 12/29/2021, stated, "...Visit Plan - No Visit Made ... Narrative Notes: SN [skilled nurse] MV [missed visit] 12/29/21 Patient is out of town. Pt is receiving hemodialysis [process of purifying the blood of a person whose kidneys are not working normally] while out of town...." The document dated 12/31/2021 stated, "...Visit Plan - No Visit Made ... Narrative Notes: SN MV 12/31/21 Pt still out of town for the holidays. Will return on Monday, January 3, 2022...." The document dated 1/5/2022 stated, "...Visit Plan - No Visit Made ... Narrative Notes: SN MV 1/5/22 Pt has court this morning. Patient says she will contact SN [skilled nurse] when she returns home. By end of day, patient did not contact SN...." The document dated 1/7/2022 stated, "...Visit Plan - No Visit Made ... Narrative Notes: SN MV 1/7/22 Patient has dialysis today. Dialysis days changed to Monday, Wednesday, Friday...." There failed to be evidence in the patient's record these visits were rescheduled. The home health agency failed to meet the patient s skilled nursing needs as ordered by the primary physician.

9. Clinical record review on 1/21/2022 for patient #13, start of care 11/23/2021, for certification period 11/23/2021 to 1/21/2022, evidenced an agency document titled "Home Health Care Certification and Plan of Care" electronically signed by RN M. This document had an area subtitled "Orders/Treatments," which stated, "...Skilled Nursing to Assess and Evaluate 11/23/2021 through 11/30/2021, Skilled Nursing;

	wk [twice a week for 4 weeks]; 1 wk 4 wk [once a week for four weeks] Beginning during week of 11/24/2021 - Ending on 1/21/2022, Physical Therapy to Assess and evaluate 11/23/2021 through 11/30/2021, Physical Therapy; 2 wk 4 wk [twice a week for four weeks]; Beginning during week of 11/30/2021 - Ending on 12/25/2021, Speech Therapy to Assess and Evaluate 11/23/2021 through 11/30/2021, Occupational Therapy to Assess and Evaluate 11/23/2021 through 11/30/2021, Occupational Therapy; 2 wk 3 wk [twice a week for three weeks]; 1 wk 1 wk [once a week for one week; Beginning during week of 11/28/2021 - Ending on 12/25/2021...." Clinical record review evidenced an agency document titled, "Physical Therapy Visit Note," dated 12/11/2021, which stated, "...Visit Plan - No Visit Made ... Narrative Notes: 12/11/21 patient's daughter returned call and said her mother not feeling too good today...." There failed to be evidence in the patient's record this visit was rescheduled. The home health agency failed to meet the patient s physical therapy needs as ordered by the primary physician. Clinical record review evidenced two agency documents titled, "Skilled Nursing Visit Note." The document dated 12/6/2021, stated, "...Visit Plan - No Visit Made ... Narrative Notes: SN [skilled nurse] MV [missed visit] 12/6/21 Pt [patient] has appointment with podiatrist today...." The document dated 12/16/2021 stated, "...Visit Plan - No Visit Made ... Narrative Notes: 12/16/21 No insurance authorization to make SN visit today...." There failed to be evidence in the patient's record these visits were rescheduled. The home health agency failed to meet the patient s skilled nursing needs as ordered by the primary physician. 10. Clinical record review on 1/20/2022 for patient #17, start of care 9/5/2021, for certification period 11/4/2021 to 1/2/2022, evidenced an agency document titled "Home Health Care Certification and Plan of Care" electronically signed by RN M. This document had an area subtitled "Orders/Treatments," which stated, "...Skilled Nursing; 1 wk 1 wk [once a week for one week]; 2 wk 4 wk [twice a week for four weeks]; 1 wk 4 wk [once a week for four weeks]; Beginning during week of 11/5/2021 - Ending on 1/1/2022...."			

	Clinical record review evidenced two agency documents titled, "Skilled Nursing Visit Note." The document dated 11/22/2021, stated, "...Visit Plan - No Visit Made ... Narrative Notes: SN missed visit 11/22/21, patient was not feeling well and wanted SN to come on next scheduled day...." The document dated 11/24/2021 stated, "...Visit Plan - No Visit Made ... Narrative Notes: SN missed visit 11/24/21, patient reported she is still 'not feeling well.' SN informed importance of patient going to ER since patient has been feeling sick recently. Patient refused and stated, 'no I'm not going, I am going back to bed.' Asked patient what symptoms she was experiencing, patient reported, 'it's my heart, it's irregular.' Patient was unsure what she meant when SN asked. Patient does not have a hx [history] of A-Fib [atrial fibrillation -irregular and often very rapid heart rhythm that can lead to blood clots in the heart]. Will contact patient next week to attempt to schedule a visit...." There failed to be evidence in the patient's record these visits were rescheduled. The home health agency failed to meet the patient s skilled nursing needs as ordered by the primary physician.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the home health agency failed to ensure the plan of care was followed in 8 of 17 patient records reviewed (#2, #4, #7, #8, #9, #10, #12, #13). The findings include: 1. Record review on 1/25/2022, evidenced an agency policy titled, CARE PLANNING PROCESS , revised 5/2014, which stated, PURPOSE to provide clinical direction to clinicians providing direct patient care & The	G0572	What action will we take to correct the deficiency cited? All actively employed field staff with the exception of the home health aide, were re-educated individually and collaboratively regarding the importance of accurate documentation, physician notification of physician ordered test results, monitoring of high risk medications and bleeding precaution monitoring documentation, fall and safety assessment and documentation, PICC line documentation and complete assessment of vital signs. Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Who is responsible to implement the corrective action? Nurse Case Managers, Licensed Practical Nurses, Registered Therapists, Clinical Supervisor and Clinical Documentation Review Coordinator will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur.	2022-01-25

	care planning decisions will be reflected in the specific services that will be provided and the associated actions planned and implemented to meet individualized patient problems and goals ... The plan of care will be based upon the physician's (or other authorized licensed independent practitioner's) orders and will encompass the equipment, supplies, and services required to meet the patient's needs...." 2. Clinical record review on 1/18/2022, for patient #2, start of care 6/6/2020, certification period 11/28/2021 to 1/26/2022, primary diagnosis of venous insufficiency (improper functioning of the vein valves in the leg, causing swelling and skin changes), evidenced an agency document titled, Home Health Care Certification and Plan of Care , signed by the physician on 1/10/2022. The plan of care had a subsection titled, Orders / Treatments , which stated, & Interventions & SN [skilled nurse]: Assess lab values; PT / INR every other week. Results to [physician A] &." Clinical record review evidenced an agency document titled, INR [international normalized ratio] / PT [prothrombin time] / PTT [partial thromboplastin time] [3 different blood tests that measure the time for the blood to clot] FLOWSHEET . The flowsheet failed to evidence any PT/INR results from 11/25/2021 to 1/4/2022. The flowsheet indicated a PT/INR was performed on 1/5/2022. Clinical record review evidenced an agency document titled, Skilled Nursing Visit Note , dated 1/5/2022, signed by RN (registered nurse) I, which failed to evidence informing the physician of the PT/INR result. Review of all communication notes for the certification period 11/28/2021 to 1/26/2022, failed to evidence physician notification of any PT/INR results. During an interview on 1/24/2022, at 10:51 a.m., the clinical supervisor indicated the clinical record failed to evidence any PT/INR was performed from 11/25/2021 to 1/4/2022. The clinical supervisor indicated the clinical record failed to evidence physician notification of the PT/INR result performed on 1/5/2022. Clinical record review on 1/18/2022, for patient #2, start of care 6/6/2020, certification period 11/28/2021 to 1/26/2022, evidenced an agency document titled, Home Health Care Certification and Plan of Care , signed by the physician on 1/10/2022. The plan of care had a subsection		What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Results will be discussed at the QAPI meetings to assess if processes have improved to the required level and what deficiencies remain. Further deficiencies will be will be addressed with individual staff members as warranted. Chart audits will be performed on a on-going basis to monitor continued compliance.	

titled, Medication: , which stated, & warfarin [a blood thinning medication] 1 mg [milligram] oral tablet; Take 1 tab(s) orally once a day for anticoagulant [blood thinner] & **High Risk. Monitor for abnormal bleeding ** &. . The plan of care had a subsection titled, Safety Measures: , which stated, Safe transfers; Transfer Precautions; Fall precautions &.

Clinical record review evidenced a group of agency documents titled, Skilled Nursing Visit Note . Nurse s notes with the following dates failed to evidence monitoring for bleeding: 11/29/2021, 12/1/2021, 12/3/2021, 12/6/2021, 12/8/2021, 12/11/2021, 12/13/2021, 12/17/2021, 12/21/2021, 12/23/2021, 12/30/2021, 1/3/2022, 1/5/2022, 1/7/2022, 1/10/2022, 1/12/2022, and 1/14/2022. Nurse s notes with the following dates failed to evidence assessments of, or interventions for safe transfers and fall precautions: 11/29/2021, 12/1/2021, 12/3/2021, 12/6/2021, 12/8/2021, 12/13/2021, 12/17/2021, 12/21/2021, 12/23/2021, 12/30/2021, 1/3/2022, 1/5/2022, 1/7/2022, 1/10/2022, 1/12/2022, and 1/14/2022.

During an interview on 1/24/2022, at 11:56 a.m., the clinical supervisor indicated safety should be addressed by all clinicians at each visit and documented in the visit notes. When queried, the clinical supervisor indicated the visit notes failed to evidence the safety precautions ordered in the plan of care.

3. Clinical record review on 1/20/2022, for patient #9, start of care 12/9/2021, certification period 12/9/2021 to 2/6/2022, primary diagnosis of Osteomyelitis (infection in a bone) of the ankle and foot, evidenced an agency document titled, Home Health Care Certification and Plan of Care , signed by the physician on 12/28/2021. The plan of care had a subsection titled, Orders / Treatments , which stated, & PICC [peripherally inserted central catheter][an IV inserted for long-term use] line Care Change PICC Line dressing once a week and PRN [as needed] if soiled or loose using sterile technique - Change caps to each lumen [opening] once a week using sterile technique Measure the PICC line arm circumference around once a week Measure the PICC line catheter length from the insertion site to the end of the catheter, once a week &.

Clinical record review evidenced an agency

document titled, SOC [start of care] OASIS [the Outcome and Assessment Information Set][the patient-specific, standardized assessment used in Medicare home health care], dated 12/9/2021, signed by RN (registered nurse) H. This assessment failed to evidence a measurement of the PICC line catheter length.

Clinical record review evidenced a group of agency documents titled, Skilled Nursing Visit Notes , dated 12/16/2021, 12/20/2021, 12/23/2021, 1/3/2022, 1/10/2022, and 1/17/2022. Review of each of the nurse s notes failed to evidence the nurse changed the caps on each lumen. Review of each of the nurse s notes failed to evidence the nurse measured the arm circumference and measurement of the PICC line catheter length.

During an interview on 1/24/2022, at 1:52 p.m., the clinical supervisor indicated all tasks performed by a clinician should be documented in a visit note. The clinical supervisor indicated the skilled nurse s notes failed to evidence the nurse changed the caps, measured the patient s arm circumference, and measured the PICC line catheter length.

4. Clinical record review on 1/20/2022, for patient #4, start of care 12/22/2021, certification period 12/22/2021 to 2/19/2022, primary diagnosis of Hemiplegia (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (a stroke), evidenced an agency document titled, Home Health Care Certification and Plan of Care , signed by the physician on 1/7/2022. The plan of care had a subsection titled, Safety Measures: , which stated, Fall Precautions & Bleeding Precautions &.

Clinical record review evidenced an agency document titled, Skilled Nursing Visit Note , dated 12/30/2021. Review of the nurse s note failed to evidence assessments of, or interventions for Bleeding Precautions.

Clinical record review evidenced a group of agency documents titled, Physical Therapy Visit Note . Review of the physical therapy notes dated 12/28/2021, and 1/4/2022, failed to evidence assessments of, or interventions for Bleeding Precautions and Fall Precautions.

During an interview on 1/24/2022, at 11:56 a.m., the clinical supervisor indicated safety should be addressed by all clinicians at each visit and documented in the visit notes. When queried, the clinical supervisor indicated the visit notes failed to evidence the safety precautions ordered in the plan of care.

5. Review of an agency policy, with an agency reviewed date of12/2015, and obtained 1/25/2022, titled "Care Planning Process," stated, "... The plan of care will be based upon the physician's (or other authorized licensed independent practitioner's) orders and will encompass the equipment, supplies, and services required to meet the patient's needs...."

Clinical record review on 1/20/2022 for patient #12, start of care 8/27/2021, certification period 12/25/2021 to 2/22/2022, evidenced an agency document titled "Home Health Care Certification and Plan of Care," which had a subsection titled "Orders/Treatments." In this subsection it stated, "... Vital ranges: Notify MD with B/P [blood pressure] greater than 160/90 or less than 100/50, Apical greater than 100 or less than 50, Respirations greater than 30 or less than 12, temperature greater than 100.5, pulse oximetry reading less than 88%...."

6. Clinical record review on 1/18/2022 for patient #7, start of care 1/6/2022, certification period 1/6/2022 to 3/6/2022, evidenced an agency document titled "Home Health Care Certification and Plan of Care," which had a subsection titled "Orders/Treatments." In this subsection it stated, "... Vital ranges: Notify MD with B/P [blood pressure] greater than 160/90 or less than 100/50, Apical greater than 100 or less than 50, Respirations greater than 30 or less than 12, temperature greater than 100.5, pulse oximetry reading less than 88%...."

Clinical record review on 1/18/2022 for patient #7 evidenced an agency document titled "Vital Signs." Entries dated 1/6/2022, 1/11/2022, and 1/13/2022 did not evidence patient temperature and respiratory rate.

7. Clinical record review on 1/18/2022 for patient #8, start of care 1/8/2022, certification period 1/8/2022 to 3/8/2022, evidenced an agency document titled "Home Health Care Certification

"Orders/Treatments." In this subsection it stated, "... Vital ranges: Notify MD with B/P [blood pressure] greater than 160/90 or less than 100/50, Apical greater than 100 or less than 50, Respirations greater than 30 or less than 12, temperature greater than 100.5, pulse oximetry reading less than 88%...."

Clinical record review on 1/18/2022 for patient #8 evidenced an agency document titled "Vital Signs." Entries dated 1/10/2022, 1/11/2022, 1/12/2022, and 1/13/2022 did not evidence patient temperature and respiratory rate.

8. Clinical record review on 1/18/2022 for patient #10, start of care 1/13/2022, certification period 1/13/2022 to 3/13/2022, evidenced an agency document titled "Home Health Care Certification and Plan of Care," which had a subsection titled "Orders/Treatments." In this subsection it stated, "... Vital ranges: Notify MD with B/P [blood pressure] greater than 160/90 or less than 100/50, Apical greater than 100 or less than 50, Respirations greater than 30 or less than 12, temperature greater than 100.5, pulse oximetry reading less than 88%...."

Clinical record review on 1/18/2022 for patient #10 evidenced an agency document titled "Vital Signs." Entries dated 1/14/2022 and 1/18/2022 did not evidence patient temperature and respiratory rate.

9. Clinical record review on 1/21/2022 for patient #13, start of care 11/23/2021, certification period 11/23/2021 to 1/21/2022, evidenced an agency document titled "Home Health Care Certification and Plan of Care," which had a subsection titled "Orders/Treatments." In this subsection it stated, "... Vital ranges: Notify MD with B/P [blood pressure] greater than 160/90 or less than 100/50, Apical greater than 100 or less than 50, Respirations greater than 30 or less than 12, temperature greater than 100.5, pulse oximetry reading less than 88%...."

Clinical record review on 1/21/2022 for patient #13 evidenced an agency document titled "Vital Signs." Entries dated 11/24/2022, 12/1/2021, 12/3/2021, and 12/6/2021 did not evidence patient temperature and respiratory rate.

G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure the individualized plan of care included all services, safety measures, medications and treatments in 3 of 12 active patient records reviewed (#1, #2, #9). The findings include: 1. Record review on 1/25/2022, evidenced an agency policy titled, CARE PLANNING PROCESS , revised 5/2014, which stated, & Definitions 1. Plan of Care: The clinical plan of care includes pertinent diagnoses, mental	G0574	What action will we take to correct the deficiency cited? All actively employed field staff with the exception of the home health aide, were re-educated individually and collaboratively regarding care planning process, including medication precaution monitoring and documentation, specific medication instructions, and accurate medication orders. Clinical Documentation Review Coordinator will ensure Plan of Care compliance before creation to ensure all patient needs are met. Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance on an on-going basis to monitor continued compliance. Who is responsible to implement the corrective action? Nurse Case Managers, Licensed Practical Nurses, Registered Therapists, Clinical Supervisor and Clinical Documentation Review Coordinator will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Documentation Review Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Results will be discussed at the QAPI meetings to assess if processes have improved to the required level and what deficiencies remain. Further deficiencies will be addressed with individual staff members as warranted. Chart audits will be performed on a on-going basis to monitor continued compliance.	2022-02-25

	of visits, goals and interventions appropriate to each discipline, prognosis, rehabilitation potential, functional limitations, precautions, activities, nutritional requirements, food / drug allergies, medications, treatments, safety measures, instructions, discharge plan. Documents include plan of treatment (485) and plans of care (all disciplines) &. 2. Clinical record review on 1/18/2022, for patient #1, start of care 12/12/2021, certification period 12/12/2021 to 2/9/2022, primary diagnosis of Type 2 diabetes (an impairment in the way the body regulates and uses sugar as a fuel) with diabetic peripheral angiopathy [problems with circulation caused by diabetes], evidenced an agency document titled, MEDICATION PROFILE , dated 12/22/2021, which stated, & clopidogrel [a blood thinner] & Take 1 tab(s) orally once a day for anticoagulant [blood thinner]; *high risk* Watch for signs and symptoms of bleeding & glimepiride [a medication used to lower blood sugar] & *high risk* Watch for signs and symptoms of hypoglycemia [low blood sugar] & levothyroxine [a thyroid medication] & Take 1 tab(s) orally once a day & losartan [a blood pressure medication] & Take 1 tab(s) orally once a day & metformin [a medication used to lower blood sugar] & Take 1 tab(s) orally 2 times a day & *high risk* Watch for signs or symptoms of hypoglycemia &. Clinical record review evidenced an agency document titled, Home Health Care Certification and Plan of Care , signed by the physician on 12/23/2021. The plan of care had a subsection titled, Medications , which failed to evidence any patient medications. Review of the plan of care failed to evidence bleeding precautions. During an interview on 1/24/2022, at 10:22 a.m., the clinical supervisor indicated the plan of care should include all medication orders and safety precautions for the patient. 3. Clinical record review on 1/18/2022, for patient #2, start of care 6/6/2020, certification period 11/28/2021 to 1/26/2022, primary diagnosis of venous insufficiency (improper functioning of the vein valves in the leg, causing swelling and skin changes), evidenced an agency document titled, Home Health Care Certification and Plan of Care , signed by the physician on 1/10/2022. The plan of care had a			

	subsection titled, Medications , which stated, & HumaLOG [a type of insulin] & Patient takes 14 units with meal plus sliding scale for adjustment &. . Review of the plan of care failed to evidence a sliding scale for Humalog. On 1/24/2022, at 11:00 a.m., when informed of the findings, the clinical supervisor reviewed the patient record and indicated the plan of care failed to evidence a sliding scale for Humalog. 4. Clinical record review on 1/20/2022, for patient #9, start of care 12/9/2021, certification period 12/9/2021 to 2/6/2022, primary diagnosis of Osteomyelitis (infection in a bone) of the ankle and foot, evidenced an agency document titled, Home Health Care Certification and Plan of Care , signed by the physician on 12/28/2021. The plan of care had a subsection titled, Orders / Treatments , which stated, & Flush the PICC [peripherally inserted central catheter][an IV placed for long-term use] line with 5 cc s Heparin [a medication used to prevent blood clots] after normal saline flush, after antibiotic is completed &. The plan of care had a subsection titled, Medications , which stated, & cefepime [an intravenous antibiotic] 2 gm [grams] & Inject 2 gm(s) intravenously every 12 hours & heparin flush & Inject 5 units intravenously every 24 hours &. During an interview on 1/24/2022 at 2:06 p.m., employee B (Quality Director) indicated the plan of care failed to include clear instruction on frequency of the heparin flush. Employee B stated, I would like it to be clearer & It shouldn t look like that. 17-13-1(a)(1)(D)(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 record review and interview, the agency failed to provide services and treatments only as ordered by a physician in 2 of 12 records reviewed receiving physical therapy (#4, #16).	G0580	What action will we take to correct the deficiency cited? All actively employed field staff with the exception of the home health aide, were re-educated individually and collaboratively regarding the importance of the consistent compliance of obtaining a physician verbal order for any treatment upon completion of the comprehensive assessment, physician notification and order for any treatment no longer indicated.	2022-01-25

The findings include:

1. Record review on 1/25/2022, evidenced an agency policy titled, CARE PLANNING PROCESS , revised 5/2014, which stated, PURPOSE to provide clinical direction to clinicians providing direct patient care & The care planning decisions will be reflected in the specific services that will be provided and the associated actions planned and implemented to meet individualized patient problems and goals &.

2. Clinical record review on 1/20/2022, for patient #4, start of care 12/22/2021, certification period 12/22/2021 to 2/19/2022, primary diagnosis of Hemiplegia (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (a stroke), evidenced an agency document titled, Skilled Nursing Visit Note , dated 1/6/2022, and signed by RN (registered nurse) H. The note had a subsection titled, NARRATIVE NOTES , which stated, & Patient fell out of moving vehicle onto pavement on 1/5/22, resulting in ER visit. Patient has a laceration [a deep cut in the flesh] to proximal [situated nearest the center of the body] left side of head resulting in 7 sutures placed, a laceration to right thumb, resulting in 5 sutures placed, and abrasions [scrapes] to bilateral [left and right] knees. Abrasions to knees were cleansed with NS [normal saline], bacitracin [an antibiotic ointment] applied, and covered with optifoam [an advanced wound dressing designed for wounds with heavy drainage]. Thumb was unable to be assesses [sic] due to non removable dressing in place. Head was assessed ... Cleansed with NS, wrapped with kerlix [rolled gauze] ... SN [skilled nurse] will contact for wound care orders...." A nurse's visit note dated 1/13/2021, signed by RN H, had a narrative note that stated, " ... Wound care provided to bilateral knees, head, and thumb. Cleansed with NS, applied bacitracin, and left OTA [open to air]...."

Review of all physician's orders for patient #4 failed to evidence any wound care orders.

During an interview on 1/21/2022, at 3:05 p.m., the clinical supervisor indicated if a clinician finds a new wound on a patient during a visit, they should measure it, and call the physician to

Who is responsible to implement the corrective action?

Nurse Case Managers, Licensed Practical Nurses, Registered Therapists, Clinical Supervisor and Clinical Documentation Review Coordinator will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur.

What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?

Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts weekly to ensure compliance. Results will be discussed at the QAPI meetings to assess if processes have improved to the required level and what deficiencies remain. Further deficiencies will be will be addressed with individual staff members as warranted. Chart audits will be performed on a on-going basis to monitor continued compliance.

	get wound care orders. When queried, the clinical supervisor indicated the nurse performed wound care without a physician order. 3. Clinical record review on 1/21/2022, for patient #16, start of care 7/25/2021, certification period 7/25/2021 to 9/22/2021, primary diagnosis of Hypertensive heart and chronic kidney disease (when the heart is not pumping well, resulting in long-term kidney problems), evidenced an agency document titled, "Home Health Care Certification and Plan of Care", signed by the physician on 7/30/2021. The plan of care had a subsection titled, "Orders / Treatments: ... SN [skilled nurse]: Perform wound care / dressing change: Cleanse with NS [normal saline], pat dry, apply alginate [an absorbing wound dressing] to right calf wound, cover with ABD [an absorbent dressing pad], wrap with kerlix [rolled gauze] then wrap with Coban [a stretchy bandage wrap that sticks to itself] twice a week...." Clinical record review evidenced an agency document titled, "Skilled Nursing Visit Note", dated 8/2/2021, signed by RN (registered nurse) R. The visit note had a subsection titled, "NARRATIVE NOTES", which stated, " ... Skin tear to Rt [right] leg scabbed over, left OTA [open to air] .... ". Review of the visit note failed to evidence any wound care performed. Clinical record review of all physician orders failed to evidence discontinuing wound care. During an interview on 1/25/2022, at 10:33 a.m., the clinical supervisor indicated RN R changed the care for the wound to assessment only because the wound had healed. When queried, the clinical supervisor indicated the clinical record failed to evidence a physician order to discontinue wound care or change to assessment only. 17-13-1(a)			
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	G0590	What action will we take to correct the deficiency cited? All actively employed field staff with the exception of the home health aide, were	2022-02-25

	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 changes in the patient's condition in 1 of 7 records reviewed with a home visit (#4). The findings include: Record review on 1/25/2022, evidenced an agency policy titled, CARE PLANNING PROCESS , revised 5/2014, which stated, PURPOSE to provide clinical direction to clinicians providing direct patient care ... All clinicians will consider the conclusions of initial and ongoing assessments in their care planning process, including, but not limited to: ... Changes in patient's condition & The care planning decisions will be reflected in the specific services that will be provided and the associated actions planned and implemented to meet individualized patient problems and goals &. Record review on 1/25/2022, evidenced an agency policy titled, "PHYSICIAN PARTICIPATION IN PLAN OF CARE", revised 12/2015, which stated, " ... Orders will be reviewed and revised by the patient's physician ... based on: A. Changes in the care or service being provided B. Changes in the patient's physical and / or psychosocial condition C. The patient's response to care D. The patient's outcome related to treatment care or services E. Changes in diagnoses or treatment, including procedures, medications and equipment...." Record review evidenced an agency policy titled, "MONITORING PATIENT'S RESPONSE / REPORTING TO PHYSICIAN", revised 2/2020, which stated, "The patient's physician will be contacted on the same day when any of the following occur: A. Changes in the patient's condition B. Changes in the patient's psychosocial status, family / caregiver support, home environment C. Inability to achieve goals within the specified time frame D. Changes in the patient's expected response to treatment or medications E. Changes that have occurred		regarding the importance of Physician notification of missed visits and missed visit rescheduling. Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Who is responsible to implement the corrective action? Nurse Case Managers, Licensed Practical Nurses, Registered Therapists, Clinical Supervisor and Clinical Documentation Review Coordinator will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Results will be discussed at the QAPI meetings to assess if processes have improved to the required level and what deficiencies remain. Further deficiencies will be will be addressed with individual staff members as warranted. Chart audits will be performed on a on-going basis to monitor continued compliance.	

	(including procedures, medications, precautions, and limitations) F. When there is any problem implementing the plan of care...." Clinical record review on 1/20/2022, for patient #4, start of care 12/22/2021, certification period 12/22/2021 to 2/19/2022, primary diagnosis of Hemiplegia (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (a stroke), evidenced an agency document titled, "Home Health Care Certification and Plan of Care", signed by the physician on 1/7/2022. The plan of care had a subsection titled, "Orders / Treatments:", which stated, " ... Physical Therapy; 2 wk 6 wk [two times per week for 6 weeks]; 1 wk 2 wk [one time per week for 2 weeks]; Beginning during week of 12/26/2021 - Ending on 2/19/2022...." Clinical record review evidenced an agency document titled, "Physical Therapy Visit Note", dated 1/6/2022, and signed by PT (physical therapist) Q, which stated, " ... No Visit Made Reason Visit Not Made; Patient Refused Home Health Services ... narrative notes Patient without authorization....". Clinical record review of all communication notes and all physician's orders failed to evidence they physician was made aware of the patient not receiving physical therapy as ordered. During an interview on 1/19/2022, at 9:15 a.m., patient #4 indicated they hadn't been receiving physical therapy, "because of insurance". During an interview on 1/24/2022, at 11:25 a.m., the clinical supervisor indicated patient #4 was not currently receiving physical therapy because they were waiting on insurance approval. When queried, the clinical supervisor indicated the clinical record failed to evidence physician notification of the patient not receiving physical therapy as ordered. 17-13-1(a)(2)			

G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on observation, record review, and interview, the agency failed to coordinate care in 2 of 3 records reviewed receiving care from other entities (#5, #9) The findings include: 1. Record review on 1/25/2022, evidenced an agency policy titled, "CARE COORDINATION", dated 12/2010, which stated, "PURPOSE To ensure the coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services ... Written evidence of care coordination will be recorded during the case conference and repeated in skilled nursing visit reports in the patient's clinical records ... Care coordination will include, but not be limited to: ... Clearly outlining each clinician's responsibilities to avoid duplication of services ... Developing complementary actions and goals ... Written evidence of care coordination may be found in the plan of care, case conference summary forms, or clinical notes in the patient's records...." 2. Observation of a home visit for patient #5 was conducted on 1/19/2022, at 3:50 p.m. Upon entering the patient's home, caregiver B from home care agency C was observed doing light housekeeping and getting a drink for the patient. At 3:53 p.m., caregiver B informed RN (registered nurse) I they found a blister on the patient's right heel during their bath. Clinical record review on 1/20/2022, for patient #5, start of care 1/6/2022, certification period 1/6/2022 to 3/6/2022, primary diagnosis of Chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe), evidenced a group of agency documents titled, "Prep Notes Communication", identified by the clinical supervisor as all communication notes from patient #5's clinical record. Review of all communication notes	G0608	What action will we take to correct the deficiency cited? All actively employed field staff with the exception of the home health aide, were re-educated individually and collaboratively regarding the importance of care coordination. Utilization of the Care Coordination form will be provided to all patient providers to adequately coordinate care. Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Who is responsible to implement the corrective action? Nurse Case Managers, Licensed Practical Nurses, Registered Therapists, Clinical Supervisor and Clinical Documentation Review Coordinator will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Results will be discussed at the QAPI meetings to assess if processes have improved to the required level and what deficiencies remain. Further deficiencies will be will be addressed with individual staff members as warranted. Chart audits will be performed on a on-going basis to monitor continued compliance.	2022-02-25

failed to evidence coordination of care with agency C. Clinical record review failed to evidence an agency coordination of care form. Review of the patient's electronic medical record (MatrixCare) failed to evidence coordination of care with agency C.

During an interview on 1/19/2022, at 3:50 p.m., caregiver B indicated they had been providing care for patient #5 since May 2021.

During an interview on 1/21/2022, at 3:06 p.m., the clinical supervisor indicated coordination of care should be documented in the communication notes and on an agency coordination of care form. When informed of the findings, the clinical supervisor indicated they did not know patient #5 was receiving services from agency C.

3. Clinical record review on 1/20/2022, for patient #9, start of care 12/9/2021, certification period 12/9/2021 to 2/6/2022, primary diagnosis of Osteomyelitis (infection in a bone) of the ankle and foot, evidenced an agency document titled, Home Health Care Certification and Plan of Care , signed by the physician on 12/28/2021. The plan of care had a subsection titled, "Orders / Treatments;" which stated, " ... Patient goes to wound clinic once a week on Tuesdays...."

Clinical record review evidenced a group of agency documents titled, "Prep Notes Communication". Review of all communication notes failed to evidence coordination of care with a wound clinic. Clinical record review failed to evidence an agency coordination of care form. Review of the patient's electronic medical record (MatrixCare) failed to evidence coordination of care with a wound clinic.

During an interview on 1/21/2022, at 3:06 p.m., the clinical supervisor indicated coordination of care should be documented in the communication notes and on an agency coordination of care form.

During an interview on 1/24/2022, at 2:08 p.m., the clinical supervisor indicated patient #9 was receiving wound clinic services. When queried, the clinical supervisor indicated the agency

	wound clinic. 17-14-1(a)(1)(F)			
G0654	Track adverse patient events 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. Based on record review and interview, the agency failed to track adverse patient events in 4 of 5 patients with falls (#1, #3, #4, #7). The findings include: 1. Record review on 1/25/2021, evidenced an agency policy titled, INCIDENT REPORTING , revised 6/2020, which stated, & The organization will maintain a process for generating incident reports and follow up corrective action, if applicable. The five (5) purposes of the incident report are: 1. To facilitate the early detection or compensable events 2. To establish a foundation for early investigation of all potentially serious events 3. To develop a database for long-range problem detection analysis and correction 4. To enable cross-reference with other risk detection systems 5. To investigate and respond to sentinel events [a patient safety event that results in death, permanent harm, or severe temporary harm, in accordance with accrediting bodies standards]. All events or occurrences listed in Examples of Specific Events or Occurrences that Must Be Reported (see Addendum 4-017 A) must be reported &. 2. Record review evidenced an undated agency policy titled, ADDENDUM 4-017.A EXAMPLES OF SPECIFIC EVENTS OR OCCURRENCES THAT MUST BE REPORTED , which stated, & 1. Attended / Unattended Fall & The patient and family / caregiver reports a fall sustained by the patient during the course of his / her time on service &." 3. Clinical record review on 1/18/2022, for	G0654	What action will we take to correct the deficiency cited? All actively employed field staff were re-educated individually and collaboratively regarding the importance of incident reporting and policy review was performed for Policy No. 4-017.1, all staff provided with policy. A weekly safety meeting will be implemented into our IDG meeting to review all patient falls or potential fall patients. Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Who is responsible to implement the corrective action? Nurse Case Managers, Licensed Practical Nurses, Registered Therapists, Clinical Supervisor and Clinical Documentation Review Coordinator will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Results will be discussed at the QAPI meetings to assess if processes have improved to the required level and what deficiencies remain. Further deficiencies will be will be addressed with individual staff members as warranted. Chart audits will be performed on a on-going basis to monitor continued compliance.	2022-02-25

patient #1, start of care 12/12/2021, certification period 12/12/2021 to 2/9/2022, primary diagnosis of Type 2 diabetes (an impairment in the way the body regulates and uses sugar as a fuel) with diabetic peripheral angiopathy (problems with circulation caused by diabetes), evidenced an agency document titled, Physical Therapy Visit Note , dated 1/11/2022, and signed by PT (physical therapist) G. The note had a subsection titled, NARRATIVE NOTES , which stated, & Patient seen for re-assessment visit, reports feeling okay but tired and weak and & had fallen last Saturday while in the bathroom &.

Review on 1/21/2022, of what was identified by the clinical supervisor as the incident log in its entirety from 1/1/2021 to 1/21/2022, failed to evidence any documented falls for patient #1.

During an interview on 1/21/2022, at 1:44 p.m., employee B (Quality Director) indicated tracking patient falls was part of the agency s QAPI (quality assurance and performance improvement).

During an interview on 1/21/2022, at 2:36 p.m., the clinical supervisor indicated the agency was focusing on witnessed patient falls, and that incident reports were not always completed for falls reported by family or caregivers.

4. Clinical record review on 1/20/2022, for patient #3, start of care 12/26/2021, certification period 12/26/2021 to 2/23/2022, primary diagnosis of Femur (thigh bone) fracture, evidenced an agency document titled, Skilled Nursing Visit Note , dated 1/3/2022, and signed by RN (registered nurse) P. The note had a subsection titled, NARRATIVE NOTES , which stated, & Patient states & is feeling quite anxious today & had a fall yesterday in the garage. Patient was taken to ER [emergency room] and evaluated with CT [computed tomography] [a medical imaging technique used in radiology to obtain detailed internal images of the body] of the head performed. Bruising noted to left side of face in addition to swelling &.

Review on 1/21/2022, of what was identified by the clinical supervisor as the incident log in its entirety from 1/1/2021 to 1/21/2022, failed to evidence any documented falls for patient #3.

During an interview on 1/21/2022, at 1:44 p.m., employee B (Quality Director) indicated tracking patient falls was part of the agency s QAPI (quality assurance and performance improvement).

During an interview on 1/21/2022, at 2:36 p.m., the clinical supervisor indicated the agency was focusing on witnessed patient falls, and that incident reports were not always completed for falls reported by family or caregivers.

5. Clinical record review on 1/20/2022, for patient #4, start of care 12/22/2021, certification period 12/22/2021 to 2/19/2022, primary diagnosis of Hemiplegia (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (a stroke), evidenced an agency document titled, Skilled Nursing Visit Note , dated 1/6/2022, and signed by RN (registered nurse) H. The note had a subsection titled, NARRATIVE NOTES , which stated, & Patient fell out of moving vehicle onto pavement on 1/5/22, resulting in ER visit. Patient has a laceration [a deep cut in the flesh] to proximal [situated nearest the center of the body] left side of head resulting in 7 sutures placed, a laceration to right thumb, resulting in 5 sutures placed, and abrasions [scrapes] to bilateral [left and right] knees &. A skilled nurse visit note dated 1/19/2022, signed by RN H, had a narrative note that stated, & Patient reported having an unwitnessed fall on Monday 1/17/22. Patient & slid out of bed &.

During an interview on 1/19/2022, at 9:07 a.m., patient #4 indicated they fell out of their vehicle 1/17/2022, when they could not fasten their seatbelt or close the car door completely due to weakness after a stroke.

Review on 1/21/2022, of what was identified by the clinical supervisor as the incident log in its entirety from 1/1/2021 to 1/21/2022, failed to evidence any documented incidents for patient #4.

During an interview on 1/21/2022, at 1:44 p.m., employee B (Quality Director) indicated tracking patient falls was part of the agency s QAPI (quality assurance and performance

	improvement). During an interview on 1/21/2022, at 2:36 p.m., the clinical supervisor indicated the agency was focusing on witnessed patient falls, and that incident reports were not always completed for falls reported by family or caregivers. 6. Clinical record review on 1/18/2022, for patient #7, start of care 1/6/2022, certification period 1/6/2022 to 3/6/2022, evidenced an agency document titled, Occupational Therapy Visit Note , dated 1/13/2022, and signed by OT (occupational therapist) F. The document had a subsection titled, Narrative Notes , which stated, & Treatment addressed challenge standing tolerance with pt [patient] improving with second stand, initiated training with Pursed lip breathing and exercise with Pt's [patient's] sats [oxygen saturation] improving with breathing technique, assessing adaptive equipment needs with hospital bed recommendation due to current bed situation and commode due to increase of fall exiting bathroom.... During an interview on 1/24/2022 at 11:15 a.m., when queried as to where patient #7's falls would be documented, the clinical supervisor indicated the home health agency only documents witnessed falls in the incident log. 17-12-2(a)			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review and interview, the home health agency failed to ensure all employees practiced universal precautions in 2 of 7 home visits observed (#5, #7). The findings include: 5. Observation of a home visit for patient #5 took place on 1/19/2022, at 3:50 p.m. At 3:55 p.m., RN (registered nurse) I removed an automatic blood pressure cuff from the patient s	G0682	What action will we take to correct the deficiency cited? All actively employed field staff were re-educated individually and collaboratively regarding the importance of infection prevention, including standard precautions, hand hygiene, and bag technique. Supervisory visits will be completed monthly to ensure these standards are met with 100% compliance. Infection prevention standards will also be addressed at annual skills competency in-services. Who is responsible to implement the corrective action? Nurse Case Managers, Licensed Practical Nurses, Registered Therapists, Home Health Aides, Clinical Supervisor and Clinical Documentation Review Coordinator will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this	2022-01-25

	bag. RN I then removed their gloves and placed them in the right pocket of their uniform shirt. At 3:57 p.m., RN I was observed removing a stethoscope from their bag. RN I failed to dispose of dirty gloves properly, and failed to perform hand hygiene before entering their bag. During an interview on 1/21/2022, at 2:40 p.m., the clinical supervisor indicated after removing gloves, the clinician should dispose the gloves, and perform hand hygiene. The clinical supervisor indicated only clean hands should enter a clinician s bag. 17-12-1(m) 1. Review of an agency policy, with an agency reviewed date of 4/2020, and obtained 1/25/2022, titled, "Standard Precautions" stated, "...Hand hygiene will be performed to prevent cross-contamination between the patient and personnel. ... Gloves are to be worn when: 1. There is actual or potential contact with blood or other potentially infectious materials ... 3. Touching contaminated items or surfaces 4. Performing invasive procedures ... 8. Obtaining laboratory specimens ... Gloves are to be changed: 1. Between tasks and procedures on the same patient...." 2. Review of an agency policy, with an agency reviewed date of 4/2020, and obtained 1/25/2022, titled, "Hand Hygiene," stated, "Purpose: To prevent cross-contamination and home-health acquired infections. ... Hand decontamination using an alcohol-based hand rub should be performed: A. Before having direct contact with patients, B. Before donning sterile gloves when performing sterile procedures; before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices, C. After contact with a patient's skin ... D. After contact with body fluids or excretions, mucous membranes, non-intact skin... G. After removing gloves...." 3. Review of an agency policy, with an agency reviewed date of 4/2020, and obtained 1/25/2022, titled, "Bag Technique," stated, "Purpose: To describe the procedure for maintaining a clean patient care supply bag and preventing cross contamination. ... Bag Technique: ... When the visit is completed, reusable equipment will be cleaned using an		deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Clinical Supervisor will complete monthly supervisory visits to monitor for infection prevention compliance. Further deficiencies will be addressed with individual staff members as warranted. Compliance will also be tested and performed annually at annual skills competency in-services.	

	acceptable approved disinfectant of agency's choice as appropriate, hands will be washed, and equipment and supplies will be returned to the bag. ... Hands will be decontaminated prior to returning clean equipment to bag...." 4. During a home visit on 1/14/2022 at 8:33 a.m., RN [registered nurse] N was observed providing care to patient #7. While providing care, RN N performed hand hygiene with alcohol-based hand rub, donned gloves, and inserted a needle into the patient's arm for a blood draw. The blood flow was inadequate for the specimen, so RN N removed the needle, placed it into a sharps container inside the dirty section of the RN's bag, and then removed their gloves. Without performing hand hygiene, RN N then reached into their bag to retrieve a baggie of new blood draw needles. The RN then performed hand hygiene with alcohol-based hand rub, placed a new needle on top of the patient, performed hand hygiene again and donned gloves. RN N then made a second attempt at a blood draw, obtained blood samples in tubes, removed the needle from the patient and placed the needle into the sharps container inside the dirty section the the RN's bag. The RN then removed their gloves, performed hand hygiene with alcohol-based hand rub, went inside their bag to retrieve a band-aid and placed it on the blood draw site without gloves on. RN N then labeled the blood tubes without gloves on and placed the blood tubes in a biohazard baggie. The RN then placed the baggie containing the tubes of blood into the dirty section of the RN bag without gloves on, then picked up previously cleaned items (blood pressure cuff, stethoscope, pulse oximeter) and placed them into the clean section of the RN bag without performing hand hygiene first. During an interview on 1/21/2022 at 2:41 p.m., the clinical manager indicated that gloves should be worn when handling and labelling vials of blood and hand hygiene should be performed any time gloves are removed.			
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 observation, record review, and	G0704	What action will we take to correct the deficiency cited? All actively employed field staff were re-educated individually and collaboratively regarding the need to consistently provide levels of excellence in the quality of care provided to patients. This includes performing and monitoring every visit, all patient vital signs; including blood pressure, pulse, 02,	2022-01-25

	interview, the agency failed to ensure the clinician performed and documented full patient assessments during visits in 7 of 12 records reviewed receiving physical therapy (#1, #3, #4, #5, #14, #15, #16). The findings include: 1. Record review on 1/25/2022, evidenced an agency policy titled, STANDARDS OF CARE AND PRACTICE , dated 12/2010, which stated, & PURPOSE & To provide guidelines for developing and implementing standards of care and practice & Use of standards of care and practice will be evident in the documentation of visits and assessments, as well as in the care planning process. 2. Record review evidenced an agency policy titled, Documentation , revised 2/1999, which stated, & PURPOSE To provide accurate and adequate written information on the patient and services provided. This is done to insure [sic] quality and continuity of care, inform staff / team members of the patient s condition, the plan of care, and skilled and supportive care provided & Entries should be accurate in time, amounts and descriptions &. 3. Record review evidenced an agency policy titled, ENTRIES INTO THE CLINICAL RECORD , revised 5/2013, which stated, & Documentation in the clinical record will be timely, detailed, accurate, and reflect the care or services provided &. 4. Record review evidenced an agency policy titled, ONGOING ASSESSMENTS , dated 12/2010, which stated, & PROCEDURE 1. During each home visit, the clinician or other discipline will re-evaluate the patient & 2. Using the standards of care identified by the organization, the clinician will reassess the patient (as appropriate) for: A. Blood pressure, pulse, respirations, temperature &. 5. Clinical record review on 1/18/2022, for patient #1, start of care 12/12/2021, certification period 12/12/2021 to 2/9/2022, primary		temperature, respirations. Further deficiencies will be will be addressed with individual staff members as warranted. Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Who is responsible to implement the corrective action? Nurse Case Managers, Licensed Practical Nurses, Registered Therapists, Clinical Supervisor and Clinical Documentation Review Coordinator will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur. What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Results will be discussed at the QAPI meetings to assess if processes have improved to the required level and what deficiencies remain. Further deficiencies will be will be addressed with individual staff members as warranted. Chart audits will be performed on a on-going basis to monitor continued compliance.	

	the way the body regulates and uses sugar as a fuel) with diabetic peripheral angiopathy (problems with circulation caused by diabetes), evidenced an agency document titled, VITAL SIGNS . Entries dated 12/13/2021, 12/15/2021, 12/17/2021, 12/21/2021, 12/23/2021, 12/27/2021, and 1/4/2022, failed to evidence patient temperature and respiratory rate. An entry dated 1/11/2022, failed to evidence a respiratory rate. During an interview on 11/24/2022, at 11:09 a.m., the clinical supervisor indicated all clinicians should record the patient s pulse, respiratory rate, blood pressure, and temperature at each visit. 6. Observation of a home visit for patient #3 took place on 1/19/2022, at 12:30 p.m. The surveyor entered the patient s home with OT [occupational therapist] F, observed the entire visit, and exited with OT F. Observation of the home visit failed to evidence OT F taking patient #3 s temperature. Clinical record review on 1/20/2022, for patient #3, start of care 12/26/2021, certification period 12/26/2021 to 2/23/2022, primary diagnosis of Femur (thigh bone) fracture, evidenced an agency document titled, VITAL SIGNS . Entries dated 12/28/2021, 1/4/2022, 1/6/2022, 1/10/2022, 1/14/2022, and 1/18/2022, failed to evidence patient temperature and respiratory rate. During an interview on 11/24/2022, at 11:09 a.m., the clinical supervisor indicated all clinicians should record the patient s pulse, respiratory rate, blood pressure, and temperature at each visit. 7. Clinical record review on 1/20/2022, for patient #4, start of care 12/22/2021, certification period 12/22/2021 to 2/19/2022, primary diagnosis of Hemiplegia (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (a stroke), evidenced an agency document titled, VITAL SIGNS . Entries dated 12/23/2021, 12/28/2021, 12/30/2021, 1/4/20022, 1/11/2022, and 1/14/2022, failed to evidence patient temperature and respiratory rate.			

During an interview on 11/24/2022, at 11:09 a.m., the clinical supervisor indicated all clinicians should record the patient s pulse, respiratory rate, blood pressure, and temperature at each visit.

8. Clinical record review on 1/20/2022, for patient #5, start of care 1/6/2022, certification period 1/6/2022 to 3/6/2022, primary diagnosis of Chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe), evidenced an agency document titled, VITAL SIGNS . Entries dated 1/6/2022, 1/7/2022, 1/12/2022, and 1/18/2022, failed to evidence patient temperature and respiratory rate.

During an interview on 11/24/2022, at 11:09 a.m., the clinical supervisor indicated all clinicians should record the patient s pulse, respiratory rate, blood pressure, and temperature at each visit.

9. Clinical record review on 1/21/2022, for patient #14, start of care 1/7/2022, certification period 1/7/2021 to 3/7/2022, primary diagnosis of Aftercare following joint replacement surgery, evidenced an agency document titled, VITAL SIGNS . Entries dated 1/7/2022, 1/11/2022, 1/14/2022, 1/17/2022, and 1/20/2022, failed to evidence patient temperature and respiratory rate.

During an interview on 11/24/2022, at 11:09 a.m., the clinical supervisor indicated all clinicians should record the patient s pulse, respiratory rate, blood pressure, and temperature at each visit.

10. Clinical record review on 1/21/2022, for patient #15, start of care 2/12/2021, certification period 2/12/2021 to 4/12/2021, primary diagnosis of Primary generalized osteoarthritis (the breakdown of cartilage in the joint causing pain and limited movement), evidenced an agency document titled, VITAL SIGNS . Entries dated 2/12/2021, 2/15/2021, 2/18/2021, 2/23/2021, 2/24/2021, 2/26/2021, 3/2/2021, 3/4/2021, 3/6/2021, 3/8/2021, 3/9/2021, and 3/12/2021, failed to evidence patient temperature and respiratory rate.

	During an interview on 11/24/2022, at 11:09 a.m., the clinical supervisor indicated all clinicians should record the patient s pulse, respiratory rate, blood pressure, and temperature at each visit. 11. Clinical record review on 1/21/2022, for patient #16, start of care 7/25/2021, certification period 7/25/2021 to 9/22/2021, primary diagnosis of Hypertensive heart and chronic kidney disease (when the heart is not pumping well, resulting in long-term kidney problems), evidenced an agency document titled, VITAL SIGNS . Entries dated 7/29/2021, 8/3/2021, and 8/5/2021, failed to evidence patient temperature and respiratory rate. An entry dated 7/27/2021 failed to evidence a respiratory rate. During an interview on 11/24/2022, at 11:09 a.m., the clinical supervisor indicated all clinicians should record the patient s pulse, respiratory rate, blood pressure, and temperature at each visit.			
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 2 of 5 records reviewed receiving only skilled nursing (#2, #9). The findings include:	G1024	What action will we take to correct the deficiency cited? All actively employed field staff with the exception of the home health aide, were re-educated individually and collaboratively regarding the importance of accurate documentation of wound locations and limb receiving treatment. Further deficiencies will be will be addressed with individual staff members as warranted. Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Who is responsible to implement the corrective action? Nurse Case Managers, Licensed Practical Nurses, Registered Therapists, Clinical Supervisor and Clinical Documentation Review Coordinator will be active participants in implementing the corrective action. The Home Health Administrator will monitor these corrective actions to ensure this deficiency is corrected and will not recur.	2022-02-25

	1. Record review on 1/25/2022, evidenced an agency policy titled, STANDARDS OF CARE AND PRACTICE , dated 12/2010, which stated, & PURPOSE & To provide guidelines for developing and implementing standards of care and practice & Use of standards of care and practice will be evident in the documentation of visits and assessments, as well as in the care planning process. 2. Record review evidenced an agency policy titled, Documentation , revised 2/1999, which stated, & PURPOSE To provide accurate and adequate written information on the patient and services provided. This is done to insure [sic] quality and continuity of care, inform staff / team members of the patient s condition, the plan of care, and skilled and supportive care provided & Entries should be accurate in time, amounts and descriptions &. 3. Record review evidenced an agency policy titled, ENTRIES INTO THE CLINICAL RECORD , revised 5/2013, which stated, & Documentation in the clinical record will be timely, detailed, accurate, and reflect the care or services provided &. 4. Clinical record review on 1/18/2022, for patient #2, start of care 6/6/2020, certification period 11/28/2021 to 1/26/2022, primary diagnosis of venous insufficiency [improper functioning of the vein valves in the leg, causing swelling and skin changes], evidenced an agency document titled, Recert [recertification] OASIS [Outcome and Assessment Information Set] [the patient-specific, standardized assessment used in Medicare home health care]-D1, dated 11/30/2021, and signed by RN [registered nurse] I. This assessment had a subsection titled, REVIEW OF SYSTEMS MUSKULOSKELETAL [having to do with the muscles and bones] STATUS , which stated, & AMPUTATION Location RLE [right lower extremity] [right leg] BKA [below-the-knee amputation] &. Clinical record review evidenced an agency document titled, Skilled Nursing Visit Note , dated 12/17/2021, and signed by LPN [licensed practical nurse] E, which stated, & Pt [patient] has a L [left] BKA. Pt has stasis ulcers [a wound that develops due to poor circulation] to left lower leg &.		What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan? Quality Improvement Team will audit 100% of active patient records to ensure these standards are met and compliance is achieved. Once compliance is achieved, Quality Improvement Team will review 10% of active charts monthly to ensure compliance. Results will be discussed at the QAPI meetings to assess if processes have improved to the required level and what deficiencies remain. Further deficiencies will be will be addressed with individual staff members as warranted. Chart audits will be performed on a on-going basis to monitor continued compliance.	

During an interview on 1/24/2022, at 10:44 a.m., the clinical supervisor indicated the patient only had a right below-the-knee amputation and had wounds to the left lower leg. The clinical supervisor indicated LPN E s documentation was erroneous.

5. Clinical record review on 1/20/2022, for patient #9, start of care 12/9/2021, certification period 12/9/2021 to 2/6/2022, primary diagnosis of Osteomyelitis [infection in a bone] of the ankle and foot, evidenced a group of agency documents titled, Skilled Nursing Visit Note , signed by RN [registered nurse] H. Each of the nurse s notes had a subsection titled, NARRATIVE NOTES . A narrative in a note dated 12/9/2021 stated, & RUA [right upper arm] PICC [peripherally inserted central catheter] [an IV inserted for long-term intravenous medication therapy] &. A narrative note dated 12/13/2021 stated, & LUA [left upper arm] PICC line dressing changed &. . A narrative note dated 12/16/2021, stated, & RUA PICC line dressing intact &. . A narrative note dated 12/20/2021 stated, & LUA PICC line dressing changed &. . A narrative note dated 12/23/2021 stated, & RUA PICC line dressing intact &. . A narrative note dated 12/27/2021 stated, & LUA PICC line dressing changed &. . A narrative note dated 1/3/2022 stated, & RUA PICC line dressing changed &. . Clinical record review failed to evidence the patient received a new or changed PICC line from 12/9/2021 to 1/20/2022.

During an interview on 1/24/2022, at 2:00 p.m., the clinical supervisor indicated the patient only had one PICC line from 12/9/2021 to 1/20/2022. The clinical supervisor indicated the findings were errors in RN H s documentation.

17-15-1(a)(7)

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